the end of their experience. At the end of the Fellowship experience, participants will present their project in a poster at the STFM Annual Meeting. Additionally, they will give a short presentation (5 minutes) to the STFM Leadership. This presentation will add a certain prestige to the program but will also allow STFM Board Members and leaders to identify "up and comers" and perhaps get them involved in projects or committees.

What's Different About This Leadership Program? Why Should I Participate?
STFM's program is designed specifically for family medicine educators. If you love family medicine, and you love teaching, then this program will teach you how to become a leader.

You will be in a leadership role when you arrive to start the program, right from the beginning.

You will learn many things, from many people, many ways (coaches, faculty, workshop), but this program starts you with actual experience selecting talent, chairing conference calls, motivating others, and leading.

If I'm Actually Leading a Group, What Will I Do if I Have Obstacles (or a Difficult Team Member)?
That's how your coach will be helpful. You'll have the ear of someone who's an accomplished leader (an STFM Winston Churchill, if you will). Your coach can tell you how to handle difficult people, difficult situations, and share secrets of motivating others. You can ask them anything, and they will set you up for success.

You can also take advantage of the "Leadership Circles." On these conference calls, you will learn new leadership topics, but can also cuss-and-discuss problems among the other participants, hear of other's lessons, and share tips and tricks for leading your group to success.

Why Should I choose This Program Over Other Options for Presenting?
Visibility. You'll present your work (and yourself) to the STFM leadership—the people who are incredible connections and may appoint you to a leadership role within STFM or another organization.

You'll attend the STFM Annual Spring Conference 2 years in a row. Nothing tops this conference for networking, exposure, and presentation experience.

A Sample Year For a Participant in Emerging Leaders

- March: Notification of acceptance in the program
- Selection of the project and team to be led
- April: Attendance at the STFM Annual Spring Conference
- Welcome reception with the faculty, participants and coaches
- Pre-conference workshop on leadership
- Meet your coach
- Summer & Fall: Lead your group to completion of the project. Get periodic feedback and advice from your coach.
- Participate in quarterly "Leadership Circles" conference calls
- Early August: Attend a mid-year meeting (to be held in conjunction with the AAFP's National Conference)
- Spring: Prepare your presentations
- April: Present your poster at the STFM Annual Spring Conference
- Present a brief oral report of your project to the STFM Board of Directors
- Attend additional leadership programming.
- Apply for Emerging Leaders at STFM.org/EmergingLeaders

Angela Broderick, MA, CAE
Deputy Executive Director, STFM

ADFM Association of Departments of Family Medicine
VISION, VOICE, LEADERSHIP

From the Association of Departments of Family Medicine

Ann Fam Med 2010;8:568-569. doi:10.1370/afm.1205.

HEALTH REFORM, ACADEMIC HEALTH CENTERS, AND FAMILY MEDICINE

The Patient Protection and Affordable Care Act (PPACA) was signed into law on March 23, 2010. In addition to expanding health insurance coverage to an estimated 32 million individuals by 2019, the bill has myriad components that will have widespread effects on the health care system.[1] Academic health centers (AHCs) will be among the many institutions touched by the reforms enacted by the PPACA. Will these reforms be powerful enough to shake AHCs out of their traditional business model of delivering highly specialized services to become more integrated, patient-centered delivery systems?

The PPACA will challenge the way hospitals do business. By 2014, hospitals will experience a cut in Medicaid and Medicare Disproportionate Share payments of $14 B and $22.1 B, respectively—and these cuts will fall disproportionately on teaching hospitals. Some of the cuts will be offset by decreases in uncompensated care liabilities as fewer patients are uninsured. A more fundamental challenge will come from the pressures on AHCs to become Accountable Care

Organizations (ACOs). To participate in Medicare ACO pilots, hospitals and their physician staff must collaborate to improve quality of care and cost efficiency for a defined population of patients in what is in essence a Medicare Shared Savings Program. The success of an ACO will depend on strong hospital–physician alignment.[2]

In the ACO model, the financial incentives for an AHC would change 180 degrees. Under the traditional fee-for-service business model, AHCs tend to value primary care physicians only insofar as they are "feeders" of patients into the lucrative tertiary care clinical enterprise—with the key metric being the "downstream revenue" a practice produces for an AHC. A high-performing primary care practice that keeps its patients out of the hospital and imaging suites may be scorned as "destroying demand." Under the shared-savings incentives of an ACO, where AHC profitability depends on achieving the best quality in the most cost-effective manner, high performing primary care practices suddenly become a business asset to an AHC.[3]

The reality is that the financial incentives for AHCs will not make a complete 180-degree turn in the near future. CMS will roll out ACOs in a scaled manner, and it remains unclear whether private health plans will follow suit. AHCs will therefore find themselves having to operate in a hybrid financial model. Much of their business will continue to consist of the traditional, highly remunerated tertiary care services, while for patients sponsored by payers that have shifted to an ACO payment model, the incentives will reward good primary care and integration of services. Departments of family medicine have a role to play at AHCs not only in leading the ACO effort, but also in helping AHCs to avoid succumbing to a pathologically split personality under a hybrid business model. Family medicine can help AHCs to recognize underlying principles of exemplary patient care that are applicable to both business models.

The changing business model for AHCs will also have implications for their educational mission. Among the strongest influences on the educational character of AHCs are NIH research funds and the traditional AHC patient care business model, both of which reward specialization and a narrow biomedical focus. AHCs have favored higher revenue-generating specialty training over primary care positions. As Iglehart recently observed,

> "Since 1997, when the BBA imposed a cap on the number of GME positions that Medicare would support, teaching hospitals have created 8000 new training positions without Medicare funding, and most of them have been in subspecialty fellowship positions, not primary care. These spots led to growth in the specialties that provided revenue for the hospitals."[4]

Pressures on AHCs to refashion themselves as ACOs may have a ripple effect that shifts their priorities for medical education, providing an incentive to train more primary care residents as part of a move to expand the primary care base of the clinical enterprise.

Historically, the missions of departments of family medicine have not been completely in sync with the missions of AHCs. Family medicine and AHCs now have an opportunity for greater alignment of their missions. More than ever, the nation seems to understand that our health care system will not survive in the absence of a robust foundation of primary care. The policies being put into motion by the PPACA have the potential to make the institutions that have been among those most resistant to this understanding—the nation's Academic Health Centers—appreciate that they now have a strong self-interest in a more fully developed role for primary care.

This commentary was prepared by the Chair and Vice Chair of the ADFM Legislative Affairs Committee and reviewed by the ADFM Executive Committee.

Mary Hall, MD, Kevin Grumbach, MD, and the Association of Departments of Family Medicine

References

1. Connors EE, Gostin LO. Health care reform—a historic moment in US social policy. *JAMA.* 2010;303(24):2521-2522.
2. The Unites States Senate Committee on Finance. Transforming the health care delivery system: proposals to improve patient care and reduce health care costs. Health Care Reform News. April 2009. http://finance.senate.gov/download/?id=699ce1e8-ab93-4c5d-af4d-5946c25e4489.
3. Tallia AF, Amenta PS, Jones SK. Commentary: academic health centers as accountable care organizations. *Acad Med.* 2010;85(5):766-767.
4. Iglehart J. Health reform, primary care and graduate medical education. *N Engl J Med.* 2010;363(1):6.

From the Association of Family Medicine Residency Directors

Ann Fam Med 2010;8:569-570. doi:10.1370/afm.1206.

AFMRD STRATEGIC PLAN: PROGRESS IN GOVERNANCE

It is said that governance is the act or process of governing as it relates to consistent management, cohesive policies, processes, and decision making for a given area of responsibility; the kinetic exercise of managing power and policy in an organization.