reduced by conducting a thematic analysis. Outcomes that were related but named differently by the participants were grouped into constructs.

Results

Thirty-two participants from 6 different countries (Canada, United States, France, Belgium, Australia, United Kingdom) contributed to the discussions. They included general practitioners, nurses, social workers, and epidemiologists.

Thirteen outcome constructs (Table 1) were identified as important by the participants. Among these, 3 were identified as very relevant by all groups: quality of life; functional status; and goal attainment considering patient preferences. Three other outcomes were identified by at least 2 groups: general well-being; diseases knowledge and insight; and patient activation.

Participants identified that potential new measures should rely on a conceptual framework, include a variety of outcomes constructs and weight constructs to patients' preferences.

Discussion

This forum gathered a sufficient number of knowledgeable participants from multiple fields and countries to allow a rich discussion. Furthermore, a post-NAPCRG blog posted in CMAJ by MacAuley, who participated in the forum discussion, reported that it was an insightful discussion on measurement by the world leaders in multimorbidity research.[4]

An extensive list of important outcomes was produced. The results offer an expert identification of multimorbidity-relevant outcomes, also suggesting that attempts to develop outcome measures should rely on a conceptual framework and be weighted to patients' preferences.

Table 1. Outcomes Constructs Identified as Important by Participants

No. of groups identifying the outcome	Outcomes constructs
3	Functional status
	Quality of life
	Goal attainment considering patient preferences
2	General well-being
	Disease knowledge and insight
	Patient activation
1	Health Status
	Patient-centered care
	Perceived care coordination
	Physical activity level
	Self-efficacy
	Self-management
	Treatment burden

Maxime Sasseville, RN, MSc[1]; Moira Stewart, PhD[2]; Tarek Bouhali, MD, MSc[1]; Martin Fortin, MD, MSc[1]
[1]Université de Sherbrooke; [2]Western University

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AAFP From the American Academy of Family Physicians

Ann Fam Med 2017;15:389-390. https://doi.org/10.1370/afm.2032.

AAFP TAKES LEADERSHIP ROLE WITH LAUNCH OF CENTER FOR DIVERSITY, HEALTH EQUITY

When patients visit a family physician, there are often more than physical symptoms influencing their health. There is growing recognition that the social determinants of health also are critical factors that affect individuals and families.

If expanding access to care is the first step in health reform, caring for vulnerable populations is the next one, according to physician panelists who spoke at a March 28, 2017 forum in Washington, DC, on high-value primary care for underserved communities.

Continuing a long history of tackling disparities in patient care head on, Julie Wood, MD, MPH, AAFP senior vice president of health of the public and science and interprofessional activities, announced the launch of the AAFP Center for Diversity and Health Equity, an initiative that will focus on addressing the social aspects of health care.

"The AAFP has developed its Center for Diversity and Health Equity to take a leadership role in addressing social determinants of health, nurturing diversity and promoting health equity through collaboration, policy development, advocacy and education," Wood told *AAFP News*.

The center will promote evidence-based community and policy changes necessary to address the social determinants of health and diversity. Social factors such as prejudice, poverty, income inequality, and lack of diversity carry the greatest impact on population health outcomes and contribute to health disparities. The center's activities will include evaluating current research on the social determinants of health and health equity, with a strong focus on collaboration, advocacy, and policy.

Call for Action From Family Physicians

A resolution adopted during the 2016 Congress of Delegates called on the AAFP to take a stronger stance on the social determinants of health, specifically by creating a new office that would enhance cultural proficiency among the medical team and help increase diversity in the physician workforce.

"The AAFP is taking an important step with the establishment of the center to improve population and community health and achieve health equity," said Bellinda Schoof, MHA, director of the AAFP Division of Health of the Public and Science.

To improve diversity, the AAFP will seek to increase the proportion of students from underrepresented minority groups who choose family medicine as a specialty. On the national level, the AAFP will look to collaborate with other organizations to actively work on these issues.

The AAFP also will develop practical tools and resources to equip family physicians and their teams to help patients, families, and communities with issues related to social determinants of health.

Needs of Vulnerable Populations

During the forum, panelists discussed several issues related to diversity and health equity, including the primary care workforce, as well as funding for federally qualified health centers, teaching health centers, and the National Health Service Corps that would address the needs of vulnerable populations.

Those needs begin in childhood. Research indicates that children who are exposed to adverse experiences—such as abuse, the death of a parent, divorce, neglect, or community violence—experience high rates of disease later in life, including heart disease, cancer, obesity, and STDs.

Increasing access to care through Medicaid expansion helps, panelists said, but health care services and medication remain an expensive prospect for many low-income individuals.

"We look at coverage as the answer, but if we don't address cost-sharing, we're not going to get there," said John Rother, CEO of the National Coalition on Health Care (NCHC), which co-hosted the forum.

William Golden, MD, medical director of Arkansas Medicaid, said US residents have the highest out-of-pocket health care costs in the world. Many patients with high-deductible insurance plans cannot afford medications or the necessary preventive interventions to change their health outcomes.

Individuals in both urban and rural areas who earn $20,000 or less per year are being priced out of health care, Golden said. He noted that prices for insulin tripled during the past 7 years and said statins that used to cost $5-$10 now cost $50.

"Because of the pricing structure, people who are considered at risk will be a larger share of the population," he said.

To help, community health clinics are taking advantage of initiatives such as the 340B Drug Pricing Program, which allows clinic patients to obtain medication at significantly reduced prices. Kemi Alli, MD, CEO of the Henry Austin Health Center, said that through the program, patients can obtain hypertension or diabetes medication that costs $340 per month on the retail market for as little as $20 per month.

The forum was the second in a 3-part series co-hosted by the AAFP, NCHC, National Association of Community Health Centers, American College of Physicians, and American Osteopathic Association.

Michael Laff
AAFP News

From the American Board of Family Medicine

Ann Fam Med 2017;15:390-391. https://doi.org/10.1370/afm.2117.

ABFM'S PHYSICIAN QUALITY REPORTING SYSTEM DEADLINE PASSES WITH OUTSTANDING NUMBERS

The American Board of Family Medicine (ABFM) is pleased to announce over 1,600 clinicians submitted data to the Physician Quality Reporting System (PQRS) through the ABFM's online submission process and through the PRIME Patient Data Registry.

The Physician Quality Reporting System (PQRS) is a quality reporting program that encourages individual eligible professionals and group practices to report information on the quality of care to Medicare. PQRS gives clinicians and group practices the opportunity to assess the quality of care they provide