Strategies to Ensure HITECH Supports the Patient-Centered Medical Home

Question: Will significant investment in promoting the adoption of health information technology (IT) and meaningful use of electronic health records (EHRs) through the Health Information Technology for Economic and Clinical Health (HITECH) Act enable primary care practices to become patient-centered medical homes (PCMHs)?

Answer: While the adoption and meaningful use of EHRs help support some aspects of the PCMH model, HITECH programs and other current Federal legislation are necessary but not sufficient for driving widespread adoption of the medical home model.

HITECH and broader health reform legislation do offer some policy options, however, that could ensure EHRs are implemented in a way that supports primary care transformation. These include the following:

1. Adding explicit functionalities that directly support the PCMH model to the recently released EHR certification standards and criteria.
2. Adding EHR meaningful-use requirements that support the PCMH model for stages 2 and 3 of the EHR Incentive Program.
3. Funding the provision of technical assistance to primary care practices on PCMH transformation through either the Primary Care Extension Program (PCEP) or the health IT Regional Extension Centers (REC).

The PCMH is a promising model of care that aims to strengthen the primary care foundation of the health care system by reorganizing the way primary care practitioners' practices provide care.[1,2] A medical home is supported by health IT and payment reform and rests on five pillars[3]:

1. **A patient-centered orientation** toward each patient's unique needs, culture, values, and preferences; support of the patient's self care efforts; and involvement of the patient in care plans.
2. **Comprehensive, team-based care** that meets the large majority of each patient's physical and mental health care needs, including prevention and wellness, acute care, and chronic care and is provided by a cohesive team.
3. **Care that is coordinated** across all elements of the complex health care system and connects patients to both medical and social resources in the community.
4. **Superb access to care** that meets patients' needs and preferences, including care provided after hours and by e-mail and telephone.
5. **A systems-based approach to quality and safety** that includes gathering and responding to patient experience data, a commitment to on-going quality improvement, and practicing population health management.

Stakeholders, including Federal and State agencies, insurers, providers, employers, and patient advocacy organizations, are striving to refashion the landscape of primary care in this country through medical home demonstrations and pilots.[4]

Adoption of the PCMH model calls for fundamental changes in the way many primary care practices operate, including adoption of health IT both for internal processes and for connecting practices with their patients and with patients' other providers. The recent HITECH Act of the American Recovery and Reinvestment Act of 2009 allocated $19.2 billion to promote the adoption and use of health IT by eligible primary care providers who serve patients covered by Medicare and Medicaid.[5] In addition, for both

public and private initiatives, the use of technology is rewarded, and in some cases required, for primary care practices to qualify to be medical homes.

As substantial investments are being made to advance both the PCMH model and IT adoption, it is important to understand how to promote adoption of health IT in a way that fosters improved primary care delivery. This brief recommends specific policies for promoting health IT that support the key principles of the PCMH model as a way to improve health care quality and efficiency.

Health IT Can Support the PCMH Model. Health IT is able to support the PCMH model because of its capacity to: (1) collect, store, manage, and exchange relevant personal health information; (2) allow communication among providers, patients, and patients' care teams for care delivery and management; (3) collect, store, measure, and report on the processes and outcomes of individual and population performance and quality of care; (4) support providers' clinical decisionmaking; and (5) inform patients about their health and medical conditions and facilitate their self-management with input from providers.

Primary Care Practices Need Help To Successfully Adopt Health IT. Technical support is essential for practices not yet using health IT as well as for many of those that have already adopted this technology. "Going all digital is easier said than done" for many providers, particularly those in solo or small practices (five or fewer physicians) that represent 78 percent of office-based primary care physicians. Effecting this transformation has been equated with "redesigning an airplane in flight." [6-8]

Practices that are considering adopting an EHR system need assistance in selecting a system, redesigning workflows to match the system's assumptions, training staff, and sometimes hiring new staff. Many need financial incentives to defray the costs of adopting and maintaining an EHR. Many practices then need assistance maintaining the EHR on an ongoing basis.

Technical assistance is critical because ineffective adoption of EHRs often creates outcomes in direct conflict with specific principles of medical homes. For instance, the patient-centered principle could be compromised if providers spend more time dealing with the technology than with the patient. Similarly, the comprehensive, team-based principle could be hampered if the EHR does not support the team's workflows.

HITECH Funding Aims To Promote Health IT Adoption. Recognizing the unrealized potential surrounding health IT to improve the quality and delivery of health care, Congress passed the HITECH Act to promote the adoption of health IT. The HITECH legislation contains a broad menu of measures to promote health IT adoption. Among HITECH's largest programs are these:

- *EHR Incentive Program*. Targeted to eligible primary care providers in Medicare and Medicaid programs, it provides incentive payments for the adoption and "meaningful use" of certified EHRs. The program will be implemented in three stages starting in 2011. Financial incentives will be replaced in 2015 by financial penalties for providers that are not using EHRs.
- *Regional Extension Center Program.* Targeted to eligible primary care practices, RECs will provide technical assistance for adopting and meaningfully using EHRs. This program established 62 regional centers in 2010 that will operate for 4 years; a new wave of funding was awarded in 2011. Among the program's goals, two are particularly relevant for the PCMH model: (1) reach out to primary care providers and disseminate knowledge about effective strategies for implementing meaningful use of certified EHR technology to improve the quality and value of health care and (2) train providers in attaining meaningful use.

HITECH Is Necessary, but Not Sufficient, To Support the PCMH Model. HITECH laid important groundwork to support the PCMH model. However, its goals and processes were not linked specifically to this model. Without explicit linkage, HITECH will miss opportunities to support the transformation of primary care practices.

A detailed analysis of all of HITECH's programs indicates that the meaningful-use concept supports some, but not

all, facets of the PCMH model. The three major limitations in the legislation are as follows:

1. The legislation does not specify from either a technical or a legal perspective how primary care providers will be able to communicate with the practice's "medical neighborhood" (the other providers seen by the patients).
2. The meaningful-use concept does not entirely overlap with the PCMH's core principle of comprehensive, team-based care and collaboration among staff within a practice.
3. HITECH's requirements do not address improved access to care, although they do support patient-provider communications via e-mail.

In addition, the RECs are tasked to provide technical assistance for EHR adoption, but are not explicitly required to help practices redesign workflows to more effectively provide primary care. HITECH programs, then, are necessary but not sufficient for facilitating adoption of the PCMH model.

Fortunately, as the Centers for Medicare & Medicaid Services (CMS) releases the EHR Incentive Program regulations over time, it has the opportunity to establish the links needed between the meaningful-use criteria for stages 2 and 3 and the PCMH concept. Likewise, there is the opportunity to fund the PCEP and have it coordinate technical assistance with the REC Program.

Bold Policy Actions Can Ensure Primary Care Transformation Is Supported by Health IT. Three policies might strengthen HITECH so it can facilitate adoption of the PCMH model with health IT support. These policies are listed below, along with the challenges they are meant to overcome, action steps toward achieving them, and suggestions for how to implement them.

Policy 1: Add explicit functionalities that directly support the PCMH model to the 2010 EHR certification standards and criteria.

Challenge: Under the 2010 final rule, standards, implementation specifications, and certification criteria for EHRs do not explicitly support the PCMH model.[9]

Action Step: EHR certification standards and criteria could be developed that incorporate the basic functionalities that practices must use to operate as PCMHs and that would allow other providers to interact with the PCMH in a way that supports care coordination. For instance, the standards could require that the various EHR systems of entire "medical neighborhoods" be able to communicate with one another. Likewise, the criteria could require that EHRs support the ability of primary care and specialty providers to generate data for estimating the quality measures used in assessing the performance of the PCMH model.

Implementation: The proposed policy action is relatively easy and inexpensive to implement because of the potential efficiency of certifying PCMH-required functionalities concurrently with meaningful-use functionalities. With approval and oversight by the Office of the National Coordinator (ONC) for Health Information Technology, and with the support of AHRQ, CMS could be the lead for implementing this policy, given CMS's responsibility for overseeing implementation of the meaningful-use and PCMH concepts for Medicare and Medicaid.

Policy 2: Add requirements that support the PCMH model for stages 2 and 3 of the EHR Incentive Program.

Challenge: The stage 1 final rule of the EHR Incentive Program contains no specific provision that would explicitly promote the PCMH model.[10]

Action Step: Meaningful-use regulations for the last two stages of the program's implementation period (2013-2016) could require the use of the PCMH model. Coordinating the exchange of health information by primary care providers and specialists, along with integrating medical and behavioral health services, would boost the likelihood that HITECH can truly facilitate the transformation of primary care practices. Information from several pilots that are testing this approach, such as New York City's Primary Care Information Pilot, will likely be useful in the implementation of this policy option.

Implementation: This policy option is also relatively easy and inexpensive to implement because it could be included

in the planned round of revisions to the EHR Incentive Program in 2012 and subsequent years. With the support of AHRQ and CMS, ONC would lead the implementation of this suggested policy, given ONC's responsibility for overseeing the development of regulations that govern the meaningful-use criteria for Medicare and Medicaid.

Policy 3: Provide technical assistance to primary care practices for effecting PCMH transformation alongside the planned assistance for health IT adoption.

Challenge: Currently, there is no funding for technical assistance designed to transform primary care. ONC's REC Program is not explicitly required to help practices transform into medical homes, and the PCEP, mandated by the recent Affordable Care Act, was not funded in 2010.

Action Steps: There are two options: (1) fund the PCEP to provide technical assistance and require close coordination with the health IT-focused technical assistance provided by the REC Program or (2) expand the mission of the REC Program to provide this technical assistance. The first option would need funding for AHRQ to build the PCEP first. During this program's design and development, AHRQ and ONC would develop regulations that formally establish the mechanism for coordination between the two programs.

The second option would require extending RECs' responsibilities and having them provide eligible primary care providers with technical assistance for enacting the medical home principles. RECs could be asked to articulate to practices the extent to which their services would prepare practices to become medical homes, and to recommend sources for assistance with any remaining transformation needs. However, adding responsibilities to the RECs could be difficult given the large scope of their currently mandated activities.

Implementation: For the first option, AHRQ and other stakeholders would need to work closely with ONC to coordinate the provision of technical assistance designed to support the PCMH model by the PCEP and the RECs.[11]

Given that AHRQ is already directing the health IT Research Center that supports ONC's RECs, this coordination would not be difficult to achieve.

For the second option—expanding the mission of the REC Program—ONC seems like the natural choice for overseeing the enhanced program, as it runs the current REC program. To proceed, ONC would need to identify financial resources to pay for the additional work of the RECs, as well as for the research center that supports them.

Conclusion

HITECH has the potential to support primary care practices' adoption of the PCMH model. Health IT is important, but it is just one potential facilitator. Other major policy changes, such as delivery-system and provider-payment reform, are needed to support the transformation of practices into medical homes through aligning the right incentives with delivery systems that can ensure better quality of care and lower costs. Likewise, major changes among practice staff—involving for example culture and service-delivery models—are also needed to achieve the goals of the PCMH model. Most important, "magical thinking"—that is, the belief that health IT alone will transform primary care delivery systems for the better—should be contained. What is needed are clear health IT policies developed and implemented by Federal Government agencies in partnership with public stakeholders.[12]

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Suggested Citation: Moreno L, Peikes D, Krilla A. Strategies to Ensure HITECH Supports the Patient-Centered Medical Home. AHRQ Publication No. 11-0013. Rockville, MD: Agency for Healthcare Research and Quality. February 2011.

This brief was prepared by Lorenzo Moreno, Deborah Peikes, and Amy Krilla. It is based on a white paper commissioned by AHRQ. Suggested Citation: Moreno L, Peikes D, Krilla A. Necessary but not sufficient: The HITECH Act and health information technology's potential to build medical homes. (Prepared by Mathematica Policy Research under Contract No. HHSA290200900019I TO2.) AHRQ Publication No. 10-0080-EF. Rockville, MD: Agency for Healthcare Research and Quality. June 2010.

Access to these publications is available on the AHRQ Web site at http://pcmh.ahrq.gov.

None of the authors has any affiliations or financial involvement that would pose a conflict of interest with this brief.

Publication No. AHRQ 11-0013
February 2011