Family Medicine Updates

ADFM Association of Departments of Family Medicine
VISION, VOICE, LEADERSHIP
From the Association of Departments of Family Medicine

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CONCEPT OF A NATIONAL PRIMARY CARE PATIENT-CENTERED OUTCOMES RESEARCH LABORATORY

The Association of Departments of Family Medicine (ADFM) recently responded to the Patient Centered Outcomes Research Institute's (PCORI) Request for Information on how best to build research infrastructure for patient centered outcomes research (PCOR). We proposed the establishment of a national primary care PCOR laboratory, to build on the strength of existing family medicine practice-based research networks, clinical enterprises located in diverse underserved communities, and the research expertise of family medicine departments. We are committed to answering critical comparative effectiveness and patient-centered outcomes research questions of national importance. This national patient-centered outcomes research laboratory will be a clinical data network (CDN) and a patient-powered research network (PPRN). It will be a network with engaged clinicians who aspire to answer important questions at the level of the patient-physician dyad where critical communication and decision-making occur.

The proposed national PCOR laboratory will be:

- Embedded in academic and clinical departments of family medicine affiliated with our nation's academic health centers where expertise resides to study and translate new evidence into practice for health care teams including doctors and patients
- Include existing family nedicine practice-based research networks (over 100 registered with the Agency for Health Care Research and Quality)
- Situated in diverse and underserved communities, broadly inclusive of primary care populations
- Tightly linked to communities through current established relationships among family medicine departments and their patients and community organizations
- A laboratory for primary health care transformation and dissemination
- A network where physicians and other members of the health care team will engage in generating research questions, answering them and rapidly improving practice
- Able to rapidly test and disseminate new findings into practice through the thousands of family physicians, nurse practitioners, physician assistants, mental health workers, and clinical pharmacists associated with the departments' clinical practice sites
- Able to engage patients, clinicians, and health systems in all aspects of the research process
- National in scale with the ability to conduct multiple studies simultaneously including large pragmatic comparative effectiveness trials

This response to PCORI was prepared and coordinated by ADFM's Research Development Committee and submitted on behalf of the academic family medicine organizations (North American Primary Care Research Group, Society of Teachers of Family Medicine and the Association of Family Medicine Residency Directors) as well as the American Academy of Family Physicians and the American Board of Family Medicine.

In our 2012 survey, 94% of ADFM Departments expressed a desire to participate in a national family medicine research network. Fifty-five department chairs reported that they had research capacity to lead PCOR projects and an additional 55 departments had clinical enterprises that they will engage in comparative effectiveness and patient outcomes research. These allopathic, osteopathic, and large regional medical center family medicine departments represent both public and private institutions across the United States. Each region of the country (standard federal regions I-X) is represented in the 55 departments with the capacity to lead development for PCOR projects.

Our proposal builds on the significant experience of our departments in establishing and conducting research in PBRNs but adds 2 important elements. First, the ADFM proposed integrated national PCOR network will provide PBRNs with significant organizational support and national integration through development of a coherent CDN partnering with DARTNet to support data infrastructure. Secondly, our plan adds the core clinical practices of family medicine departments, many not previously involved in funded research, to the national research infrastructure. Our vision for an integrated national research network provides an important foundation for ongoing pragmatic clinical trials that are critical to comparative effectiveness and patient outcomes research success.

While family medicine has significant experience with PBRNs, it has not found funding support to build the significant research infrastructure required to perform large scale clinical trials that link a large number of PBRNs. Historically, large RCTs have recruited subjects divorced from the clinical care setting and community, and have been costly. The ADFM proposal to support an integrated national research network will enable large scale comparative effectiveness research and patient outcomes research in a cost effective manner. We believe that it has the potential to become a "reusable rocket" to power important future research.

Paul James, MD and the ADFM Research Development Committee, Wilson Pace, MD (DARTNET)

From the Association of Family Medicine Residency Directors

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ACCOUNTABLE CARE ORGANIZATIONS: AN OPPORTUNITY FOR SYNERGY

With the reelection of President Obama, full enactment of the Patient Protection and Affordable Care Act is all but certain. Part of that legislation is the establishment of Accountable Care Organizations (ACOs). These large networks require a minimum of 5,000 Medicare patients, and will assume the total costs for their care in many cases. Over 140 ACOs are already established with over 130,000 physicians and 2.2 million beneficiaries.[1] Much of the broad legislation governing ACOs has yet to be converted to specific regulations, which will vary between states. Because so much of this change has yet to be decided, and large systems will have to rapidly adapt, ACOs may become a sudden order of business for family medicine program directors.

ACOs are a model of shared risk for costs and savings of a defined population. The more patients a network has, the more easily they can spread the costs of expensive care of the relatively few. In the ACO model, hospitals will shift from revenue centers to cost centers. ACOs have the potential to shift systems to embrace wellness rather than reactive illness care. In the future, we may get reports on how much our patients *cost* the system, rather than how much revenue we generated with our level-4 visits, inpatient billing, and procedures. Many systems will need to increase their primary care workforce as more patients have health coverage, and systems shift their emphasis to outpatient and preventive care.

Insurance and payment reforms are the first 2 steps in health care reform. The third phase is delivery system reform.[1] A need to educate those making ACO formation decisions will exist, regarding the value of family medicine residency programs to ACO networks. One of the fundamental objectives of the National Institute of Program Director Development (NIPDD) training is to understand the worth of your program; in the world of ACOs, our 2 principal strengths to promote will be cost-effective care and workforce generation.

To truly provide population health care (rather than just those who come to see us) will require a fundamental shift in perspective for our systems, and most of us as well. Many of us will need to learn new skills; we will need to strongly advocate for resources such as case managers, chronic disease registries, and searchable electronic health records to provide high quality, cost-effective health care to a population. We also need to advocate for payment reforms that truly reflect our value to our systems. If we are not involved in the early formation and leadership of ACOs, we risk maintaining the status quo of huge payment disparities between procedure-based specialists and diverse primary care practices. These disparities discourage future medical students from entering primary care, which eventually will hurt all of our patients.

Residency education about cost-effective care is optimized if the system can provide each resident with clinical quality and cost data on their own panel of patients, rather than having them subsumed under the faculty patient panel. We need to advocate for not just *teaching* about quality improvement, but *doing* it in our residency practices.

Family medicine has a long and celebrated history of advocating for our patients. With the formation of ACOs, there is a moral imperative that we advocate for systems that reflect our values as a specialty. In the next few months, many decisions will be made that will affect both process values (the rules that govern decision-making processes such as transparency, accountability, and participation) and content values (clinical effectiveness, cost-effectiveness, justice/equality, and autonomy).[2] We all need to ensure that family medicine has a voice at the table, and that we are proud of the end result. After all, the ACOs created in the next few months will be the ones our graduates will be practicing in for the foreseeable future.

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