

Assembling Patient-centered Medical Homes—The Care Principles

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The Patient-centered Medical Home (PCMH) is a model for providing patients with the services they need. It also reflects our core values, but the vision of the PCMH can seem rather abstract and perhaps unrealistic and unattainable. Is it really possible to create a PCMH? What do the principles (personal physician, physician-directed medical practice, whole-person orientation, care is coordinated and/or integrated, quality and safety, enhanced access, payment for added value) really mean?

It helps me to think of the principles in two categories: the type of care we provide to patients and the practice infrastructure that supports our work. The “care principles” are personal physician, physician-directed medical practice, whole-person orientation, and care is coordinated and/or integrated. The “infrastructure principles” are quality and safety, enhanced access, and payment for added value. I address the care principles in this column and the infrastructure principles in the next column.

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The medical home becomes more tangible for me when I reflect on patients whose care exemplifies the values and features of the PCMH. In each and every one of our practices, we could recount the stories of our patients who exemplify the first four care principles of the PCMH. By discovering and telling these stories, we strengthen the culture of our practices and reinforce the view that we are capable of achieving a PCMH in every one of our teaching practices. I will briefly sketch illustrative cases from my practice to encourage others to begin to share their stories. These are not ideal examples but ones that quickly came to mind as I read the principles.

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

Sometimes the relationship with a patient does not start out well but becomes strong over time. Kathryn is a college teacher in her early 60s whose first visit to our practice was in early 2005. The day we met, I was running well over an hour behind schedule, which happens now and then but is not typical. I was apologizing to each patient as we shook hands, but before I could say anything, Kathryn asked if I made all of my patients wait so long. I felt guilty and was a bit defensive, so our interchange began with testy

feelings on both sides. I addressed her concerns, and we had cleared the air somewhat before she left. Through 2005, she had regular visits for her hypertension, insomnia, menopause, and depression, as well as steps to evaluate a possible lesion noted on her colonoscopy. In 2006, she was away for 6 months for a scholarship and returned for evaluation of a carotid bruit detected when she had some dizziness. She also reported that she and her husband had become the guardians of their 4-year-old grandson. In 2007, she first saw one of my partners for nausea, vomiting, abdominal pain, and dizziness. In follow-up with me, she also described a feeling of “head feeling thick” and worried something was seriously wrong. All of the tests were negative, and she improved. She later attributed the illness to “bugs” her grandson brought home from school and the stress of being in her 60s and having a child in kindergarten. We now have a warm relationship that will continue to be ongoing.

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.

Patients with straightforward chronic illnesses can develop a cascade of problems that require involvement of many members of

the practice team. Elizabeth and her husband joined my practice in 2004. She was in her late 60s and had well-controlled diabetes, chronic mild anemia, gastroesophageal reflux disease, and Barrett's esophagus. Her husband was the same age and had diabetes, hypertension, and morbid obesity. Their son always accompanied them to office visits. In 2005, Elizabeth was diagnosed with esophageal cancer and received radiation treatment. In 2006, she had multiple hospitalizations for weakness and anemia that required transfusions. She had upper gastrointestinal bleeding from her esophagus that was not controlled with recurrent laser treatment. The family asked if the physician treating her was the best in the city for treating this condition, which I confirmed with one of my gastroenterologist colleagues. Elizabeth required weekly lab tests and blood transfusions. Our staff and I were on a first-name basis with the nurses and technicians at the transfusion center. Several of our staff faxed orders, the transfusion staff paged me weekly with the lab results and for the transfusion or drug orders, and my partners responded to the calls if I was away. During this time, she also had a breast mass that was a cluster of superficial hemorrhagic cysts up to 3 cm in diameter. Multiple needle biopsies were negative for malignancy, but a mastectomy was planned due to the discomfort and disfigurement. Surgery was postponed twice due to weakness and significant anemia. The mastectomy was finally done with pathology showing both carcinoma and sarcoma, but the oncologist determined that she was too weak for chemotherapy. In 2007, she developed a pleural effusion and a lung mass, and continued having weekly transfusions. During two hospitalizations, the hospital team presented hospice options. At office visits, I discussed hospice again

and discussed with her son what to do if she died at home. At her last office visit, it was obvious the end was near. Her son called 3 days later when she became unresponsive. She died 2 days later at home. Our staff checked on how the family was coping. Her husband has made office visits since her death, with his son present as before. The practice team fully comprehends their loss.

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.

Rose was a former accountant in her mid 60s when she joined my practice in 1997. She had hypertension, diabetes, hypercholesterolemia, cardiomyopathy, dysrhythmia, a history of renal disease, incontinence, and Parkinson's disease. She frequently remarked, "You're going to get tired of seeing me and will fire me someday as your patient." I never did. She called me "sweetie" and other endearments. She had regular chronic care visits for blood tests and periodic medication adjustments. Her daughters would sometimes accompany her to office visits. There were tragedies in her life that deepened our bond. In 1999, her granddaughter was killed in a motor vehicle accident on her way back to college. In 2005, her grandson had dinner with his estranged wife, hoping for reconciliation, but she refused his efforts. They were outside a restaurant sitting in his car when he pulled out a gun, put the barrel in his mouth, and pulled the trigger. Rose was devastated with the second loss of a grandchild, especially her favorite grandson. The images of him with the gun in

his month plagued her for months. Two years earlier in 2003, Rose was diagnosed with b-cell lymphoma and was treated at a cancer center. In 2007, she had weight loss and fatigue. Testing did not reveal any other cause, so it was presumed to be due to the lymphoma, but she still refused to return to the cancer center for evaluation or treatment. She did not want to see any more specialists saying "You are the only doctor I am seeing from now on."

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.

Don was a former chair of a college science department and in his early 80s when he joined my practice in 1995. He and his wife had an adopted son and daughter. The son had schizophrenia and lived in a sheltered setting. He visited his parents periodically but mostly sat watching television, which pained Don, whose entire career had valued the mind and intellect. Don had chronic dizziness, headache, fatigue, and mood disorder. In the decade after joining my practice, he had several hospitalizations and a number of procedures: a subdural hematoma, a hip fracture and replacement, a pacemaker for sick sinus syndrome, a ventricular-peritoneal shunt for dizziness and increased intracranial pressure that was placed and then closed, and a transurethral resection prostate for benign hypertrophy. His consultants included a neurologist, an otolaryngologist, a neurosurgeon,

a cardiologist, a urologist, an orthopedic surgeon, a psychiatrist, and a physical therapist. Much of the time during his visits was spent on coordinating and integrating this care.

These are just a few of the patients who bring to life for me the care principles of the PCMH. I recall many more patients for whom I have had or continue to have an ongoing relationship as their personal physician, our practice has cared for them as a team, we have cared for a broad array of problems directly and with the help of consultants, and we have coordinated care with ancillary ser-

vices across a number of sites. I am sure you can recall many patients from your practice in this way as well, for in many practices we have already been patient centered and providing medical homes. By telling and sharing stories about our patients, we reinforce the importance of our core values of continuing, comprehensive, compassionate, and personal care provided within the context of family and community. Remembering these stories can also motivate us to focus on the next priority of achieving the infrastructure principles of the PCMH: quality

and safety, enhanced access, and payment for added value. These principles are quite challenging but have the potential to improve our care even further.

I would like to hear your stories of your patients who reflect the four care principles. Please send them to me at president@stfm.org.

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