The ICPF is the result of the hard work and aspirations of researchers, health care professionals, and facilitators dedicated to the development and dissemination of practice facilitation. Evaluation comments reflecting high enthusiasm and engagement throughout include, "I thought the use of multiple types of learning opportunities was very innovative and fit the purpose of this first conference," "You did a great job fostering thoughtful and honest discussion, and "I enjoyed the interactive nature of the entire conference."

True to the spirit of facilitation, conference participants played a crucial role in determining the effectiveness of the conference by contributing their expertise with enthusiasm and honesty. Comments on the value of the conference highlighted opportunities for "Candid exchange among colleagues facing similar challenges," "Meeting so many other people in the field and hearing about the kind of work they are doing," and "The breakouts and table discussions made it easy to ask questions, have conversations, and learn from each other."

Videos of the plenary presentations are available on the NAPCRG website http://www.napcrg.org/Conferences/PastMeetingArchives/2017InternationalConferenceonPracticeFacilitation.

The 2018 ICPF will take place in Tampa, Florida on December 10-11. The ICPF Steering Committee extends a warm invitation to all who are interested in practice facilitation! Registration is now open and abstracts are being accepting until July 20, 2018. http://www.napcrg.org/ICPF.

Melinda M. Davis, PhD; Zsolt Nagykaldi, PhD; Paula Darby Lipman, PhD; Jill Haught; On behalf of the ICPF Steering Committee

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QUICK APPROVAL REQUESTED FOR AAFP'S NEW PAYMENT MODEL

After winning support from a panel of experts convened by Congress, the American Academy of Family Physicians (AAFP) has reminded the US Department of Health and Human Services (HHS) that testing for a new payment model created by the AAFP and tailored for primary care is only awaiting federal approval.

In a March 19 letter (https://www.aafp.org/dam/AAFP/documents/advocacy/payment/apms/LT-SecretaryAzar-APCAPM-031918.pdf) to HHS Secretary Alex Azar, the AAFP said the Advanced Primary Care Alternative Payment Model (APC-APM) (https://www.aafp.org/content/dam/AAFP/documents/advocacy/payment/apms/PR-PTAC-APC-APM-41417.pdf) would help more than 200,000 primary care physicians promote coordinated care and provide incentives for practices to change the way patient care is delivered. The Academy urged Azar to approve the model quickly so testing can proceed.

"The APC-APM proposal is wholly consistent with the administration's goals of preserving independent medical practices, lowering the cost of health care, and reducing the administrative burden for physicians and other health care providers," the AAFP stated in the letter, which was signed by Board Chair John Meigs, MD, of Centreville, Alabama.

In December, the Physician-Focused Payment Model Technical Advisory Committee (PTAC), formed by Congress to review new Medicare payment models, recommended that HHS test the APC-APM on a limited scale. Six committee members voted for testing, 4 for implementation as a high priority and 1 for implementation—which, the AAFP pointed out, was just 1 vote shy of a recommendation to implement the model.

"In subsequent discussions, PTAC members, including those who voted for limited-scale testing, emphasized that the action on the model should be a high priority and undertaken urgently to support primary care and ensure robust access in all areas of the country," the letter stated.

PTAC members suggested that the APC-APM could be tested on a scale as large as or larger than that used for the Comprehensive Primary Care Plus (CPC+) model, and 1 member called the AAFP model superior to CPC+.

"As our nation grapples with the escalating costs of health care, we feel it is time to prioritize primary care, and wide-scale testing of the APC-APM is an important step toward achieving our mutual goals," the AAFP wrote to Azar.

Practices participating in the APC-APM would receive a monthly fee that covers face-to-face patient evaluation and management services. Separate monthly payments for population-based care would eliminate the need to bill for chronic care and transitional care management.

The traditional fee-for-service model asks primary care physicians to spend more time on administrative tasks without an increase in payment. The APC-APM, on the other hand, is designed to reduce administrative burden while supporting efforts to move into more advanced forms of patient care, and it includes both some risk and incentives for high performance.

"The overall goals of the APC-APM are to strengthen the primary care system in the US, improve outcomes for Medicare beneficiaries and reduce costs for the program," the letter stated.

The AAFP emphasized the urgency of approving the new model.

"There is comprehensive and compelling evidence showing that a health care system built on a foundation of primary care equates to healthier individuals and lower cost," the letter stated. "Current literature also demonstrates that primary care practices are collapsing under the weight of poor payment and an avalanche of administrative and regulatory mandates."

News Staff
AAFP News Department

From the American Board of Family Medicine

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A MESSAGE FROM THE PRESIDENT

It is hard to believe that I have completed my 16th year at the American Board of Family Medicine (ABFM). Time has passed quickly as I and our incredible staff became immersed in the task of transforming this organization from one which simply delivered an examination on the second Friday of July each year to one which has become heavily invested in helping family physicians provide the very best care to their patients. The journey has been an exciting one, and I have come to work each day enthused about the continuing transformation of our organization into one which not only helps family physicians provide high quality care, but also gathers data to better inform others about the important work that they do on behalf of their patients.

We gather these data from several sources. One of the most important has traditionally been the demographic survey that is completed when family physicians apply to take one of our examinations. These data have been invaluable in helping us better understand what they actually do in practice so that we can continuously improve the assessment tools that we use to help them provide better care. However, the data serve other useful purposes as well. Perhaps the best example of this was the use of the data by the American Academy of Family Physician's (AAFP) Robert Graham Center to inform rule-making after passage of the Affordable Care Act in 2010 for the Primary Care Incentive Payment. Graham Center research using ABFM data convinced the Center for Medicare and Medicaid Services (CMS) to include most rural-based family physicians who would otherwise have been penalized for providing broad, full-scope care to their patients; they would have otherwise been precluded from receiving the primary care bonus written into the Act based upon the limited CPT code methodology upon which eligibility for the bonus was being determined.

We have rapidly expanded the data sets that we are gathering to provide us with additional information about the specialty. These have included the Milestones data that we receive from the ACGME for every family medicine resident in training, and data from the Resident Graduate Survey, developed and administered in collaboration with the Association of Family Medicine Residency Directors (AFMRD), that characterizes the work of recently graduated family medicine residents. Important examples of the use of these data sets include recent data that we have published on burnout among family physicians, the changing nature of the scope of practice of recently graduated family physicians, and the powerful and long-lasting imprinting that occurs as a function of the environment in which family medicine residents train.

We have also used this data to document the effectiveness and utility of the assessment tools that we have created for use in the Family Medicine Certification process. We have reported on the data shared with us in the evaluations of the Performance in Practice Modules describing the relevance and clinical utility of these modules in practice, and we have also published similar data for the Clinical and Knowledge Self-Assessment modules, showing how all of these tools have improved quality of care. However, we have just begun to harness the power of these data.

The PRIME registry now has nearly 4 million patients and these data, under approved research protocols, are extremely powerful for research, such as helping develop better case-mix adjustments for primary care payment. As a Qualified Clinical Data Registry (QCDR), we can also develop, test, and propose better primary care quality measures. We strongly believe that the quality measures that are currently in use are sorely insufficient in accurately and effectively measuring the quality of care that family physicians deliver to their patients. They provide little information on how the cornerstones of family medicine–comprehensiveness, continuity, first contact care, and care coordination–improve the quality and reduce the cost of care that family physicians provide to their patients. We will be using the data described above to validate the importance of these measures and the influence they have on