Strategies for Achieving Whole-Practice Engagement and Buy-in to the Patient-Centered Medical Home

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ABSTRACT

PURPOSE The current model of primary care in the United States limits physicians' ability to offer high-quality care. The patient-centered medical home (PCMH) shows promise in addressing provision of high-quality care, but achieving a PCMH practice model often requires comprehensive organizational change. Guided by Solberg's conceptual framework for practice improvement, which argues for shared prioritization of improvement and change, we describe strategies for obtaining organizational buy-in to and whole-staff engagement of PCMH transformation and practice improvement.

METHODS Semistructured interviews with 136 individuals and 7 focus groups involving 48 individuals were conducted in 20 small- to mid-sized medical practices in Pennsylvania during the first regional rollout of a statewide PCMH initiative. For this study, we analyzed interview transcripts, monthly narrative reports, and observer notes from site visits to identify discourse pertaining to organizational buy-in and strategies for securing buy-in from personnel. Using a consensual qualitative research approach, data were reduced, synthesized, and managed using qualitative data management and analysis software.

RESULTS We identified 13 distinct strategies used to obtain practice buy-in, reflecting 3 overarching lessons that facilitate practice buy-in: (1) effective communication and internal PCMH campaigns, (2) effective resource utilization, and (3) creation of a team environment.

CONCLUSION Our study provides a list of strategies useful for facilitating PCMH transformation in primary care. These strategies can be investigated empirically in future research, used to guide medical practices undergoing or considering PCMH transformation, and used to inform health care policy makers. Our study findings also extend Solberg's conceptual framework for practice improvement to include buy-in as a necessary condition across all elements of the change process.

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INTRODUCTION

Primary care in the United States, intended to address acute and episodic illness, unintentionally limits comprehensive and coordinated preventive and chronic care and is in need of repair.[1-4] The patient-centered medical home (PCMH) care model addresses these limitations through organizing patient care, emphasizing team work, and coordinating data tracking.[5] According to the National Committee for Quality Assurance (NCQA), a US PCMH-accrediting agency, PCMH transformation requires successful redesign across 6 categories of standards (summarized in Table 1) that (1) enhance access and continuity, (2) identify and manage patient populations, (3) plan and manage care; (4) provide self-care support and community resources, (5) track and coordinate patients, and (6) measure and improve performance.[6]

In 2010 a PCMH Stakeholder Collaborative (endorsed by the NCQA[6]) reviewed prospective US studies evaluating PCMH implementation and found that PCMH transformation improved quality of care and patient experiences and reduced hospital and emergency department utilization.[5]

Table 1. Summary of NCQA Patient-Centered Medical Home (PCMH) 2011 Standards

PCMH Standard	Content Summary
1. Enhance access/ continuity	Patients have access to culturally and linguistically appropriate routine/urgent care and clinical advice during and after office hours
	The practice provides electronic access
	Patients may select a physician
	The focus is on team-based care with trained staff
2. Identify/manage patient populations	The practice collects demographic and clinical data for population management
	The practice assesses and documents patient risk factors
	The practice identifies patients for proactive reminders
3. Plan/manage care	The practice identifies patients with specific conditions, including high-risk or complex care needs and conditions related to health behaviors, mental health, or substance abuse problems
	Care management emphasizes:
	Previsit planning
	Assessing patient progress toward treatment goals
	Addressing patient barriers to treatment goals
	The practice reconciles patient medications at visits and after hospitalization
	The practice uses e-prescribing
4. Provide self-care support/community resources	The practice assesses patient/family self-management abilities
	The practice works with patient/family to develop a self-care plan and provide tools and resources, including community resources
	Practice clinicians counsel patients on healthy behaviors
	The practice assesses and provides or arranges for mental health/substance abuse treatment
5. Track/coordinate care	The practice tracks, follows-up on, and coordinates tests, referrals, and care at other facilities (eg, hospitals)
	The practice manages care transitions
6. Measure/ improve performance	The practice uses performance and patient experience data to continuously improve
	The practice tracks utilization measures, such as rates of hospitalizations and emergency department visits
	The practice identifies vulnerable patient populations
	The practice demonstrates improved performance

NCQA = National Committee for Quality Assurance.

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In 2013, Jackson et al published a systematic review of PCMH outcomes describing small, positive effects on patient experiences, small to moderate effects on preventive care service delivery and staff experiences, and reduced emergency department visits (in older adults), but results related to chronic illness care processes, clinical outcomes, hospital admissions, and costs of care were inconclusive.[7] Although PCMH is included in the Patient Protection and Affordable Care Act (PPACA) as a successful pilot model for achieving national health care reform goals,[8] mixed results in evaluations of PCMH interventions call for a deeper understanding of practice change efforts.[9,10]

Several change models address PCMH transformation; Solberg's conceptual framework for practice improvement[11] was used to guide the current study. Solberg draws on organizational development theory,[12] which argues systems change occurs as a result of planned change "dependent on agreement between individuals and organization goals."[11] Within this framework, 3 elements must be substantially present to produce the desired organizational change and quality improvements: priority, change process capability, and care process content.

Our study findings illustrate and extend Solberg's notion of priority. When articulating priority, Solberg argues that for any major change to happen, it must be tethered to both a strong desire for change and an internalized belief for the need for change; otherwise, it is unlikely to occur. Solberg posits that organizational leaders must do more than say change is a priority: implied in his argument is a need for personnel buy-in at all organizational levels to assure a shared value for making change a priority. We were guided by the model conceptually, but we also explored the implied concept of buy-in more completely, extended the model to include buy-in as a necessary condition, and illustrate lessons learned about how to foster organizational buy-in to PCMH transformation.

The relationship of buy-in to organizational change is explored in quality improvement literature and is implicit in discussions of organizational change in health care. For example, Nutting and colleagues[13,14] argue that a shared vision is an essential ingredient in managing practice change. Hroscikoski and colleagues[15] suggest systemic change requires agreement between individual and organization goals. Similarly, Clarke[16] argues there must be a negotiation between the understandings of the organizational members toward congruence of thought. Garside[12] argues a need for staff buy-in when making recommendations for organizational change in health systems, highlighting the need for clarity of vision and a supportive organizational culture. Unfortunately, even though shared visions and staff consensus appear to be key elements in facilitating organizational change, little information exists to guide leaders who are directing PCMH transformation in ways to obtain buy-in among personnel at all organizational levels. Buy-in is conceptualized in this study as a person's agreement about

the value and need for proposed change.[17] In the case of PCMH transformation, whole-staff engagement entails practice members at all levels not only making the intellectual decision that PCMH transformation is necessary and beneficial but also agreeing that quality improvement and organizational change are priorities. It is important to know what strategies practices use to obtain buy-in as well as which are perceived as most effective. Both may assist in identifying barriers to or facilitators of successful transformation.

To investigate PCMH buy-in strategies, we focused on the transformation experiences of personnel in 20 adult medicine practices participating in the first regional rollout of a state-led, multipayer-supported, chronic care–focused PCMH initiative in Pennsylvania.

Self-appointed multidisciplinary teams from each practice participated in a regional state-funded learning collaborative supported by multipayer supplemental payments to practices, reported monthly quality measures, and utilized Improving Performance in Practice coaches funded by payers and the state of Pennsylvania.[18] Specifically, we aimed to understand and illustrate how practices achieved buy-in to and whole-staff engagement in the PCMH transformation process.

METHODS

As part of a larger institutional review board–approved evaluation study, semistructured interviews with 136 individuals and 7 focus groups involving 48 individuals were conducted in 20 medical practices. Table 2 describes the practices in terms of size, type, service area, and initial NCQA recognition level. Participants were chosen by practice leaders and purposefully included learning collaborative team members and those not involved in the collaborative. Individual interviews were conducted with 59 clinicians (physicians and nurse practitioners), 28 medical assistants, 16 office administrators, 11 care managers, 6 front office staff, 5 nurses, 5 patient educators, and 6 others. Interviews and focus groups were conducted in person during researcher site visits; however, telephone interviews were used when schedules did not allow in-person meetings. Interviews were guided by a script of open-ended questions and probes designed to elicit participants' perceptions of their PCMH transformation. Interviews were conducted at the end of the second or third year of PCMH implementation, audio-recorded with participant consent, transcribed verbatim, and corrected for accuracy. Site visit field notes and monthly practice narrative reports were also reviewed.

Table 2. Description of Primary Care Practices Studied

Practice	Practice Size[a]	Practice Type	Service Area	Initial NCQA Level[b]
1	Small	Private	Urban	2
2	Small	FQHC	Suburban	1
3	Small	Private	Urban	3
4	Medium	Private	Urban	3
5	Medium	Private	Suburban	3
6	Solo/partner	Private	Suburban	1
7	Medium	FQHC	Urban	1
8	Small	FQHC	Urban	1
9	Solo/partner	FQHC	Urban	1
10	Large	Residency	Urban	3
11	Medium	Residency	Suburban	1
12	Medium	Residency	Urban	1
13	Medium	Private	Urban	3
14	Small	Private	Suburban	2
15	Small	FQHC	Urban	1
16	Small	FQHC	Urban	1
17	Medium	System[c]	Suburban	1
18	Solo/partner	Private	Suburban	3
19	Medium	Private	Suburban	2
20	Solo/partner	Private	Urban	1

FQHC = federally qualified health center; FTE = full-time equivalent; NCQA = National Committee for Quality Assurance.

Note: Includes the 20 practices used in this study. Five other practices were excluded because they had no data for this study.

[a] Practice size based on the number of FTE clinicians in each practice, as follows: solo/partner = 1-2 FTE clinicians; small = 3-4 FTE clinicians; medium = 5-9 FTE clinicians; large = ≥10 FTE clinicians.

[b] To achieve NCQA level 1 recognition, practices must comply with at least 5 of 10 must-pass elements in practice standards; achieving level 2 or 3 depends on overall scoring and compliance with all 10 elements (http://www.ncqa.org/portals/0/PCMH%20brochure-web.pdf).

[c] Community-based practice owned by a system.

Efforts to enhance the trustworthiness of data collection and interpretation included a variety of recommended strategies[19-21]: triangulating data and researchers, collaborating among medical and social science researchers, interpreting process memoranda documentation, attending to disconfirming evidence, peer review and debriefing, and applying a consensual team-based qualitative research approach to analysis.[22,23] This consensual approach involved 3 phases.

In phase 1 (the larger study), 2 qualitative researchers performed data reduction, creating a coded list of key concepts that emerged across the data. They conducted line-by-line analysis, using the constant comparison method to compare and contrast ideas discussed in each

text.[24,25] Codes were negotiated and refined in weekly meetings through discussions and writing memos. The research team included a PCMH practice coach, 1 physician, and 2 qualitative social science researchers.

In the second phase, 2 researchers synthesized and coded on[26,27] the phase 1 coding for descriptive information pertaining specifically to personnel buy-in and strategies for achieving buy-in. Coders used 2 strategies. First, they conducted a search for the terms "buy-in," "vision," and "agreement" and examined transcripts to assess whether the discourse addressed the question at hand, conceptually defined as agreement about the value and need for proposed change. At this point, change could refer to personal, team, or organizational change. Only search terms yielding data relevant to our questions were retained for analysis. The second strategy identified phase 1 codes conceptually aligned with the idea of buy-in and applied a focused coding of those data for insight about member buy-in to PCMH transformation. For example, phase 1 data, coded into the category "roll out" (conceptually defined as commentary about how practices got started with PCMH implementation) would likely contain useful information about the concept of buy-in. Second-phase (focused) coding identified the specific strategies discussed in the data related to achieving buy-in. The final stage of analysis—data abstraction—linked strategies and findings to identify broad lessons learned. All data management and analyses were performed using NVivo 9.0 qualitative data management software (QSR International).[28]

RESULTS

We identified 13 strategies across 3 overarching lessons for obtaining medical practice buy-in and whole-staff engagement to PCMH transformation. There were no discernible differences in responses when comparing categories of medical practice staff, and there was general consensus across individual participants and across practices on the usefulness of these strategies.

Lesson 1: Effectively Communicating and Internally Campaigning for PCMH Facilitates Practice Buy-in

A major lesson garnered from participants' accounts is that buy-in is facilitated by a comprehensive internal campaign that uses clear and effective communication. Seven key strategies are summarized below, with supporting data in Table 3.

Ensure Clear, Concise Communication and Support From Accessible Practice Leadership

Effective communication emphasizes teamwork to overcome challenges (vs requirements or mandates). Practice personnel value acknowledgement of how their input was utilized (or logical explanation when not), a process

Table 3. Effective Communication and Internal Campaigning Strategies That Facilitate Practice Buy-in to PCMH

Strategy	Exemplary Qualitative Data
Ensure clear and concise communication and support from accessible practice leadership	"We have monthly staff meetings...communicate with everybody when there are any changes. I send group e-mails out to update things or new ways we are going to do something. Of course, I see everybody every day, so anything that is new or different or any problems that anyone is having, we try and address them, so that people don't get too frustrated.... As the director, I've always directed with consensus as much as possible. Sometimes things come from the top that can't be flexible, 'we just have to do it this way because of whatever reason,' but generally, they are rational decisions that we make. I think everyone has bought into it, felt like it lets us provide better care. We want to see our numbers doing better, and everybody likes each other, and everybody has the same mission or goal."
Educate about PCMH: not just what and how, but why	[In response to why there was lack of buy-in at the beginning]: "There was not much information that was given to us when it started...that's why one of our physicians just said no.... Why would I want to do this? What's the benefit?"
Provide concrete information and guidance on known or learned techniques that achieve PCMH-like medical practice	"[We] brought in a rep from [Company] who had a really...a formal...program—Motivational Interviewing, smoking cessation. So now...they start the process...query the patient on every visit about smoking.... They're maintained those measures for the diabetics. They take it on very seriously."
Provide constant feedback on PCMH implementation	"I bring the graphs in, and I'll show them, and we try to do little celebrations. We try to give positive reinforcement. And then I think they can see the benefit of it as they see patients coming in."
Use external and internal data to benchmark, reinforce benefits, highlight success	"The only thing that has changed for me is the pride that I feel in this agency, and what we have been able to accomplish because of the data. And I think that communicates out to the whole staff. I also feel that I have grown a lot in terms of skills and tools to use."
Leverage respect of PCMH champions to foster buy-in	"You have to have very strong leadership that is going to pursue those things with everybody that comes into the practice.... The administrative people working with the docs to get it taken care of and convincing the staff that they have to do it and have enough time to do it and be paid enough money to do it."
Concentrate advocacy efforts on skeptical or hesitant members, dispel misconceptions	[In response to how to handle skeptical clinicians]: "And trying to explain and have a more global picture of 'yes, I understand it adds 2 steps to your process, but it cuts down on 6 other steps.' "

PCMH = patient-centered medical home.

that can be formalized. Frequent meetings (especially in year 1) engage respondents and were important in defining, discussing, and refining evolving practice goals, missions, strategic plans, policies, roles, and responsibilities.

Educate About PCMH: Not Just What and How but Why?

Presenting evidence as to why PCMH is an optimal care model fosters an additional level of intellectual buy-in. Presenting and demonstrating the benefits of PCMH compared with the current model is particularly effective, for example, benefits to the practice (eg, increased revenue) and to patients (eg, improved outcomes, higher satisfaction). More challenging and complex elements of PCMH transformation (eg, new health information technology [HIT] systems) necessitate additional education, training, and campaigning.

Provide Concrete Information and Guidance on Known or Learned Techniques That Achieve PCMH-like Medical Practice

Major practice redesign involves the difficult task of breaking habits and revisiting staff roles and composition, which necessitates the provision of concrete information and guidance on how to conduct more PCMH-like medical practice. Sought-after information includes evidence-based practices and novel tactics used at other practices. Examples include creating and using documents or technology to track chronic disease in patients; using motivational interviewing as a patient engagement technique that maximizes patient-centered, self-managed care; and involving successful self-managing patients in small group-therapy sessions with less-successful patients.

Provide Constant Feedback on PCMH Implementation

Positive reinforcement after successful, exceptional, and improved performance motivates respondents and increases productivity and creative problem solving. Examples include public displays of improved clinical outcomes, internal awards, and recognition of success and effort. Constructive criticism and team evaluations of when something did not work are valuable and best received through participatory problem solving (ie, soliciting personnel for novel solutions as opposed to management-imposed solutions).

Use External and Internal Data to Benchmark, Reinforce Benefits, Highlight Success

Strategic use of data heightens commitment to quality improvement and a sense of accomplishment, pride, ownership, and buy-in to the PCMH. External data are useful in demonstrating benefits of PCMH when compared with the current model. Internal performance data are useful to benchmark individuals within practices, fostering healthy competition and sharing of best practices. Allowing for a brief period (1 to 2 months) for performance improvement before sharing data mitigates concerns.

Leverage Respect of PCMH Champions to Foster Buy-in

PCMH champions (knowledgeable, passionate PCMH advocates) emerge or are designated in many practices. Leveraging champions' respect, especially when dealing with the larger challenges of PCMH implementation, helps legitimize new ways of practicing and thinking, avoids perceptions that changes are managerial mandates, and encourages others to be patient with and accepting of changes. High-status champions (otherwise revered practice leaders) enhance these effects.

Concentrate Advocacy Efforts on Skeptical or Hesitant Members, Dispel Misconceptions

Despite best efforts, not all team members will endorse PCMH change. Reinforce the why of PCMH and the altruism necessary to get there, as well as the data that reflect PCMH success at the local level. Individual meetings with skeptics (ideally led by champions) can be used to discuss the implications of poor performance on the practice, provide coaching on new procedures, and positively reinforce appropriate, successful behavior. Persistently skeptical and stubborn members may warrant careful, targeted use of managerial mandates.

Lesson 2: Utilizing Resources That Effectively Implement PCMH Increases Practice Confidence and Buy-in

A second major lesson that emerges from participant accounts is that PCMH transformation buy-in is facilitated by appropriate use of resources (especially existing resources). Study participants identified 3 strategies, summarized below and with supporting data in Table 4.

Appropriately Manage and Organize Staff for PCMH

Having the right personnel for PCMH involves changes in existing personnel roles and sometimes hiring new personnel. Conveying that these changes are optimal for PCMH-like practice increases self-efficacy, confidence, and buy-in. It might be necessary to let employees go who cannot (or refuse to) adhere to such change. Helpful new staff hires include patient tracking and outreach personnel (often medical assistants), health coaches to assist patients with self care, specialists in health information technology, social workers or care managers to coordinate care for high-risk or hard-to-reach patients, medical-legal consultants to guide practices and patients through the complicated and chang-

ing medical-legal system, and someone to manage the above changes (often discussed as program coordinators, office managers, or work flow consultants).

Administrators described 2 additional tactics: (1) temporarily hiring ancillary staff for work not requiring licensure/specialization, and (2) expanding the role of existing personnel to maximal credentialing.

Secure Sufficient Funding to Make PCMH Changes

Financial support for PCMH transformation was perceived as necessary, though not every practice interested in PCMH transformation will be able to participate in a state-led, multipayer-supported initiative. Respondents emphasized efforts to secure funds from other sources, eg, maximizing pay-for-performance incentives, or pursuing grants for specific components of PCMH implementation, such as for new HIT systems.

Participate in PCMH Learning Collaborative(s)

Participation in learning collaboratives raises confidence, self-efficacy, and buy-in. Support, training, and education are the biggest benefits.

Lesson 3: Creating a Team Environment Encourages Ownership, Accountability, Support, and Confidence, All of Which Increase Buy-in to PCMH

When dealing with significant practice redesign, such as PCMH transformation, a third major lesson emerged in the study participants' stories: creating a team environment with whole staff engagement increases ownership of, accountability to, sense of support for, and confidence in transformation. Three strategies emerged, summarized below, and with supporting data in Table 5.

Table 4. Effective Resource Utilization Strategies That Increase Practice Confidence and Buy-in to PCMH

Strategy	Exemplary Qualitative Data
Appropriately manage and organize staff for PCMH	[When asked what change had the most positive impact on the practice]: "On a more systematic level…we tried very hard to get [personnel] to identify tasks they were doing that they could unload to other team members, so that more of their time would be available for doing [new responsibilities]. That was probably the biggest thing, that kind of re-shifting of responsibilities to free up more time…. Then we hired this new medical assistant to enable this health-coaching process. "
Secure sufficient funding to make PCMH changes	[When asked, "Do you think any of these changes would have been possible if you didn't have the financial support from the Initiative?"]: "Absolutely not. As it is, we are running the practice on a shoestring. The doctors' earnings every year is at the very low end of what primary care physicians earn, and we have accepted that because we would rather spend more time with patients than see more patients, and generate more revenue that way."
Participate in PCMH learning collaborative(s)	"Getting people to go to the collaborative, and getting understanding of what really the collaborative was about, and also seeing their peers there from other practices and how other practices were embracing the collaborative—that was very helpful, and it made people understand this was a bigger deal than just my ruminations…. They could see what their peers were doing, and to one degree other people were embracing the process, and so why couldn't we do the same thing?"

PCMH = patient-centered medical home.

Table 5. Strategies That Increase Practice Buy-in to PCMH by Creating Team Environment Encouraging Ownership, Accountability, Support, and Confidence

Strategy	Exemplary Qualitative Data
Have a work flow of defined, overlapping, and flexible roles and responsibilities within an incremental transformation plan	"Everyone just falls right in the flow…if there's something that's on one person more, we'll try to spread it out and say 'maybe you can have this person do this so you're not so overworked with doing a certain task.' Whatever it is that we have to do for the patients. So we just spread out the work."
Create an open environment where everyone's input is sought and respected	"Staff is encouraged to share their buy-in or lack of, their ideas, so conflict to us is probably not viewed as conflict, more of a negotiation. Sometimes, I think I know everything, but I don't. Staff will ground me and say 'that's not going to work,' and I think I speak for the providers when I say they are open…to the ideas of everybody."
Foster a culture of creativity and innovation	"It's not like someone is coming in and imposing a program on us. We're designing our own program. We're seeing what works for us. We're experimenting with different ways of doing things…being willing to experiment and not have anything written in stone…if it doesn't work, onto the next one."

PCMH = patient-centered medical home.

Have a Work Flow of Defined, Overlapping, and Flexible Roles and Responsibilities Within an Incremental Transformation Plan

An effective transformation plan includes (1) clearly defined yet flexible roles and responsibilities promoting task-sharing and team mentality that use members at maximum licensure and training; and (2) achievable, incremental action items. Develop this plan with input from all personnel, and acknowledge that PCMH transformation takes time and is an evolving process.

Create an Open Environment Where Everyone's Input is Sought and Respected

Open environment involves organizational culture where all personnel feel accountable and empowered

to freely offer suggestions, thoughts, ideas, and criticisms. Recommended formal, incentivized mechanisms to regularly seek such input include meetings, suggestion boxes, and special recognition for input.

Foster a Culture of Creativity and Innovation

Distinct from an open environment is one that encourages and experiments with creative, innovative ideas, "returning to the drawing board" until achieving success. Respondents also desired this approach to be formalized and incentivized. A tangible example popular with respondents was using plan-do-study-act (PDSA) cycles to formally test changes on a small scale.

DISCUSSION

Our first lesson highlights the value of an intentional internal campaign characterized by effective, concise communication plans for PCMH implementation, especially in the beginning stages of transformation. Consistent with existing organizational change literature,[29-33] buy-in was enhanced through frequent meetings to discuss evolving organizational change. Novel findings of this study are that practice personnel strongly desired formalized solicitation of their input, access to leaders, and acknowledgement of how their input was or was not used. Whether through e-mails, bulletins, newsletters, or informal discussions, participants agreed on the importance of integrating the language of PCMH values into everyday communication, as other studies have found.[34-36]

In addition to clear and consistent communication, participants emphasized the need for education and training of personnel on the precepts of PCMH, particularly given the lack of preparation within most teams for collaborative, evidence-based, accountable care. Generally, the literature suggests that education and training were most effective when provided early and often and when they included concrete information and guidance on what the PCMH is and how it is implemented. Most commonly cited educational and training needs revolved around health information technology systems.[38] One study supported our finding of using motivational interviewing as a general patient engagement method.[39] Another novel contribution of this study is the finding that team members strongly desired to understand why PCMH is an optimal care model, not just what it is or how to achieve it.

Our study findings also emphasized the effectiveness of positive reinforcement and participatory problem solving based on objective comparative data, such as benchmarked clinical performance. Data sharing may cause concern in some personnel, though our study suggested allowing clinicians a 1- to 2-month buffer period to improve their measures before sharing. Because these issues can be complicated, others have suggested drafting a policy statement or establishing a task force for responsible, safe, and secure collection and use of shared data.[40,41]

A general point in our study findings, which is found abundantly in the literature, was the importance of champions of change in their abilities to send clear messages, encourage team mentality, and provide thought leadership by promoting PCMH values. Some researchers argued having both administrative and physician champions working in conjunction is optimal to minimize the perception of change as a managerial mandate (especially among older, more seasoned personnel, who are more likely to be skeptical and hesitant).[29,32]

Our second lesson was the importance of mobilizing resources. Participants espoused the value of appropriate use of resources (especially of existing resources, when possible) during PCMH transformation, and they were adamant about the need for external resources, both financially and in terms of technical and transformation assistance. Two key human resource strategies were developing the role of the medical assistant[42] and adding care management and coordination capabilities focused on the highest risk patients.[43-45] Practices in our study relied on the multipayer financial incentives they received as part of the statewide initiative to fuel their transformation engines. Many acknowledged they would have been unable to both start and sustain PCMH work without the added payments, supporting arguments for realigning financial incentives in the health care system.[46-48] Likewise, they credited the learning collaborative for providing essential know-how and peer support for transforming their care processes.

Finally, promoting team synergy was perceived as central to securing buy-in to transformation.[49] Participants in our study articulated the need for organizational culture that promotes an open exchange of ideas, shared creativity, overlapping but clear roles and responsibilities, and system-wide incremental change. Other researchers suggested that a culture of creativity and innovation can be accomplished through an organizational adhocracy model that maximizes decentralized structure, encourages creative problem solving, values flexible and adaptive responses, tries new ideas, and promotes development of innovative programs.[50-52] Practices in our study emphasized the importance of being clear that PCMH transformation takes years and is an evolving process.

There are 2 limitations of this study. First, it is restricted to primary care practices in a single geographic region (in which the practices differed by size, specialty, ownership type, and communities served);

and second, the participating practices received additional funding and technical support to help with transformation. Both limitations could impede generalizability. Conversely, an important strength was that the research team was balanced with medical and nonmedical analysts, thus reducing positivity bias in interpretation and offering multiple opportunities for challenging, discussing, and revising data interpretations. The presented interpretations are meant to be descriptive, rather than predictive or causal; they are intended to inform future policy and practice. Future studies should formally assess the effectiveness of these strategies in a comprehensive model of PCMH implementation; such empirical evidence would provide a better understanding of the predictive or causal nature of these strategies in accomplishing successful, efficient PCMH transformation.

Given the promise of PCMH for providing a better model of primary care, it is likely that the PCMH will continue to grow nationally. To successfully achieve quality improvement and transformation, health care organizations must make improvement a priority by promoting a strong desire for transformation and a shared agreement for change among personnel at all organizational levels. Upon close examination of the lessons learned from these medical practices, we contend that organizational buy-in might usefully be added to Solberg's conceptual framework for practice improvement as a necessary condition to embrace and prioritize change, to capably facilitate the change process, and to effectively implement concrete changes.

This study also contributes to the growing literature providing a deeper understanding of change efforts within practice systems, in general, and specifically to PCMH transformation. Practice leaders promoting transformation in their own organization might find some or all of these strategies useful in their efforts to improve and change. By creating an organizational culture that reflects teamwork and ownership of organizational ideals, bolstering confidence and efficacy of personnel, and communicating clearly and consistently about transformation, leaders may be more successful in attaining buy-in and accomplishing their change goals.

Practices seeking to become a PCMH face numerous challenges. In our study, however, participants affirmed that the benefits can be substantial and showed that given necessary internal and external supports, long-term buy-in to PCMH can be achieved.

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Key words: patient-centered care (medical home); primary health care; organizational innovation (organizational change); qualitative research

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