coordination and communication in the ambulatory setting aligns financial incentives with good medicine.

Low Threat

Subspecialists must see enough patients face-to-face for eConsults to succeed in the current funding environment. The study sites report that their specialists are not threatened because demand is still substantial. Since eConsults provide for greater efficiency, specialists feel like they waste less time on referrals of marginal value.

The concept of improving communication between specialists and primary care physicians to achieve better care coordination and more appropriate use of specialty services is not new, but it has been hard to implement among busy clinicians whose incentives are not well aligned. To date, the CORE Program appears to be effectively working across a wide range of specialties. It is a user-friendly, scalable, and mutually beneficial method carried out in the current EMR environment. Greater alignment between primary care and specialty care is critical to building value-based health care systems. The CORE model supports the development and continual adjustment of this provider interface, and can serve as a real-time continuous educational source for the best practices of medicine. Evaluation of this innovation is ongoing across the collaborative, but published evidence on similar models has been promising.[2]

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PROGRAM DIRECTORS AND CERA: AN IMPORTANT RELATIONSHIP

How many acronyms do you know where one of the acronym letters stands for an acronym? An acronym within an acronym? We hope most family medicine program directors think of CERA right away. CERA stands for CAFM Educational Research Alliance; CAFM is the Council of Academic Family Medicine.

Program directors are critical to the ongoing success of CERA for 2 reasons. CERA facilitates about 5 surveys every year. Only the program director population is surveyed twice every year and receives more proposals than all the other surveys combined, which tells us that we hold the answers to a lot of important questions from the rest of the "family" of family medicine organizations.

CERA surveys contain questions that are submitted by a variety of family medicine researchers and educators. For example, the last CERA program director survey contained submissions from medical schools, community programs, program directors, residency faculty, social scientists, and pharmacists.

CERA understands that program directors have limited time; therefore, they accept only proposals that include a good hypothesis, are related to what program directors do, contain decent questions, and finally, will likely end up in a published paper. Additionally, the results are archived to help others answer their research questions.

For these reasons, responding to CERA surveys should rank as a high priority for program directors. This seems to be the case, as the PD response rate, at 38% for the first CERA survey of program directors, has increased to over 60%. This is great; but clerkship directors' response rate is more than 90%!

Another reason program directors are critical to the ongoing success of CERA is *relevance*. As program directors, we know the relevant questions to ask in order to advance family medicine education. We are in the midst of tremendous changes in both our clinical and educational infrastructures, and there is very little evidence to support any of the educational changes. We as program directors need to do our part to ensure our residents are still learning how to provide high-quality care to patients in the face of changing environments. CERA surveys can be excellent tools along these lines.

Most program directors think of themselves as clinician-educators, and CERA gives us the means to ask questions in a rigorous way. Once a proposal is accepted, CERA provides institutional review board approval through the American Academy of Family Physicians (AAFP) as well as experienced mentors. This collegial support from the rest of our family medicine community through CERA is invaluable as program directors expand our scholarship into the realm of educational research. An added benefit of CERA involvement is that it also provides an excellent opportunity to help you and your faculty meet the

review committee for family medicine's faculty scholarly activity requirement.

The AFMRD benefits greatly from the active involvement of its members in various organizations and activities, including CERA. For the last 2 years, Dr Paul Crawford, program director at Nellis Family Medicine Residency in Las Vegas, Nevada, has served as the AFMRD liaison to CERA. Dr Wendy Barr, associate program director at the Greater Lawrence Family Health Center in Lawrence, Massachusetts, is the new liaison.

CERA covets proposals from program directors, yet a limited number of proposals are received from program directors because, for one reason, program directors find many questions in the CERA surveys lack relevance to their roles. This lack of relevance is also the reason the AFMRD is taking the initiative to assist program directors in developing CERA proposals.

Those of us who consider ourselves novices at educational research and survey design will appreciate that the AFMRD Board is partnering with several researchers familiar with the CERA process to offer program directors mentoring, feedback, and suggestions *prior to submission to CERA*. Interested AFMRD members will be connected with a mentor/reviewer by contacting Lynn Pickerel at afmrd@aafp.org.

CERA accepts program director proposals twice a year, but please do not wait until the deadline—plan now. Develop your research question and hypothesis and start on the path to getting relevant questions about residency education answered!

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EXPANDING NAPCRG'S LEADERSHIP CAPACITY

Over the past 2 years, the North American Primary Care Research Group (NAPCRG) has undergone an intentional transformation of its leadership engagement and governance structure. NAPCRG's mission statement states "NAPCRG is committed to a nurturing, informative and inspiring environment for all members." One approach to meeting this commitment is to engage members in organizational activities, and specifically leadership activities. In March 2013, with this priority as a guide, Norman Oliver, MD, MA, chair of NAPCRG's Nominations Committee, set about developing goals to increase membership engagement and leadership capacity.

One recommendation approved by the Board of Directors was a policy modification changing the terms of all members of the board from 3 two-year terms to 2 two-year terms. Limiting the number of terms creates frequent turnover in leadership positions allowing more members to get more involved. The board also approved a change in the term for the president of NAPCRG from a 2-year term to a 3-year term—a year as vice president, president, and immediate past president. The Nominations Committee suggested that one of the best ways for members to get involved is to serve as members of committees. Potential leaders can be identified leaders through several mechanisms including signup sheets for leadership roles and committees at the NAPCRG Annual Meeting.

During the NAPCRG 2013 Annual Meeting in Ottawa, Ontario, members expressed concerns about a lack of transparency regarding elections to the NAPCRG Board of Directors. Traditionally, outgoing members nominated their replacements, rather than placing an open call for nominations. Concerns were also expressed about a lack of diversity in board and committee chair positions. The board asked Dr Oliver and the NAPCRG executive director to draft recommendations for a new, fair, and transparent process for soliciting nominations and electing members to the Board of Directors. In February 2014, the board adopted a diversity statement affirming its commitment of a diverse membership, leaders, meetings, programs, research, and employment. In addition, the Nominations Committee proposed a transparent nominations process with job descriptions for every position on the board, and a revamped nominations and elections process. The board sought additional feedback from members on the policy and delayed adoption of the new process until the board met in April of that year. On April 7, 2014, the NAPCRG Board of Directors approved an election process where board job descriptions and open positions are publicized to the membership; the Nominations Committee reviews, screens, and prioritizes nominees based on the relevance of their qualifications; and finally the final slate of nominations are approved by the NAPCRG Board of Directors. NAPCRG is now in its second cycle of the transparent and open nominations and election process, resulting in positive feedback thus far.

Furthermore, in an effort to increase awareness of leadership opportunities within NAPCRG, a special