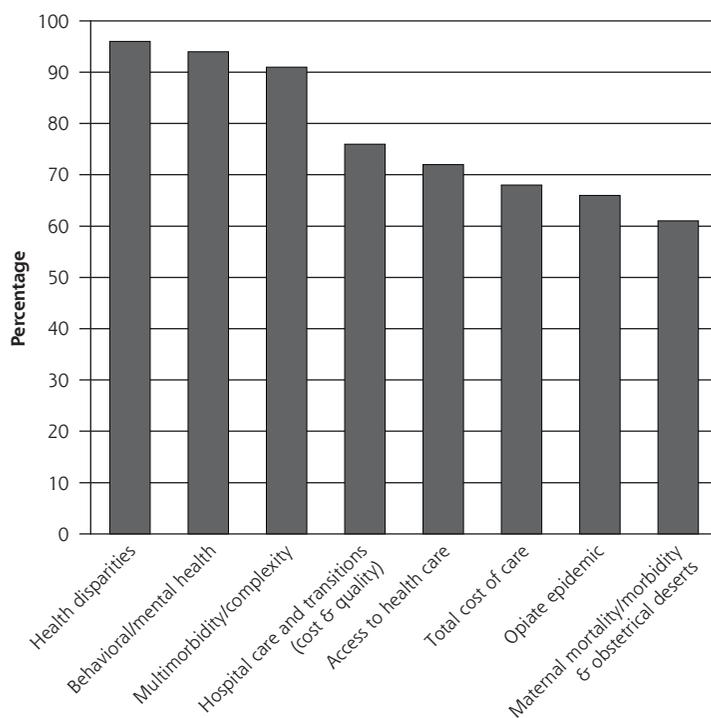


Figure 1. What clinical and health care problems should all family medicine residents of the future be trained to address?



(Percentage participants including as priority, N = 54).

- Training residents to be master adaptive learners
- 5. We must also improve our national system of residency education:
 - Core faculty must have dedicated time for education
 - We must build in both substantial innovation and better standardization
 - The processes by which individual residencies continuously improve their education, clinical care, and response to community needs must be more robust
 - The overall GME system must become more accountable to the needs of society

The summit closed with a consideration of how much change in Family Medicine residency was necessary. After reading all the papers and deliberating for 2 days, 94% believed that change was necessary. When asked how much, on a scale of 1 = none, 5 = moderate change in target areas, and 10 = aggressive change across many areas, the average rate was 6.5. The specialty wants substantial change quickly.

The specialty has spoken. Now the ball is in the court of the ACGME Standards Task Force and the ABFM. The Writing Group, most of whom are former or current Residency Directors and members of the Review Committee for Family Medicine, reviewed the papers and observed the summit. As we write this

editorial, they are beginning to integrate the results of the summit process and a parallel scenario planning process. They plan to post draft principles for the new residency standards soon.

We are now at the “end of the beginning.” We anticipate at least a 15-month process to develop the new Program Requirements. We invite you to read, comment, and get involved, not just now but as the standards are drafted and as they go through the ACGME review process. Residencies are the future of the specialty.

Warren P. Newton, MD, MPH (WNewton@theabfm.org), American Board of Family Medicine and Department of Family Medicine, University of North Carolina, Karen B. Mitchell, MD, American Academy of Family Physicians, Michael K. Magill, MD, American Board of Family Medicine and Family and Preventive Medicine, University of Utah.

References

1. Newton WP, Bazemore A, Magill M, Mitchell K, Peterson L, Phillips RL. The future of family medicine residency training is our future: a call for dialogue across our community. *JABFM*. 2020;33:636-640.



AAFP TO DEVELOP VALUE-BASED PAYMENT MODEL FOR PRIMARY CARE

Ann Fam Med 2021;19:187-188. <https://doi.org/10.1370/afm.2680>.

In many ways, family medicine has been ahead of the value-based care (VBC) delivery curve for years. In a policy statement on value-based payment developed more than a decade ago, the AAFP recognized the urgent need to “improve both efficiency and effectiveness in the delivery of medical care, in which ‘efficiency’ is understood to mean ‘doing the thing right’ and ‘effectiveness’ means ‘doing the right thing.’”

For their part, family physicians are hard-wired to deliver high-value, evidence-based care, which they do in 90% of counties across the United States. Although FPs make up only 15% of all US outpatient physicians, they provide nearly one-quarter of all outpatient visits and are more equitably distributed than any other physician specialists.

In other words, family physicians are foundational to the success of VBC in this country.

To best position family physicians for that role, in April 2020 the AAFP Board of Directors approved and funded a special project. Dubbed Vision 2025: Defining the Future of Value-Based Payment, the 3-year project is designed to empower AAFP members to successfully navigate a rapidly evolving VBP environment and prepare them to partner with payers to help improve quality and control total costs of care.

Vision 2025 encompasses 2 workstreams. The 1st focuses on member education and activation. The 2nd centers on defining the future of primary care payment while continuing to play a critical role in shaping current advanced payment models to increase investment in primary care.

Vision 2025 took a major step forward in December 2020, when the AAFP convened the Value-Based Care Advisory Group for its inaugural meeting. Members of the group represent a diverse cross-section of movers and shakers in this space, including leading health plan officials, policy experts, community advocates, and research and academic authorities.

AAFP Senior Vice President of Advocacy, Practice Advancement and Policy Stephanie Quinn opened the meeting, delivering an overview of the project and its goals. Division of Practice Advancement Director Heidi Robertson-Cooper followed up by outlining the advisory group's anticipated role during the meeting and beyond.

Specifically, said Robertson-Cooper, the Academy is seeking the group's observations on VBP models currently deployed in primary care settings and how those lessons can be applied as the AAFP moves forward with developing and implementing its next-generation primary care VBC model.

The Academy is also looking for the group's suggestions for potential partners in that endeavor from the payer and primary care practice communities, she added, as well as their recommendations regarding the best ways to notify and educate AAFP members about opportunities to participate in VBP models.

Those introductory statements sparked a round of questions participants said should be considered when envisioning a VBP model that appropriately elevates primary care, such as:

- What is the proper alignment of payment mechanisms and incentives to promote adoption of value-based models, and how does that differ from practice to practice?
- What are the barriers to adoption of downside risk

models, especially among solo and small independent practices, and how they can be mitigated?

- What level of business acumen is needed for practices to adopt and sustain a robust VBC model?
- What data elements do practices need to facilitate decision-making in a value-based environment, and what education/training is needed to act on that data?
- How can the patient experience—especially patient satisfaction with their care—be reliably measured?

Also informing the discussion was an environmental landscape assessment by health policy consulting firm CapView Strategies that evaluated more than a dozen primary care-centric VBP models operated by public as well as private payers (ie, CMS/Center for Medicare and Medicaid Innovation, Medicare Advantage, Medicaid, and commercial payers).

CapView's findings were grouped into 5 categories: basic elements of each model (scope, eligibility, and participation); payment requirements and structure; care delivery requirements; performance measurement and feedback; and evaluations and results.

Key observations from the assessment included:

- Variability in payment structures and participation requirements creates challenges
- Primary care incentive requirements and impacts are difficult to assess in larger accountable care organizations
- Evaluation endpoints and timeframes differ significantly across models
- CapView also made a number of recommendations that called for the use of uniform performance measures across models to permit greater comparability, standardization of evaluation endpoints to enhance understanding of primary care's impact, and an increased focus on evaluating patient experience in these models.

Finally, group members voiced other basic questions that deserve further consideration before moving forward, such as:

- What is the role of primary care in the future of health care?
- What is the future of small, independent practices?
- Is payment reform or delivery reform needed?
- What are the likely implications of VBP for those now in fee-for-service?

More than 1 participant observed that the current health care environment offers a unique window of opportunity to create change. Group members agreed to examine these and other takeaways and follow up with action items before meeting again in March 2021.

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