The Academy
The Health Management Academy

Quick-Hitting Survey

Patient-Centered Medical Homes

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Executive Summary

Methodology

In November 2018, The Health Management Academy conducted a quick-hitting survey of Leading Health Systems to assess health systems' adoption of the Patient Centered Medical Home (PCMH) delivery model. The 16 responding and Medical Group Leaders represent health systems with an average Net Patient Revenue of $5.2 billion that own or operate 289 hospitals with 57,000 beds and approximately 2.8 million admissions per annum.

Key Findings

- All (100%) responding health systems currently utilize the PCMH model in some capacity, although not all health systems have pursued NCQA certification.
- Health systems are prioritizing implementing strategies that optimize the PCMH, including building new care models, streamlining clinic operations, and incorporating resources to improve care coordination and patient access.

Results

Utilization of the PCMH Model

The PCMH model is a team-based approach to care delivery in which care is coordinated through a patient's primary care physician (PCP) to ensure patients receive the appropriate care, in the appropriate setting, in a way that a patient can understand. At their core, PCMHs are comprehensive, coordinated, accessible, and committed to quality and safety.1 As health systems move toward assuming more financial risk and prioritize a value-based approach to care delivery, many organizations view the PCMH as a useful model for supporting these objectives.

Reflective of these benefits, all (100%) responding health systems currently utilize the PCMH model in some capacity. Multiple health system executives report participating in the PCMH model due to financial incentives and pressure from payers. While executives support the overall principles of PCMHs, not all health systems seek out certification as an official PCMH site by the National Committee for Quality Assurance (NCQA). Cost and administrative complexity were a few of the reasons noted for not seeking NCQA certification.

"We only move forward with the PCMH model in markets where there are financial incentives available such as fee-for-service bumps. However, we have incorporated many of the PCMH elements into our system as standard operating procedures." - Medical Group Leader

Among health systems that have not pursued NCQA certification, several report incorporating many of the core components of a PCMH (e.g., team-based care, guideline implementation) while customizing their approach for their own organization. Health system executives are supportive of the primary goals and components of the PCMH model; however, some executives note that they would rethink formal participation in the model if they did not have a financial incentive.

"We still are doing the PCMH model as dollars are tied to it by our biggest payer. If that were to change, we might take a different approach to this issue. We would still keep a lot of the basic elements, but we would potentially tweak some areas to work better for us and what we want to accomplish." – Medical Group Leader

Priorities for Optimizing the PCMH

As health systems continue to optimize care delivery, continuous improvement and evolution of the PCMH is essential. Health systems are focused on a variety of areas to optimize their PCMH, primarily directed around building and implementing new models of care, streamlining clinic operations (e.g., EHR integration, standardizing recognition work), and incorporating additional resources to facilitate care coordination and patient access (e.g., chronic care managers, case managers) (Figure 1).

While all health systems are utilizing the PCMH model to varying degrees, most organizations are investing in primary care redesign to achieve larger objectives such as improved care coordination, accessibility, and outcomes, rather than to satisfy PCMH requirements.

Figure 1. Focus areas for PCMH Evolution and Improvement