CERA provides mentoring and education to junior researchers, facilitates collaboration between medical education researchers, and guides the specialty by providing leadership and vision in the arena of medical education research. To date, 9 CERA manuscripts have been submitted, and multiple conference presentations are scheduled.

Research at STFM Conferences

Each year, the STFM Annual Spring Conference highlights research presentations. More than 50 podium presentations and 100 posters are presented, including skill-building sessions and educational and clinical research findings. One of 4 general session slots is reserved for research. STFM also has dozens of research posters at the Conference on Medical Student Education and the Conference on Practice Improvement.

The Best Research Paper Award

For more than 20 years, this yearly STFM Award has recognized the best research paper published by an STFM member in a peer-reviewed journal. The STFM Research Committee bases the award selection on the quality of the research and its potential impact. The list of research leaders on this winners' list, available at http://www.stfm.org/about/awards/bestresearch.cfm, is impressive.

Research Advocacy

This initiative is still in its infancy, but the organizations within Council of Academic Family Medicine have made advocacy for increased research funding a priority.

National Research Network

The Conference on Practice Improvement, which STFM presents with the American Academy of Family Physicians, is the home for presentations and meetings of the National Research Network. Significant linkages between practice improvement and the translation of the research are coming out of this network.

Family Medicine Research Wiki

The STFM Group on Research in Residency offers a comprehensive but relatively unknown resource to build research capacity. Topics include: Getting Started with Family Medicine Research, Journal Clubs & Critical Appraisal, Scholarly Projects in Residency Training, IRB Issues and Participant Safety, Writing A Research Paper, Reviewing a Manuscript, and more. The wiki is available at http://www.fmdrl.org/1563.

Management Contract With the North American Primary Care Research Group

STFM provides staff to run NAPCRG. STFM does this because STFM leadership believes that NAPCRG can do things that STFM can't to advance the generation of new knowledge.

More needs to be done to move scholarship forward. STFM will continue to lead research initiatives that align with its educational mission and collaborate with others to develop family medicine faculty and learners' skills in educational research and innovation. "STFM, through its Research Committee and initiatives like CERA, is providing infrastructure, mentoring, and collaboration to help family medicine educators move from ideas to publishable new knowledge that will benefit us all," said STFM Research Committee Chair Arch Mainous, PhD, Medical University of South Carolina.

Stacy Brungardt, CAE
STFM Executive Director

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

From the Association of Departments of Family Medicine

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IT'S NOT ABOUT US: MOVING THE FOCUS TO THE TEAM AND THE PATIENT

Shaping messages to promote the interests of family medicine has a well-honored place in academic family medicine. Although serving a variety of purposes, the central goal of our messaging is to promote improvement in the health of the discipline and of our patients. Whether in catch phrases like "the future of family medicine," or with key words and metaphors (continuity, family, primary care), we work towards the diffusion, spread, and adoption of our principles and opinions. Might it be time to change the conversation?

1. Moving the Money Focus from Docs to Teams/Infrastructure

Is it time to shift the national primary care conversation on reimbursement from "family doctors don't earn enough money" to "family doctors don't have the help they need to create systems that work for patients and populations"? Family medicine needs to promote payment models like global capitation, value-based care and pay-for-population that will facilitate infrastructure development needed to effectively serve patients, families, and communities. This would require a departure from focusing on the income of physicians to support for the team, the system, and ultimately the patient and the population. Creating the infrastructure for transformed health care, whether patient-centered medical

homes (PCMHs) or Accountable Care Organizations (ACOs), is critical to meeting the triple aim (better outcomes, better patient experience, lower costs) and cannot come too soon. Recently published articles, such as the article by Nocon, et al in *JAMA*,[1] have verified that practices which become patient centered medical homes cost more to run. Increased funding/alternate payment schemes are needed for practices and systems undertaking this transformation.

2. Changing the Ratio of Primary Care Physicians to Specialists

Is it time to change the conversation from "we need more family physicians" to "we need the right mix of primary care to specialty care to improve the health of the nation and lower health care costs"? The Council on Graduate Medical Education's and most work force analyses estimate that the ratio of primary care to specialists needs to be at least 40% to achieve these goals. Rather than talking about the need for more Graduate Medical Education (GME) slots for family medicine, we should be advocating for a rational process for determining both the number and distribution of GME slots; a process that is based upon the needs of the nation as opposed to one that preserves the status quo or protects certain specialties.

3. Finally Marrying Primary Care and Population Health

Our discipline has never quite fulfilled the promise of joining public and population health, though not due to lack of effort. Valiant efforts to achieve such a union have been attempted through community-oriented primary care (COPC), through adding public health, community, and preventive medicine to our departments and many important grant-funded initiatives. But a failure to complete this integration appears to be increasingly unacceptable. We cannot address the root causes of chronic illness without relying on public health—primary care partnerships that are sustainable, responsive to communities, and effective. One of the key barriers to integrating these 2 disciplines is the chronic underfunding of both. As called for by the Institute of Medicine, it is time to finally achieve the elusive goal of integrating public health and primary care.

The rhetoric of our discipline should change to reflect the evolution of our aspirations. Our messages should derive from our best efforts to define changes in health care delivery and payment mechanisms that are urgently needed to improve health. We need to "take the high road" and continually and loudly advocate for what is best for the health of our patients and for the nation. We need to persistently advocate for what will help our health care system achieve the triple aim of improved health, better patient experience and lower costs. We need to change the conversation from what we believe we need as a discipline to what is best for the country. It is not about us, it is about the health of our patients and the nation. We can, however, take an active role in helping lead the way.

Jeff Borkan, MD PhD, Tom Campbell, MD, Rich Wender, MD, and Barbara Thompson, MD

References

1. Nocon RS, Sharma R, Birnberg JM, et al. Association between patient-centered medical home rating and operating cost at federally funded health centers. *JAMA*. 2012;308(1):60-66.

From the Association of Family Medicine Residency Directors

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CERA: WHAT? SO WHAT? NOW WHAT?

Research is a word that intimidates many faculty and program directors and while the Review Committee for Family Medicine mandates the generation of scholarly output, we often shy away from research involving data collection and analysis. The lack of residency faculty-lead research contributes to the paucity of family medicine (FM) researchers and the diminishing FM research pipeline. The Council of Academic Family Medicine (CAFM) Educational Research Alliance (CERA) was designed to assist faculty in residency programs to conduct research. So, what is CERA? How does it benefit residency programs? What should we do next?

What?

CERA, a CAFM initiative, was created as a tool for FM researchers. It provides infrastructure, researcher consultation, and facilitated collaboration to conduct research via survey. It will develop a vigorous FM research database which will be available to all. One of CERA's primary initiatives is to improve the process of administering research surveys to the constituents of the CAFM organizations (STFM, NAPCRG, AFMRD, and ADFM). CERA sends calls for proposals to CAFM members for survey questions that have potential to yield peer-reviewed publications. The number of survey questions on a particular topic is generally limited to 10. A 13-member steering committee makes decisions on proposals and provides mentorship to applicants.