Taconic Health Information Network and Community

Frequently Asked Questions

Lisa M. Kern, MD, MPH; Alison Edwards, MStat; and Rainu Kaushal, MD, MPH. "The Patient-Centered Medical Home, Electronic Health Records, and Quality of Care." Annals of Internal Medicine. 2014;160:741-749.

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About the study

What's the key finding?
Practices using patient-centered medical home (PCMH) with EHRs have improved quality of care, but simply having an EHR isn't responsible for the improvement. PCMH practices using EHRs achieve better quality of care than non-PCMH practices using EHRs or paper health records.

How did they arrive at this conclusion?
Researchers compared insurance claims across 10 quality measures. They found that, over time, practices using the PCMH model improved their quality of care at a rate significantly higher than non-PCMH practices. Overall, the odds of receiving recommended care in the PCMH practice were 7 percent higher than in the paper group and 6 percent higher than in the EHR group.

So the "PCMH effect" is independent of the EHR technology?
Yes. EHRs are necessary, but not sufficient. The EHR technology, on its own, seemed to be insufficient to achieve improvements in care. The findings suggest that changes to organizational culture necessitated by the PCMH seem to play a role in improving quality.

What makes this study setting different from other PCMH studies?
Previous PCMH success has been tracked, but almost exclusively in closed, integrated health systems. The Hudson Valley study practices were independent practices of varying sizes and types—from large group practices to small and even solo practices;

some were federally qualified health centers. Medical home quality improvement in the Hudson Valley can translate into success for other open, diverse medical communities.

Can we expect more research in this area?
Yes. A companion study, to be released later in 2014, looks at utilization of health care services. In addition, the researchers continue to monitor quality: They have two more years of data to study.

The basics

What is a patient-centered medical home?
The patient-centered medical home, or PCMH, is a model of care that emphasizes a team-based approach to care coordination and management of diseases. It relies heavily on EHRs, or electronic health records. The primary care medical home provides primary health care that is relationship-based with an orientation toward the whole person The Agency for Healthcare Research and Quality[1] identified five attributes: Patient-centered, comprehensive, coordinated, accessible and committed to quality and safety.

In 2007, five of the nation's largest primary care physician organizations, together representing about one-third of U.S. physicians, agreed on a set of Joint Principles of the Patient-Centered Medical Home.[2] The document defines the patient-centered medical home (PCMH) as "an approach to providing comprehensive primary care for children, youth and adults…in a health care setting that facilitates partnerships between individual patients, and their personal physicians, and when appropriate, the patient's family." Within this model the primary care physician, in a trusting relationship with the patient, guides both preventive and episodic care, including referrals to specialists when needed. Elements of the PCMH model include vital services such as care coordination, the use of health information technology, enhanced access to care using email and telephone messaging, and a team approach to care.

What are electronic health records?
Electronic health records (EHRs) are a secure, real-time, point-of-care, patient-centered information resource for clinicians. The EHR aids clinicians' decision-making by providing access to patient health record information where and when they need it and by incorporating evidence-based decision support. The EHR automates and streamlines the clinician's workflow, closing loops in communication and response that result in delays or gaps in care. The EHR also supports the collection of data for uses other than direct clinical care, such as billing, quality management, outcomes reporting, resource planning, and public health disease surveillance and reporting.[3]

[1] http://www.pcmh.ahrq.gov/page/defining-pcmh
[2] http://www.aafp.org/dam/AAFP/documents/practice_management/pcmh/initiatives/PCMHJoint.pdf
[3] Health care Information and Management Systems Society. 2003. http://www.himss.org/content/files/EHRAttributes.pdf

About the Hudson Valley Experience

What makes the Hudson Valley experience important?
The scale of the project and the shared vision among competing health plans to work side by side to improve care make this project unique. Six health plans that cover about 70 percent of the commercial insurance market in the Hudson Valley provided incentives for the physician practices to undergo transformation to the PCMH model. That means the benefits of the medical home extend to patients in a PCMH-recognized practice regardless of whether they have a certain type of insurance. PCMH practice transformation benefits all the patients served by a practice—in this case, the total number of patients served by the medical home physicians approaches half a million residents of the Hudson Valley.

What role did health information technology play?
Because health IT is a foundational tool for many aspects of the medical home model, THINC worked with physician practices that were already robust users of health IT. The medical home is facilitated by use of patient tracking and registry tools, electronic prescribing, electronic medical records, electronic communication and scheduling tools, and other means to ensure patients get the indicated care when and where they need and want it.

How do health plans play a part in practice transformation?
Health plans have been very interested nationwide in pursuing the medical home model because it has demonstrated improved health outcomes and patient satisfaction while lowering costs. Improved care management and other medical home elements have been shown to reduce hospitalizations and emergency room visits, especially for patients with chronic illness. The medical home is a win-win for patients, providers and payers.

What does this mean to the patient?
In other evaluations of the medical home thus far, the model has delivered a much better coordinated approach to care. Quality of care is greatly enhanced when a primary care physician takes responsibility to guide patients through the care system, when providers work as a team instead of in independent silos of care, and when care is a collaborative process that puts the patient at the center of decision-making.

What role did THINC play?
THINC --Taconic Health Information Network and Community -- acts as a neutral convener for health care quality improvement in the Hudson Valley. THINC's Quality Committee developed the project goals and implementation. THINC managed the project and worked with the payers to determine the incentive payment process and goals.