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

only 2,730 positions to fill. That's a drop in the bucket when you consider that the Council on Graduate Medical Education projects that 63,000 more primary care physicians are needed to meet the nation's health care needs. If health reform boosts the number of insured individuals, that number may grow even bigger.

We also must communicate as effectively as possible with students about our specialty's promising future to attract enough of them to fill the residency positions we hope to create. The AAFP uses a multipronged, evidence-based approach to student interest. First, we work hard to get the right young people into medical school. After they are medical students, we try to ensure a good educational experience and good family medicine role models. And we support student membership coordinators and family medicine interest groups (FMIGS) in the schools. We stay in touch with students to help them keep family medicine top of mind.

Our Web site for students, the Virtual FMIG, plays a key role in this effort. It offers a wealth of information about the specialty, the premed years, medical school, residency selection and the Match. It also links to the latest news about the Academy's advocacy efforts in Washington.

Our approach to student interest is evidence-based, so it will evolve as research reveals new insights into factors that influence career decisions among medical students.

We also must continue to foster collaborative relationships to amplify our efforts on many fronts. For example, we have a tighter working relationship than ever before with the other family medicine organizations as we collaborate on workforce development. We also participate in the Partnership for Primary Care Workforce, which includes medical groups outside the specialty and other interested organizations.

The Academy's regional Stakeholder Collaboration Workshops offer another good example. These exciting events, held in 2010 and 2011, bring together representatives from all the groups interested in family medicine workforce development, including students, academic family medicine, premedical advisers, AAFP chapters, practicing family physicians, and local communities. The objective is to improve communication and develop infrastructure to facilitate local collaboration focused on student interest.

Our ultimate goal for all of these efforts is to create a primary care-based system that provides appropriate reimbursement for us as AAFP members, as well as the comprehensive, coordinated care that all Americans deserve. That's a worthy goal, indeed.

Roland Goertz, MD, MBA
AAFP President

From the American Board of Family Medicine

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ABFM'S PHYSICIANS QUALITY REPORTING SYSTEM REGISTRY

In 2006, Congress passed the Tax Relief and Health Care Act, which included provisions requiring the Centers for Medicare and Medicaid (CMS) to establish a quality reporting system, the Physicians Quality Reporting Initiative (now called the Physicians Quality Reporting System) for eligible health care providers, which would include financial incentives for participants.[1] This system initially used a fairly cumbersome set of "G-Codes" for reporting quality indicators as part of the claims process. Subsequently, the Medicare, Medicaid, and SCHIP Extension Act of 2007 and the Medicare Improvements for Patients and Providers Act of 2008 provided an alternative registry method for reporting quality indicators in the incentive program.[1] Under the registry method, quality organizations could apply to become approved registries and submit data on behalf of their clients. The application process included interviews by CMS staff, as well as a description of the organization's proposed registry architecture and structure. The first registries approved became active in the second half of 2008. The American Board of Family Medicine (ABFM) was the only medical specialty board approved in the initial group of registries.

ABFM built upon its Diabetes Performance in Practice Module (PPM) in implementing its registry.[2] The registry program allows participating organizations to use "measures groups" for reporting quality information,[3] and the indicators in the diabetes measures group correspond closely to those included in ABFM's Diabetes PPM (eg measurement of HbA1c and LDL levels, foot examination etc.)[4] Because the registry started in mid-year 2008, Diplomates who participated reported data for only the last 6 months of the year. In 2009 and 2010, participants collected patient information for the whole year. Participants are required to report measures information for 30 diabetic patients over the year, and the patients they select must include at least 2 Medicare part B recipients. ABFM provides templates that Diplomates use for extracting their measures information, and then submit these data (de-identified) online via a secure connection to ABFM servers. ABFM then submits these data on behalf of the Diplomates, using submission templates specified by CMS.[5]