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
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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

to their patients, helping to ensure that patients get the right care at the right time. The PQRS phases out in 2017 and is folded into the CMS Quality Payment Programs created by the Medicare and Children's Health Insurance Program Reauthorization Act (MACRA). ABFM research demonstrates that family physicians who do their Practice Improvement activities in conjunction with PQRS not only reduce their quality and reporting burdens, but have greater improvement in outcomes. The ABFM is pleased to support so many Diplomates in both regards.

The PRIME Registry Helps Primary Care Clinicians Liberate EHR Data and Prepare for MIPS

The PRIME Registry is a population health and performance improvement tool for clinicians and practices. It extracts patient data from the physician's electronic health record (EHR) and turns it into actionable measures. PRIME is registered as a Qualified Clinical Data Registry and Specialty Registry open to all primary care physicians—in family medicine, pediatrics, internal medicine, obstetrics/gynecology—as well as physicians assistants and nurse practitioners. Nearly 3,000 primary care clinicians are now using their PRIME Dashboard to track their quality, identify patients with gaps in care, and report their data to wherever they need. The early PRIME users are mostly small and rural practices who would have otherwise struggled to report for PQRS in 2017 and the Merit-Based Incentive Payment System (MIPS) in 2018. A family physician at a micropractice in Winter Park, Colorado, says, "It's quick, it's easy and saves money in the long run—it's slick." PRIME supports the Comprehensive Primary Care Plus and several other federal payment or practice transformation programs. It is also being configured to support new NCQA PCMH reporting requirements. The ABFM's Practice Improvement modules will migrate into the PRIME Registry this summer and have been submitted to CMS as MIPS-qualified Practice Improvement activities so Diplomates can look at their quality measures and move directly into planning a PI activity and then report it for MIPS. The ABFM is making every effort to enable PRIME to reduce burden. PRIME works with more than 100 EHRs and has 46 measures available. The ABFM is planning to submit new measures more valuable to primary care, such as continuity and comprehensiveness, so that PRIME users can choose measures they feel are more meaningful and use those MIPS. For more information, go to http://www.primenavigator.org or email PRIME@theabfm.org.

Robert Phillips, MD, MSPH