

NEW PERSPECTIVES: PART I

A General Internal Medicine Resident's Appraisal of the Medical Home: Innovation or Evolution?

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Change and adaptability were definitely the themes at the recent Colorado Residency Patient-centered Medical Home (PCMH) Project Learning Collaborative in Denver, CO. I had the opportunity to represent High Street Primary Care Center, a University of Colorado practice that is the newest addition to the Collaborative as well as the only general internal medicine residency program of the group. There was a palpable sense of creative energy throughout the two-day event as individuals and programs came together to discuss their progress in the past year and review the successes and obstacles that other programs had experienced. I attended a number of breakout sessions and group discussions on topics such as disruptive innovation, managing complex patients, and professionalism, as well as the role of the personal physician within the PCMH model.

I heard quite a bit about PCMHs during my medical education, but I do not think I ever really had a good understanding of what makes them so unique. None of the ideas I had previously heard seemed very radi-

cal to me. Group visits, patient registries, quality improvement processes, electronic health records, transitioning toward team-based care, and increasing access through open-access scheduling just seem like common-sense practices that should be standard of care rather than some revolutionary new concept. Unfortunately, these practices are a lot less common than they should be, are often difficult and costly to implement, and rarely have demonstrable benefits in the short term. During this collaborative I gained a deeper appreciation for the goals of the PCMHs and the difficulties faced in making them a reality.

The transition from a physician-centered "doctor's office" to a "patient-centered" medical home is a profound one and not to be overlooked. The terminology itself is even important, as it signifies the trend in medical care toward patient autonomy and away from physician paternalism. The core of the PCMH seems to be a commitment to patient care supported by quality improvement systems, with an ability to evaluate reliable outcomes data by using and configuring electronic

health records for standard reporting. Many of the problems encountered were similar across different programs, and it was interesting to note the variety of different approaches to solving them. Creating a culture of change when financial support is lacking and overcoming the inertia to change are difficult. The process is not always smooth in the evolution of a PCMH and often progresses in fits and starts as unique obstacles are faced and various solutions are implemented.

This is without a doubt a very exciting time for primary care. As residents, we are uniquely positioned to take a prominent role in delivery system redesign. Whether or not the PCMH model remains a dominant model of change or merely a chapter in the history of primary care will depend on whether collaboratives, such as the one I attended, continue to exist and help practices push the envelope for change. I do believe that the focus on patient care and many of the driving forces behind the PCMH initiation will continue to transform primary care for the better.