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.

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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.

In August 2010 we celebrated 20 years as a full-fledged organization, 2 decades that included our first steps as a home for program directors, the impressive institution of NIPPD, and the success of the osteoporosis and diabetes workshops. We are now emerging from the founding phase of our existence with a solid foundation and the need to take deliberate steps toward an equally solid future.

In the fall of 2009, the AFMRD Board set out to delineate a strategic plan that would guide the Board over the coming 3 years by defining clear goals in crucial areas. Each area of the strategic plan includes a time frame for implementation as well as assignment to a specific committee. Governance became one of these areas, championed by the more experienced Board members and agreed by all. The following outlines the major points of the strategic plan related to governance. Included in the overall concept of governance is the underlying belief in fiscal prudence, integrity, and transparency. Of equal importance to the Board is service to membership, open communication, and collaboration.

Governance

The governance of the AFMRD will be defined by a culture of member engagement, mission focused collaboration, leadership accountability, organizational adaptability, and financial stewardship and transparency.

Strategies:

1. Develop a plan to enhance member participation in AFMRD Board appointed committees and liaison activities. Committee: AFMRD Board of Directors, Membership Committee.
2. Deploy innovative, user-friendly, and cost effective technologies to enhance real-time communication and collaboration of AFMRD members, leaders, and staff. Committee: AFMRD Board of Directors, Communications Committee.
3. Engage in a "futures study" every other year to identify and publish information about emerging trends impacting AFMRD members, family medicine residency programs, graduate medical education, and the needs of the public. Establish a systematic approach to design a blue print for moving AFMRD forward in a strategic way. Committee: AFMRD Board of Directors.
4. Investigate and develop strategic alliances with public, private, and non-profit organizations that support the mission and strategic plan of the AFMRD. Alliances should be pursued in such a way that protects the organization from perceived bias and maintains the organization's integrity. Committee: AFMRD Board of Directors.
5. Provide professional, non-profit leadership by the AFMRD Board of Directors and its staff to assure that the operations and management of the AFMRD abides by its bylaws, financial policies, and the legal requirements of a non-profit, charitable organization. The executive committee and Board will stay abreast of regulatory requirements to determine compliance and maintain organizational stability. The financial position and finance policy of the AFMRD must be reported annually during its annual business meeting and available to all AFMRD members upon request. Committee: AFMRD Board of Directors.
6. Develop an AFMRD e-newsletter to enhance member familiarity with AFMRD programming and initiatives, feature member best practices, and inform others of the issues important to program directors. Committee: Communications Committee.
7. Identify unmet AFMRD member needs. Query members with strategically focused tools and collaborate with key agencies to identify services that will be of benefit to AFMRD members. Committee: AFMRD Board of Directors.
8. Enhance non-dues revenue with a goal of protecting the financial stability of AFMRD and to enhance programmatic support of the membership. Committee: AFMRD Board of Directors.

Additionally, to focus its efforts on future endeavors, the Board has now updated its formal fiscal policy and strategic plan. This is to ensure preservation of adequate financial reserves for the organization while also investing in ongoing and new initiatives that will enhance service to our members and our discipline. Initial focus toward these goals will be in the area of items 4 and 5. Currently the Board and staff of the Board expend high effort in the area of professional, non-profit leadership, and consider this a high importance item that is fundamental to the health of the organization. A second priority established for the coming year is the establishment of strategic alliances. In the past year, new alliances resulted in Immunization and COPD curricula development that are available to all members. Initial tactics to push this effort will be tasking Board members to identify potential alliances with follow up on progress as a standing agenda item at Board meetings.

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