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.

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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]

The financial incentives for participants have been potentially substantial: in 2008, the incentive consisted of 1.5% of all of a participant's Medicare billings; the incentive rose to 2% in 2009, fell back to 1.5% for 2010 and will equal 1% in 2011. Medicare doesn't report to the registries the amounts paid to participants, but anecdotal information suggests that ABFM registry participants have averaged bonuses of approximately $1,200 (James Puffer, MD, personal communication 3/9/11.)

The registry has experienced varied participation since inception. 383 Diplomates submitted data in 2008, 722 in 2009, and we expect to submit 2010 data for 867 participants.

Our registry process includes an audit of 3% of participants' submissions. ABFM selects at random 3% of the participants, and contracts with a third party to audit the charts used for abstracting and reporting performance data. The audit process consists of comparing actual chart entries with the data submitted to the registry. These reviews have indicated high concordance between the reported and chart data: the 2008 submissions indicated 96% concordance between the registry submission and medical record data. The 2009 audit revealed approximately 94% agreement. The 2010 audit will occur later this spring.

In developing the registry, ABFM has striven to provide enhanced value for Diplomates who participate. Since the data elements correspond closely to those in the Diabetes PPM, Diplomates can choose to use their registry submissions for both the Physicians Quality Reporting System program and for the patient data required for the Diabetes PPM. Participants who select this option can use 1 year's Physicians Quality Reporting System data as their PPM pre-intervention submission, and the next year's Physicians Quality Reporting System data for their PPM post-intervention submission. This allows a Diplomate to accomplish a "threefer" for the same activities: 2 years of Physicians Quality Reporting System participation, as well as satisfaction of their MC-FP Part IV stage requirement.

In summary, ABFM engaged in the Physicians Quality Reporting System program to provide a service to our Diplomates (ABFM does not charge for Diplomate participation in the registry), and to enhance the value of MC-FP in Diplomates' ongoing professional activities. We hope more Diplomates will take advantage of this process!

Michael D. Hagen, MD; Senior Vice President

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STFM AND CAFM CREATE TASK FORCE TO ASSIST RESIDENCIES IN MEASURING RESIDENCY COMPETENCY

Residency training is once again experiencing significant pressure to transform. New requirements on duty hours will be going into effect in July 2011 for all disciplines of Graduate Medical Education under supervision of the Accreditation Council for Graduate Medical Education (ACGME). The Review Committee for Family Medicine (RC-FM) has been working on a revised set of training content rules for family medicine residencies, which will be significantly different from the existing guidelines. Over recent years, the ACGME has moved toward competency-based requirements. This move to a competency-based curriculum, along with other prospective changes in the upcoming RC revision, will challenge the variable structures and resources of residency programs, with some residencies perhaps unable to provide what is required by the RC-FM, as the next set of guidelines transition from the previous paradigm of counting experiences and duration of training rotation time to actually demonstrating resident competence. Evidence suggests faculty are not prepared to assess competencies for learners engaged in new systems, like interdisciplinary teamwork and evidence-based practices.[1]

To prepare our family medicine residencies to address the new training program challenges of assessing resident competency, the Council of Academic Family Medicine, with facilitation from STFM, created an interdisciplinary task force with broad representation from academic family medicine. The task force,