

## Assembling Patient-centered Medical Homes in Teaching Practices—One Strategy

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I have asserted that “STFM should spread the patient-centered medical home (PCMH) model to all teaching practices: medical school faculty, residency programs, and community preceptor practices.”<sup>1</sup> This would be a big job: “There are more than 100 medical school practices and approximately 450 residency program practices that would need to become PCMH teaching practices. In addition, if you estimate that each medical school has a minimum of 30–50 community practices in which they place students, we are talking about roughly 3,000 to 5,000 community teaching practices we would want to remodel into PCMHs.”<sup>2</sup> Dividing the principles of the PCMH into two groups helped me understand the challenge of this job: “The ‘care principles’ are personal physician, physician-directed medical practice, whole-person orientation, and care is coordinated and/or integrated, and the ‘infrastructure principles’ are quality and safety, enhanced access, and payment for added value.”<sup>3,4</sup>

“I believe that we have been achieving the care principle of the PCMH at a reasonably acceptable level. We can always improve, but that core part of the PCMH is quite well established. The infrastructure principles are the least well devel-

oped and offer the greatest promise but also at the greatest price.”<sup>4</sup>

“For years, we have been teaching our students and residents how to practice medicine that reflects these ideals [continuing, comprehensive, compassionate, and personal care provided within the context of family and community]. Continuing to teach these standards will ground our learners in the ‘care principles’ of the patient-centered medical home (PCMH). While we have been teaching about some ‘infrastructure principles’ of the PCMH, these areas provide new teaching challenges.”<sup>5</sup>

To spread the PCMH to teaching practices, our priority will be on achieving the infrastructure principles. We will need to maintain or enhance performance of the care principles, but our primary effort will be addressing the infrastructure of teaching practices.

The roadmaps for this work are the TransformMED Medical Home Model (<http://www.transformed.com/transformed.cfm>) and the National Committee for Quality Assurance’s Physician Practice Connections-Patient-centered Medical Home (PPC-PCMH) Recognition Program (<http://web.ncqa.org/tabid/631/Default.aspx>). The TransformMED National Demonstration Project has taught us about the process of following these road maps:

“Creating a PCMH is much more than a sum of implementing discrete model components. Such transformation is exceedingly difficult, and those who attempt it are heroic. To achieve transformation, full engage-

ment of critical members of the practice is needed. At the same time the practice needs to remain in charge of its own destiny. They may need assistance in making the changes, but the decision what to change needs to be theirs. They also need to remain full partners in their learning and development process. In addition to implementing the TransformMED model components, the path to creating a PCMH requires particular attention to:

- The clinical process—the interaction between patient and practice clinicians and staff members. This is by no means limited to the exam room, although the patient-physician interaction begs for special attention.

- The relationships among all members of the practice.

- The relationships between the practice and the larger health system and community.

- The motivation and capacity of key stakeholders within the practice.”<sup>6</sup>

Over the next couple of years we will learn “how predoctoral programs are attempting to remodel their clerkship clinical practice sites to expose students to the principles of the PCMH model”<sup>7</sup> from the STFM Clerkship Medical Home Initiative and how residency program directors are doing it from the P4 Project (<http://www.transformed.com/p4.cfm>). How might clerkship or residency program directors approach this challenge? I will outline one potential strategy below, but let’s start with assumptions.

(Fam Med 2008;40(4):237-40.)

(1) The ultimate purpose of the effort to develop teaching practices into PCMHs is to recruit and train family physicians who can provide care in PCMH practices. The clinical experience of third-year family medicine clerkship students is pivotal for specialty selection, and residents need to be prepared to transition smoothly into PCMH practices.

(2) Clerkship and residency program directors have established good working relationships with their teaching practices and are capable of paying “particular attention” to:

(a) “The relationships between the practice and the larger health system and community.

(b) The motivation and capacity of key stakeholders within the practice.”<sup>6</sup>

(3) TransformMED will continue to develop and provide materials to help practices change, such as the “TransformMED Workingpapers: Best Practices in Practice” (<http://www.transformed.com/LLworkingpapers.cfm>) and “Resources on . . . Access to Information, Access to Care, Comprehensive Practice, Disease Registries, Information Systems/EHR, Patient-centered care, Practice Management, Redesigned Offices, Quality and Safety, and Team-based Care” (<http://www.transformed.com/resources.cfm>).<sup>7</sup> Clerkship and residency program directors can use the TransformMED resources in their efforts as well as other resources at [www.fmdrl.com](http://www.fmdrl.com), such as the STFM competency-based curricular modules on PCMH elements.<sup>5</sup>

(4) Practice certification through the NCQA’s PPC-PCMH Recognition Program will likely be necessary for practices to receive enhanced reimbursement for care coordination. Helping practices attain this recognition would be a tangible way medical schools could contribute to teaching practices, while at the same time students and residents could learn about and

potentially experience the PCMH elements.

(5) Teaching practices may benefit from support like that provided to the facilitated practices in the TransformMED National Demonstration Project (NDP) (<http://www.transformed.com/methodsMeasures.cfm>) or may make substantial changes without the help of a facilitator like those accomplished by the self-directed practices in the NDP (<http://www.transformed.com/Self-Directed-First-Year.cfm>). Clerkship and residency program directors could be effective facilitators, especially after training in change management. A lesson from the NDP supports facilitation by these directors: “However, nearly all practice leaders said they would welcome a facilitator to step in the mix and provide third-party support and motivation, someone to provide structure, keep the practice on track, and hold people to deadlines. Otherwise, they report, it is too easy to get caught up in the daily grind.”<sup>6</sup>

(6) There are three different types of skills needed for practices to become PCMHs and to effectively teach about the PCMH: the capability of performing the PCMH element such as using an EHR or conducting a group visit, the ability to teach the element to others, and the capacity to facilitate or implement changes in the practice. Clerkship and residency program directors and practice medical directors or PCMH champions will need all three skill sets, while clinical practice faculty may only need the first two skill sets.

(7) Teaching about the PCMH requires all aspects of the experiential learning cycle: abstract conceptualization, active experimentation, concrete experience, and reflective observation.<sup>8</sup> Abstract conceptualization and reflective observation, which are typical classroom instruction activities, are important but are incomplete without the concrete experience, reflective observation,

and active experimentation in the clinical teaching practice. This cycle describes in further detail the teaching activities and skills necessary in the classroom and clinical settings. Clerkship and residency program directors will likely need skills in all four domains while clinical practice faculty may only need skills in concrete experience and reflective observation, namely allowing students or residents to experience the PCMH element and helping the student or resident reflect on and learn from that experience.

Building on these assumptions, here is a possible strategy for teaching clerkship students and residents about the PCMH and helping teaching practices become PCMHs:

(1) Explicitly state an immediate goal that all clerkship students and residents learn about the elements of the PCMH and an eventual goal that all students and residents will have a clinical experience in a PCMH teaching practice.

(2) Inform teaching practices of these goals and the rationale for them.<sup>2</sup>

(3) Outline to the clinical practice site faculty the initial methods of introducing students and residents to the PCMH elements:

(a) Abstract conceptualization: Didactic presentation, online video ([http://www.maxwellreplay.com/archives/merck/020508\\_medicalHome/start.html](http://www.maxwellreplay.com/archives/merck/020508_medicalHome/start.html)), or assigned independent study of material at [www.transformed.com](http://www.transformed.com).

(b) Reflective observation: Rating of the assigned teaching practice on elements of the PCMH using available forms (see #5 and #7 below).

(4) Offer the teaching practices help with obtaining certification through NCQA’s PPC-PCMH Recognition Program.

(5) Assess the current overall status of a teaching practice on PCMH elements on an annual basis using available questionnaires. These instruments would be completed once

a year by a student or resident in consultation with the practice physicians and staff as part of the learning process outlined in #3 above.

(a) Use the TMED Medical Home Vitals quick checklist of 12 yes-no questions, which provides a score for the practice and resources tailored to the practice's level of implementation of the TransforMED Medical Home Concepts (<http://www.transformed.com/Vitals/index.cfm>) and/or

(b) Use the Status of New Model of Family Medicine questions from the P4 Project's Continuity Practice Survey consisting of 28 questions rated as Absent, Planning, Present, or Mature, which provides further insight into the practice's current status and future plans.

(6) Determine whether the practice is interested in more in-depth assessment of some of the domains of the PCMH and if so, identify for which domains the practice would like this assessment.

(7) Use the TransforMED Medical Home IQ (MHIQ) instrument with individual modules for rating the PCMH domains selected by the practice. This instrument will show the practice how it would score on the NCQA PPC-PCMH Recognition Program standards and identify explicit changes necessary to achieve that recognition. A student or resident in consultation with the practice physicians and staff could complete the questions for each module. The eight modules are:

(a) Access to Care—18 questions

(b) Continuity of Care Services—16 questions

(c) Information systems—16 questions

(d) Patient-centered Medical Home—12 questions

(e) Point of Care Services—13 questions

(f) Practice Management—35 questions

(g) Quality and Safety—15 questions

(h) Team-based Care—12 questions

(8) The MHIQ will provide recommendations and resources for practice change. The practice could decide to implant changes, and this step could be self-directed by the practice or facilitated by the clerkship or residency program director.

(9) Irrespective of the responses to #6 and #8, determine whether the practice would allow a student in each clerkship rotation or a resident on a practice management rotation/elective to complete the questions in one of the MHIQ modules as an assignment to learn more about the PCMH elements. Rotating assignment of MHIQ modules among students and residents would take eight rotations to complete all of the modules.

(10) Continually keep in mind the ultimate goal of recruiting and training physicians for PCMH practices and attend to the assumption that clerkship and residency program directors have established good working relationships with their teaching practices and are capable of paying particular attention to:

(a) "The relationships between the practice and the larger health system and community,

(b) The motivation and capacity of key stakeholders within the practice."<sup>76</sup>

As stated above, this strategy presumes that practices are doing rather well on the patient-centered care principles of the PCMH so it is focused mostly on implementing the infrastructure principles. This perspective is confirmed by findings from the TransforMED NDP: "Early data from patient surveys suggest that some facilitated and self-directed practices are seen as PCMHs by their patients. This is encouraging and suggests that a PCMH can be achieved, although it should be acknowledged that there are multiple pathways to get there. However, the data also suggest that this characteristic *was largely in place in these practices at baseline*."<sup>76</sup>

While this supports the focus on infrastructure, there is a risk, however: "Early analysis from the NDP

(using both qualitative data and the quantitative scores from two waves of Patient Outcome Surveys) does suggest that implementing components of the original TransforMED model does not automatically lead to a patient-centered medical home. A primary focus of the NDP has been implementation of the TransforMED model components and to a certain extent, this focus on technical innovations has competed with efforts to address relationship-centered patient care within the practice." "Successful implementation of new model components does not automatically lead to the relationship-centered organization, necessary for sustained change and learning. This is understandable, as the hard work of implementing technology and revamping work flow means the difficult task of building practice relationships retreat to the back burner. For the most part, the practices that are relationship-centered were so in the beginning."<sup>76</sup> So we need to be cautious as we work on infrastructure and not forget that relationship-centered care is the core of the PCMH and that the purpose of the infrastructure is to support that care, not divert from it.

Will the strategy outline above work? It parallels the processes that have been used successfully in the TransforMED and P4 projects, so it has promise. Will clerkship and residency program directors put in the effort? Will department heads allocate the necessary resources? Those questions are as yet unanswered but will be addressed in part by the information collected through the STFM Clerkship Medical Home Initiative. However, we cannot wait for answers before acting. Time is of the essence, and we need to start trying different strategies, for as quoted above "There are multiple pathways to get there."<sup>76</sup> The time for change is now.

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