New Faculty Scholars

The New Faculty Scholars Award provides STFM members who are in their first 2 years as full-time faculty, and who exhibit outstanding leadership potential, the opportunity to attend the STFM Annual Spring Conference. This introduction to 1,000 or more STFM members provides exposure for new faculty to discipline leaders and community-building activities that might not have occurred without the program. The program is sponsored by the STFM Foundation.

Family Medicine Leadership Programs

STFM created an online inventory of the leadership development activities sponsored by the family of family medicine to share information about the family's various leadership programs. This online leadership program inventory is available at http://www.stfm.org/leadership/leadershipuser.html.

Too often we assume that if someone is an effective clinician, they can transition to be an effective leader. The skills required to provide comprehensive, compassionate care to patients may be important in a leader, yet alone are not sufficient. The ability to channel passion for an issue or the calling to advocate for change into demonstrable progress in achieving a goal requires both practical leadership and managerial skills. Creating organizational culture, managing change, recognizing the systems barriers to progress and opportunities for improvement require, among others, skills in negotiation, conflict management, and strategic thinking. Only by dedicated attention to acquiring, practicing, and implementing leadership skills can we hope to develop effective leaders for family medicine.

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

From the Association of Departments of Family Medicine

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IN PURSUIT OF A TRANSFORMED HEALTH CARE SYSTEM: FROM PATIENT CENTERED MEDICAL HOMES TO ACCOUNTABLE CARE ORGANIZATIONS AND BEYOND

Well before the federal Affordable Care Act legislation, the concept of a "Patient Centered Medical Home" (PCMH) was promoted within academic and clinical family medicine as the foundation for health care delivery transformation. Yet the PCMH is not sufficient in itself—it must be part of integrated health care delivery systems that span the continuum of care that a patient receives. As a result, new federal efforts through the Center for Medicare and Medicaid Services (CMS) to develop Accountable Care Organizations (ACOs) have arisen. Efforts to transform health care for communities and large populations will undoubtedly continue to push forward, regardless of nomenclature and regulatory definitions. Although formal definitions and regulations are emanating from CMS, the commercial world may actually be more influential in the long run, as businesses demand health care that is less expensive and that results in a healthier, more productive workforce.

The Association of Departments of Family Medicine, as part of a collective effort by the Council of Academic Family Medicine (CAFM) recently provided feedback to CMS on its proposed ACO regulations; 3 key points are worth emphasis:

I. Practice transformation on the level of the patient centered medical home is a critical first step to improving care of the patient and putting our own house in order—but it is just a first step

Features of the PCMH, where accountability for prevention, acute and chronic disease care, and coordination of care that patients receive outside of the primary care office is provided primarily within interdisciplinary practice teams, are fundamental to health care delivery. The PCMH alone, however, does not address the care of a community or a population size that is more than that of typical primary care panels. Partnerships beyond the PCMH are necessary for larger system improvement.

Additionally, the future of the PCMH is at risk if reimbursement for care does not align with the model. In the context of numerous demonstration projects, grant funding has established interdisciplinary, interprofessional teams that have proven the model to be effective and lower costs, but the PCMH will not adequately spread nor be self-sustaining without significant payment reform.

II. We need to be concerned with the other parts of the health care system—the medical neighborhood, the ACO, or a regional or national integrated, comprehensive, accessible system

The payment structure proposed through ACOs may be more sustainable in the long-term: it combines fee-for-service with annual shared savings and performance bonuses tied to specified quality performance standards. Joint accountability for care by all providers in an ACO is fundamental—the providers within a PCMH form a critical foundation for this type of delivery system transformation. Blended payment

systems are essential for the most effective health system reform, and therefore must be supported in the ACO and other value based reimbursement structures that evolve. One of the main challenges for any ACO is to modify physicians' behaviors; immediate reinforcement in the form of payment for services provided both directly in the office, and the plethora of outside-the-office care that occurs in primary care settings (telephone and e-mail follow-up, review of diagnostic tests and coordination with specialists, time spent studying registry results to identify and contact patients in need of services, and completion of insurance and prior authorization forms) as well as a per-patient/per-month care management fee are viable mechanisms to accomplish this.

III. The ACO model as proposed by CMS is clearly flawed but we need to be both open to new ideas and to generate models with shared savings

Unless, or until, CMS is able to pay ACOs (and, in turn, facilitate ACOs paying their participants) in a manner more consistent with the desired outcomes (ie, through a blend of fee-for-service, partial capitation, etc), the Medicare ACO program may never succeed. From the experience of many state Medicaid programs, such as those in North Carolina and Illinois, we know that blended payment systems that include both prospective care coordination payments and fee-for-service payments lead to impressive health care cost savings and improvement in quality indicators—the value proposition that our health care system so desperately needs.

The proposed ACO model from CMS creates significant practical challenges; in particular, the quality reporting requirements are onerous and would prevent most primary care practices from engaging in this endeavor. A much more focused set of high priority quality reporting measures that have the greatest likelihood of major impact on health care quality and costs would attract more family physicians. With time, more measures might be added as participating systems establish a more robust reporting infrastructure, and as health services research defines additional effective quality reporting metrics.

The conversation about improved health care delivery for the health of the public has never been more important. We must continue to be actively engaged and open to new possibilities on the horizon.

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THE DELTA-EXCHANGE

Imagine, if you will, a large boardroom with a mahogany table. Around this table sit the 500 smartest people in the world. In the front of the room is a fully connected white board that collects the myriad of ideas that this group generates. This miracle of science categorizes all the great ideas generated by this august body. It allows other members to comment and refine these ideas. It automatically links these ideas to information resources. You also notice that in front of each of the guests around the table sits a toolbox. In this toolbox there are thousands of resources already created by the myriad of smart people who have sat at this table before. These tools are categorized, and easily accessible. Those around the table have gathered to solve the problems that family medicine faces. You then notice that all the guests are wearing their pajamas and slippers. If you have this picture in your mind, you now understand the potential of Delta-Exchange.

As its name implies the Delta-Exchange is a tool to create, refine, and disseminate change. It provides a place to "ask the experts" about an issue or topic. It allows one to disseminate and view online seminars. It contains "how to" articles on things like group visits and building teams. It allows us to build a wiki—a Web site developed collaboratively by a community where members can add and edit content using interlinked Web pages. It allows us to post ideas and build on them as a community. In essence, it is our asynchronous boardroom.

The problem is that the big mahogany table, our fancy whiteboard, and our cool toolbox are completely useless without those 500 smart people sitting around the table. Therefore, the AFMRD, whose strategic plan calls for new forms of communication, needs you to take a chance and sit at the table (bunny slippers allowed). We cannot tackle problems such as innovation in residency training, a Residency Performance Index (RPI), RC-FM changes, changes to our certification exam, or a national curriculum for family medicine without you (the smart people). So we challenge you to sign on today at http://www.deltaexchange.net, post a question or a really cool article, read about ACOs, create a tool to be used on our RPI. Let us begin the task