believe that the growing ability to measure clinical outcomes is an opportunity to more clearly demonstrate that family physicians are this nation's best hope to create a higher quality, lower cost health care system, but we must provide residents new skills to lead PCMHs and ACOs. Innovation, new ways of looking at and solving problems, therefore, is an imperative for our specialty. We may need to look outside medicine to find ideas and solutions from other business industries to improve our model of delivery of care.

We have over 450 federally funded test sites called family medicine residencies which are a ready-built system to test new ideas to train better primary care physicians and provide better health outcomes than anyone else. If we don't, others will; and those others may not have the values of the family physicians of the past that inspire us to create "classics" for the future.

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From the North American Primary Care Research Group

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FAMILY MEDICINE, NAPCRG, AND THE GREAT MANDELLA

(Excerpts from acceptance of the Maurice Wood Award at the North American Primary Care Research Group Annual Meeting, Seattle, Washington, 2010.)

In the mid 1970s, I remember NAPCRG as a small band of family physicians, none professing to be a researcher, but all believing that the future of medicine should be created out of the best evidence, in an apolitical and non–discipline-specific environment. Those initial years of NAPCRG were marked by a fervent desire to describe and understand our practice and create and use tools for practice and research. Inquisitiveness about practice kept the physician vital, improved practice, and if systematic, was "research."

Before computers or even electric typewriters had come to medicine, the small group constituting NAPCRG was interested in the generalist physician's role in all settings and developed new practice research tools and measurement systems that would allow us to understand our world. In 1976, our world shook. Maurice Wood's group published what became known as the "Virginia Study" using data from half a million visits.

Through those years a small group of us in the new breed of residency-trained faculty interested in research formed bonds that have lasted a lifetime. NAPCRG became the mentored environment wherein our ideas could blossom. With the support of our mentors, the Ambulatory Sentinel Practice Network became a vehicle for our discipline's research. And the International Primary Care Network helped convey to other countries the excitement of research in North America.

In 1985, I surveyed all departments and residencies of family medicine in the United States and found that no family physician faculty had received NIH support for research fellowship training or other federal career research support. We've come a long way since then. However, many of the challenges are the same. Maurice Wood's generation viewed themselves and family medicine as outside of mainstream medicine with no voice in most medical schools or in the enterprise of medicine. In contrast, my generation grew up in the halls of medicine, and saw the possibility of becoming a part of the house of medicine.

We are now at a point where we will become the core of the house of medicine as demanded by health care reform, Accountable Care Organizations (ACOs), and Patient Centered Medical Homes (PCMHs). However, we desperately need the guidance of research inspired from the world view of the generalist and driven by the core principles of primary care—access, comprehensiveness, and continuity, and the ability to provide coordination and accept accountability for quality and cost.

I want to share observations regarding 3 threats and opportunities.

First, for our patients, the nodal points in their medical lifespans are when they need access to us and our guidance. If we abandon our roles in the hospital, including in maternity service, we forfeit major value for our patients, and give up a major opportunity to guide the development of medicine for decades to come.

Second, while much of our focus as generalist physicians has been on our relationship with our specialist colleagues, we need as much emphasis on engaging over the long-term with the communities where our patients live. How we leverage our roles as physicians in communities has been a theme explored at NAPCRG. Unfortunately, we have not had powerful research tools to describe and disseminate these community outreach initiatives and bring them into the mainstream of practice. Yet PCMHs will need to mobilize the power of their communities in like manner.

The third opportunity we have is the "4th dimension." Time is fundamentally different in primary care

than for our specialist colleagues. This is due in part to the tyranny of the office visit and the 1-year medical insurance contract. Diagnosis, the prized focus of specialty care, is cross-sectional; prognosis, central to primary care requires the dimension of time. How do we as healers interact with our families around time? Time will be a critical dimension to optimize and measure the performance of the primary care team nested in the PCMH and the ACO.

At my stage of life, while I still enjoy the mentorship of Maurice Wood, I find my greatest joy in mentoring others. For those who are successful mid-career investigators, I extend a job offer. Your discipline needs you. Over the next few years, there will be many openings for chairs of departments. Right now few departments have chairs with research backgrounds. If you are a successful seasoned investigator, you likely have refined the skills that will make you a magnificent departmental and institutional leader. The rewards of mentoring a department have been the highlights of my life and have allowed me opportunities to have far greater impact through research being conducted by mentored faculty than I would have as an investigator. When the time and opportunity come in your life, take up the challenge.

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AAFP **From the American Academy of Family Physicians**

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MATCH SHOWS MED STUDENTS BELIEVE IN SPECIALTY'S FUTURE

Great news abounded for family medicine in this year's National Resident Matching Program, with a record-breaking 94.4% of our residency positions filled. More than 100 additional medical students chose family medicine this year compared with last, and the percentage of US seniors who chose the specialty rose as well.

We had similar good news in last year's match, with a then-record 91.4% fill rate. However, as we all know, a single year does not a trend make. With this year's results, we do have a trend -and the trend is *up*.

The media have been all over this story. As president of the AAFP, I fielded a number of media calls after this year's match. Reporters typically wanted to know if the Patient Protection and Affordable Care Act had anything to do with our rising Match numbers. "Of course it did," I told them.

There continues to be intense political disagreement about aspects of the Affordable Care Act, but I think everyone would agree that the debate laid everything on the table for the world to see, including the care-enhancing, cost-saving benefits of the patient-centered medical home (PCMH), and the critical need for more family physicians.

The family medicine match results show that medical students have been paying attention to the debate in Washington. This is reinforced for me every time I meet with medical students, because I'm always impressed with how astute and well-informed they are.

They're aware of the present state of payment for family physicians, and they know they could make more money in the short term by becoming "Botox specialists." But they also know that the system is in the throes of change and that the only substantial proposal under consideration to actually change the process of care is our proposal for moving the system to a primary care base with the PCMH and paying appropriately for care within that model.

Many of these students are doing what hockey great Wayne Gretzky described when he said, "I skate to where the puck is going to be, not where it has been." They're choosing a career in family medicine with their eyes fixed firmly on the reformed system of the future, not on the dysfunctional, economically unsustainable one we have today. I salute them for their foresight.

This heartening trend in the Match, along with last year's surge in AAFP student membership and resident conversion to active membership, tell us we must be doing something right. But after a brief moment of celebration, it's back to work. So much remains to be done.

For example, we must keep pushing to make primary care the bedrock of a reformed system, and to convince Congress to give us appropriate payment so that family physicians can thrive in practice, and not just scrape by.

My most recent president's message described our progress on these fronts. In addition, the AAFP has just backed a House bill that could do much to improve our payment situation. The bill would require CMS to use independent contractors to identify and analyze misvalued codes for Medicare services -- in addition to using guidance from the AMA/Specialty Society Relative Value Scale Update Committee, or RUC. The RUC has made some effort to correct the undervalued codes family physicians typically use, but it too frequently turns a blind eye to overvalued codes mostly used by nonprimary care specialists.

In addition, we must press ahead on family medicine workforce development. We have to convince Congress to support a significant increase in our residency positions. This year's match fill rate was great, but we had