

Family Medicine Updates



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REFLECTIONS ON PRIMARY CARE RESEARCH. POST-STARFIELD SUMMIT: THINKING PRAGMATICALLY, THINKING BIG

The Starfield Summit crystallized key challenges and opportunities as primary care enters an era of value-based payment (VBP). New primary care models must reinforce Starfield's core primary care functions while achieving the quadruple aim.

Achieving these objectives requires pragmatic, rapid-cycle research embedded within existing demonstration projects. It requires research that informs whether, when, why, and how key practice transformation drivers (ie, payment, practice facilitation, training, etc) succeed and for which practices and under what circumstances. A successful research agenda requires attention to the current context of primary care, judicious collection and use of data that informs progress, and new research partnerships.

Context

Primary care confronts a historic opportunity amidst an existential crisis. Payment reform is coming fast. There is growing recognition of team-based care and social determinants in health. At the same time, primary care clinicians are burning out and adaptive reserve for change is critically low.

Adaptive reserve is the élan vital of practice transformation. Yet, Centers for Medicare and Medicaid Services (CMS) medical record documentation regulations undermine adaptive reserve by sapping clinician time and energy. This drain on clinicians is compounded by poorly designed EHRs and limited exchange of structured data.

What could help during this transition to VBP? Primary care groups could band together to advocate for CMS key changes. First, there is an urgent need for clarification of CMS medical record documentation (or waivers) that reflect new care models. Second, changes in MACRA payments should support time for team development, piloting new models, and participation in learning collaboratives/PBRN research. Last,

partnerships among CMS, electronic health record (EHR) vendors, and primary care are needed to design functional EHRs for new care models coupled with interoperable exchange of structured data, eg, preventive procedures, hospitalization, etc.

Population Health

VBP success hinges on primary care's ability to improve population health and reduce costs while optimizing patient experience. This will require primary care to assume accountability for improving behavioral determinants of health, ie, smoking, diet, physical activity, mental health, and substance use while addressing social determinants that constrain behavior. Meaningful progress requires teamwork, integrated behavioral care models, and effective community partnerships.

Success in improving population health and health equity entails access to reliable data on sociodemographic factors (race, education, language, etc), social determinants (housing, food security, etc), and behavioral determinants (lifestyle, mental health, etc).

Success also requires access to health outcomes data, eg, emergency department visits, hospitalizations, and deaths. These data would enable practices to monitor progress and improve. Aggregated data permit real time tracking of community health. CMS standards are needed to ensure practices have access to these data in importable/extractable fields.

Success further requires an informatics infrastructure. A lack of registries that report on population health hinders assessment of progress and hampers pragmatic research that seeks to understand how practices can improve population health and equity. Large registries that interface with practice EHR systems offer a feasible means for practices to track progress in improving population health and equity. Examples include the ABFM Prime registry and DARTNet.

Last, success requires VBP to account for the added costs of addressing social and behavioral determinants. This will require payments that adjust for social, behavioral, and health risk and reward progress in improving population health and health equity.

Research is needed to inform each of these steps, including identifying non-burdensome methods for collecting social and behavioral determinants of health data and optimal strategies for improving population health.

Partnerships With Payers

The speed of payment reform hinders establishing project-specific research partnerships with payers. The

speed of change, coupled with limited practice adaptive reserve and insufficient embedding of primary research within demonstration programs, increases risk for catastrophic failure. Aligning primary care research with the timelines and priorities of payers entails establishment of a long-term partnership between primary care researchers and payers.

Such partnerships could be operationalized through establishment of a center for primary care research/transformation within CMS, somewhat analogous to the Veterans Health Administration's QUERI. This center would be charged with establishing a primary research agenda in collaboration with the primary care research community and patients and also with supporting rapid cycle research. CMS would fund primary care research embedded within existing demonstration projects.

CMS could partner with major research funders, eg, the Agency for Health Research and Quality (AHRQ), the National Institutes for Health (NIH), and the Patient-Centered Outcomes Research Institute (PCORI), to support pragmatic primary care research through contracts that aligned with CMS timelines and priorities.

Such a CMS Center would align research with policy, create a replicable national model for collaboration between primary care research and payers, and provide a sustained stream for rapid cycle, pragmatic primary care research that addresses emerging priorities.

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THE SINGLE ACCREDITATION SYSTEM: MORE THAN A MERGER

In February 2014 the Accreditation Council for Graduate Medical Education (ACGME), American Osteopathic Association (AOA), and American Association of Colleges of Osteopathic Medicine (AACOM) announced an agreement outlining a single graduate medical education accreditation system in the United States (<http://www.acgme.org/What-We-Do/Accreditation/Single-GME-Accreditation-System>; <http://www.acgme.org/Portals/0/PDFs/Nasca-Community/FAQs.pdf>). This single accreditation system allows graduates of allopathic and osteopathic medical

schools to complete their residency and/or fellowship education in ACGME-accredited programs and demonstrate achievement of common competencies and milestones. The single accreditation system is intended to achieve 4 significant benefits:

1. To maintain consistent evaluation and accountability for the competency of resident physicians across all accredited GME programs
2. To eliminate duplication in GME accreditation
3. To provide cost savings and efficiencies for institutions currently sponsoring dually accredited or parallel accredited allopathic and osteopathic programs
4. To ensure that allopathic and osteopathic residency and fellowship applicants are eligible to enter accredited programs in the United States and can transfer from 1 accredited program to another without repeating training and without causing sponsoring institutions to lose Medicare funding

There are 4 broad dimensions to the agreement:

1. The agreement outlines the process for ACGME accreditation of current AOA-accredited programs. After June 30, 2020, the AOA will no longer accredit residency programs, so these programs must receive initial ACGME accreditation by June 30, 2020.

Upon receipt of a completed institutional application, the ACGME may assign pre-accreditation status to the sponsoring institution. When the institution receives the pre-accreditation designation, the institution's AOA-accredited programs can begin the process for ACGME designation. AOA-approved programs with and without matriculated residents are eligible for ACGME "pre-accreditation status." Pre-accreditation is not synonymous with initial accreditation but rather indicates that the program remains under AOA approval while in the process of attaining ACGME accreditation. Initial accreditation and ultimately continued accreditation are awarded by the ACGME Review Committee when the applicant is in substantial compliance with the applicable Program and/or Institutional requirements. Programs that are not AOA accredited by July 1, 2015, must apply for ACGME accreditation similar to any other new program (<http://www.acgme.org/Portals/0/PDFs/Nasca-Community/PathwaystoACGMEAccreditationforAOA-ApprovedPrograms.pdf>).

2. The agreement clarifies the eligibility of osteopathic graduates entering into advanced training in ACGME-accredited programs. Physicians who graduate from programs with pre-accreditation status will be eligible for entry into ACGME-accredited advanced standing residencies and fellowships.
3. The agreement endorses incorporation of osteopathic medical principals within ACGME-accredited programs. ACGME-approved residency programs