President’s Column

How to Build a Medical Home in Your Residency Program

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As I have mentioned in previous President’s Columns, I have been working extensively over the past 10 years in primary care practice redesign, recently focusing particularly on assisting residency practices and programs in becoming Patient-centered Medical Homes. Because of these experiences, I get a lot of e-mails and phone calls from residency programs interested in embarking on their own transformational journey, asking how they should go about getting started. With the large number of programs that are at various points in the stages of change in becoming a PCMH, I thought that it would be worthwhile to share some key points on starting this transformation process based on experiences with this work.

(1) Establish a Vision

The leaders of the residency program and practice need to set an initial vision that establishes as a priority the transformation to become a PCMH. The specifics of this vision can and should then be worked out in an interactive, team-based process involving everyone in the program and practice. As part of the refinement of the specific goals for the effort, a careful assessment of the current level of “medical homeness” of the practice and the curriculum can be very helpful. This can involve both self-assessment and evaluation by external sources. Self-assessment is important, but can be tricky, as initially people think that they are much further along in key areas of the PCMH model than they really are. For example, many think that they already provide a pretty high level of team-based care, but few are actually anywhere close to the level of interdisciplinary teamwork that is required for a highly functioning PCMH. As part of this assessment, determination of where the practice stands regarding the National Committee for Quality Assurance (NCQA) PPC-PCMH Standards can be useful. However, it is clear that that true transformation to become a medical home goes far beyond accomplishment of NCQA recognition, which may be necessary but is not at all sufficient.

(2) Engagement of the Sponsoring Organization

Discussions with the leadership of the residency’s sponsoring organizations can be important in achieving commitment of the hospital to the project and at least some level of alignment of the often divergent goals of the practice and the hospital. The quality and extent of hospital assistance or interference can be a major determinant of the success of the effort. Hospital leaders may or may not have much understanding of the PCMH concepts or the overall transformation of the health care system that this may represent, so some focused education may be necessary. Hospitals are often resistant to the prospect of a transformation to a system based more heavily around primary care due to the likely reduction in hospitalizations, procedures, and other revenue sources, and this can be a barrier. The primary concerns of the hospital leaders tend to be centered around “What is this going to cost, and what is in it for me and my hospital?” and consideration of these issues in the discussion is important. Key things to request from the hospital can include support for participation of staff members in the change and improvement process (as below), assistance in overcoming barriers that the practice may face in its change efforts, and commitment to an ongoing process of active discussion and negotiation regarding the cost of possible changes that the practice may contemplate. Hospital leaders can sometimes be engaged through consideration of how to support private practices associated with the hospital in their efforts to become medical homes, with the residency practice’s transformative efforts serving as a learning experience that could be disseminated to other practices.

(3) Adopt and Sustain a Change Management and Quality Improvement Process

Most primary care practices do not have a robust, interdisciplinary change management and quality improvement process, and residency practices are no different. A vital early step in the transformation process is the establishment of one or more improvement teams that...
meet regularly (preferably weekly) to plan and implement the necessary changes in a reflective and interactive process using sound quality improvement principles. These teams must have a diverse membership, drawing from all of the key roles in the practice, including residents and staff members. Some smaller practices may have only one improvement team, but most residencies I have worked with have ended up forming several improvement teams corresponding to care teams within their practices, with a central “steering committee” that coordinates the activities and disseminates the learnings across the teams. Practice and program leaders should provide the improvement teams with (1) time to meet, (2) an appropriate and defined level of power and autonomy to make decisions, (3) assistance with obtaining resources for planned changes, (4) a buffer from institutional interference and obstacles, (5) expectations for accountability from team members, (6) permission to be innovative and to fail at times, and (7) input as needed—but only as needed. The development of staff-level team leaders can particularly facilitate the success of the improvement teams. To be fully functional, these teams have to develop a culture of shared decision making and leadership. It is difficult and costly for any practice to free up the time for these meetings, but it is absolutely necessary and will pay dividends on many levels. Since some residency programs do not have control of their staff members’ time and schedules, this can often involve difficult negotiations with their sponsoring hospitals to make these activities part of the staff’s duties. Once established, these teams can provide a structure and process for any type of change and improvement that the practice might need to undertake in the future. As mentioned in my last column, residents need to participate actively in these improvement teams, both to help drive the change process in the practice and to learn these vital skills for their own future practices. I will talk more about teamwork in the medical home, including in improvement teams, in a future column.

(4) Seek Outside Support
Practice coaching has been increasingly used as a method for assisting practices in implementing organizational change, particularly including the chronic care model and the PCMH. The practice coach generally serves a variety of roles with the practice, including an assessor of current practice status, a source of information regarding possible improvements, a facilitator of the improvement process (including the formation and initial facilitation of an improvement team), a connector to other resources, a source of initial impetus and accountability, and a link to the experiences of other practices attempting similar changes. In our residency project, our coaches also provide training and support for internal team leaders for the improvement teams, often staff members but sometimes physicians. The presence of a practice coach can assist in tailoring the approach to an individual practice situation, improving the incorporation of the intervention into the daily routine of the practice system and increasing the sustainability of change. Once the practice’s improvement process is well established and moving forward, the coach can gradually withdraw, although generally remaining available for future assistance as needed. This type of practice facilitation/ coaching has been shown effective at assisting practices in accomplishing change in the TransforMED National Demonstration Project and other programs. From my multiple qualitative interviews and informal conversations with practices undertaking these transformative changes, it is clear that the assistance of an external practice coach greatly facilitates these efforts. Many practices have indicated that it would have been impossible for them to get “over the hump” and implement the necessary change and improvement process without the assistance of the coach. Practice coaching support is available from a number of possible sources with variable levels of expense, including TransforMED, Improving Performance in Practice in some states, and a variety of other local or regional practice support efforts. The health reform legislation passed earlier this year included the establishment of a “regional extension agent” model of practice support to take effect in 2011. Details have not yet been released, and this will still require funding by Congress next year. So, stay tuned for further information.

(5) Form a Collaborative With Other Residency Programs
Collaboratives of multiple practices such as the Breakthrough Series have been one of the primary methods developed for helping practices implement large scale changes. In these collaboratives, practices typically send representatives (generally a physician and a key staff person but sometimes multiple people) to a central location for regular 1- to 3-day meetings with presentations and discussions covering the improvement process and the area being targeted for improvement. Evaluations of quality improvement collaboratives have shown somewhat mixed results, but it is clear that they have helped many practices in implementing a QI process and improving various aspects of their patient care. Collaboratives can be expensive for sponsoring organizations to implement and for practices to make available the time and travel support for people to participate. In addition, the “practice champions” who attend the collaboratives often have a difficult time translating their
learning from the collaboratives into their practices’ systems and behaviors at home. However, collaborative meetings can serve as a great source of education about the PCMH model and the “lessons learned” from other practices and can energize participants to move forward. Combining practice coaching with collaboratives gives an almost ideal environment for encouraging and accomplishing change. Most collaboratives have been externally organized by practice support organizations of various types, but self-organized collaboratives have also been successful (as evidenced by the PCMH collaborative formed by South Carolina, North Carolina, and Virginia residency programs). I would strongly encourage residency programs undertaking a PCMH transformation to consider partnering with other programs in their area to form a collaborative to support their efforts. In addition, meetings such as the Conference on Practice Improvement, sponsored by STFM and the American Academy of Family Physicians, and the STFM Annual Spring Conference can serve as a great source of information from other programs and practices working on various aspects of the PCMH.

**Faculty Development**

As I have mentioned in previous columns, one of our problems in this transformative process is that our faculty members have themselves not been trained in many of these areas. We faculty like to be experts in the areas that we are teaching and can be resistant to new areas that we don’t know much about. It is extremely important that we develop faculty development resources covering the PCMH and practice improvement and train our faculty members aggressively in these areas. This involves far more than the addition of a few new skills, as the PCMH involves a much broader transformation in basic approach to practice, teamwork, and patient care. An approach to building PCMH skills utilizing a team-based, shared learning model is also extremely useful. Faculty do not have to be the sole experts; all of the members of our practice team can seek out information, training, and skills in various areas of the new model of care and share them with the rest of the team. This approach is more consistent with adult learning theory, and our residents and other learners will likely benefit from a shift from an expert-driven to a shared learning approach. Increased focus on interprofessional education opportunities, including for faculty development, will also advance our transformative efforts; more to come on that in a future column.

**Conclusions**

Residency practice and curriculum transformation to the PCMH model (or whatever we end up calling this model of advanced primary care) is difficult and takes time, resources, and commitment. However, this effort is critical for our discipline and our health care system, as our programs must take on responsibility for preparing our residents to be part of the new model of advanced primary care necessary to improve care and contain costs. This column has only provided a brief overview of some of the key steps and issues involved in this transformation. I hope that everyone out there doing this type of work will share their successes, failures, and lessons learned in our various professional meetings and publications. More than ever, we need to be a learning community to advance family medicine and primary care.

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