Innovation and Creativity in Education Curricula for the Medical Home

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This special edition focuses on medical education to prepare physicians for the Patient-centered Medical Home (PCMH). There are several challenges to curricular redesign within this framework as illustrated in the following articles. More broadly, we recognize that while there may be a generally accepted definition of the PCMH, there are multiple variations on how practices implement PCMH principles. There are also different ways to achieve recognition as a medical home on the national (ie, National Committee for Quality Assurance or Accreditation Association for Ambulatory Health Care) or state levels, whose criteria are not uniform. The array in curricular approaches described in the following papers parallels the variability in the implementation approaches and recognition processes. The articles included in this special edition of *Family Medicine* reflect the many possible paths for developing education programs for the PCMH.

Educators often begin curriculum design with a needs assessment, and the paper by Joo et al reports a survey of student knowledge about the medical home in two schools without formal curricula on the medical home. Many students did not understand the overall concept but did recognize most of the individual principles of the medical home and thought learning about it was important. Unfortunately, one third of the students thought that the primary care physician in the medical home functions as a gatekeeper. The findings indicate a need for a systematic curriculum.

While recognizing the importance of the PCMH model in reforming how primary care is delivered, Evans et al acknowledge the challenges that exist within residency programs to create clinical environments and educational experiences that lead to competent practice and leadership in PCMH models of care after graduation. This project focused on chronic pain as a recognized difficult condition and patient population to treat in primary care. After implementing a new pain clinic model of care, the authors reviewed outcome measures and concluded that specialized training and positive new experiences lead to less negative attitudes and increased understanding of patients as a whole and the treatment of chronic pain.

The value of medical group visits has been widely recognized for clinical outcomes. Barr et al assert that their study is the first to focus on the educational impact of group care. Through the use of a quality improvement initiative that was already in place and the Centering Pregnancy curriculum that existed outside of the residency program, a new curriculum was developed aimed at improving the process of caring for pregnant patients. Results of the retrospective study revealed that residents who learned in the new curriculum, including co-facilitating groups, were able to generalize improved methods of care to all patients, regardless of modality of care.

The paper by Lausen et al reports a clerkship curriculum on the PCMH and the impact of primary care on health care quality. The teaching methods were didactic presentations and self-study/reflection. The satisfaction ratings of the clerkship increased after the curriculum was implemented while NBME shelf exam scores were unchanged. A secondary benefit of the content was its relevance to students’ decisions about career choice. It is reassuring that the curriculum did not have a negative impact on student ratings or exam.
scores, so faculty can present new curriculum material other than typical clinical problems without adverse effects.

Shared decision making is a cornerstone of patient activation necessary for effective self-management of health conditions. The report by Morrow et al\(^8\) describes a curriculum and a standardized patient experience to teach advanced communication skills. Students learned to appreciate patient involvement in care and noted that shared decision making is more than just explaining options and letting patients choose but includes exploring values and preferences. The students observed a lack of shared decision making in current clinical practice, which highlighted the need to discuss how the lack of use in current practice does not diminish the importance of shared decision making.

Brown et al\(^5\) attempt to capture the complexity of implementing, while simultaneously teaching, the PCMH model within a residency setting. The authors describe a model of care that transitioned from individually based to team based while collection methods for patient-centered data were implemented. They demonstrated that while data-driven care for every visit was cumbersome at the outset, the method improved patient outcomes and population management. The use of decision support tools for patient care and population management increased residents’ understanding of practice-based learning and improvement competencies.

Team care is a hallmark of well-developed medical homes but is not easy to develop and know when it has been achieved in a practice. The paper by Lurie et al\(^7\) reports on the development of a short, focused instrument to assess teamwork, which can be used to evaluate the effectiveness of interventions to create team care in a practice. In addition, the items included in the long form of the questionnaire could help potential team members learn about important team behaviors.

While the article by Fields and Cohen\(^8\) was not focused on team-based care, the authors noted that a culture shift occurred as a result of team involvement in decision making, defining metrics, and understanding the role of data in quality improvement. This article details the process of creating a balanced scorecard and implementing the documentation practices necessary for the balanced scorecard. The authors argue that information technology and evidence-based tools that support clinical decision-making and performance help practices develop into learning organizations.

This reflective piece by Cheng and Loafman\(^9\) focuses on personal perspectives regarding the journey from student to clinician and educator. The authors note the increased need for primary care physicians and decreased student interest in primary care but express hope that the PCMH model will renew students’ interest in primary care. These authors believe that the model offers reform opportunities to primary care, improved training and clinical experiences, as well as improved patient outcomes. Personal reflections are presented to support the arguments presented.

A central purpose of a PCMH is to provide the best possible experience for patients. The stories reported in the paper by Leighton et al\(^10\) illustrate how connecting with patients in a time of particular need creates a relationship bond that can improve later comprehensive care. The use of novel communication methods that fit with the patient’s circumstances, such as cell phone text messages, led to improved patient engagement in care and improved health outcomes. Modeling such responsive care for learners is a powerful instructional strategy.

The breadth of topics covered in this special issue focused on the PCMH reflects the wide range of factors that are affected by this model of care, both in clinical practice and education. Many primary care providers are knowledgeable about, and understand, the PCMH model of care. However, knowledge and understanding alone do not easily enable medical educators to implement changes in clinical practice or education that are aligned with this model. Medical educators are just learning how to redesign curricula for the PCMH model, which promises to change the face of medicine for the better, for patients and physicians alike. These papers offer a glimpse at the creativity and innovation occurring throughout the country.

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**References**


