formed practices in which students and residents can experience these innovations first hand.

Clearly this is a topic which has great interest within a broad swath of family medicine. We will work closely with other organizations in the family of family medicine and the Council of Academic Family Medicine (CAFM) to coordinate efforts in this area and disseminate materials to the widest possible group.

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This commentary was reviewed by the PCMH Taskforce Co-Chair and members of the ADFM Executive Committee.

Reference

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INNOVATION IN FAMILY MEDICINE RESIDENCIES: STRUGGLING TO CREATE CLASSICS FOR THE FUTURE

"Innovation distinguishes between a leader and a follower." Steve Jobs

"Innovation! One cannot be forever innovating. I want to create classics." Coco Chanel

Program directors work each day to produce graduates prepared for future practice yet rooted in the ideals and values of the classic family medicine past. Residency programs are currently engaged in a dramatic outburst of activity in new curricular models as well as practice transformation directly involving residents, most commonly using the PCMH model. Students and residents show great enthusiasm for this new model which provides them a possible path out of a "hamster care" future as health care payment models begin to move away from a fee-for-service methodology.

The AFMRD Board of Directors considers the "support and spread of innovation in family medicine residency education" as a major component of its 2011 strategic plan. Defining "innovation" can be a challenge. Does it actually enhance residency recruitment, provide better service for patients, deliver better quality, or ensure our graduates can deliver the new models of care? Is it disruptive or incremental? Will "innovative" ideas actually result in a better family physician? How will we know?

Working with other family medicine organizations through the Council for Academic Family Medicine (CAFM), the AFMRD has developed an "Innovation Needs Assessment Task Force" to create and administer a needs assessment inventory. The task force's gap analysis of the current mechanisms to support mutual assistance and shared learning across multiple residency sites will help identify a strategy to measure and track the scope of innovation in the nation's residencies and family medicine departments. The task force will also create a communications strategy to disseminate the scope and impact of family medicine innovation to students, policy makers, and the public.

The AFMRD efforts in promoting innovation include enhancing inter-program collaborative efforts and providing program director input for the revision of RC-FM requirements that would more easily allow for innovative training. In addition, the development of Web-based platforms has been shown to be an effective means of supporting innovation and outcomes. TransforMED has created Delta Exchange, an interactive, asynchronous tool to share what's being learned and to engage other innovators. The AFMRD worked to secure free access to this for our members (http://www.transformed.com) to further enhance conversations about transformation and take advantage of this next generation interactive tool.

Is there funding out there to support innovation? The donations of $30 million by an anonymous donor to Harvard Medical School and another $20 million to Boston's Partners Healthcare for the express purpose of supporting innovation in primary care tell us yes. Since these donations went to 2 institutions that do not formally even acknowledge the specialty of family medicine (no clinical or academic department in either one) suggests that the builders of the old medical-industrial complex still hold sway in the psyche of many of our nation's power brokers. FM residencies need to become a network of "innovation exemplars" and better communicate these examples to those outside the discipline which may assist us in attracting more financial support.

What about upcoming ACGME revisions to the program requirements? Will barriers to residency innovation be reduced? We think the answer is yes, but with a caveat. The freedom of having reduced prescriptive, time-based, check-off requirements creates more space for innovative ways to train residents, but the burden of proving actual outcome competency measures is also more present. External accountability of our graduates will also inevitably increase. We

believe that the growing ability to measure clinical outcomes is an opportunity to more clearly demonstrate that family physicians are this nation's best hope to create a higher quality, lower cost health care system, but we must provide residents new skills to lead PCMHs and ACOs. Innovation, new ways of looking at and solving problems, therefore, is an imperative for our specialty. We may need to look outside medicine to find ideas and solutions from other business industries to improve our model of delivery of care.

We have over 450 federally funded test sites called family medicine residencies which are a ready-built system to test new ideas to train better primary care physicians and provide better health outcomes than anyone else. If we don't, others will; and those others may not have the values of the family physicians of the past that inspire us to create "classics" for the future.

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FAMILY MEDICINE, NAPCRG, AND THE GREAT MANDELLA

(Excerpts from acceptance of the Maurice Wood Award at the North American Primary Care Research Group Annual Meeting, Seattle, Washington, 2010.)

In the mid 1970s, I remember NAPCRG as a small band of family physicians, none professing to be a researcher, but all believing that the future of medicine should be created out of the best evidence, in an apolitical and non–discipline-specific environment. Those initial years of NAPCRG were marked by a fervent desire to describe and understand our practice and create and use tools for practice and research. Inquisitiveness about practice kept the physician vital, improved practice, and if systematic, was "research."

Before computers or even electric typewriters had come to medicine, the small group constituting NAPCRG was interested in the generalist physician's role in all settings and developed new practice research tools and measurement systems that would allow us to understand our world. In 1976, our world shook. Maurice Wood's group published what became known as the "Virginia Study" using data from half a million visits.

Through those years a small group of us in the new breed of residency-trained faculty interested in research formed bonds that have lasted a lifetime. NAPCRG became the mentored environment wherein our ideas could blossom. With the support of our mentors, the Ambulatory Sentinel Practice Network became a vehicle for our discipline's research. And the International Primary Care Network helped convey to other countries the excitement of research in North America.

In 1985, I surveyed all departments and residencies of family medicine in the United States and found that no family physician faculty had received NIH support for research fellowship training or other federal career research support. We've come a long way since then. However, many of the challenges are the same. Maurice Wood's generation viewed themselves and family medicine as outside of mainstream medicine with no voice in most medical schools or in the enterprise of medicine. In contrast, my generation grew up in the halls of medicine, and saw the possibility of becoming a part of the house of medicine.

We are now at a point where we will become the core of the house of medicine as demanded by health care reform, Accountable Care Organizations (ACOs), and Patient Centered Medical Homes (PCMHs). However, we desperately need the guidance of research inspired from the world view of the generalist and driven by the core principles of primary care—access, comprehensiveness, and continuity, and the ability to provide coordination and accept accountability for quality and cost.

I want to share observations regarding 3 threats and opportunities.

First, for our patients, the nodal points in their medical lifespans are when they need access to us and our guidance. If we abandon our roles in the hospital, including in maternity service, we forfeit major value for our patients, and give up a major opportunity to guide the development of medicine for decades to come.

Second, while much of our focus as generalist physicians has been on our relationship with our specialist colleagues, we need as much emphasis on engaging over the long-term with the communities where our patients live. How we leverage our roles as physicians in communities has been a theme explored at NAPCRG. Unfortunately, we have not had powerful research tools to describe and disseminate these community outreach initiatives and bring them into the mainstream of practice. Yet PCMHs will need to mobilize the power of their communities in like manner.

The third opportunity we have is the "4th dimension." Time is fundamentally different in primary care