Strengthen the Core and Stimulate Progress: Assembling Patient-centered Medical Homes

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This is my first column as STFM president, and my purpose is to outline why I chose this theme for 2007–2008. I will address other issues related to the patient-centered medical home (PCMH) in future President’s Columns throughout the year. I decided on this theme months before the Annual Spring Conference in Chicago and was struck by how the plenary presentations reinforced the timeliness of this choice, as have recent announcements about the PCMH and the Patient-centered Primary Care Collaborative by the AAFP.1,2

Family medicine is still in a crisis! In his plenary address at the Annual Spring Conference, Terry McGeeney, MD, MBA, repeatedly said, “Houston, we have a problem.” He described the disheartening state of family medicine clinical practice revealed by the TransformED project. Jim Mold, MD, MPH, in his plenary presentation, presented an optimistic picture of a statewide learning community that can lead to practice improvement, but his data showed far from optimal performance. Family medicine, we still have a problem. However, I believe that we have a solution. If together we strive to assemble PCMHs, we can strengthen the provision of our core clinical services and stimulate progress toward optimal high-quality care.

While this theme addresses the challenge facing our field, it also reflects my career of 25 years. Like others, my focus has been on the teaching and evaluation of core clinical skills with an emphasis on performance assessment. In Miller’s scheme for competence (knows, knows how, shows how, does),3 I concentrate on the latter two levels. I expect students and residents to demonstrate mastery of basic skills and follow the adage that learners respect what you inspect. My inspection involves measurement of attitudes using validated instruments and measurement of behavior using clinical performance examinations with standardized patients, paying particular attention to patient-centered care.

This focus on core skills and performance resonates with the empirical studies of organizations in Jim Collins’ books Built to Last,4 Good to Great,5 and Good to Great for the Social Sectors.6 Visionary organizations are those that preserve core values and purpose and stimulate progress toward an envisioned future. I immediately saw parallels between this work and my personal life as an athlete and adventurer (strengthen core fitness and push for the next marathon, mountain, or whitewater), my academic career (attend to core issues and refine programs), my leadership role (persevere on core missions and learn new skills), and my clinical work (provide basic preventive and chronic care services and attract athletes to my sports medicine practice). I invite you to reflect on the parallels with your personal and professional life—what are your core values and purpose and envisioned future?

“Preserve the core and stimulate progress” is also very relevant to the discourse about family medicine’s identity. While there are disagreements about what our scope of practice should be—obstetrics, hospital care, procedures, specialization with CAQs, ambulatory care, emergency medicine—there seems to be a core that unites us:

The development of family medicine and its identity as a discipline has been grounded in the core values of continuing, comprehensive, compassionate, and personal care provided within the context of family and community. These core values of family medicine are responsible for much that the public currently values and trusts in family physicians. They have shaped the identity of individual family physicians and contributed to establishing a legitimate position for family physicians in academia and in the larger medical community.7

Unfortunately, there are some rather heated disagreements about our identity that are characterized as seemingly incompatible distinctions and at times with inflamm-
tory labels: Full-scope practice with obstetrics and hospital care or focused-scope practice in ambulatory settings (“partialist”), care of underserved or concierge practice (“elitist”), commitment to service or financially lucrative practice, broad generalist practice or restricted specialist practice (emergency department, sports medicine). Collins offers a perspective: “Instead of being oppressed by the “Tyranny of the Or,” highly visionary companies liberate themselves with the “Genius of the And”—the ability to embrace both extremes of a number of dimensions at the same time.” Collins quotes F. Scott Fitzgerald:

The test of a first-rate intelligence is the ability to hold two opposed ideas in the mind at the same time, and still retain the ability to function.4

Our field is filled with first-rate minds, and I believe that both/and reflects our value of inclusivity and embracing diversity far more than either/or does. I believe that by being united by a common core, we can be enriched by the extremes of practice options, instead of being torn apart by them. The health needs of our population and the regional differences in health care are so great that we need full-scope and focused-scope practices, underserved and concierge practices, commitment to service and financially lucrative practices, broad generalist and restricted specialist practices, and more!

I also agree with these views of what our core clinical services should be:

- All family physicians will share a common commitment to provide or coordinate all care specified in the family physician’s basket of services, thereby serving as effective personal medical homes for their patients.7

- The medical home serves as the focal point through which all individuals—regardless of age, sex, race, or socioeconomic status—receive a basket of acute, chronic, and preventive medical care services.7

- Through their medical home, patients can be assured of care that is not only accessible but also accountable, comprehensive, integrated, patient-centered, safe, scientifically valid, and satisfying to both patients and their physicians.7

Unfortunately, Dr McGeeney, Dr Mold, and others have presented evidence that we are not doing such a good job of delivering on this commitment to patients, particularly in terms of providing preventive services and chronic illness care.8 We would be well served if we strengthened our core!

Can we fulfill this commitment to patients by doing more of the same that we have been doing? There is widespread agreement that continuing the status quo will not strengthen our core and that we must change toward a new envisioned future of the PCMH. The name is important for branding and recognition of whether it is New Model, Medical Home, Patient-centered Medical Home, or Family Medical Home. However, it is even more critical to have a concept that provides a vision or benchmark by which we can assess progress. The PCMH can be a standard for evaluating our progress toward providing patients with the services they need and we have promised to provide.9 The principles of the PCMH (Appendix 1) are specific enough to provide a prototype for which to strive, a guide for what to improve, a set of indicators to describe what has improved, and variables to measure in to evaluate interventions. Yet the principles are not so specific that they are a rigid blueprint that constrains innovation and continuous improvement.

We may have different opinions on the scope of family medicine practice, but I believe we must unite around our core values and purpose. We must deliver on those values and our commitments to our patients by strengthening our delivery of core preventive services and chronic illness care. We must stimulate progress toward a shared vision of the future, as described in the principles of the PCMH. We need to build family medical homes in many different styles and designs to learn from one another and to best meet our patients’ and families’ needs. We need to be persistent in our focus with the meticulous attention to detail required when striving ceaselessly toward excellence. I believe that strengthening the core and stimulating progress by assembling PCMHs can advance the cause of family medicine.

The AAFP is promoting the PCMH through the TransforMED project, the Patient-Centered Primary Care Collaborative, and its advocacy in Congress. The ABFM and AFMRD are fostering the PCMH vision in residencies in the P4 Project. STFM should spread the PCMH model to all teaching practices: medical school faculty, residency program, and community preceptor practices. One strategy is to unite with ADFM and AFMRD to develop a teaching practice learning community to help remodel the hundreds of teaching practices in our educational programs. I am sure there are other potential strategies for ensuring that our teaching practices provide all medical students and family medicine residents with clinical experiences in patient-centered medical homes. What are your ideas? Write to me at president@stfm.org.

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References
Joint Principles of the Patient-centered Medical Home, February 2007

Introduction
The Patient-centered Medical Home (PCMH) is an approach to providing comprehensive primary care for children, youth, and adults. The PCMH is a health care setting that facilitates partnerships between individual patients and their personal physicians and, when appropriate, the patient’s family.

The AAP, AAFP, ACP, and AOA, representing approximately 333,000 physicians, have developed the following joint principles to describe the characteristics of the PCMH.

Principles
Personal physician—each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous, and comprehensive care.

Physician-directed medical practice—the personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.

Whole person orientation—the personal physician is responsible for providing for all the patient’s health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life, acute care, chronic care, preventive services, end-of-life care.

Care is coordinated and/or integrated across all elements of the complex health care system (eg, subspecialty care, hospitals, home health agencies, nursing homes) and the patient’s community (eg, family, public and private community-based services). Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.

Quality and safety are hallmarks of the medical home:
• Practices advocate for their patients to support the attainment of optimal, patient-centered outcomes that are defined by a care planning process driven by a compassionate, robust partnership among physicians, patients, and the patient’s family.
• Evidence-based medicine and clinical decision-support tools guide decision making
• Physicians in the practice accept accountability for continuous quality improvement through voluntary engagement in performance measurement and improvement.
• Patients actively participate in decision making, and feedback is sought to ensure patients’ expectations are being met.
• Information technology is utilized appropriately to support optimal patient care, performance measurement, patient education, and enhanced communication.

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Appendix 1

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- Practices go through a voluntary recognition process by an appropriate nongovernmental entity to
demonstrate that they have the capabilities to provide patient centered services consistent with the
medical home model.
- Patients and families participate in quality improvement activities at the practice level.

Enhanced access to care through systems such as open scheduling, expanded hours, and new options for com-
munication among patients, their personal physician, and office staff.

Payment appropriately recognizes the added value provided to patients who have a patient-centered medical home. The payment structure should be based on the following framework:
- It should reflect the value of physician and nonphysician staff patient-centered care management work
  that falls outside of the face-to-face visit.
- It should pay for services associated with coordination of care both within a given practice and among
  consultants, ancillary providers, and community resources.
- It should support adoption and use of health information technology for quality improvement.
- It should support provision of enhanced communication access such as secure e-mail and telephone
  consultation.
- It should recognize the value of physician work associated with remote monitoring of clinical data
  using technology.
- It should allow for separate fee-for-service payments for face-to-face visits. (Payments for care
  management services that fall outside of the face-to-face visit, as described above, should not result in
  a reduction in the payments for face-to-face visits).
- It should recognize case mix differences in the patient population being treated within the practice.
- It should allow physicians to share in savings from reduced hospitalizations associated with
  physician-guided care management in the office setting.
- It should allow for additional payments for achieving measurable and continuous quality improvements.

Background of the Medical Home Concept
The AAP introduced the medical home concept in 1967, initially referring to a central location for archiving a
child’s medical record. In its 2002 policy statement, the AAP expanded the medical home concept to include
these operational characteristics: accessible, continuous, comprehensive, family-centered, coordinated, compas-
sionate, and culturally effective care.

The AAFP and the ACP have since developed their own models for improving patient care called the “medical
home” (AAFP, 2004) or “advanced medical home” (ACP, 2006).

For More Information:
American Academy of Family Physicians: www.futurefamilymed.org
American Academy of Pediatrics: http://aappolicy.aappublications.org/policy_statement/index.dtl#M
American College of Physicians: www.acponline.org/advocacy/?hp
American Osteopathic Association: www.osteopathic.org