The Education Centered Medical Home: A new curricular model for the 21st Century

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**Goals and attributes: Seven Pillars of the ECMH**

**Personal Physician:** Definition: Each patient has an ongoing relationship with a personal physician trained to provide first, continuous and comprehensive care.

**Whole Person Orientation:** Definition: 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 for all stages of life: acute care; chronic care; preventive services; and end-of-life care.

**Care Coordination and Integration:** Definition: Care is coordinated and/or integrated across all elements of the complex health system (e.g. subspecialty care, hospitals, home health agencies, nursing homes) and the patient’s community (e.g. family, public and private community based organizations). This 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 it and want it, in a culturally and linguistically appropriate manner.

**Payment and Medical Economics:** Definition: Payment appropriately recognizes the added value provided to patients who have a PCMH. Recognizes and values work that is done outside of face-to-face visits. Pays for care coordination, ancillary providers and community resources. Supports adoption of HIT for quality improvement.

**Quality and safety are hallmarks of the medical home:** Definition: Advocacy for attainment of optimal, patient centered outcomes defined by collaborative care planning process. Evidence based medicine and clinical decision support tools guide decision making. Physicians accept accountability for quality improvement (QI) through voluntary engagement in performance measurement and improvement. Patients actively participate in decision making and patient feedback is sought to assure expectations are being met. HIT is used to support optimal patient care performance measurement, patient education and enhanced communication. Practices go through a voluntary recognition process to demonstrate that they have PCMH capabilities. Patients and families participate in quality improvement activities at the practice level.

**Physician-Directed Medical Practice:** Definition: The personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.

**Enhanced Access to Care:** Definition: Access to care is available through systems such as open-access scheduling, extended hours, and new options for communications between patients, their personal physician and practice staff.

**Learning Resources:**

**Assessment Opportunities**

**Looking Forward**

**Some advantages of ECMH Model**

- Early and comprehensive student exposure to patient care.
- Longitudinal follow-up of patients.
- Empowers students to “Take ownership” of patients longitudinally.
- Early and comprehensive educational exposure to team-based medicine and net-driven medical information technology.
- Early educational exposure to Continuous Quality Improvement, its design, implementation and monitoring.
- Early educational exposure to the factors that positively affect the relationship between a physician and his or her patients.
- Ability to positively affect the clinical outcomes of both individuals and communities over a four year period as a result of student cohort patient care and focused community interactions.

**References**
