

SPECIAL COMMUNICATION

The Future of Family Medicine Version 2.0: Reflections from Pisacano Scholars

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The Future of Family Medicine (FFM) project has helped shape and direct the evolution of primary care medicine over the past decade. Pisacano Scholars, a group of leaders in family medicine supported by the American Board of Family Medicine, gathered for a 2-day symposium in April 2013 to explore the history of the FFM project and outline a vision for the next phase of this work—FFM version 2.0 (v2.0). After learning about the original FFM project (FFM v1.0), the group held interactive discussions using the World Café approach to conversational leadership. This commentary summarizes the discussions and highlights major themes relevant to FFM v2.0 identified by the group. The group endorsed the FFM v1.0 recommendations as still relevant and marveled at the progress made toward achieving many of those goals. Most elements of FFM v1.0 have moved forward, and some have been incorporated into policy blueprints for reform. Now is the time to refocus attention on facets of FFM v1.0 not yet realized and to identify key aspects missing from FFM v1.0. The Pisacano Scholars are committed to moving the FFM goals forward and hope that this expression of the group’s vision will help to do so. (J Am Board Fam Med 2014;27:142–150.)

Keywords: Affordable Care Act (ACA), Community Medicine, Delivery of Health Care, Primary Health Care, Public Health, Quality of Health Care

For decades, the US health care system has struggled to address problems surrounding access to care, quality of care, and rising costs of care.^{1–7} The landmark Future of Family Medicine (FFM) publication addressed many of these issues and proposed solutions.⁸ Innovative changes in systems of

care delivery that sprang from the FFM project, such as the patient-centered medical home (PCMH) and the patient-centered primary care collaborative, have shown early promise.^{9–19} Models such as communities of solution and direct primary care practices provide needed innovations.^{20–23} With change mandated by the Affordable Care Act (ACA) and new opportunities supported by the implementation of this legislation, primary care inhabits a rapidly evolving health care landscape.²⁴ This time of great change in primary care prompted a group of Pisacano Scholars to gather in April 2013 to reflect on the original FFM project (FFM version 1.0) and to look forward to the future (FFM version 2.0), envisioning how family physicians can continue to contribute to an improved health care system for all.

The Pisacano Leadership Foundation was founded by the American Board of Family Medicine (ABFM) in 1991 in honor of Nicholas Pisacano, the founder and first executive director of the ABFM, to identify leaders entering family medicine and to offer group training and networking opportunities. Pisa-

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cano Scholars are selected in their fourth year of medical school, receive financial support through residency, and maintain their connection to the group throughout their careers. Most Pisacano Scholars grew up as physicians alongside the FFM project of 2004, which was a guiding light, a manifesto for excellence, and a call to action amid the chaotic and fragmented US health care system. Thus, this group has a unique vantage point from which to reflect on the original FFM (v1.0) as well as to envision its future (FFM v2.0). This group also is aware that more improvements are needed in the US health care system and that these improvements need to happen at a faster pace. To optimize the health of patients, family physicians need to be prepared to lead bigger and faster changes in the system.

The Group and Discussion Process

Thirty-five Pisacano Scholars (12 in their final year of medical school or in residency, 23 who have completed residency) gathered in Chicago in April 2013 for a 2-day series of facilitated discussions centered on the theme of “The Future of Family Medicine.” Invited speakers included Jim Martin, MD, Bob Phillips, MD, MSPH, and James Puffer, MD. Table 1 describes the basic sociodemographic characteristics of this subgroup of 35 Pisacano Scholars compared with all 105 Pisacano Scholars. Because young family physicians will play an important role in the future, their voices should be heard in discussions regarding the future of our discipline.

Using the World Café approach to conversational leadership,²⁵ the group responded to 6 questions:

1. After hearing the history of the FFM, what are your thoughts?
2. How has this project succeeded?
3. What elements of the FFM still need to be developed?
4. Given the changes in health care since the last FFM, what new elements need to be considered and/or added?
5. Given the changes in health care since the last FFM, what elements are no longer relevant?
6. Have you seen and/or experienced elements of the original FFM project in your own practice or doctor-patient relationship?

Table 1. Characteristics of the 35 Pisacano Scholars and Alumni Who Participated in the 2013 Chicago Conference on the Future of Family Medicine Compared with All 105 Pisacano Scholars and Alumni

Characteristics	35 Pisacano Scholars in Attendance the Chicago Conference	105 Pisacano Scholars (as of June 2013)
Age (years)		
<30	10 (29)	12 (11)
31–35	7 (20)	20 (19)
36–40	8 (23)	24 (23)
41–45	7 (20)	30 (29)
46–50	2 (6)	16 (15)
>50	1 (3)	3 (3)
Residency Completion		
Currently in medical school or residency	12 (34)	15 (14)
Completed residency ≤5 years ago	9 (26)	23 (22)
Completed residency >5 years ago	13 (37)	66 (63)
Other path after medical school	1 (3)	1 (1)
Medical School Graduation Year		
2012–2013	9 (26)	10 (10)
2010–2011	9 (26)	12 (11)
2005–2009	5 (14)	23 (22)
2000–2004	5 (14)	25 (24)
1994–1999	7 (20)	35 (33)
Geographic Residence		
Northeast	6 (17)	18 (17)
Midwest	10 (29)	23 (22)
South	6 (17)	15 (14)
West	13 (37)	47 (45)
International	—	2 (2)

Data are n (%).

These questions were designed to be broad and open ended; however, we acknowledge that they might not have allowed groups to cover every major issue of importance to the FFM v2.0 discussion. The meeting participants moved through small group discussions focused on each question, then came together as a large group to share ideas. We compiled notes taken throughout the discussions, creating a foundation for this article.

Reflections and Recommendations

While reflecting on the goals of the FFM project, the group reaffirmed the original 10 FFM recommendations as a guide to transforming family med-

icine and the health care system. The group identified many tangible outcomes and marveled at the progress being made toward these goals. The greatest accomplishments of FFM v1.0 identified by the group were the PCMH becoming a cornerstone of the ACA, the solidification of the identity of family physicians (including officially changing the name to family medicine), and the improvements to family medicine training and lifelong learning processes (eg, maintenance of certification [MOC], 4-year residency pilots, and the P4 Project [Preparing the Personal Physician for Practice]).

Much of the discussion focused on scholars' ideas for the future, and 12 broad themes for FFM v2.0 arose from the workshop. Some of these FFM v2.0 themes overlap with the original FFM project discourse (as noted in parentheses after the description of each theme), and others move beyond FFM v1.0 (Table 2).

Theme 1: Leading Health Care System Transformation

Family physicians are well suited to lead the transformation of the US health care system in primary care settings, hospital systems, and communities.²⁶ Leadership training opportunities should be available through all phases of career development and in diverse health care and community settings. These lifelong leadership opportunities would ideally produce a pipeline of leaders in family medicine, beginning in medical school (or earlier) and continuing through residency, fellowship, and into practice. The model could include traditional didactics and continuing medical education programs, as well as internships, mentorships, and apprenticeships at all career stages. (FFM v1.0 recommendation #10: leadership and advocacy).

Theme 2: Advocating for Policies That Improve Health

Family physicians are well positioned to advocate for policies that improve the health of patients and the public. To do so, family physicians must be supported to maintain expertise in the current health care environment, including knowledge of the provisions of the ACA.²⁷ Advocacy efforts should be further enhanced by scholarly work on topics such as health policy, health economics, health services research, dissemination and implementation science, health literacy, and social determinants of health in collaboration with academic

institutions and policy research organizations, such as the Robert Graham Center and the Institutes of Medicine. Family physicians should also be well equipped to work alongside politicians and policy makers to influence legislation and funding streams that support and promote the benefits of primary care and improve the health of populations. (FFM v1.0 recommendation #10: leadership and advocacy).

Theme 3: Assuring That Family Physicians Are Well Trained

Family physicians must engage in lifelong learning to maintain clinical and population health skills and provide high-quality, up-to-date health care throughout their careers. Current MOC programs can be seamlessly integrated into daily clinical workflows. Electronic health records (EHRs) and other technologies should rapidly evolve to foster "real-time" learning and support the delivery of care to individuals and populations. New models of delivering clinical care, engaging patients, and caring for populations must be integrated into family medicine residency training. There must also be pathways for new training and retraining so that family physicians already in practice can change or broaden their scope of practice based on current or future community needs. The group felt that it was more important to support family physicians in obtaining skills and a scope of practice that meets the unique needs of their communities rather than enforcing a uniform scope of practice for every family physician. There was also discussion about the need for family physicians to be trained alongside other members of the health care team to ensure effective and high-quality patient-centered teamwork. (FFM v1.0 recommendation #4: lifelong learning).

Theme 4: Improving Personal Relationships With Patients

Relationships must remain at the core of medicine and healing.^{28–34} Long-term relationships with a personal physician can improve health outcomes and are important for promoting shared decision making.^{35,36} The personal relationship at the center of the patient-physician partnership must be nurtured and sustained even as excellent new models for team-based and data-driven care are developed and implemented. Care models that support these relationships, such as direct primary care

practices, should be explored and expanded. Personal physicians should be meaningfully involved and have influence over their patients' care throughout the health care system, working alongside specialist colleagues in all settings of care. (FFM v1.0 recommendation #1: new model of family medicine; FFM v1.0 recommendation # 6: quality of care).

Theme 5: Putting Patients Truly in the Center

As the PCMH continues to develop, it must be truly patient centered and not simply practice centered. Best practices are needed to define the ideal patient-centered team models and tailor these models to fit unique patient and population needs. Family physicians and the PCMH must partner with patients, engaging them in self-management and educating them about how to most effectively navigate the health care system. Continuity of care is critical for achieving a patient-centered approach. The group recognized that patients have different preferences and needs: some patients prioritize visits with the same physician; some patients prefer to schedule a visit at a time most convenient for them; others prefer to communicate about health concerns via telephone and E-mail. Meeting these diverse needs will require a combination of flexible office hours, virtual care delivery, and continued assessment of patients' desires and opinions about their PCMH. (FFM v1.0 recommendation#1: new models of primary care).

Theme 6: Providing Healthcare that is Guided by Best Evidence

The continued processes of learning, expanding the knowledge base, and creating new evidence to support best practices should evolve alongside changing medical practices and technology. Family physicians should be involved in creating and identifying evidence that is relevant to care provided in primary care and community health settings. This should also include actively contributing to the evaluation of new evidence and the dissemination of evidence-based best practices into diverse settings. Studies should focus on outcomes that improve community health as well as individual health. (FFM v1.0 recommendation #5: enhancing the science of family medicine; FFM v1.0 recommendation #6: quality of care).

Theme 7: Defining the Role of the Family Doctor

Family medicine organizations should communicate the role of the family physician to the community and educate the public about the importance of having a primary care medical home. While family physicians are diverse and deliver services based on the unique needs of the communities in which they serve, it is still essential to speak with "one voice" and have clear internal and external messaging. Family medicine needs a concise slogan such as "doctors for all people." Family medicine should also develop an "elevator speech," such as "family physicians are the personal physicians who know you and are experts at providing and integrating your care in the context of your community and family relationships." There is also a need to communicate the unique role of the family physician in health care teams and how family physicians contribute to the needs of individual patients and entire communities. (FFM v1.0 recommendation #9: unified communications strategy).

Theme 8: Building a Family Medicine Workforce for the Future

A robust, well-trained primary care workforce is essential to meet the needs of the aging US population. Furthermore, as millions of previously uninsured individuals gain coverage under the ACA, it is likely that the demand for primary care services will grow.³⁷ Through innovations such as middle and high school programs, the workforce pipeline should start early to promote primary care health careers, accelerated pathways to careers in family medicine for students from rural communities, and opportunities for mentorship from a diverse cohort of family physicians. (FFM v1.0 recommendation #8: promoting a sufficient family medicine workforce; and FFM v1.0 recommendation #3: family medicine education).

Theme 9: Making Technology Meaningful

"Smarter" EHRs are needed to assist in asynchronous communication with patients, provide feedback on quality of care, support clinical decision making, incorporate advanced analytics, allow for interactive patient engagement, and integrate data from multiple EHRs and health care settings. Family physicians must be experts at putting data "into" EHRs to document visits and patient care, but they should also be experts at getting data "out of" EHRs to inform improvements in patient care and

Table 2. Summary of Themes from the Pisacano Scholars' Vision for the Future of Family Medicine (FFM) Version 2.0, Related FFM Version 1.0 Recommendations, and Representative Quotes

Themes Representative of Pisacano Scholars' Vision for FFM v2.0	FFM v1.0 Project Recommendations	Representative Salient Quotes
1. Leading healthcare system transformation	10. Leadership and advocacy	<p>"The healthcare system needs us; this is a call to action."</p> <p>"This is about leading the transformation within primary care but also stepping up to be leaders across the health care system and in the community."</p> <p>"Step into the role—walk the walk."</p>
2. Advocating for policies that improve health	10. Leadership and advocacy	<p>"Let's provide 'leadership with guts' to clearly define our goals."</p> <p>"We need to come out of the closet and support the ACA."</p>
3. Assuring that family physicians are well trained	4. Lifelong learning	"Integrate MOC more seamlessly into daily work."
4. Improving personal relationships with patients	1. New model of family medicine 6. Quality of care	"Although rethinking structure and processes in medical care is undeniably essential, <i>relationships</i> must remain at core of medicine and healing."
5. Putting patients truly in the center	1. New models of primary care	<p>"We need to achieve meaningful transformation, not just check boxes."</p> <p>"Don't stifle innovation."</p> <p>"Innovation is key."</p> <p>"We need to put the <i>heart</i> into the vision."</p>
6. Providing healthcare that is guided by best evidence	5. Enhancing science of family medicine 6. Quality of care	<p>"Let's put forth practical models of what actually works (not just the philosophical models)."</p> <p>"We can focus on implementation but we also need to focus on measurement: are we really putting forth measurable goals to assess success?"</p> <p>"Who will be accountable for ensuring that 'stuff' gets done?"</p>
7. Defining the role of the family doctor	9. Unified communications strategy	<p>"Let's put some of this information into the <i>New Yorker</i>, not just the JABFM."</p> <p>"Doctors for the Whole Person . . . Doctors for All People"</p> <p>"We would like our patients to say to us: 'You're my everything doctor.'"</p>
8. Building a family medicine workforce for the future	8. Promoting a sufficient family medicine workforce 3. Family medicine education	<p>"We need to expose medical students to the FFM vision out in the 'real world'—not just at the academic health centers."</p> <p>"Resident education will drive change."</p>
9. Making technology meaningful	2. Electronic health records	"Are we talking about using the EHR as a medical record, or are we talking about meaningful use?"
10. Engaging all family physicians in "learning communities" to share and learn best practices	1. New model of family medicine 5. Enhancing the science of family medicine	<p>"We need to move beyond statements of intent to implementation of ideas."</p> <p>"Has the FFM moved down into the trenches? How do we work to create a universal language and move this into the world of the average family physician?"</p> <p>"We cannot leave behind small communities, rural practices, and underserved populations."</p>
11. Using resources wisely and equitably	Task force 5 but was not explicitly a recommendation of FFM v1.0	"Maybe we should pay for an air conditioner rather than a hospitalization?"

Continued

Table 2. Continued

Themes Representative of Pisacano Scholars' Vision for FFM v2.0	FFM v1.0 Project Recommendations	Representative Salient Quotes
12. Addressing the needs of populations to eliminate health disparities	No FFM v1.0 recommendation or task force explicitly addresses this theme.	<p>"We need to create a community-centered medical home and integrate with social services and use their resources."</p> <p>"Our job is to fundamentally solve problems. We should define ourselves by what problems we solve and how we help communities."</p>

ACA, Affordable Care Act; EHR, electronic health records; JABFM, *Journal of the American Board of Family Medicine*; MOC, maintenance of certification.

population health. This technological expertise and ease of use should extend other technologies such as tele-health, in-home devices, and remote physical examination tools that will likely become part of the toolkit for providing optimal primary care in the future. Residency training should emphasize technology, and family medicine should be branded as both "high tech" and "high touch." Family physicians and patients should be intimately involved in leading the development of next-generation technologies. (FFM v1.0 recommendation #2: electronic health records).

Theme 10: Engaging All Family Physicians in "Learning Communities" to Share and Learn Best Practices

Once effective models of care are defined, these best practices must be shared throughout the country through learning communities. Mechanisms for sharing information, adapting practices, and testing the feasibility of best-practice models in different settings should be developed.³⁸ Protected administrative time is essential to implement these changes, and new training programs should be developed to teach family physicians how to mentor colleagues in other places. Mentors can serve as "community champions" in "patient-centered medical communities" that bring together PCMHs to share best practices.³⁹ The development of a national cohort of practice facilitators, care managers, and primary care improvement advisors as pollinators and change agents can also make vital contributions to implementation and dissemination of ideas.⁴⁰⁻⁴² A particular challenge will be developing practice transformation models tailored to rural physicians and mechanisms to disseminate these models to rural communities. Family physicians and practice-based research networks must contribute to the

evolving science of implementation and dissemination so that we can understand what works and what does not work well and why. (FFM v1.0 recommendation #1: new model of family medicine; FFM v1.0 recommendation #5: enhancing the science of family medicine).

Themes 11 and 12 (below) go beyond the original FFM v1.0 statements, which focused on "medical" care. These FFM v2.0 themes move primary care further into the community, integrating it with population and global health, representing new pathways for expansion and change.

Theme 11: Using Resources Wisely and Equitably

Traditional payment mechanisms incentivize over-treatment and provide the highest reimbursements when patients remain sick and become sicker. Instead, physicians should be reimbursed for keeping patients healthy. New payment models should reimburse for office visits but also for e-visits, care coordination, telephone counseling, home visits, leadership of community wellness events, and other efforts that address social determinants of health. Meaningful and robust tests of alternative payment methodologies are needed. Health care systems built on a strong primary care foundation can provide better outcomes at lower cost.^{19,43,44}

Theme 12: Addressing the Needs of Populations to Eliminate Health Disparities

Family physicians should look beyond the patient and family to include the broader contexts of communities and populations. They may best accomplish this by integrating primary care, preventive care, and public health. This also will require that access to basic medical care, health insurance, and a medical home is seen as a "public good." Driven by

a social justice ethic, many family physicians already devote their careers to ensuring this access to individual patients, whether by working in federally qualified health centers, volunteering among the neediest of the needy, or working abroad in global health programs. Family physicians should also be trained to work toward policies that can guarantee this access for populations. In addition, family physicians should strive to be healthy and serve as role models for health and life balance within the communities they serve. To achieve this, they should maintain a healthful work-life balance and be supported in their efforts to do so.

Discussion and Some Suggested Next Steps

The themes and concepts discussed in this article emerged from a thoughtful discourse within a group designated by the ABFM as young leaders in family medicine, many of whom are within 10 years of completing residency training. The Pisacano Scholars' vision for FFM v2.0 echoes voices from the past while adding next-generation perspectives. Nicholas Pisacano stated in 1967, "First, we must do what is best for the American public. Second, we must do what is best for medicine. Finally, we must do what is best for family medicine."⁴⁵ In that spirit, this commentary outlines themes important to the continued transformation of family medicine, with the larger goals of improving US and global health. This document also is intended to demonstrate one model for documenting and reflecting on a large group's conversations about a critical topic. We hope the format used herein will be beneficial to other groups wanting to share their processes in the future.

Many of the themes put forth by this group highlight the great progress being made toward meeting goals from FFM v1.0. Other themes identified in the Pisacano Scholars' vision for FFM v2.0 highlight areas where the specialty has not made substantial progress with recommendations from FFM v1.0 and needs to move forward. The group also identified areas not addressed by FFM v1.0 recommendations. These create opportunities for new pathways for improvement, discourse, and professional development.

While Family Medicine has made great progress in the past decade toward the inspirational goals of FFM v1.0, much work lies ahead. We suggest a few tangible next steps:

1. It is urgent that we revitalize and expand the FFM v1.0 task forces #5 (family medicine's role in shaping the future health care delivery system) and #6 (enhancing practice reimbursement).
2. A new task force should be created to address family medicine's role in population health, including communities of solution and the integration of primary care with community and public health.
3. Similar to continuous quality improvement, FFM v2.0 should involve an ongoing process of evaluation and reflection. To ensure that this evaluation occurs for FFM v2.0, an entity such as the ABFM must "own" this process and be supported in doing so.
4. The personal physician should coordinate care not only in the PCMH but throughout the health care system. Under the ACA, institutional financial reimbursement will hinge on well-coordinated care.¹ Thus, we propose a new "chief" role in every large health care institution: Chief Primary Care Medical Officer. This physician will develop and oversee systems that preserve the critical role of the personal physician in assuring coordinated care, integrated services, and continuity of care for patients. These services will be tailored to patients' wishes and appropriate to their social and cultural backgrounds.^{35,46}
5. It is time to move forward, continue discussions about the future, and develop the full blueprint for FFM v2.0. This process should include a diverse group including clinicians, patients, researchers, educators, policy makers, and communities.

Of note, discussions did not focus on defining a uniform scope of practice for family physicians; instead, the group felt it was more important for family physicians to be able to identify and deliver services needed in their unique communities. This included discussions about the need for mid-career retraining opportunities and support for physicians wishing to expand their scope of practice. There was also little discussion regarding addressing shortages in the primary care workforce; instead, the group focused more on quality rather than quantity. They saw a great need for improving family physician's contributions to the US health care system and envisioned our discipline working collaboratively

alongside others in the field to improve the health of patients and communities.

Conclusion

The US health care system is at a crossroads. Fragmented care, skyrocketing costs, variations in quality, and poor access to care threaten the system and adversely affect the health of many Americans.^{1,47} The ACA aims to address these issues and will dramatically alter the landscape of US health care. The authors of the ACA incorporated the PCMH into the ACA's structural model because they recognized that high-quality, patient-centered primary care can improve the health of populations. The challenge now, as outlined in this commentary, is to improve and disseminate that medical home, to move beyond a practice-centered medical home to one that is truly patient-centered and community-centered, and to move beyond treating disease to promoting wellness. The goals of the FFM v2.0 should focus not only on the future of family medicine but also on the future of US and global health.

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References

- Berwick DM HA. Eliminating waste in US health care. *JAMA* 2012;307:1513–6.
- Berwick DM, Nolan TW, Whittington J. The triple aim: care, health, and cost. *Health Aff (Millwood)* 2008;27(3):759–69.
- Institute of Medicine. *Unequal treatment: confronting racial and ethnic disparities in healthcare*. Washington, DC: National Academies Press; 2003.
- Institute of Medicine. *Informing the future. Critical issues in health*. 2nd Ed. Washington, DC: National Academies Press; 2003.
- Institute of Medicine. *Insuring America's health: principles and recommendations*. Washington, DC: National Academies Press; 2004.
- Institute of Medicine, Committee on Quality of Health Care in America. *Crossing the quality chasm: a new health system for the 21st century*. Washington, DC: National Academies Press; 2001.
- Congressional Budget Office. *The long-term outlook for health care spending*. Available from: <http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/87xx/doc8758/11-13-lt-health.pdf>. Accessed November 29, 2010.
- Martin JC, Avant RF, Bowman MA, et al. The Future of Family Medicine: a collaborative project of the family medicine community. *Ann Fam Med* 2004;2(Suppl 1):S3–32.
- Bodenheimer T, Pham HH. Primary care: current problems and proposed solutions. *Health Aff (Millwood)* 2010;29:799–805.
- Nutting PA, Miller WL, Crabtree BF, Jaén CR, Stewart EE, Stange KC. Initial lessons from the first national demonstration project on practice transformation to a patient-centered medical home. *Ann Fam Med* 2009;7:254–60.
- Rittenhouse DR, Shortell SM. The patient-centered medical home: will it stand the test of health reform? *JAMA* 2009;301:2038–40.
- Rittenhouse DR, Shortell SM, Fisher ES. Primary care and accountable care – two essential elements of delivery-system reform. *N Engl J Med* 2009;361:2301–3.
- Crabtree BF, Nutting PA, Miller WL, Stange KC, Stewart EE, Jaén CR. Summary of the National Demonstration Project and recommendations for the patient-centered medical home. *Ann Fam Med* 2010;8(Suppl 1):S80–90.
- Patient Centered Primary Care Collaborative. 2009 PCPP pilot guide: proof in practice. A compilation of patient centered medical home pilot and demonstration projects. 2009:90. Available from: <http://www.pcpcc.org/sites/default/files/media/PilotGuidePip.pdf>. Accessed November 23, 2013.
- Patient-Centered Primary Care Collaborative [homepage]. Available from: <http://www.pcpcc.net/index.php>. Accessed November 9, 2013.
- Stange KC, Nutting PA, Miller WL, et al. Defining and measuring the patient-centered medical home. *J Gen Intern Med* 2010;25:601–12.
- Kilo CM, Wasson JH. Practice redesign and the patient-centered medical home: history, promises, and challenges. *Health Aff (Millwood)* 2010;29:773–8.
- Landon BE, Gill JM, Antonelli RC, Rich EC. Prospects for rebuilding primary care using the patient-centered medical home. *Health Aff (Millwood)* 2010;29:827–34.
- Margolius D, Bodenheimer T. Transforming primary care: from past practice to the practice of the future. *Health Aff (Millwood)* 2010;29:779–84.

20. Folsom Group. Communities of solution: the Folsom Report revisited. *Ann Fam Med* 2012;10:250–60.
21. American Board of Family Medicine Young Leaders Advisory Group. Improving America's health requires community-level solutions: Folsom revisited. *Am Fam Physician* 2012;86:1–2.
22. Griswold KS, Lesko SE, Westfall JM; Folsom Group. Communities of solution: partnerships for population health. *J Am Board Fam Med* 2013;26:232–8.
23. Wu WN, Bliss G, Bliss EB, Green LA. Practice profile. A direct primary care medical home: the Qliance experience. *Health Aff (Millwood)* 2010;29:956–62.
24. Grundy P, Hagan KR, Hansen JC, Grumbach K. The multi-stakeholder movement for primary care renewal and reform. *Health Aff (Millwood)* 2010;29:791–8.
25. Hurley TJ, Brown J. Conversational leadership: thinking together for a change. *The Systems Thinker* 2009;20:2–7. Available from: <http://www.theworldcafe.com/articles/Conversational-Leadership.pdf>. Accessed July 11, 2013.
26. Donahue KE, Halladay JR, Wise A, et al. Facilitators of transforming primary care: a look under the hood at practice leadership. *Ann Fam Med* 2013;11:S27–33.
27. Phillips RL Jr, Kaufman A, Mold JW, et al. The primary care extension program: a catalyst for change. *Ann Fam Med* 2013;11:173–8.
28. Miller WL, Crabtree BF, Stange KC, Nutting PA, Jaén CR. Primary care practice development: a relationship-centered approach. *Ann Fam Med* 2010;8(Suppl 1):S68–79.
29. Peabody FW. The care of the patient. *JAMA* 1927;88:877–82.
30. Loxterkamp D. Being there: on the place of the family physician. *J Am Board Fam Pract* 1991;4:354–60.
31. Loxterkamp D. Border crossings: on the boundary of the physician-patient relationship. *J Am Board Fam Pract* 1998;11:487–9.
32. Loxterkamp D. A vow of connectedness: views from the road to Beaver's farm. *Fam Med* 2001;33:244–7.
33. Loxterkamp D. Doctors' work: eulogy for my vocation. *Ann Fam Med* 2009;7:267–8.
34. Loxterkamp D. A change will do you good. *Ann Fam Med* 2009;7:261–3.
35. DeVoe JE, Nordin T, Kelly K, et al. Having and being a personal physician: vision of the Pisacano scholars. *J Am Board Fam Med* 2011;24:463–8.
36. Atlas SJ, Grant RW, Ferris TG, Chang Y, Barry MJ. Patient-physician connectedness and quality of primary care. *Ann Intern Med* 2009;150:325–35.
37. Kenney GM, McMorro S, Zuckerman S, Goin DE. A decade of health care access declines for adults holds implications for changes in the Affordable Care Act. *Health Aff (Millwood)* 2012;31:899–908.
38. TranforMED. Delta exchange. Available from: <http://www.transformed.com/delta-exchange/index.cfm>. Accessed July 11, 2013.
39. DeVoe JE, Sears A. The OCHIN Community Information Network: bringing together community health centers, information technology and data to support a patient-centered medical village. *J Am Board Fam Med* 2013;26:271–8.
40. Taylor EF, Machta RM, Meyers DS, Genevro J, Peikes DN. Enhancing the primary care team to provide redesigned care: the roles of practice facilitators and care managers. *Ann Fam Med* 2013;11:80–3.
41. Baskerville NB, Liddy C, Hogg W. Systematic review and meta-analysis of practice facilitation within primary care settings. *Ann Fam Med* 2012;10:63–74.
42. Culler SD, Parchman ML, Lozano-Romero R, et al. Cost estimates for operating a primary care practice facilitation program. *Ann Fam Med* 2013;11:207–11.
43. Starfield B, Shi L, Macinko J. Contributions of primary care to health systems and health. *Milbank Q* 2005;83:457–502.
44. Lee TH, Bodenheimer T, Goroll AH, Starfield B, Treadway K. Perspective roundtable: redesigning primary care. *N Engl J Med* 2008;359:e24.
45. American Board of Family Medicine. NJPMF Foundation Update. *ABFM Newsletter* 1994.
46. Stange KC. The generalist approach. *Ann Fam Med* 2009;7:198–203.
47. Stange KC. The problem of fragmentation and the need for integrative solutions. *Ann Fam Med* 2009;7:100–3.