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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This commentary was written by the ADFM Executive Committee and PCMH Taskforce Co-Chairs

From the Association of Family Medicine Residency Directors

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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

of taking our specialty training to the next level by more effectively collaborating and solving these very difficult challenges.

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From the North American Primary Care Research Group

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NAPCRG PUTS THE INCREASE OF PRIMARY CARE RESEARCH FUNDING AT THE TOP OF THE PRIORITY LIST

Most primary care physicians are well aware of the countless research studies across disciplines that show the strength of a country's primary care system is directly linked to its population's health status. When people have access to primary care, treatment occurs before more severe problems can develop. People who receive primary care also have fewer preventable emergency department visits and hospital admissions than those who don't.[1] It also is linked to improved workforce productivity and lower overall health care costs. Yet, historically, research funding dollars have gone towards research of a specific disease, organ system, cellular or chemical process, not for primary care.

While this research is of importance, it does not help the greatest number of patients at the point where they receive the majority of their health care. In 2008, primary care physicians had more patient visits compared with other medical specialist groups or care settings; for every 100 people, there were more than 193 primary care office visits.[2]

It seems obvious that adequate funding for research in primary care is essential to inform practice that will in turn create better outcomes for patients—especially given the number of patients treated in a primary care setting.

On the contrary, recent studies by the Robert Graham Center found that of the $95.3 billion that the National Institutes of Health (NIH) awarded in research grants from 2002 to 2006 (including the 3 years after the NIH budget doubled), family medicine researchers received just over $186 million—only about 2 pennies for every $10 spent. Furthermore, nearly 75% of all grants to family medicine came from only 6 of the NIH's 24 funding institutes and centers, and one-third of the institutes and centers did not award any grants to family medicine.[3]

These numbers just don't add up to better health outcomes for patients. Despite having the most costly health system in the world, the United States consistently underperforms relative to other countries on most dimensions of performance. Very little is known about important topics such as how primary care services are best organized, how to maximize and prioritize care, how to introduce and disseminate new discoveries so they work in real life, and how patients can best decide how and when to seek care.

At the NAPCRG Annual Meeting in November 2010, NAPCRG leadership put funding for primary care research at the top of its priority list. The NAPCRG Advocacy Committee meets regularly to determine and execute tactics to further this cause. NAPCRG leadership is working diligently to increase awareness with key decision-makers and is calling upon government funding centers to bring the research funding model in balance with the increased reliance on primary care. They developed a set of key messages to be used when meeting with lawmakers and funding sources.

NAPCRG encourages primary care physicians and researchers to join this effort and utilize the messages below in advocacy activities.

The Importance of Primary Care and Primary Care Research

The overall health of a population is directly linked to the strength of its primary health care system. A strong primary care system delivers higher quality of care and better health for less cost.

Primary care provides a "medical home" and considers the whole person, as they exist in family, community, and population, including multiple illnesses, preventive care, health promotion, and the integration of mind and body.

Primary Care Is

- complex and comprehensive
- where most people first bring their symptoms and health concerns and have their first touch with the health care system
- where people develop healing, trusting relationships with their physician and other primary care providers

Primary Care Research Includes

- translating science into the practice of medicine and caring for patients
- understanding how to better organize health care to meet patient and population needs