What about accreditation issues? While many directors point to the 38 pages of program requirements as innovation-stifling, many P[4] innovations do not conflict with existing requirements. Our hope is that the ACGME will streamline their procedure for creating innovation, perhaps even rewarding creative programs.

The AFMRD Board is open to other ideas on what role the organization can play to disseminate our members' innovative ideas. As Steve Jobs, cofounder of Apple Computer has stated, "Innovation distinguishes between a leader and a follower."[5] As leaders in our training programs, program directors must make leading and encouraging innovation part of our job description.

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From the North American Primary Care Research Group

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THE PATIENT-CENTERED MEDICAL HOME: A DISCUSSION AT NAPCRG 2008

During the 2008 NAPCRG Annual Meeting, a facilitated open forum was held to discuss opportunities and concerns deriving from the contemporary interest in the United States in establishing the patient-centered medical home (PCMH), with a particular focus on important researchable questions. The PCMH was presented as a metaphor for redesigning the delivery of primary care. Several participants were recruited in advance to express opinions to stimulate discussion by the group. Three listeners noted comments on flip charts from which this summary was developed.

Some participants noted favorable reactions to the metaphor of the home, where, as Robert Frost penned, "they have to take you in." The national alignment of purchasers and payers with primary care clinicians to develop the medical home was seen as creating newsworthy, positive movement toward enhanced primary care, something quite different from "business as usual." The potential transformative effects of becoming patient centered were emphasized, including: elevating this notion to the national policy scene; involving families, teams, and communities in caring for patients who are actively involved in their own care; and tapping into consumerism with patients sharing decisions and making choices. Learning how to fully incorporate all the elements of the PCMH was seen as a rich academic opportunity to use multiple scientific methods to understand effects and to teach learners how to work together on behalf of all the people through/in the PCMH.

There was apprehension that the PCMH remains "in the belly of the beast"—not radical enough to escape from old "medical" models and provider-centeredness into the concepts of health and community linkage. Transforming primary care practice is very hard; it involves more than doing a few quality improvement cycles. Underlying genuine practice transformation are hidden assumptions and fears about primary care, physicians, values, and expectations that have not been sufficiently exposed; these threaten progress, possibly resulting in the PCMH becoming another passing fad. There is much ignorance—about how to actually achieve the attributes and functions of the PCMH and about how to measure the existence and performance of the PCMH—making sweeping claims and over-promising inadvisable. Balancing legitimate professional prerogatives, commercial interests, use of new technologies, and roles among patients and teams is very challenging. Mis-positioning the PCMH as a miracle that will solve conflicting interests could condemn the PCMH to not succeeding sufficiently to please anyone. Broader system changes, particularly financing arrangements, are necessary for the PCMH to work properly, and these are beyond the control of primary care, threaten powerful interests, and, thus, there is no guarantee that such changes will occur.

Not surprisingly for a group of investigators, many important issues were quickly identified, ranging from very specific questions to much broader topics representing possible programs of research:

- What IS a PCMH?
- What are its proper metrics?

• Does the PCMH make care more effective, efficient, equitable, safe, timely, and/or patient-centered?

• What are the effects of the PCMH on: trust, healing relationships, patient-oriented results, prioritization of care?

• What are the effects of the PCMH on: understanding primary care, other health care enterprises, student and clinician interest in primary care, workforce requirements, scopes of practice for various health care givers, practice size, liability?

• What are the effects of the PCMH at different levels: individual, small groups, local community, system, society?

• What are the best ways to transform an existing practice to be a PCMH and to start a new practice aspiring to be a PCMH?

• What training is necessary to prepare people to work in the PCMH and for people to fully use the PCMH?

• What are the natural experiments now emerging that should be compared?

• How can patient-centeredness be operationalized to become routine reality?

• What are the effects of scale on the PCMH, specifically small vs larger practices?

• What constitutes comprehensiveness, how can it be measured, and what are the effects of its presence or absence?

• What current legal and regulatory requirements enable and impede the PCMH?

• What are the critical technologies of the PCMH?

• What motivates different constituencies to change?

• What are the number and levels of ways to engage patients?

• What are the proper relationships among the PCMH, mental health, and public health?

• Does improving various proposed parts of the PCMH improve the whole?

• Which technologies help and which hinder the PCMH?

• What influences corrupt the PCMH as envisioned?

• What was useful and unuseful in initial National Center for Quality Assurance (NCQA) measures of the PCMH?

• What constitutes the PCMH team, what is the irreducible minimum and the optimum configuration, and how do health care workers learn to collaborate effectively?

• How long does it take to make the transformative change from past practice to the PCMH?

• What are the key linkages between the PCMH and the community in which it resides?

• What professional rivalries and political developments helped and hurt the development and implementation of the PCMH?

• What are the best approaches to paying for the PCMH?

• What practical techniques and skills enable "fixing the bike, while riding it?"

• What are the expected effects of modeling different approaches to the PCMH?

• What does history teach us about how the PCMH is likely to evolve?

• What could and should be the proper role of government in the PCMH?

• What should the name of the PCMH be?

The discussion was arbitrarily limited to 70 minutes and concluded with participants having further ideas and suggestions not expressed. Thus, this recounting is only a partial listing of what was an invigorating moment of sharing hopes, concerns, and investigative opportunities by a forthcoming convenience sample of the 2008 NAPCRG attendees.

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AAFP RELEASES MEDICAL HOME RECOGNITION GUIDE, RELAUNCHES ENHANCED FAMILYDOCTOR.ORG WEB SITE

The AAFP is continuing its commitment to the patient-centered medical home (PCMH) with the release of a guide to medical home recognition and the relaunch of its popular consumer Web site, FamilyDoctor.org, with enhanced video capabilities.

As a service to members, the AAFP has produced a guide to help FPs who are interested in achieving PCMH recognition from the National Committee for Quality Assurance (NCQA).

"Road to Recognition—Your Guide to NCQA Medical Home," which was supported in part by grants from the United Health Foundation and Pfizer Inc, is available free to Academy members and can be downloaded from the Academy's Web site.