President's Column

Assembling Patient-centered Medical Homes—Teaching Resources

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Family medicine’s core values of continuing, comprehensive, compassionate, and personal care provided within the context of family and community have shaped the identity of generations of family physicians. For years, we have been teaching our students and residents how to practice medicine that reflects these ideals. Continuing to teach these standards will ground our learners in the “care principles” of the patient-centered medical home (PCMH): personal physician, physician-directed medical practice, and whole-person orientation. While we have been teaching about some “infrastructure principles” of the PCMH, these areas provide new teaching challenges: coordinated care, quality and safety, enhanced access, and payment for added value.

In the era of competency-based education, we need to articulate the competencies necessary for functioning in a PCMH and to develop curricula for providing learners with the knowledge and skills required for that environment. The Competency-based Curriculum Workgroup of the STFM Special Task Force on the Future of Family Medicine has developed modules that address the chronic care model, informatics, performance improvement, advanced access, and group visits. These modules are available on the Family Medicine Digital Resources library at www.fmdrl.org. In addition, faculty members throughout the country have uploaded their resources to help their colleagues teach about the PCMH principles. Use the following search terms on www.fmdrl.org to locate the teaching resources:

- Personal physician—each patient has an ongoing relationship with a personal physician trained to provide first contact and continuous and comprehensive care. Search: personal physician, continuity of 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. Search: team.
- Whole person orientation—the personal physician is responsible for providing for all the patients’ 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, and end-of-life care. Search: chronic care model, comprehensive 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. Search: informatics, coordinated care, integrated care, registries, information technology, health information.

Quality and safety are hallmarks of the medical home. Search: performance improvement, quality of care, safety, quality improvement, performance measurement, medical home.

Enhanced access to care is available through systems such as open scheduling, expanded hours and new options for communication among patients, their personal physician, and practice staff. Search: advanced access, access, open scheduling, communication, electronic communication.

Payment appropriately recognizes the added value provided to patients who have a PCMH. Search: pay for performance, reform.

There are several conferences this year focused on the PCMH where there will be presentations about teaching the care and infrastructure
principles in the classroom and the clinic. Some of these materials will be available on www.fmdrl.org after the conferences:

**Conference on Families and Health**

“The Medical Home Team: Collaborating With Families and Communities to Restructure Health Care”  
February 28–March 2, 2008, New Orleans

**Annual Spring Conference**

“Strengthen the Core, Stimulate Progress: Assembling Patient-centered Medical Homes”  
April 30–May 4, 2008, Baltimore

**Forum for Behavioral Science in Family Medicine**

“Integrating and Expanding Behavioral Science in the New Medical Home”  
September 25–28, 2008, Chicago

**Conference on Practice Improvement: Health Information and Patient Education**

“Blueprint for the Medical Home”  
December 4–7, 2008, Savannah, Ga

Assembling PCMHs offers us an opportunity to reenergize our teaching of core family medicine values and to teach about new topics. The emphasis on competency-based curricula provides a guide for the types of outcomes we expect from our instruction. Sharing resources at meetings and on www.fmdrl.org continues the tradition of STFM, helps us prepare our learners for a changing world, and reflects STFM’s core values: learning, relationship-centered, nurturing, openness, excellence, and integrity.

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