reducing health care disparities, improving access to care and addressing social factors that impact health."

The Academy went on to detail a number of recommendations, including:

Maximizing the Use of Physician-Led Teams

"If we are to reduce maternal mortality, we must have high-functioning maternity care teams capable of recognizing and handling obstetrical emergencies," the letter advised. "Promoting nonphysician clinicians at the expense of such highly functional teams will be counterproductive."

As examples, the letter pointed to

- Patient-centered medical homes and other team-based care models
- The Strong Start for Mothers and Newborns Initiative, a discontinued federal program for which the Academy advocated
- Medicaid medical homes

Improving Coverage and Care Standards

"Patients with a usual source of care, which is fundamental among primary care physicians, have fewer expensive emergency room visits and unnecessary procedures than those without it," the Academy wrote. With primary care as the baseline, then, the letter called for:

- Reducing health care barriers for those with high-deductible health plans through passage of the Primary Care Patient Protection Act (S. 2793)
- Expanding postpartum Medicaid coverage through passage of the Helping Medicaid Offer Maternity Health Services Act (H.R. 4996)
- Increasing Medicaid primary care reimbursements to at least the Medicare rate
- Investing in quality-improvement initiatives such as the Alliance for Innovation on Maternal Health Program
- Establishing a standardized system for evaluating hospital obstetric care, such as one proposed by the American College of Obstetricians and Gynecologists

Addressing Health Disparities

"The AAFP believes many health disparities could be addressed by increasing primary care access and supporting programs that address the social factors that impact individuals' health," said the letter, noting that 5 million US women live in obstetric deserts.

The majority of women facing pregnancy complications are women of color, the Academy wrote—a fact stemming from decades of structural, systemwide inequities, institutionalized racism, and the unconscious biases of health care professionals.

To combat this, the Academy recommended:

- Educating physicians about implicit bias and strategies to address it to support culturally appropriate, patient-centered care and reduce health disparities
- Increasing the number of diverse family medicine physicians who provide obstetric care in rural and other underserved areas by reducing their liability insurance premiums
- Retaining primary care physicians through loan repayment and other incentives
- Enhancing the primary care workforce with initiatives such as the highly effective Teaching Health Center Graduate Medical Education Program
- Passing the Rural Physician Workforce Production Act of 2019 (S. 289)

Streamlining Data Collection and Evaluation

The Academy said it continued to support the Rural Maternal and Obstetric Modernization of Services Act (S. 2373), among other efforts to improve outcomes and quality.

Supporting Social Services for Mothers and Children

The federal government should provide adequate funding for programs addressing social determinants of health, the AAFP said, including home visiting, which more than 30 states cover through Medicaid.

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CLINICAL QUALITY MEASURES IN A POST-PANDEMIC WORLD: MEASURING WHAT MATTERS IN FAMILY MEDICINE

COVID-19 altered the way the American public lived their lives; the way they worked, ate, socialized, traveled, and ultimately received their health care. Family Medicine largely closed its doors to face-to-face preventive and chronic care visits and made a large shift to telephone and online video visits. Ten days after the World Health Organization pronounced that the COVID-19 outbreak was a global pandemic,

Centers for Medicare and Medicaid Services (CMS) Administrator Seema Verma announced that CMS was granting exceptions from reporting requirements, "so the health care delivery system can direct its time and resources toward caring for patients."[15] Suddenly quality reporting requirements were optional, and clinicians who did not submit data would not be penalized, but instead receive neutral payment adjustments. This pause led the ABFM to ask, if current clinical quality measures are not valuable in a pandemic, what does that tell us about what we are measuring?

Current measure sets presume that quality primary care is the sum of quality measures for individual diseases and health screening. Value-based payments to primary care physicians frequently employ measures that are not aligned or do not recognize the higher-level integrating, personalizing, and prioritizing functions of primary care and the needs of patients, communities, or health care systems.[4,16] These measures are then tied to financial incentives which drive behavior to maximize these rudimentary measures. Driving clinicians' behavior toward low-value measures produces burnout and diminishes the value of primary care for people and populations.

Clinical quality measurements should drive improved patient-centered care, align physician assessment and payment to produce high-value care, reduce physician burden, reduce high-cost behaviors, prevent low-cost physicians from changing their behaviors, and enable assessment and comparison of health systems that employ primary care physicians. Moreover, quality measurement should support the Quadruple Aim: improve health outcomes, improve patient experience, decrease clinician burnout, and lower health care costs. As we move beyond the public health emergency, we need to ensure we are measuring what is most meaningful and useful to patients, providers, regulators, payors, employers, the public, and communities. If such measures were currently in place, they would retain their value, even in a pandemic.

The Center for Professionalism & Value in Health Care (CPVHC) is addressing this challenge through the Measures that Matter (MTM) Initiative. At the outset of Family Medicine for America's Health (FMAHealth), all of the national family medicine organizations asked for a role definition for the family physician.[1] The evidence review behind that definition made it clear that the key functions of primary care were not part of how it was being measured or valued and this became a primary focus of FMAHealth.[2] The ABFM accepted the lead role for improving the measures by which primary care is assessed and paid and the ABFM Foundation funded the MTM initiative. That effort supports 3 partnering centers, the CPVHC, the Robert Graham Center (RGC), and the Larry A. Green Center (LAGC). A patient-reported outcome measure was created with the input of hundreds of patients and clinicians, along with prior work of the RGC and a comprehensive literature search resulted in the identification of 4 high-value functions of primary care for all stakeholders: continuity, person-centeredness, comprehensiveness, and value.

CPVHC is executing the MTM Initiative lead with a 2-person measures team who have the measure development expertise and leadership needed at each step of the quality measure lifecycle (Figure 1). This modest team manages a complex evolution from research concept through quality measures' substantive and political processes leading to widespread private and public payor adoption. Once research partners develop and test a research concept, the measures team creates quality measure specifications and begin testing and validating the specification in a clinical environment. This crucial step, performed within the PRIME Quality Clinical Data Registry (QCDR), allows the measures team to receive feedback from front-line clinicians on data availability, feasibility, use, and collection burden. The PRIME QCDR has become an important laboratory for developing and testing the measures produced by the MTM effort.[5] It's capacity of more than 800 primary care practices in 47 states caring for more than 5 million patients makes it not only a measures laboratory, but the start of a pathway to endorsement and prioritization of high-value primary care. Once quality measure testing completes, the measures team submits the measures through the rigors of the National Quality Forum (NQF) and CMS review processes for endorsement and use in many CMS quality reporting and payment programs. In order to receive endorsement, the measures team must defend the quality measures importance, data collection feasibility, clinician usability, and scientific acceptability (Figure 2). We seek strategic partnerships to assist with spreading measure adoption nationally to primary care practices, patients, policy makers, private payors, health systems, and employers.

Measures in Development

Continuity of Care is defined as seeing the same primary care clinician over time and it remains one of the pillars of a high-functioning health care system.[6–8] Continuity of care is shown to improve patient outcomes and provider wellbeing, and decrease health care costs. When continuity is poor, it suggests fragmented care and an associated lack of a trusting relationship in primary care. Poor continuity is associated with a significantly greater hospitalization risk and resulting higher levels of spending.[9,10] At a patient

level, Bice-Boxerman Continuity of Care is a measure that considers the dispersion of primary care visits across clinicians, such that patients with higher scores have most of their primary care visits to the same clinician or a small number of clinicicians, while those with lower scores see a larger number providers. ABFM is studying the effects of COVID-19 on continuity. The Continuity of Care Measure has completed quality measure testing, is available in the PRIME Registry Measure Set, and is endorsed by CMS for use in the MIPS quality payment program (Figure 1).

Patient Centered Primary Care Measure (PCPCM) is a patient-reported outcome measure (PROM) of exemplary primary care that has been developed by the LAGC Center based on the extensive input of patients, clinicians, and employers noted above.[3] The PCPCM PROM focuses attention and support on the integrating, personalizing, and prioritizing functions that patients and clinicians say are important. The parsimonious 11-item Person-Centered Primary Care Measure has excellent psychometric properties and factor analyzes into a single factor—this shows the coherence of the diverse domains and broad scope of integrated primary care practice.[3] The PCPCM PROM uses a survey to ask patients to assess 11 distinct yet highly interrelated items regarding their assessment of the care they receive. These items capture different facets of continuity and comprehensiveness as well as elements of advocacy and allegiance. The PCPCM, which won NQF's 2019 Patient-Reported Outcomes Next-Generation Innovator Abstract Award, has completed quality measure testing, available in the PRIME Registry Measure Set, and endorsed by CMS for use in the MIPS quality payment program (Figure 1).

Comprehensiveness is lauded as 1 of the 5 core virtues of primary care and the RGC and others find that higher comprehensiveness is associated with lower costs and hospitalization.[11,12] The Institute of Medicine, in an often-referenced 1996 publication on primary care, defined comprehensiveness as "…the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs."[11,17] Comprehensiveness is a more complex measure than continuity since it overlaps scope or practice and sites of care. The current measure is based on claims data and defining it using electronic health record data requires further study and development. The EHR-derived comprehensiveness research measure is currently being conceived of in a collaboration between ABFM and RGC (Figure 1).

Low-Value Care. Key to the measurement and reporting of total cost of care is our effort to develop and test Low-Value Care measures that can help clinicians identify specific, modifiable behaviors as a mechanism to improve primary care's well-documented moderation of total health care spending. Choosing Wisely[18] is a widely heralded effort to reduce low-value care, like x-rays for low back pain, which has received a lot of attention and could lead to measures. Measuring Low-Value Care sets up capacity for long-term evaluation of practicing clinician behaviors on total cost of care. Low-value care measures in current use largely derive from the Choosing Wisely consensus process.[13] The RGC recently found that it does not explain much cost variation among primary care physicians.[14] The Low-Value Care research concept is being developed in collaboration with Stanford University and Mount Sinai Health System (Figure 1).

The COVID-19 pandemic has made it clear that the ways primary care is measured and paid often have little value for health systems and patients. Health care in the United States is presently going through a public health emergency that has derailed quality payment programs due to their burdensome administrative requirements and irrelevant quality measures. As we rebuild after COVID-19, it is essential that American primary care physicians have quality measures based on reducing the depersonalization experienced by patients, clinician measurement burden, and the associated burnout and crisis of meaning experienced by clinicians. ABFM is striving to align and study what we know to be high-value primary care measures that are embraced by patients and clinicians with how primary care is measured and paid. ABFM researchers will compare the MTM measures in a cross-sectional and longitudinal analysis with existing quality/performance measures in the PRIME Registry as part of ongoing effectiveness and feasibility evaluation. Providing relief to clinicians during this time was the right move so they could direct their time and attention to patient care. Going forward, we need to create and implement quality measures that provide valuable and actionable information not only during public health emergencies and other health or national disasters, but also during routine health care situations.

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