



## Thoughts on the Patient-centered Medical Home

This article was originally a long e-mail contribution submitted to the Optimizing Practice Through Research and Quality Improvement Work Group where I am the community physician member of the group. Several members of the Work Group enjoyed the perspectives I shared and suggested it may be useful to other NAPCRG members.

In 2003, I joined forces with a few other like-minded idealistic docs to build and live in a new model of care. We were all dissatisfied with our varied previous care models including community health centers, migrant clinics, staff model HMOs, residency faculty positions, student health, and various medical director positions.

With our student loans in tow, we all took pay cuts, embraced sleepless nights, empty exam rooms, cheap lawn chairs in the office, craftsmen tool boxes in our procedure rooms, and tried to do something different. Through thousands of volunteer hours connecting to people in a new community to all of us, prayer, passing out flyers at grocery stores, biting our finger nails, and toasting with nice California wines at the

small victories along the way—we are enjoying our journey building a different kind of practice. Little did we know back then we were building a “medical home.”

In 2007, our six-doctor practice was chosen for the 2-year Transformed National Demonstration Project (NDP). We were randomized to the control arm. The consistent feedback we kept getting from the research team is—hmmmm, we’re not really sure how to measure what is going on here. They used the measurement tools available in their tool box, though as Leif Solberg has accurately summarized, the box is still difficult to define. I think the reason it might be difficult to define is that there is too much reliance on payer-oriented quantitative measures. This method has limitations in the questions it can ask or answer. For example, try throwing the following question into the evidence-based medicine machine: “What is the meaning of life?” The EBM machine will spit out an error message and tell you: invalid question, please try again. The reality of patient care, however, involves frequent and practical exploration of these questions with our patients as they make lifestyle and

medical decisions. These conversations require quality time with patients and mutual trust—two elements difficult to demonstrate.

My hunch is that the momentum behind the Medical Home movement for both physicians and patients is the cry to “Please put meaning, purpose, compassion, soul, and real value” back into my medical experience. When we measure or orient practices around payer criteria, we often miss the mark. What the NDP showed is that the doctor-patient experience suffered in the transition—a tragic and unintended outcome. What we were hoping to improve was the one factor that definitely suffered.

When our medical group was dreaming about our practice model, we came up with the following mission statement: “Caring for people as family.” We wanted our practice to be one where it would feel like a fun and comfortable home (not a convalescent home). The patient’s experience and outcomes are king. The doctor’s experience and outcomes are also king. We like to use the mantra, “If the parents in a home aren’t happy, no one is happy.” We set out to



make our practice feel like our own ideal home—fun, peaceful, financially sound, meaningful, and full of purpose.

We all have different ideas of what home should feel like. Some people like antiques, classical music, and fine art. For our practice home, our docs like sports, action, high-energy fun, fine California wines, and loud music. That’s just who we are (for better or worse!). As we shaped our practice, we embraced

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## Stand Up and Be Heard at Our Next Annual Meeting in Banff

NAPCRG invites you to submit a proposal to present a paper, poster, workshop, or forum at the 2011 NAPCRG Annual Meeting in Banff, Alberta, Canada. The meeting will be held November 12–16, 2011. Proposals on any topic relating to primary care research are welcome from researchers throughout North America and the rest of the world. Submissions are also welcome in French or Spanish; please contact Jill Haught at NAPCRG for further instructions (JHaught@stfm.org). Submissions are due April 18, 2011. Refer to the instructions for submission on the NAPCRG Web site: <http://www.napcr.org/napcr presenter/submission/start.cfm?confid=137>

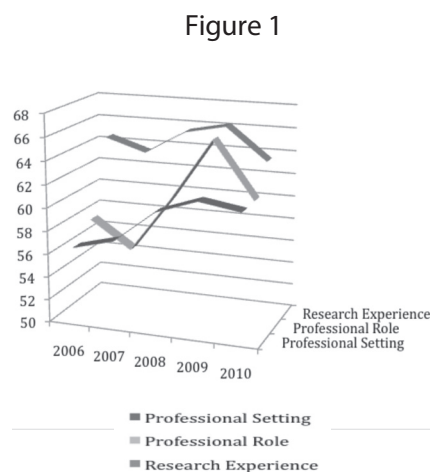


## Changing Diversity of NAPCRG

NAPCRG prides itself on its diversity. In fact, since 2006, NAPCRG has tracked its diversity and richness using measures developed in ecological settings.

“Diversity” reflects the homogeneity of distributions across finite categories. Simpson’s Diversity Index ranges from 0–100, with 100 being maximally diverse. This index has been used by RAND and other research groups as a measure of neighborhood diversity. When applied to NAPCRG’s membership in terms of its members’ professional setting (eg, community-based residency), role (eg, faculty), and research experience, the following changes in diversity were observed over the past 5 years (Figure 1)

In general, diversity has been highest in research experience and lowest in professional setting. In addition, diversity steadily increased from 2007–2009 across categories but appears to decline in 2010.



“Richness” deals with the number of unique types but has no ceiling. For our purposes, total richness is the product of the number of specialties and countries represented. In addition, to better reflect true richness, core richness limits its components to those needed to describe 95% of the membership. Thus, NAPCRG’s richness has varied considerably over the past 5 years (Figure 2).

While total richness has varied

considerably due to fluctuations in the number of countries represented (generally more countries attending US-based meetings), core richness peaked in 2008, coinciding with the Puerto Rico meeting. While variability in total richness is based

more upon the number of countries represented, variability in core richness is based more on the specialties represented.

Although we can revel in the diversity and richness of NAPCRG, we need to appreciate that there is room for improvement.

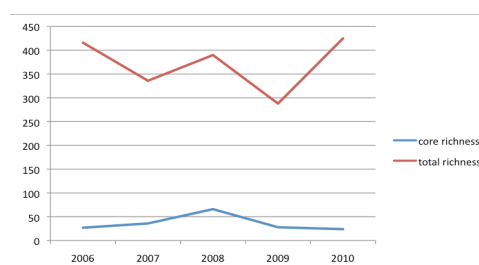


The Membership Committee will continue to work, with your help, to increase the diversity and richness of NAPCRG.

—David Katerndahl, MD,  
Chair, NAPCRG Membership  
Committee

University of Texas Health  
Science Center  
at San Antonio

Figure 2



## WHO/PLoS Collection “No Health Without Research:” A Call for Papers



The World Health Report (WHR) from WHO will, for the first time in its history, focus on research for better health. The primary target audience of the report will be ministers of health in the WHO member states, and the goal of the report is to provide new ideas, innovative thinking, and pragmatic advice for member states on how to strengthen their own health research systems.

The report will have three aims:

- To show that research is important for meeting health needs and improving health outcomes
- To encourage countries to therefore invest more resources in developing and strengthening their national health research systems
- To argue that countries should not see research as an expense or as an afterthought but as an investment for a better, healthier future

The WHR 2012 aims to provide impetus for a change to the problematic state of affairs of health research. Given the stated

goals of the report, of particular importance is the documentation and sharing of real experiences from the countries where the research has been done. We therefore wish to invite the submission of articles, especially from low- and middle-income countries, on topics related to the strengthening of key functions and components of national health research systems.

We would then aim to publish a WHO/PLoS (Public Library of Science) Collection culminating in 2012 to coincide with the release of the WHR. Thus, we welcome examples of research and/or case studies in the following areas:

- Experience with setting and implementing health research priorities
- Experience with building, strengthening, and retaining research capacity, at both the individual and institutional levels
- National research and development initiatives and experiences to produce needed medical products, including development of national pharmaceutical

production capabilities, using TRIPS (trade-related aspects of intellectual property rights) flexibilities for essential medicines, technology transfer

- Examples of appropriate use of evidence in health policy development
- Models of how to organize research within a country, including the establishment of effective research networks and sustainable governance mechanisms
- Standards and mechanisms to ensure the responsible conduct of research (eg, ethics review, access to research results, codes of conduct, etc)
- Exercises to evaluate the impact of research investments
- Experiences with external foreign aid for research

Ideally, studies or reports should not be merely descriptions of activities but should include evaluation of the impact of initiatives after their implementation. Special consideration will also be

given to systematic and well-performed multi-country comparative studies on the topics mentioned above, including systematic reviews, in selected topic areas.

In addition to primary research (both quantitative and qualitative) and well-developed case studies, we also invite the submission of review and policy articles on how national health research systems contribute to the broader international research endeavor, especially in the context of the following areas:

- Global health research governance
- Inequitable access to the benefits and products of research
- Global standards for responsible research conduct
- Future research trends with implications for the developing world.

Further information on the submission and selection process is available at <http://bit.ly/feLC85>.

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## Get Your Research Noticed by the Press in Your Local Community



There are myriad ways to get the media to take notice of your research. Dare it be called a “science,” but in many ways it is. It takes some preparation, tough questions, and execution, all with the hopes of a positive outcome. And like research, you never know what the outcome will be until all is said and done. Media coverage of your research is good for you as a researcher, your institution (if you are associated with one), and good for the primary care research discipline as a whole. Pages and pages can be written on how to go about this, but for now here are a few pearls of wisdom to get started with.

### Ask yourself...

Are my research findings newsworthy? Would my next-door neighbor care about what we’ve learned? Is it interesting to the general public because it might change the way they receive medical care? If the answer is no to any of these questions, then go no further and pat yourself on the back for a job well done in identifying the difference between newsworthiness and not. If the answer is yes, then move to the next step.

### Do your homework.

Make sure your announcement gets into the hands of journalists who care. For example, a writer of the *Home & Garden* section probably doesn’t care too much about your research on care of diabetics in a primary care setting. Look on your local media’s Web site for the right contact person in the science, health care, or medical news beat. These are the people you will want to contact.

Write a press release, e-mail, or pick up the phone. And when doing so:

- Keep it simple and simplify your language. When describing your findings, avoid medical jargon, lots of statistics, and acronyms. Lead with the key findings and go light on the details of the methodology.
- Only give them the sausage, not the “how to” instructions or mid-stream updates. No one wants to know how the sausage was made, right? The same goes for research and the media. Only tell the press about your research after it is complete and there are findings to share. Don’t tell them you’re working on “XYZ” and will be finished in 2013. Call them when all is complete and there’s something to say.
- Make it local. Know your audience and try to make your issue relevant to the community where

the story will appear. If you have facts, figures, or statistics about the local market, use them to help make the story meaningful. People want to know how this will affect them and their community.

### Be available.

Once you’ve distributed your press release, made the call or e-mail, be available for the journalist to call you back. Make it easy for them to get in touch with you, and be flexible when scheduling an interview.

### Follow up.

Once you’ve completed an interview, follow up with them to make sure they have all of the information they need and thank them for their interest in your story. Relationships are important, so do your best to be friendly, easy to work with, and accessible.

—Kristin Robinson  
NAPCRG Public  
Relations Specialist

## Research Ethics Quiz

What is the most important factor in your decision on which statistical test to use? (circle the best answer)

- |  |     |
|--|-----|
| A. The recommendation of a statistician              | 33% |
| B. The most appropriate test for the data            | 62% |
| C. The test that yields the lowest p-value           | 3%  |
| D. The recommendation of a colleague                 | 0%  |
| E. The test that is used in studies similar to yours | 5%  |

From opinion survey of NAPCRG members (41 respondents conducted at the 2009 NAPCRG Annual Meeting).

## Show Me the Money: Funding Opportunities for Researchers

### Robert Wood Johnson Foundation Calls for Proposals for Healthy Eating Research: Building Evidence to Prevent Childhood Obesity

Grants totaling approximately \$2.35 million will be awarded to public entities or nonprofit organizations working to build research on environmental and policy strategies with strong potential to promote healthy eating among children. Active Living Research, a national program of the Robert Wood Johnson Foundation (RWJF), supports research to inform policy and environmental strategies for increasing physical activity among children and adolescents, decreasing their sedentary behaviors, and preventing obesity. The program places special emphasis on reaching children and youth ages 3 to 18 who are at highest risk for obesity.

This call for proposals will support opportunistic, time-sensitive studies on emerging or anticipated changes in physical activity-related policies or environments. Rapid-response grants are expected to accelerate progress toward policy and environmental strategies to prevent and reduce childhood obesity. The final deadline is August 2, 2011.

For additional information, go to <http://www.rwjf.org/childhoodobesity/cfp.jsp?ID=21121>.

### Harold Amos Medical Faculty Development Program

The Harold Amos Medical Faculty Development Program was established to increase the number of faculty from historically disadvantaged backgrounds who can achieve senior rank in academic medicine and who will encourage and foster the development of succeeding classes of such physicians. Four-year postdoctoral research awards are offered to universities, schools of medicine, and research institutions to support the research and career development of physicians from historically disadvantaged backgrounds who are committed to developing careers in academic medicine and to serving as role models for students and faculty of similar background. The program defines the term *historically disadvantaged* to mean the challenges facing individuals because of their race, ethnicity, socioeconomic status, or similar factors. Up to eight 4-year awards will be funded in this grant cycle. Scholars will receive an annual



stipend of up to \$75,000 each, complemented by a \$30,000 annual grant toward support of research activities. The application deadline is March 16, 2011. For additional information, go to <http://www.rwjf.org/applications/solicited/cfp.jsp?ID=21348>.

### Canadian Institute of Health Research Announces Team Grant: Chronic Disease Risk and Intervention Strategies

This funding opportunity will support research teams comprised of investigators from at least two and preferably more universities AND three or more disciplines AND representative of at least two of CIHR's research themes (ie, biomedical, clinical, health systems and services, population, and public health). In addition, the multidisciplinary collaborative program needs to address a focused research question that will advance the prevention and/or management of a specific or related cardiovascular and/or respiratory chronic disease(s).

As such, the objectives of this funding opportunity are:

- to support high-quality, novel, innovative, and inventive research to address chronic

cardiovascular and/or respiratory diseases that is best approached through a collaborative team

- to advance knowledge transfer and translation concerning chronic cardiovascular and/or respiratory diseases into improved health, policies, services, products, and health care systems
- to encourage team-based research that spans from molecules to populations, is multi-disciplinary (three or more disciplines), multi-thematic (at least two of CIHR's research themes, ie, biomedical, clinical, health systems and services, population, and public health), and involves cross-disciplinary interaction among investigators from at least two and preferably more universities (Updated: 2-1-2011)
- to support expert teams of talented and experienced researchers
- to provide superior research training and mentorship environments

A letter of intent is due March 31, 2011. For further information, see <http://www.hsf.ca/research/en/general/home.html>.

## Patient-centered Medical Home (Cont'd)

who we are and tried to make work feel as fun as our homes. If this were a Medical Home started by people with different styles, interests, and tastes, I imagine it might look quite different—a good and wonderful different! I don't think medical home measurements can underestimate the "feel of home component" for patients and physicians. I think too many times in implementation of a medical home, groups/systems are trying to build medical houses. A medical house is not a home. If you have ever toured a new stucco subdivision filled with empty new houses, you won't find a single "home" there. Patients intuitively know the difference; payers do not. The challenge is to figure out how to measure this real difference. From a good home, good outcomes and value will usually be the result.

As my children get ready to become teenagers, I want to have a home where all their friends want to hang out. This will allow me to better know my kids and their friends, understand them, enjoy them as part of the family, and keep a closer eye on them. I want to be an important part of their lives and hopefully help out if their lives get too far off track. This philosophy needs to be embraced in the Medical "Home" (not medical house) movement.

Our practice has music playing through high-end sound systems (probably

a little too loud), high-definition television screens as wall art (17 screens in our six-doc practice—our patients/docs like nice TVs), three video game console systems in the waiting room where kids like to come early for their appointments, and Bistro tables in the back office where the docs can shoot the breeze and talk about patient care in a private and communal place. We still have our craftsmen toolboxes in the exam rooms and many more strange things that make it feel like home to us and our patients. New patient appointments are 1 hour, and all follow-up visits are scheduled 30 minutes with no double-booking to allow for relationship development. Our patients can access the doctor on call by cell phone after hours. We usually can come in after hours to sew up lacerations and provide initial fracture care to save them long ER waits (and give us high-yield procedures) and many more features. We have a 2-year waiting list to get into the practice. Our patients like the home, and we like them hanging out there. Just like at home, strong relationships make for a strong practice.

By 2003, we were outgrowing our space and began dreaming with some other docs in town about buying some property and building an office. Avoiding rent was the first motivation, though as we thought about what we wanted in our home, the ideas quickly exceeded

our pocketbooks. Part of our medical home success model has been building great relationships with people inside and outside the office. Our group puts in more than 1,000 hours each year volunteering—covering sporting events, participating in service events, teaching in schools, church groups, health fairs, etc. We asked for help from many of those strong relationships who shared our vision and found many community investors that helped us build a multidimensional medical mall. This home was not built just for efficient patient care and effective outcomes (important quantitative concerns), but it had to be beautiful, inviting, usable by the community and a fun place to hang out!

### **Sam Romeo, MD, MBA**

(who many of you may know from quality measurement and accreditation circles), took the lead in gathering people, sharing the vision, and enlisting resources. Three years later, the Tower Health & Wellness center was born. The idea was a Tuscan Village concept with a beautiful architecture similar to a Santa Barbara-style mission on the outside and Tuscan village on the inside. It includes a large atrium with WiFi, a Starbucks coffee stand, and many sitting tables for enjoying the day or meeting a friend. We were originally scoffed at by the architect for providing a large "unprofitable" space. Our concept was not to use it to make gobs of money but build relationships that made the community "healthier," with a place for concerts,

gatherings, health lectures and even weddings. Also there is a nice restaurant with great California wines, flower shop, day spa, pharmacy, surgery center, audiology, physical therapy, dentist, sleep center, cardiology, ENT, pulmonology, neurology, lab/X ray, and OB-GYN—all independent businesses and practices. When a patient walks in, they feel like they are at home and their needs are the primary concern. It's a place where you go to celebrate life and feel better, not sick. The idea is to try to move the current health care paradigm beyond the status quo of fixing fenders at the "body shop," or medical house, after the car accident has already happened. We are trying to move upstream and promote health in the context of a great life with meaning and purpose. Our architecture, delivery system, and relationships make this a reality. This is our perception of the medical home concept. Quality and outcomes are the secondary by-products of meaningful and rich alliances with people and their Medical Home. If we can measure the strength of the relationship that the patient has with the staff and the physicians and the ease of navigation of the delivery system, I think other secondary outcomes such as cost-effectiveness and clinical outcomes will follow suit.

Another important voice that I haven't heard mentioned much in the Medical

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## Patient-centered Medical Home (Cont'd)

Home movement is the Accreditation Association for Ambulatory Health Care (AAAHC) medical home accreditation process. Our group was the first private practice to earn a 3-year accreditation as a medical home. We found the process rewarding and engaging. To our practice, the *National Committee for Quality Assurance* (NCQA) model seems to be very payer defined (not patient defined). If we try to build medical houses according to this model, I doubt our patients will know the difference as we

fill out our NCQA forms/reports and get that stamp of approval. Our practice found the AAAHC model to be a collaborative, onsite process that improved our patient care. It's one thing to say you do things well and produce a report that shows you are compliant (NCQA model), it's another to have someone rifle through your sock drawer and spend 2 days with you in observation—and then say "Yes, this is indeed a medical home."

One last anecdote (and if you are still reading—I'm

amazed and hope this cures your insomnia). When we opened the Tower Health and Wellness Center in early 2006, one of our first patients in our primary care office had a suspicious abdomen for appendicitis. The general surgeon walked over to our office/home and verified the diagnoses. I had the honor of walking the patient over to the surgery center (which seems like a nice hotel), help her get checked in and get labs done, she had her surgery and went home that afternoon. Great office visit! The delivery system, the access, the strength of relationship with primary care to trust this strange

surgeon who walks into the exam room, puts the patient at the center of the medical home. This makes primary care fun again! I won't bore you with the financial challenges of making an undertaking like this viable; this is too long already.

Most importantly, as NAPCRG strives to make the Medical Home a reality for more patients in North America and beyond, I hope these stories give some fuel to the efforts.

—Chris J. Hawley, MD,  
Medical Director,  
Wellness and Prevention  
Romeo Medical Clinic  
Turlock, CA



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## NAPCRG Annual Meeting Presenters

### *Please Post Your Presentations on the STFM Resource Library*

To access the STFM Resource Library (FMDRL), go to [www.fmdrl.org](http://www.fmdrl.org), enter your NAPCRG username (usually your e-mail address) and password since it is the same as your Resource Library username and password. If you don't yet have a NAPCRG log in or Resource Library account yet or have forgotten your password, you can create a new one by going to <http://fmdrl.org/index.cfm?event=c.showSignUpForm>. Once you follow the directions to create a log in, you should remember this log in as it is the log in you will also use for posting to the STFM Resource Library and for accessing the NAPCRG Members Only Web site.



**Join us in Banff for a great time!**

**NAPCRG Annual Meeting**

**November 12–16, 2011**

## Chairperson of the Department of Family Medicine and Public Health Sciences



Wayne State University School of Medicine is seeking a distinguished physician for the position of Chairperson for the Department of Family Medicine and Public Health Sciences (DFMPHS).

The DFMPHS at WSU is one of the most highly rated programs in the country and has made numerous pioneering contributions to the field of family medicine. With 37 faculty and a research portfolio of \$3.1M, the WSU DFMPHS is ranked 4th in NIH research expenditures with considerable expertise in the areas of racial and ethnic health disparities, practice-based research, occupational/environmental health and cancer epidemiology.

Its affiliated hospitals include Crittenton Hospital Medical Center, Karmanos Cancer Center, John D. Dingell Veterans Administration Hospital and Henry Ford Health System, with Crittenton Hospital MC as the principal teaching hospital for DFMPHS. The department has two strong GME programs: WSU/Crittenton Family Medicine Program and a Transitional Year Residency Program both of which have been recognized in WSU's GME reviews as exemplary programs and received commendations by the ACGME. The DFMPHS is also home to the MPH Program at WSU.

Candidates must possess consummate leadership skills, finance acumen and a strategic vision to provide future direction to a preeminent multi-faceted department with a robust research program. The successful applicant will hold an MD or MD, MPH or other combined degree from an accredited institution, and be board certified in family medicine.

Interested and qualified applicants please submit a letter of interest and CV to [cvolpe@med.wayne.edu](mailto:cvolpe@med.wayne.edu) and addressed to:

Andre Konski, MD, MBA, MA, FACR  
Chair, DFMPHS Search Committee  
c/o Caryn Volpe  
Wayne State University School of Medicine  
C.S. Mott Center for Human Growth and Development  
275 E. Hancock  
Detroit, MI 48201