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.

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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.

CERA sent its first survey to all residency programs in June 2011. Currently it surveys residency directors 2 times per year; general residency faculty annually, and clerkship directors and medical school faculty annually. This coordinated effort around surveying constituents results in higher quality questions and fewer surveys.

So What?

Have you ever considered conducting a survey you thought explored important issues in family medicine and could have enduring value for our discipline, but never pursued it because of any of the following barriers?

- My program is too small so my sample would be too small
- I don't know how I would get other residency programs to take part in this
- I have never been trained in survey design and there is no one in my program or institution to help me
- I don't know how to move from a survey question to a research project

The mission and purpose of CERA address all of the barriers above.

Now What?

As requirements around scholarly activity for faculty put greater emphasis on peer review, CERA can play an important role in faculty development for your program and help increase scholarly productivity. The mentoring and guidance built into the infrastructure of CERA can provide the resources that are simply lacking and unavailable to many programs. Programs should encourage faculty to submit questions to CERA for primary research as well as utilize the data in the CERA clearinghouse for secondary data analysis.

We cannot rely on the designated department researchers to solely carry the responsibility of creating and sustaining family medicine research efforts. Teaching scholarly inquiry and evaluation is an obligation of family medicine residency programs and we must continue to explore opportunities like CERA that can help us fulfill that obligation.

For more information regarding CERA, visit http://www.stfm.org/initiatives/CERA.cfm.

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NORTH AMERICAN PRIMARY CARE RESEARCH GROUP

From the North American Primary Care Research Group

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PBRN CONFERENCE A SUCCESS

On June 21-22, 2012, NAPCRG tried something new. It worked. On these dates NAPCRG held its first annual practice-based research network (PBRN) conference. This meeting was supported by a conference grant from AHRQ, who has a longstanding interest in PBRN work, and who, until now had put on an annual PBRN conference. This meeting therefore represents a new, formal relationship with AHRQ, a new annual meeting for NAPCRG, and a chance to work with a whole new set of scientists, educators, and clinicians who care about practice-based research. Over 200 registrants attended the conference, from 6 countries. Japan! Romania! Brazil! Australia! And 30 investigators from Canada! Under NAPCRG's stewardship, this conference could well become—most likely will become—a world forum for PBRN work. Moreover, a broad range of disciplines were represented, including family medicine, general internal medicine, pediatrics, nursing, public health, dentistry, pharmacy, psychology, and social work.

All of this is good, but the real news has to do with how PBRNs are evolving. For 3 decades, practice-based research networks have been a core resource in the primary care research armamentarium, and a preferred platform for describing practices and clinical conditions, as well as for testing clinical interventions. At this PBRN meeting we heard about:

- Networks of networks linked together with elegant, efficient, lean infrastructures to answer difficult clinical or services questions
- Very large networks of practices linked together by their electronic health records. Some of these networks are large enough to tackle detailed comparative effectiveness trials
- Hybrid PBRN/CBPR networks that incorporate community resources, community boards, and deep community partnerships. These networks can test interventions that make use of public health, community health, and primary care resources
- PBRNs whose datasets are linked to very large administrative datasets, or claims datasets, that can produce complete services data
- PBRNs that cut across disciplines (eg, primary care, public health, dentistry, behavioral health)