laboration with other academic family medicine organizations. Also emerging from these discussions was the need for focused work in 4 areas: (1) developing leaders in departments of family medicine; (2) transforming education; (3) transforming health care delivery; and (4) developing research capacity. Four new strategic committees aligned with these areas, each with defined membership, expectations, and accountability to the board, were formed in 2011 and quickly took on focused activities.

All of this momentum galvanizing ADFM's focus in 2010 and 2011 led the Board to engage outside consultation in late 2011 to move us from strategic thinking to delineation of a complete 3-year strategic plan to guide ADFM. The board of directors, with feedback from the membership of ADFM, has since approved the following mission, vision, and goals for ADFM in a new 3-year (2012-2015) Strategic Plan.

ADFM Strategic Plan (2012-2015): Mission, Vision and Goals

Mission

The Association of Departments of Family Medicine (ADFM) is the organization of departments of family medicine and is devoted to transforming care, education, and research to promote health equity and improve the health of the nation.

Vision

Departments of Family Medicine will lead transformation of medical education, research, and health care to improve the health of the nation.

Goals

Goal 1: Transform Health Care Delivery
Goal Statement: ADFM will assist departments in transforming the clinical delivery enterprise to advance the triple aim of higher quality, improved health and lower cost.

Goal 2: Develop Leaders
Goal Statement: ADFM will enhance the leadership skills of chairs, administrators and future department leaders to improve the effectiveness of DFMs.

Goal 3: Strengthen Research
Goal Statement: ADFM will assist DFMs to build research capacity and to strengthen the quality of their research.

Goal 4: Transform Education
Goal Statement: ADFM will assist departments to develop, implement and evaluate innovative models of education across the UME/GME/Faculty development continuum.

Goal 5: Develop ADFM Infrastructure/Governance
Goal Statement: ADFM will create and maintain the appropriate staffing, governance and technological resources to support membership services and organizational effectiveness.

Four ADFM Committees and a board infrastructure/governance taskforce are working to flesh out specific objectives within each of the 5 goals over the coming months with anticipated approval of the full strategic plan by the time the ADFM Board convenes in November 2012.

ADFM is excited about the explicit guidance this new 3-year strategic plan provides to help our departments of family medicine and to collaborate with other leaders and organizations as we forge ahead to create a healthier future.

ADFM Executive Committee
Tom Campbell, MD, President
Richard Wender, MD, Board Chair, Past-President
Barbara Thompson, MD, President-elect
Ardis Davis, MSW, Executive Director

From the Association of Family Medicine Residency Directors

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PRIMARY CARE PAYMENT REFORM: THE MISSING LINK

Over the past several years as the patient-centered medical home (PCMH) has become a prominent feature in the design of family medicine in the future, we are seeing supportive data suggesting that this model has great potential to improve our health care system and lower cost of care. However, we've also had reports of the impact of implementing the PCMH model in various clinical settings with differing payment models. The basic summary of this information is that clinics operating with a fee-for-service model attempting to implement PCMH have very high rates of staff and physician burnout and are losing revenue for non-office visit encounters with patients, making the model unsustainable within the fee-for-service environment. Furthermore, systems where there is either primary care capitation or full capitation that support PCMH implementation are showing just the opposite—high provider satisfaction, patient satisfaction, and improved revenues to support the clinic operations.

The other obvious danger of jumping onto the PCMH bandwagon without reformed payment models is that the intense amount of work that is done in care management or non–office-based care (ie, e-visits, phone visits) will go unrewarded. It is clearly in the interest of the insurance industry to encourage family physicians to fully embrace the PCMH model without having to pay for it. If we allow this to happen, we will doom ourselves to a practice model that is high demand but we will not be able to shrink our panel sizes or visit volumes to manageable levels and still keep our office open unless we are paid in a different way.

If we step back and look at what kind of payment model would best motivate physicians and their health care teams to perform at the highest level in the care of their patients, it would not be a fee-for-service model. The closer we tie the responsibility for the outcomes of care to both physician and patient, the greater the accountability. Developing primary care capitation payments to family medicine clinics based on population management with specific incentives for patient experience markers (a strong correlate to quality) and for key disease management and prevention measures would be our best blend of incentives for payment reform. Our European counterparts have experimented with multiple models and have found that having the bulk of a payment to physicians being a primary care capitation with careful incentives creates an optimal balance. The only way to resource clinics to carry out the work of an effective medical home is to shift more resources into the clinic via payment enhancements but how those payments are structured is critical to getting what we all want—accessible, rational, quality primary care delivered by care teams led by family physicians.

How does this impact residency training? The simple answer is that if the PCMH is the model of care for now and the future, then we need to train residents in an environment that fulfills that model. However, given the high stress and high burnout risk, we need to couple our PCMH implementation with education on change management, burnout prevention, and leadership skills. In doing this we will position the next generation of family medicine graduates to be the PCMH leaders of the future.

Michael Tuggy, MD and Grant Hoekzema, MD; Stoney Abercrombie, MD; Sneha Chacko, MD; Joseph Gravel, MD; Karen Hall, MD; Lisa Maxwell, MD; Michael Mazzone, MD; Todd Shaffer, MD, MBA; Martin Wieschhaus, MD

From the North American Primary Care Research Group

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LARGE DATA SETS IN PRIMARY CARE RESEARCH

With the widespread adoption of electronic health records (EHRs), researchers have growing access to large data sets that are being used for quality improvement, comparative effectiveness research, and public health policy decision making. In the recent past, large managed care organizations had almost exclusive access to these rich patient data sets. However, EHRs are rapidly leveling the playing field, with academic family medicine programs well positioned to take advantage of this resource and pioneer new fields of study. At the University of Wisconsin Department of Family Medicine (UW-DFM), we recently embarked on a study of polypharmacy that highlights the advantages and challenges of working with large EHR data sets and illustrates both what is possible and what the future may hold.

We began with a simple research question: "What are the patterns and predictors of medication use in our family medicine clinics?"[1] Previous studies of polypharmacy have been limited to not only small sample sizes, but also focused primarily on elderly populations. Although insurance claims could provide us with a large, diverse sample, they generally do not include many clinically relevant over-the-counter medications and supplements. In addition, insurance claims do not capture prescription medications purchased without insurance, such as those on discount medication lists. Networked EHRs provide new opportunities for obtaining more comprehensive data regarding health services received, especially among populations who are discontinuously insured.[2] Fortunately, UW-DFM has access to an EHR database from a network of 28 ambulatory-care clinics in Wisconsin that compiles over 300,000 annual visits. For the study described above, using anonymized data we were able to look at the prevalence of polypharmacy across a wide range of variables, including age, body mass index, smoking status, marital status, and major comorbidities. In the end, we analyzed nearly 2 million unique pieces of data from over 110,000 patients which, to our knowledge, far exceeds any previous study of polypharmacy.

Despite the readily available access to such vast data, our project highlights some of the challenges that face primary care researchers new to working