fix intentionally; leadership requires us to develop skills we did not benefit from earlier in our careers; and that institutions make decisions based on economics and other factors, while individuals take emotions into account.

Because LEADS participants are mid- to senior-career faculty, early- and mid-career axioms represent ideas respondents would have liked to know at that stage. The group shared the senior-career axioms as beneficial to their current career stage.

While it can be challenging to recruit family physicians into leadership positions, LEADS motivated some fellows to seek chair positions and helped others learn about what they want to do with their careers. LEADS also taught us that all family physicians in academic medical centers can lead, even if it is not as a chair. We hope these LEADS axioms are helpful to readers as they reflect and plan their careers in family medicine and may have broad use across all medical specialties.

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FROM FLOOR TO "SOAR" – AIMING FOR EVIDENCE-BASED RESIDENCY INNOVATION

Funding for graduate medical education (GME) costs the American public approximately $20 billion per year.[1] While this funding reflects a positive investment in the health of Americans, has it resulted in significantly decreased health care costs, improved patient experience, improved health of populations, improved clinician well-being, and advances in health equity? This "Quintuple Aim" of health care is embedded in the definition of GME in family medicine,[2] yet by most measures, our return on investment has been poor indeed.[3]

From 2017-2019, the Board on Health Care Services of the National Academies of Sciences, Engineering, and Medicine agreed that the goals of GME are to train physicians who:

- provide excellent, cost-effective care
- address the US population's physician workforce needs (regarding specialty distribution, geographic distribution, and diversity)
- advance biomedical and health systems science
- contribute to leadership in health care[4]

We in family medicine willingly share our innovations, methods, and curricula in meetings and member forums, without particular synergy or organized purpose. Enter the collaborative effort of SOAR, Strengthening Outcomes and Assessments in Residency. This initiative between the Association of Family Medicine Residency Directors (AFMRD) and the American Board of Family Medicine (ABFM) began in 2023, with the goal of enabling family medicine residency programs to harness one another's successes and the wealth of data available to the ABFM to grow in the direction of greater social and community accountability.[5]

SOAR has used 3 primary mechanisms to advance this lofty goal:

- Appreciative inquiry: At the last 2 AAFP Residency Leadership Summit meetings, many residency leaders met in a preconference workshop. We heard from leaders whose program outcomes indicated they were positive examples in chosen focus areas (eg, care of children and behavioral health care), who had been invited to reflect on the uncommon practices/behaviors which led to those outcomes. Attendees were challenged to apply these innovations, and design and plan implementation of activities in their own programs.
- SOAR Scholars: The inaugural SOAR Scholars have completed their year of study. Dr Alex Reedy Cooper examined the relationship between Catholic affiliation of a sponsoring institution and GME outcomes, and Dr Varshaben Songara

compared the milestone progression for international and US medical graduates. They will be reporting their findings in the coming year.

• Communities of practice: These are learning networks, with a focused, well-defined purpose. Built on a foundation of trusted relationships, members learn and develop practice based on existing knowledge in order to generate/discover new knowledge. SOAR has been working to create platforms and environments which will enable such communities to develop the trust, mutual respect, reciprocity, and commitment to surface innovative residency structure and experiment together.[6]

In family medicine, our core purpose is to heal patients and communities. In order to meet that call, our vision is for SOAR to become a hub which helps program directors help each other to standardize our training efforts AND to innovate in meaningful ways. Working together, we can SOAR to accomplish what is most needed—to train physicians who are equipped and empowered to make the Quintuple Aim a reality for every person.

Barbara H. Miller, MD, FAAFP, and Jay Fetter, MSHA

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PBRNS ARE BACK, BABY!

On June 16, 2024, Starfield VI Summit, supported by NAPCRG, brought together 50 practice-based research network (PBRN) leaders and government officials to imagine how PBRNs can generate relevant new knowledge to advance health in the current moment of challenge and opportunity.

New Opportunities

Using an appreciative inquiry approach, participants celebrated the substantial contributions of PBRNs to moving research from the ivory tower to the settings where most people get most of their care most of the time. The conference identified ripe new opportunities that have the potential to rejuvenate PBRNs as a source of new knowledge that is relevant to patients and the primary care practices that serve them. These opportunities include:

• The NIH Director is investing $30 million to advance the ability of rural Americans to participate in NIH research, and sees PBRNs as the way to make this happen.[1] The American Diabetes Association recently hired longtime PBRN leader Kevin Peterson as their VP for Primary Care and is investing in PBRN research, supporting DARTNet Institute to engage PBRNs.[2] AHRQ, which always has tried to do a lot with a little to support PBRNs, has been on a listening tour and is developing learning modules to support PBRNs.[3]

• National Institute of General Medical Sciences is supporting the Clinical & Translational Research Networks and is requiring these networks to have a PBRN.[4,5] PCORI's requirement of real stakeholder engagement and Community Engaged Research framework and their substantial funding provide opportunities for PBRNs that are increasingly recognized.[6]

Top-Down AND Bottom-Up

This moment of opportunity comes on the heels of substantial challenges in practice autonomy, administrative burden, infrastructure support, and workforce. These challenges have made PBRNs an increasingly top-down enterprise, with decision making held in the hands of funders and academic partners. This imbalance of top-down leadership and power has strangled the most vital aspects of PBRNs[7]—the wisdom of those on the frontlines of caring for people in primary care, and their commitment to advocate for them.[8] The Starfield VI Summit recognized that successful PBRNs have both top-down and bottom-up leadership.[9] For this current moment of opportunity to be successful, PBRNs need to increase support for clinicians and practices to lead the generation of knowledge that is relevant to the needs of the patients and communities they serve.