

# Patient-Centered Models of Care: Closing the Gaps in Physician Readiness

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**KEY WORDS:** patient-centered medical home; medical education; leadership; quality improvement; information technology.

J Gen Intern Med 30(7):870-2

DOI: 10.1007/s11606-015-3282-x

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Nearly every medical student and practicing physician aspires to provide the best possible patient-centered care. They went into medicine to do so and are trained to place patients' wellbeing at the center of their work. What physicians are not trained to do, however, is to engage with and change the powerful systems that shape their ability to provide patient-centered care: funding models, organizational structure, information technology, and others. The messy business of leading change is, more often than not, handled by managers, accountants and legislators, most of whom are adept at looking at the bottom line, but are ill-equipped to understand the reality of providing patient-centered medical care. Physicians can play a key role in delivery system reform, and must now achieve fluency in domains beyond medical knowledge and technical skills.<sup>1</sup>

In this issue of *JGIM*, Fontaine and colleagues describe six success factors critical to front-line implementation of the patient-centered medical home (PCMH): leadership, organizational culture, finances, quality improvement, information technology, and patient involvement.<sup>2</sup> These factors likely not only facilitate PCMH implementation, but also characterize knowledge and skills that physicians need to lead any meaningful systems change. How is medical education doing in addressing these domains of knowledge and skill? We will briefly examine the current state of medical education through the lens of the six areas identified by Fontaine.

## LEADERSHIP

The Institute of Medicine calls for leaders who “define the future, align people with a vision, and remove obstacles.”<sup>3</sup> Unfortunately, skills development around strategic planning, conflict resolution, and self-management are not routine aspects of medical education. Medical students and residents often complete their training without either a deep understanding of their unique opportunity to lead, or a sense of efficacy

around their own abilities to lead. Medical students are increasingly asking for more leadership training. Those at Duke University School of Medicine created their own educational program in response to this felt need.<sup>3</sup> At the University of Michigan Medical School, competencies such as teamwork, influence, and communication are being taught through leadership coaching and training workshops. These creative strategies to integrate leadership training appear to pay off in measurable outcomes. Applying the U.K. National Health Service Medical Leadership Competency Framework, a 2014 systematic review described 24 successful undergraduate medical education leadership curricula globally, with outcomes ranging from change in learner attitude to change in organizational cost, quality, and efficiency.<sup>3</sup> Leadership development initiatives are empowering physicians to recognize that their scope of influence extends from “this patient” to “these colleagues, systems, and populations.”

## ORGANIZATIONAL CULTURE

Professional identity formation depends on socialization, defined as “the process by which a person learns to function within a particular group by internalizing its values and norms.”<sup>4</sup> Today, the socialization process for students, residents, and fellows is still largely discontinuous and individualistic, with more attention to personal performance on knowledge-based examinations than on the performance of health care practices and systems.<sup>5</sup> This individualistic culture does not contribute to a provider community committed to positive change. PCMHs and other practice models that are values-driven and interdependent in nature can serve as catalysts for changing the culture of medical education by exposing physician trainees to environments that align practice behavior with mission.<sup>5</sup> Immersing trainees in patient-centered training environments encourages future physicians to move from “doing” a task requested by others to physicians who “own” the challenges of our healthcare systems, promote patient-centered values, and take an active role in innovating solutions.<sup>4</sup>

## FINANCES

Navigating health care finance is at the top of the list of skills expressed as needed by physicians. As of 2007, the

Association of American Medical Colleges (AAMC) Medical School Graduation Questionnaire revealed that students were least satisfied with the training that they received in medical economics.<sup>6</sup> Efforts to bridge this gap include the Health Resources and Services Administration (HRSA) Undergraduate Medical Education for the 21st Century (UME-21) project, which encouraged medical schools to collaborate with health care organizations in advancing physician preparedness for practice within systems. In addition, the number of combined MD/MBA programs grew from six in 1993 to over 50 today, with over 500 graduates per year.<sup>2</sup> Nevertheless, the need remains great to prepare physicians to develop facility with speaking the language of health care finance, understanding health care policy and applying that knowledge and skill in the health care environment. A greater proficiency with the business side of health care will also help future physicians to responsibly address costs of care and at the same time innovate new policy approaches that optimize the wellbeing of patients and caregivers.

### QUALITY IMPROVEMENT

Quality improvement (QI) processes are foundational to the evolution of high-quality health care systems. A movement to increase the integration of quality improvement and patient safety into physician education is gaining traction. AAMC's 2013 *Teaching for Quality (Te4Q)* report recommended the integration of quality and safety principles into meaningful learning experiences across the continuum of medical education. The ensuing 13 on-site faculty development workshops across the country sought to build capacity in the teaching faculty workforce and increase the proficiency of clinical faculty members in quality and safety. Faculty are applying these new skills in three ways: (1) to formal curricula that incorporate quality improvement concepts and methods, (2) in educational activities on specific improvement or safety tasks, or (3) by incorporating trainees as participants in local quality improvement initiatives.<sup>7</sup> A systematic review of 41 published QI curricula for students and residents demonstrated improvements in knowledge, processes and clinical outcomes.<sup>8</sup> Additionally, a number of organizations such as the World Health Organization (WHO), Institute for Healthcare Improvement (IHI), and the Mayo Clinic have developed resources for QI training. These tools to support continuous learning around quality and safety can foster a shift in attitude among physicians from quality improvement being something that "someone else does" to something that "I do."

### INFORMATION TECHNOLOGY

Medicine is slowly embracing the role of information technology (IT) in health care practice. Clinical informatics is now a robust field, and has its own set of competencies and fellowships as of 2014.<sup>9</sup> Yet instruction around IT and electronic

health records (EHR) in undergraduate medical education lacks standardization and integration.<sup>9</sup> Trainees are not routinely provided with guidance on how to make the EHR an effective tool for communication. A lack of clear expectations on what constitutes high quality documentation has instead led to poorly constructed templates and "copy-paste" functions that hamper both patient care and the development of independent clinical reasoning. The power of information technology to drive research and continuous performance improvement through the use of well-crafted data elements is also not routinely taught. Medical education needs to embrace a world of medicine shaped by "big data" and train providers to effectively use data and technology to enhance care. The goal is to move away from "someone should build a better IT system" to "I can help build and use a system that optimizes patient care and knowledge creation."

### PATIENT ENGAGEMENT

Patient engagement improves health, decreases errors, and lowers costs.<sup>10</sup> Patients have been involved in health professions education for decades as clinical skills teachers. While learners are routinely exposed to patients for the purpose of educating future clinicians, they often have few hands-on learning experiences to witness the power of our patients' role in improving care delivery systems. Many providers still view patients through a paternalistic lens and have little appreciation of the multiple barriers patients encounter in their efforts to engage with their health. Sample pilot education innovations, including initiatives at Pennsylvania State College of Medicine and University of California San Francisco School of Medicine, create different relationships between patients and learners with students serving in patient activation roles such as patient navigators or health coaches. These trainees have the opportunity to listen deeply both about what individual patients need for their own health, and their collective ideas on improving the health care experience for others like them. Tangible training in patient engagement and better understanding of the patient's health care experience will move providers away from "what is the matter with you" to "what matters to you?"<sup>10</sup>

In conclusion, physicians have always desired to improve the wellbeing of patients. Their toolkit, however, has not included the knowledge and skills needed to be catalysts in improving the health care systems that their patients need to navigate. Just as medical education claims responsibility to sharpen skills in diagnostics and therapeutics, it now must equip future physicians with the knowledge, skills and discipline to affect systems level change. Fontaine's success factors provide a roadmap to systematically weave new knowledge and skills into medical education, with the goal of fostering a spirit of

activism and empowerment in the next generation of health care providers.

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