

1                   **American Academy of Family Physicians (AAFP)**  
2                   **American Academy of Pediatrics (AAP)**  
3                   **American College of Physicians (ACP)**  
4                   **American Osteopathic Association (AOA)**  
5

6                   **Joint Principles for the Medical Education of Physicians as**  
7                   **Preparation for Practice in the Patient-Centered Medical Home**  
8                   **December 2010**  
9

10                   **INTRODUCTION**  
11

12                   The Patient-Centered Medical Home (PCMH) is an approach to providing  
13                   comprehensive, continuous healthcare that is based on the foundation of a  
14                   healing personal relationship between a patient, their physician, and members of  
15                   a proactive, collaborative care team. Care provided through a PCMH is facilitated  
16                   through partnerships between these individuals and the patients' families. Since  
17                   the original adoption of the Joint Principles of the Patient Centered Medical  
18                   Home in February 2007, it has been recognized that a remaining need exists for  
19                   a similar set of principles to guide the education of medical students, in order to  
20                   provide a foundation in primary care medicine and PCMH relevant for all  
21                   students, irrespective of their eventual specialty choice.  
22

23                   In June 2010, representatives from the AAFP, AAP, ACP and AOA (the original  
24                   organizations that ratified the Joint Principles of the PCMH) re-engaged to create  
25                   the following principles to guide the education of physicians who graduate from  
26                   medical schools within the United States. While similar principles can, and  
27                   should, be applied to other health professions students, it was the specific charge  
28                   of this committee to create training principles for physician education.  
29

30                   A matrix was created to support the cross-walk among the original Joint  
31                   Principles of the PCMH, the attributes and competencies needed to address  
32                   them, and the corresponding educational sub-principles to support each one. In  
33                   addition, each educational sub-principle was linked with the pertinent  
34                   ACGME/ABMS core competencies of medical education. [Appendix A]  
35

36                   **PRINCIPLES OF THE PATIENT CENTERED MEDICAL HOME**  
37

38                   *Personal physician* - Each patient has an ongoing relationship with a personal  
39                   physician trained to provide first contact, continuous and comprehensive care.  
40

41                   Attributes/Competencies Needed

42                   Medical students should demonstrate knowledge about the definition\_of  
43                   patient-centeredness and must be able to demonstrate the ability to  
44                   provide patient centered care in their clinical encounters.  
45

46                   Corresponding Educational Sub-Principles

- 47 Medical students are expected to:
- 48 1. experience continuity in relationships with patient(s) in a
  - 49 longitudinal fashion within practices that deliver first-contact,
  - 50 comprehensive, integrated, coordinated, high-quality and affordable
  - 51 care.
  - 52 2. communicate effectively and demonstrate caring and respectful
  - 53 behaviors when interacting with patients and their families and
  - 54 fellow professionals.

55

56 *Physician directed medical practice* - The personal physician leads a team of

57 individuals at the practice level who collectively take responsibility for the ongoing

58 care of patients.

59

60 Attributes/Competencies Needed

61 Medical students should be able to demonstrate collaborative care via

62 leadership skills that result in effective information exchange and teaming

63 with patients, their patients' families, and professional associates.

64

65 Corresponding Educational Sub-Principles

- 66 Medical students are expected to:
- 67 1. work effectively with others as a member or leader of a health care
  - 68 team or other professional group via interdisciplinary team
  - 69 experiences (i.e. those involving nurses, social worker, case
  - 70 managers, mental health professionals, diabetes educators,
  - 71 community partners, pharmacists, etc).
  - 72 2. articulate the roles, functions and working relationships of all
  - 73 members of the team.
  - 74 3. apply knowledge of leadership development, quality improvement,
  - 75 change management and conflict management.

76

77 *Whole-person orientation* - The personal physician is responsible for providing for

78 all the patient's health care needs or taking responsibility for appropriately

79 arranging care with other qualified professionals. This includes for all stages of

80 life: acute care; chronic care; preventive services; and end-of-life care.

81

82 Attributes/Competencies Needed

83 Medical students should be able to provide patient care that is

84 compassionate, coordinated, appropriate, and effective for the treatment

85 of health problems and the promotion of health.

86

87 Corresponding Educational Sub-Principles

- 88 Medical students are expected to:
- 89 1. demonstrate knowledge and an appreciation of life cycle concepts.
  - 90 2. practice motivational interviewing and utilization of other tools to
  - 91 promote patient and family engagement and health behavior
  - 92 change.

- 93 3. promote patient and family self-efficacy and shared decision-  
 94 making.  
 95 4. experience partnerships with health coaches and care coordinators  
 96 who care for patients with complex conditions.  
 97 5. demonstrate sensitivity and responsiveness to patients' culture,  
 98 age, gender and disabilities via opportunities to elicit from patients  
 99 and/or their families their cultural, spiritual, and ethical values and  
 100 practices.  
 101 6. understand the importance of health literacy and its impact on  
 102 patient care and outcomes; utilize effective listening and other skills  
 103 in the assessment of health literacy.  
 104 7. describe and discuss strategies needed to address patient  
 105 transition(s) of care.  
 106

107 *Care is coordinated and/or integrated* across all elements of the complex health  
 108 system (e.g. subspecialty care, hospitals, home health agencies, nursing homes)  
 109 and the patient's community (e.g. family, public and private community based  
 110 services). Care is facilitated by registries, information technology, health  
 111 information exchange and other means to assure that patients get the indicated  
 112 care when and where they need and want it, in a culturally and linguistically  
 113 appropriate manner.  
 114

#### 115 Attributes/Competencies Needed

116 Medical students should be able to demonstrate an awareness of and  
 117 responsiveness to the larger context and system of health care and the  
 118 ability to effectively call on system resources to provide care that is of  
 119 optimal value.  
 120

#### 121 Corresponding Educational Sub-Principles

122 Medical students are expected to:

- 123 1. know how the economics of health care systems across a  
 124 community, including all settings of care, affect patient care and  
 125 outcomes.  
 126 2. apply knowledge of the relationship between payment models and  
 127 health care delivery models.  
 128 3. experience the use of electronic health records, e-visits, e-  
 129 prescribing and electronic billing.  
 130 4. learn the basics of medical informatics and the technologies that  
 131 support care coordination, population health management, quality  
 132 management, care management and decision support.  
 133 5. understand basic principles of population health, including how  
 134 patient registries can be used to manage population health  
 135 6. use information technology to manage information, access on-line  
 136 medical information; and support their own education.  
 137 7. know and apply the principles of patient safety.  
 138 8. assess and recommend solutions to address patient risk during  
 139 transitions of care including use of tools such as care plans.

- 140 9. demonstrate knowledge of community resources and the  
 141 importance of working with non-physician partners  
 142 10. understand how to collaborate with specialists from various  
 143 disciplines to provide patient-focused co-management of care over  
 144 time.  
 145

146 *Quality and safety are hallmarks* of the medical home:

- 147 - Advocacy for attainment of optimal, patient centered outcomes defined by  
 148 collaborative care planning process
- 149 - Evidence based medicine and clinical decision support tools guide decision  
 150 making
- 151 - Physicians accept accountability for quality improvement (QI) through  
 152 voluntary engagement in performance measurement and improvement
- 153 - Patients actively participate in decision making and patient feedback is sought  
 154 to assure expectations are being met
- 155 - HIT is used to support optimal patient care performance measurement,  
 156 patient education and enhanced communication
- 157 - Practices go through a voluntary recognition process to demonstrate that they  
 158 have PCMH capabilities
- 159 - Patients and families participate in quality improvement activities at the  
 160 practice level

161

162 Attributes/Competencies Needed

163 Medical students should be able to use of point-of-care evidence-based  
 164 clinical decision support and know principles of performance improvement,  
 165 measurement and how to use information to make decisions within  
 166 practice via interpretation of quality reports, patient and family  
 167 engagement, self-assessment of one's own performance, knowledge of  
 168 the principles of community health assessment and awareness of the  
 169 need for patient and family advocacy skills.  
 170

171

172 Corresponding Educational Sub-Principles

173 Medical students are expected to:

- 174 1. understand evidence-based medicine as the standard of care.
- 175 2. participate in teams within practices as they develop a culture of  
 176 learning to improve the care process and patient experience.
- 177 3. learn how health care is operationalized outside of the hospital  
 178 setting.
- 179 4. participate in multi-disciplinary patient safety training experiences.
- 180 5. engage in opportunities to review quality data and recommend  
 181 evidence-based systems changes to respond to performance  
 182 measurement.

183

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

187 Attributes/Competencies Needed

188 Medical students should be able to demonstrate knowledge about the  
 189 rationale and principles of enhanced access and practice the use of non-  
 190 traditional encounter types including telephone medicine, E-visit care,  
 191 group visits, visits with non-physician providers, and care outside of the  
 192 location of the physical practice.

193

194 Corresponding Educational Sub-Principles

195 Medical students are expected to:

- 196 1. experience a variety of different encounter types such as face-to-  
 197 face, telephone and electronic messaging, home-based care and  
 198 group visits.  
 199 2. use information technology to support patient care decisions and  
 200 patient education.  
 201 3. apply knowledge of care partnership support and demonstrate  
 202 understanding of the role of that support in addressing patient  
 203 access and communication related to roles/responsibilities,  
 204 appointments, emergency/urgent situations, etc.

205

206 *Payment* appropriately recognizes the added value provided to patients who  
 207 have a PCMH.

- 208 - Recognizes and values work that is done outside of face-to-face visit  
 209 - Pays for care coordination, ancillary providers and community resources  
 210 - Supports adoption of HIT for quality improvement  
 211 - Supports provision of e-communication  
 212 - Recognizes values of physician work associated with remote monitoring of  
 213 clinical data using technology  
 214 - Maintains fee-for-service (FFS)  
 215 - Recognizes case mix differences  
 216 - Allows shared savings from reduced hospitalizations  
 217 - Allows for quality bonus or incentive payments for measurable improvement

218

219 Attributes/Competencies Needed

220 Medical students should demonstrate knowledge of the elements of  
 221 population-based care, non-visit work, and have an appreciation of the  
 222 value of these aspects of care through an understanding of enhanced  
 223 payment opportunities and both an understanding and capacity to apply  
 224 the principles of advocacy and effective negotiation.

225

226 Corresponding Educational Sub-Principles

227 Medical students are expected to:

- 228 1. know various physician payment methodologies (including those  
 229 encompassing of past, current and future policies).  
 230 2. assist patients in dealing with system complexities via advocacy  
 231 and negotiation

- 232 3. be informed of the public and private policy development processes  
 233 that establish and/or influence coverage and payment  
 234 determinations.  
 235 4. understand the importance of effectively advancing those policies  
 236 that are in the best interests of their patients and the nation's health  
 237 care system.  
 238 5. be familiar with current data on the overall cost of health care  
 239 including an understanding of the proportion of health care dollars  
 240 spent on various segments of the health care system, those costs  
 241 incurred by patients, as well as the overall costs of health care for  
 242 employers and the government.  
 243

## 244 RESOURCES

245  
 246 Adding these components to undergraduate education in a cohesive manner will  
 247 also require additional resources. Some of the sub-principles can be  
 248 implemented by adding students into already existing patient-care and practice-  
 249 based activities. However, in other cases, it will be necessary to dedicate faculty  
 250 and staff to create and oversee new experiences for the students. This may  
 251 require including disciplines that have not traditionally taught medical students,  
 252 including faculty with expertise in economics, health policy, or business  
 253 administration. Additionally, it may be necessary to find ways to better assist and  
 254 compensate community-based ambulatory practices for taking on students.  
 255 Finally, resources may be needed for infrastructure development to provide  
 256 students with the necessary tools, including access to electronic health records,  
 257 registries, and quality improvement tools, to experience some of the systems-  
 258 based aspects of the PCMH.

259

## 260 UNMET NEEDS

261

262 Professional development to prepare faculty for health reform changes is a  
 263 prerequisite to training medical students in both primary and specialty care. It is  
 264 recognized that resident physicians will also be integral components of medical  
 265 student education in PCMH concepts. Faculty development is a current **unmet**  
 266 **need** of this generation of faculty members with respect to how to teach medical  
 267 students and residents about the PCMH.

268

269 The current educational system lacks the necessary tools for the evaluation and  
 270 the assessment of learners with regard to the education of medical students and  
 271 residents in the principles and attributes/competencies of the PCMH.

272

273 There is an urgent need for demonstration projects that will inform both methods  
 274 of faculty development as well as the development of assessment tools and  
 275 outcomes measures.

276

## 277 BACKGROUND OF THE MEDICAL HOME CONCEPT

278  
279 The American Academy of Pediatrics (AAP) introduced the medical home  
280 concept in 1967, initially referring to a central location for archiving a child's  
281 medical record. In its 2002 policy statement, the AAP expanded the medical  
282 home concept to include these operational characteristics: accessible,  
283 continuous, comprehensive, family-centered, coordinated, compassionate, and  
284 culturally effective care.

285  
286 The American Academy of Family Physicians (AAFP) and the American College  
287 of Physicians (ACP) have since developed their own models for improving  
288 patient care called the "medical home" (AAFP, 2004) or "advanced medical  
289 home" (ACP, 2006).

290

## 291 **WORKING GROUP CONTRIBUTORS**

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293 Members of the working group who volunteered their time and expertise to  
294 prepare this document are listed in Appendix B.

295

## 296 **FOR MORE INFORMATION:**

297

298 American Academy of Family Physicians

299 <http://www.futurefamilymed.org>

300 <http://www.aafp.org/online/en/home/membership/initiatives/pcmh.html>

301 <http://www.transformed.com/>

302 <http://www.stfm.org/fmhub/fm2007/January/Ardis24.pdf>

303

304 American Academy of Pediatrics:

305 [http://aappolicy.aappublications.org/policy\\_statement/index.dtl#M](http://aappolicy.aappublications.org/policy_statement/index.dtl#M)

306 <http://www.medicalhomeinfo.org>

307 <http://www.pediatricmedhome.org>

308 [http://www.medicalhomeinfo.org/how/performance\\_management.aspx](http://www.medicalhomeinfo.org/how/performance_management.aspx)

309

310 American College of Physicians

311 [http://www.acponline.org/running\\_practice/pcmh/](http://www.acponline.org/running_practice/pcmh/)

312 [http://www.acponline.org/advocacy/where\\_we\\_stand/medical\\_home/](http://www.acponline.org/advocacy/where_we_stand/medical_home/)

313

314 American Osteopathic Association

315 <http://www.DO-Online.org>

**Joint Principles Mapping Grid for Educational Sub-principles Development Project  
July 2010**

**Column 1** – Existing Joint Principles of the Patient Centered Medical Home

**Column 2** – Attributes/competencies needed by physicians for medical home practice. Listed are a few examples – this will be developed by working group members based on their knowledge and experience in the PCMH module and the relevant literature provided.

**Column 3** – This is intended for listing key concepts that the working group desires to have included in the language of the educational sub-principles

**Column 4** – This is intended to cross walk the educational sub-principles to the core competencies.

| Joint Principle of the PCMH   | Attributes/Competencies Needed   | Corresponding Educational Sub-principle  | Crosswalk to Core Competencies<br><small>Key: PC = Patient Care; MK= Medical Knowledge; IC= Interpersonal &amp; Communication Skills; P= Professionalism; PBL= Practice-based Learning &amp; Improvement; SBP= Systems-based Practice</small> |
|---|--|--|---|
| <b>Personal physician.</b> Each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care                           | <ul style="list-style-type: none"> <li>• <i>Defining and demonstrating patient-centeredness in their clinical encounters</i></li> <li>• <i>Demonstrating enhanced, timely, multi-modal communications between the practice and patients/families to assure continuous care</i></li> <li>• <i>Including patients/families as advisors to the medical home, eliciting input and feedback on a continuous basis</i></li> </ul>                            | <ul style="list-style-type: none"> <li>• <i>Curriculum should provide students with longitudinal experience(s) in continuity relationships with patient(s) in practices that deliver first-contact, comprehensive, integrated, coordinated, high-quality and affordable care.</i></li> <li>• <i>Curriculum should include training in communication skills with patients, families and fellow professionals.</i></li> </ul>  | <ul style="list-style-type: none"> <li>• <i>PC, P, SBP</i></li> <li>• <i>IC, P</i></li> </ul>   |
| <b>Physician-directed medical practice.</b> The personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients. | <ul style="list-style-type: none"> <li>• <i>Collaborative care</i> <ul style="list-style-type: none"> <li>– <i>All team members are accountable for their roles and responsibilities in delivering high-quality care</i></li> <li>– <i>All team members demonstrate respect for all other team members</i></li> </ul> </li> <li>• <i>Team building</i></li> <li>• <i>Leadership skills</i></li> <li>• <i>Change and conflict management</i></li> </ul> | <ul style="list-style-type: none"> <li>• <i>Students should experience interdisciplinary teams (i.e. nurses, social workers, case managers, mental health professionals, diabetes educators, community partners and/or pharmacists)</i></li> <li>• <i>Students should be able to articulate the roles, functions and working relationships of all other members of the team.</i></li> <li>• <i>Curriculum should include experiences in leadership development, quality improvement, and change management.</i></li> </ul> | <ul style="list-style-type: none"> <li>• <i>SBP, IC, P, PC</i></li> <li>• <i>SBP, P</i></li> <li>• <i>P, PBL</i></li> </ul>   |
| <b>Whole-person orientation.</b> The personal physician is responsible for providing for all the patient's  | <ul style="list-style-type: none"> <li>• <i>Life cycle knowledge/appreciation</i></li> <li>• <i>Patient engagement /motivational interviewing</i></li> </ul>   | <ul style="list-style-type: none"> <li>• <i>Students should be taught to assess patient/family readiness to engage in health behavior change, to promote patient self-efficacy, and to facilitate health behavior change.</i></li> </ul>   | <ul style="list-style-type: none"> <li>• <i>MK, IC,</i></li> </ul>  |



|   |   |  |   |
|---|---|--|---|
| <p>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.</p>   | <ul style="list-style-type: none"> <li>• <i>Promotion of patient self-efficacy</i></li> <li>• <i>Promotion of shared decision-making</i></li> <li>• <i>Transitions of care</i></li> <li>• <i>Promotion of health and wellbeing</i></li> <li>• <i>Assessment of and respect for cultural values and practices</i></li> <li>• <i>Assessment of health literacy</i></li> </ul>   | <ul style="list-style-type: none"> <li>• <i>Students should be exposed to health coaches and care coordinators who care for patients with complex conditions.</i></li> <li>• <i>Students should have opportunities to elicit from patients and/or their families their cultural, spiritual, and ethnic values and practices.</i></li> <li>• <i>Students should be taught how to assess and accommodate to diverse levels of health literacy.</i></li> </ul>  | <ul style="list-style-type: none"> <li>• <i>MK, SBL, IC, P</i></li> <li>• <i>MK, PC</i></li> <li>• <i>MK, PC, IC</i></li> </ul>   |
| <p><b>Care is coordinated and/or integrated</b> 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 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.</p>   | <ul style="list-style-type: none"> <li>• <i>Effective transitions of care</i></li> <li>• <i>Knowledge of community resources and working with non-physician partners</i></li> <li>• <i>Use of EMRs/HIT at points of care</i></li> <li>• <i>Registry use</i></li> <li>• <i>Population health</i></li> <li>• <i>Coordination/collaboration with specialists, co-management of care over time</i></li> <li>• <i>The value of patient advocacy</i></li> </ul>   | <ul style="list-style-type: none"> <li>• <i>Students should be exposed to the economics of health care systems across a community, including all settings of care.</i></li> <li>• <i>Students should learn the relationship between payment models and health care delivery models.</i></li> <li>• <i>Students should learn the basics of medical informatics and the technologies that support care and population management..</i></li> <li>• <i>Students should be exposed to electronic health records, e-visits, e-prescribing and electronic billing.</i></li> <li>• <i>Students should be taught principles of population health, including how patient registries can be used to manage population health.</i></li> <li>• <i>Students should be taught principles of patient safety.</i></li> <li>• <i>Students should be able to assess and recommend solutions to address patient risk during transitions of care, including use of tools such as care plans.</i></li> </ul> | <ul style="list-style-type: none"> <li>• <i>SBP</i></li> <li>• <i>SBP</i></li> <li>• <i>MK, PBL</i></li> <li>• <i>PBL, SBP</i></li> <li>• <i>MK, SBP</i></li> <li>• <i>PBL, MK</i></li> <li>• <i>PBL, MK</i></li> </ul> |
| <p><b>Quality and safety are hallmarks</b> of the medical home:</p> <ul style="list-style-type: none"> <li>• Advocacy for attainment of optimal, patient centered outcomes defined by collaborative care planning process</li> <li>• Evidence based medicine and clinical decision support tools guide decision making</li> <li>• Physicians accept accountability for quality improvement (QI) through voluntary engagement in performance measurement and improvement</li> <li>• Patients actively participate in decision making and patient feedback is sought to assure expectations are being met</li> <li>• HIT is used to support optimal patient care performance measurement, patient education and enhanced communication</li> </ul> | <ul style="list-style-type: none"> <li>• <i>Use of point-of-care evidence based clinical decision support</i></li> <li>• <i>Interpretation of quality reports</i></li> <li>• <i>Knowing principles of performance improvement, measurement and how to use information to make decisions within practice</i></li> <li>• <i>Patient and family engagement</i></li> <li>• <i>Self-assessment of one's own performance</i></li> <li>• <i>Knowledge of the principles of community health assessment</i></li> <li>• <i>Patient and family advocacy skills</i></li> </ul> | <ul style="list-style-type: none"> <li>• <i>Students should participate in teams within practices as they develop a culture of learning to improve the care process and patient experience.</i></li> <li>• <i>Students should learn how health care is operationalized outside of the hospital setting.</i></li> <li>• <i>Students should participate in multi-disciplinary patient safety training experiences.</i></li> <li>• <i>Students should have opportunities to review quality data and recommend evidence-based systems changes to respond to performance assessment.</i></li> </ul>   | <ul style="list-style-type: none"> <li>• <i>SBP, PBL</i></li> <li>• <i>SBP</i></li> <li>• <i>PBL, P, MK</i></li> <li>• <i>PBL</i></li> </ul>  |

|   |  |   |  |
|---|--|---|--|
| <ul style="list-style-type: none"> <li>Practices go through a voluntary recognition process to demonstrate that they have PCMH capabilities</li> <li>Patients and families participate in quality improvement activities at the practice level</li> </ul>   |  |   |  |
| <p><b>Enhanced Access</b> to care is available through systems such as open scheduling, extended hours, and new options for communications between patients, their personal physician and practice staff</p>  | <ul style="list-style-type: none"> <li>Understanding of rationale and principles of enhanced access</li> <li>Phone medicine</li> <li>Electronic communication</li> <li>Group Visits</li> <li>Visits with non-physician providers</li> <li>Care outside of the location of the physical practice</li> </ul> | <ul style="list-style-type: none"> <li>Students should experience a variety of different encounter types provided by other team members (e.g. shadowing experiences with pharmacists, nurses, social workers, schedulers and receptionists)</li> <li>Students should experience a variety of different encounter types such as face-to-face, telephone and electronic messaging, and group visits</li> </ul>  | <ul style="list-style-type: none"> <li>PC, IC</li> <li>PC, IC</li> </ul>               |
| <p><b>Payment</b> appropriately recognizes the added value provided to patients who have a PCMH</p> <ul style="list-style-type: none"> <li>Recognizes and values work that is done outside of face-to-face visit</li> <li>Pays for care coordination, ancillary providers and community resources</li> <li>Supports adoption of HIT for QI</li> <li>Supports provision of e-communication</li> <li>Recognizes values of physician work associated with remote monitoring of clinical data using technology</li> <li>Maintains FFS</li> <li>Recognizes case mix differences</li> <li>Allows shared savings from reduced hospitalizations</li> <li>Allows for quality bonus or incentive payments for measurable improvement</li> </ul> | <ul style="list-style-type: none"> <li>Knowledge of elements of population-based care, non-visit work and appreciation of value of these aspects of care</li> <li>Understanding of enhanced payment opportunities</li> <li>Understanding and application of the principles of advocacy</li> </ul>          | <ul style="list-style-type: none"> <li>Students should receive well-balanced instruction on physician payment methodologies that is encompassing of past, current and future policies.</li> <li>Students should be informed of the public and private policy development processes that establish and/or influence coverage and payment determinations. It is desirable that students learn how they, as future physicians, can effectively advance those policies that are in the best interests of their patients and the nation's health care system.</li> <li>Students should be familiar with current data on the overall cost of health care. This should include an understanding of the proportion of health care dollars spent on various segments of the health care system, those costs incurred by patients, as well as the overall costs of health care for employers and the government, and to the extent known, the relationship between costs and quality of care..</li> </ul> | <ul style="list-style-type: none"> <li>MK</li> <li>MK, SBP</li> <li>MK, SBP</li> </ul> |

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\*\*\* Prerequisite to training: Faculty development is a current **unmet need** of this generation of faculty members, with respect to how to teach medical students and residents about the PCMH – this needs attention.

**Working Group Contributors**

330

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