bers of the PCPCC were encouraged that the Senate health reform bills reported out of the Finance Committee and the Committee on Health Education Labor and Pensions (HELP) include these provisions that emphasize a foundation of primary care:

1. A Medicaid state plan option in which enrollees with at least 2 chronic conditions can designate a primary care provider in a PCMH
2. A CMS Innovation Center authorized to test, evaluate, and expand new payment structures that will foster patient-centered care, improve quality, and slow the rate of Medicare cost increase
3. A 10% bonus for primary care practitioners
4. Medicare direct and indirect Graduate Medical Education funding for Teaching Health Centers (ie, GME funding that is paid directly to non-hospital entities to foster education in outpatient and community venues)

The PCPCC was concerned that the bills included only high-need, high-cost patients and ignored the fact that the entire population is benefited by access to primary care. In an excerpt from the letter, the Senators were reminded that:

"a guiding principle of the PCMH is that comprehensive, continuous, coordinated and preventive care, managed by a highly trained clinician in a transformed practice, can prevent complications that could result in a patient becoming high-need or high-cost. If Congress' goal is to improve outcomes, lower costs, and prevent disease and complications associated with chronic illnesses, as it must be, it would be a missed opportunity to limit PCMH eligibility. In addition, practices are much more likely to make the investment in practice transformation to become PCMHs if many of their patients are eligible to participate and they will receive care coordination payments for such patients. Furthermore, we have concerns about the feasibility and unintended administrative burden of practices identifying those patients".

The PCPCC recommended that:

1. The Medicare and Medicaid pilots should be broadly inclusive of all patients who will benefit from preventive and coordinated care and not be restricted to "high-cost" or "high-needs" patients
2. Payment models should recognize differences among the patient populations and the differing needs of care or care coordination
3. Payment models should include both private and public payers to maximize the impact of the pilot programs for a majority of patients in a practice

If health and health care in the United States are to be improved, the clear and powerful voice of a unified coalition must articulate the evidence of effectiveness, the expectation for transformation, and the vision for innovation. The PCPCC has begun this foundational work and the voice needs to grow louder. The PCPCC will be most effective when members spur their constituencies to action. Departments of family medicine must not only encourage our own faculties, but must also energize medical schools and academic health centers to join the movement to build a more effective coalition for systemic change. ADFM is forming a task-force to help coordinate this forward movement within our own organization. We encourage all of the organizations of the family to become engaged with us.

This commentary was written by
members of the ADFM Legislative Affairs Committee,
with review and comment from the ADFM Executive Committee
Mary Nolan Hall, MD
Jerry Kruse, MD, MSPH
and the Association of Departments of Family Medicine

References

1. Patient-Centered Primary Care Collaborative. Sign-on letter to Senate regarding the role of the PCMH in health care reform. http://pcpcc.net/content/sign-letter-senate-regarding-role-pcmh-health-care-reform-3.

From the Association of Family Medicine Residency Directors

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AFMRD—IMPROVING CONTINUITY OF COMMUNICATION

Program directors (PDs) and faculty deal with issues of ensuring and enhancing patient continuity of care by residents. In much the same way, the AFMRD strives to keep members informed and up to date on topics of common interest.

Silence may be golden, but open, honest, and interactive communication is pure gold. One of the board's tasks is to improve continuity of communication with our members. This is the responsibility of the AFMRD Communication Committee.

Ascertaining the questions and concerns of our over 450 PDs, located in geographically diverse locations and working in a multitude of different practices, is a monumental task. Questions arise on a daily basis for PDs and family medicine faculty. To whom should the question be directed? Who is a recognized content expert?

Many questions are posted on our AFMRD program director list serve. The traffic can be heavy and often redundant. Senior directors recognize that there

are patterns of recurrent questions. Some of this may be due to high turnover rates. According to ACGME data, there have been 323 new or changed residency directors from 2004 to 2009 (http://www.acgme.org). With so many new or different leaders, continuity of communication is difficult.

The AFMRD Communication Committee is choosing the most common frequently asked questions (FAQs) and seeking volunteer PDs to research and write a concise 250-word answer that will be posted on the AFMRD Web site (http://www.afmrd.org). These helpful answers will be located in the PD Toolbox. Hopefully, this will be a beneficial resource for new PDs as well as a quick reference for established directors. This will be an ongoing process with the ability to add new FAQs.

"The AFMRD Board encourages you (directors) to actively participate in discussions on our list serve and to share your "best practices" with our membership by sending them to our staff for posting on our PD's Toolbox section of our Web site," wrote Dr Stan Kozakowski, President of AFMRD, on a recent AFMRD Web page.

The PD Toolbox is one of the important components of the new and improved AFMRD Web site. To enhance communication, the AFMRD has a Features section of the home page covering current events of pertinent importance updated on a regular basis. The Highlights section emphasizes topics of timely information as well as board and member spotlights.

Other important avenues of communication on the Web site include: (1) salary survey, (2) membership directory, (3) National Institute for Program Director Development (NIPDD), (4) financial management, (5) PD leadership awards, and (6) leadership and innovation.

"I challenge each of you to share something that you think you do well with the rest of us," encourages Dr Kozakowski in a recent AFMRD Web-page article. With so much change and stress in our workplace, PDs and faculty need the steadiness and support of an ongoing, open opportunity to communicate.

Stoney Abercrombie, MD; Sandra Carr, MD; Joseph Gravel, Jr, MD; Karen Hall, MD; Grant Hoekzema, MD; Stanley Kozakowski, MD; Djinge Lindsay, MD, MPH; Elissa Palmer, MD; Todd Shaffer, MD, MBA; Martin Wieschhaus, MD