COMMENTARY

# Patient-Centered Medical Home (PCMH) Recognition: A Time for Promoting Innovation, Not Measuring Standards

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Disruption, uncertainty, fear, promise, change, frustration, and energy all bundle together uncomfortably in our current unstable and unpredictable climate of health care reform and turbulence. The troubled landscape of family medicine and primary care offers stark evidence of this, and the patient-centered medical home (PCMH) represents an exciting possibility out of this predicament. In such times, it is all the more essential that primary care practices, payers, policymakers, and users get much needed guidance, assurance, and transparency about what changes and emerging innovations are most likely to be beneficial. The National Committee for Quality Assurance's (NCQA) PCMH recognition program intends to do just that. The policy brief in this issue[1] strongly suggests otherwise. Only 40% of a national cohort of primary care practice innovators sought and achieved NCQA PCMH recognition, and 45% of this national cohort did not even consider seeking such recognition for their work and innovations. Unfortunately, these findings are not surprising and support what others have suggested.[2] Why? One possibility is that the NCQA criteria do not recognize many of these innovations. Another is that the innovators find the burden of obtaining recognition greater than any benefit. But it does not have to be this way.

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See Related Article on Page 312.

## What's the Problem with Current PCMH Recognition Standards?

The 2008, 2011, and newest 2104 NCQA PCMH recognition requirements function more as standards for certification rather than guideposts of progress worthy of recognition as they are reached. The current checklists and cumbersome compilation and submission process assumes we know what a PCMH and practice transformation explicitly look like. We do not—the "best practice" PCMHs are still emerging and being invented. PCMH is a label or meme for a particular and critically important movement in primary care. As a meme, the PCMH represents a place of care integration, family and patient partnership and engagement, and operationalization of the primary care core attributes of personal, first-contact access, comprehensive, and coordinated care.[3] It establishes a promise—the triple aim[4] of optimal population health and an exceptional experience for patients and families at a lower cost as well as greater equity—and sets a direction. The PCMH recognition approach should support both the PCMH movement's intentions and its current need for rapid-cycle learning of what models and processes best achieve those intentions. This is not the time to prematurely set standards. A more useful PCMH recognition process will keep it simple, provide motivation and direction, and recognize the developmental trajectory of change.[5]

Over the past 6 years, the NCQA has adjusted its PCMH recognition requirements. The 2011 version expanded beyond 2008's emphasis on information technology and care management to acknowledge an emerging emphasis on teams, population management, cultural sensitivity, and patient experience. The new 2014 requirements continue this expansion. Unfortunately, little comes off the lists and the expectations remain overspecified.

Meanwhile, disruptive innovations in the delivery of primary health care services keep emerging—some in an effort to achieve primary care's promise of the triple aim and others seeking to take advantage of currently unmet primary care needs in the hope of making a profit. Examples include retail clinics, urgent care, e-health, mobile health, telehealth, direct care, nurse-led practices, behavioral health integration, patient and community advisory councils, flow stations, and workforce innovations. Many of these innovations present exciting opportunities for the PCMH, whereas others are more problematic. Overspecification of recognition requirements prevents us from discerning the difference or even paying attention. Innovators imagine and create new possibilities. Early adopters seek those innovations that hold much promise, while the early majority scans the horizon for what the future may bring and begins preparing. What are we doing to foster and direct creative imagination, to identify and spread the promising innovations, and to help prepare practices for the emerging future?

### *Is There a Better Way to Motivate, Assess, and Recognize the Work of PCMH Transformation?*

Fortunately, we already know 5 simple rules and 3 corollaries or attractors necessary for a PCMH to achieve the triple aim.[3,6,7] The 5 rules are as follows: (1) engage patients and families in both their own care and the processes of change; (2) promote and assure first contact access at all times; (3) assure that all care needs are met at the point of service and that the care is appropriate and the highest quality at least 80% of the time; (4) coordinate, track, and assist all other needed care; and (5) keep it personal and over time. The 3 corollaries include (1) organize medical services around the needs of everyone in the family; (2) assess and address community health strengths and needs; and (3) assure cultural sensitivity and responsiveness.

Since 2006, more than 100 pilot or demonstration projects on PCMH were implemented, and at least 52 have reported outcomes after 2 years.[8,9] An overview of these reveals at least 5 variations of PCMH that seem to be on a developmental trajectory. These include the "add-on," the "renovated," the "hybrid," the "integrated," and the "transformed." We can also identify some important stepping stones as practices seek to implement the simple rules and corollaries[5,10] as they develop their PCMH. Practices first need to become aware of how they are already performing in the 8 areas and create forums for conversations about those data in their practices. At this point, they can begin adding care management functions or behavioral health and/or choose to work on renovating workflow, developing teams, and improving practice processes. Once the selected initial changes are in place and stable, they can begin the other and become a "hybrid" PCMH. The next stage, integration, involves the most difficult changes, as shifts in mental models and identity often are necessary. Integration refers to fully integrating behavioral health, connections with community agencies, and the medical neighborhood into practice processes and teams. Finally, practices face the challenges of sustaining these multiple changes over time along with continuous improvement as they pursue transformation. All this work focuses on meeting the 5 simple rules and 3 corollaries.

What if the NCQA or other PCMH recognition processes are simply about how each practice successfully addresses the 5 simple rules and 3 corollaries? There would be PCMH readiness recognition for those practices that are transparent about their current state relative to the rules and corollaries; they can assess and visualize all 8. Level 1 recognizes those practices that successfully implement an add-on function and/or renovate workflow in ways that measurably improve the core attributes. Level 2 recognizes the difficult work of integrating behavioral health, the community, and medical neighborhoods into the PCMH, and level 3 represents sustained and demonstrated improvement of the 8 core attributes over at least 2 years. The innovations created or implemented are not specified. The practices share their means of assessment, their results, and the story of their innovations and processes so others may learn. That might well be a recognition process that innovators and early adopters would eagerly embrace. It would also promote meaningful change, communicate value to payers and the public, and accelerate the emergence of truly transformative PCMHs.

There is a way for PCMH recognition to help us move from peril toward prosperity and better health if we recognize the turbulent times we are in, learn from our many PCMH pilot tests and demonstration projects, and follow a few simple rules. Now is not the time for setting standards. It is the moment for arousing creative imagination,

sharing stories of innovation, and recognizing those family medicine clinicians who courageously lead us toward better, joyful, and thriving primary care.

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