

Linking the Use of HIT to Patient-Centric Care

The use of health information technology (HIT) plays an essential role in a successful patient-centered medical home (PCMH) model. Such support systems have shown to offer the most effective way to keep track of patients' health care needs, communicate with patients effectively and efficiently, and provide evidence-based clinical approaches to medical care. Linking care coordination and support systems together will result in overall quality improvement and enhanced communication access. Unfortunately, the cost of acquiring HIT prohibits many practices from taking full advantage of these support systems – making the need for targeted incentives an essential element to advancing the PCMH.

Systems of Care to Support Care Coordination

Experts agree that the use of HIT can revolutionize health care delivery by putting clinically relevant patient information and evidence-based clinical decision support in the hands of physicians and other providers. Linked to a model with the attributes of the PCMH emphasizing coordination and prevention will result in a health care system that delivers higher quality at a lower cost. PCMHs would be encouraged to incorporate such support systems that include:

- Patient registry systems to better track patients with chronic diseases;
- Evidence-based clinical decision support for the most up-to-date information;
- Secure/convenient email exchanges with patients for care outside the practice;
- Open scheduling and group visits to expedite the delivery of care;
- The use of Personal Health Records for patients to monitor their care;
- Remote monitoring; and
- Leading to a fully functional, interoperable EHR that includes all these elements and is able to participate in quality measurement and reporting programs.

Creation of Targeted Incentives to Support Medical Home Systems of Care

The most effective way to encourage physician adoption of HIT is to offer ongoing targeted incentives. Payment to physicians who practice in qualified PCMHs using robust systems of care must recognize the tremendous value they provide to patients. These payment incentives must consider: (1) the acquisition and use of HIT support systems to facilitate patient-centric care; and (2) care management and preventive services that fall outside the face-to-face visit, especially to those patients with chronic illnesses. ACP recommends a tiered-payment framework for Medicare and other payers that builds off the successful Bridges to Excellence model using a scoring system of higher payments for more advanced systems:

- Tier 1 – the reporting on evidence-based standards and maintenance of patient registries;
- Tier 2 – the use of electronic systems to maintain patient records (EHRs); clinical-decision support tools; electronic orders for prescriptions and lab tests (e-prescribing), patient reminders; e-consults; and managing patients with multiple chronic illnesses;
- Tier 3 - whether a practice's systems are "interoperable" and can automatically send, receive and integrate data such as lab results and medical histories from other systems.

Payment that appropriately recognizes the value added to patients who have a PCMH and the necessary support systems of care will result in improved quality, better outcomes, and a reduction in overall spending.