Editorial

Patient-centered medical home: Ushering a perestroika in diabetes care

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Diabetes has evolved as a costly lifestyle disorder globally.[1] Medical fraternity has come a long way since the discovery of insulin in designing strategies for intervention at the secondary and tertiary levels. Recent guidelines[2] have proposed patient-centered approach to manage the "medical" aspect of diabetes. Individualized and customized approach has been encouraged more and more, and quite justifiably so.

In this context, a new approach called patient-centered medical home (PCMH) deserves special mention. At the present time, the four core attributes of diabetes care are patient-centered approach, self-management, patient empowerment, and team-based care.[3] Unfortunately, the approach of health care delivery system in developing countries like India towards chronic care is discordant and episodic, to say the least. Even if we understand and discuss a lot, we are yet to formulate a vision of chronic care in the backdrop of the aforesaid attributes. Hence, it becomes pertinent to discuss and critically appraise the PCMH model [Tables 1 and 2].

The existence of PCMH can be best described as conceptual than physical or institutional. In a conventional approach of care, patients receive care only when they seek it, which is through mere episodic contact between them and the health care providers. Here, patients and relatives are solely responsible for coordinating the different elements of health care delivery system such as receiving medical nutrition therapy, interpretation of laboratory results, receiving requisite prescriptions, and interventions by allied sub-specialties for secondary and tertiary prevention, psychological counseling etc., to name a few. In the PCMH model, patients are no longer responsible for the coordination part because the collective responsibility lies with the entire team of professionals under the leadership of the physician/diabetologist. Such reversal of responsibility enables the patients to access to their

Access this article online	
Quick Response Code:	Website: www.joshd.net
	DOI: 10.4103/2321-0656.152798

Table 1: Important components of PCMH model in South Asian context

Philosophy of service	Domains of service	Provision of service
Person-centered Bio-psychosocial approach Life stage sensitivity Cultural competency	Diagnostic and therapeutic services Integrated lifestyle, medical management Integrated diabetes education, counseling, support Management of simple complications Referral for complex challenges	Team-based Interactive communications Active patient participation Family involvement Çommunity involvement Quality check and audit

PCMH: Patient-centered medical home

Table 2: The core attributes of PCMH which are relevant to diabetes care

Appropriateness
Awareness
Availability
Accessibility
Affordability
Authenticity
Adaptability
Acceptability
Accommodativeness
Accountability
Accomplishment

PCMH: Patient-centered medical home

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HCP on 24/7 basis, and episodic contacts during actual clinic visits are supplanted by meaningful inputs and fruitful interactions between patients and HCPs. If the implementation of the PCMH model is done to a logical end, it would no doubt usher a *perestroika* of some sort in the chronic care where patients will receive care when they need it, not only when they seek it.[4]

In the US, PCMH model has made deep inroads to the existing chronic care delivery systems in general, and diabetes care, in particular. Availability of skilled manpower in terms of resident nurse practitioners, diabetes educators, and dieticians/nutritionist has made their job a lot easier. The problem in developing countries like ours is mainly two; on one hand, we have huge numbers of patients to care for, and on the other hand, we have to do the same with far smaller pool of skilled HCPs. That should not imply that we discard the PCMH model as a supreme luxury. In fact, thoughtful inputs and meaningful intervention to prevent the complications related to diabetes at the primary and secondary levels have proven to be far more cost effective than expensive tertiary care which can be provided only in well-equipped institutions. It is high time society and government of the day took serious note of this.

Assigning part of responsibilities of chronic care to family members can play a complementary role in a holistic approach to providing chronic care. A recent multinational study has shown that the role of families in assisting patients needing diabetes care is more elaborate and active in countries like India than the West.[5] Integration of such unique quality of our society in the PCMH model, as suggested by experts[6] may help us overcome limitations such as lack of skilled HCPs in our endeavor to ushering in the *perestroika* in current standard of chronic care in our country.

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How to cite this article: Baruah MP, Das AK, Kalra S. Patient-centered medical home: Ushering a perestroika in diabetes care. J Soc Health Diabetes 2015;3:70-1.

Source of Support: Nil. **Conflict of Interest:** None declared.