Family Medicine Updates

From the American Board of Family Medicine

Ann Fam Med 2021;19:564-566. https://doi.org/10.1370/afm.2058.

FROM ABFM: IMPLEMENTING A NATIONAL VISION FOR HIGH QUALITY PRIMARY CARE: NEXT STEPS

On May 4, 2021, the National Academies of Science, Engineering and Medicine (NASEM) issued a report with specific recommendations on implantation of high value primary care[1] in the United States—the first National Academies report on primary care in 25 years. The report summarizes abundant information reviewed by the consensus committee across 5 different areas: financing; access; community-based training; digital health; and accountability. Four months later, the findings continue to reverberate, and government officials, philanthropies, and payers are still addressing many aspects of the report. In this editorial, we ask what family medicine should prioritize to help patients, communities, and the specialty.

Progress will require active engagement across all 5 independent but interrelated areas. Most important is changing the financing of primary care. The committee argues that primary care is a public good. Primary care is the largest clinical care delivery platform in the country and can help address the big challenges health care faces in equity, patient experience, cost, and burnout. To do this, however, given chronic underinvestment, a major change in financing is necessary. The report calls for payment for *care*, rather than payment for *services*. Few family physicians would disagree with the need to move away from the fee-for-service system; a hybrid capitation and fee-for-service model as an initial phase seems reasonable and is consistent with the AAFP's principles for payment reform.[2]

The challenge—and where organized family medicine needs to focus—is the details. Some venture capital models and PACE programs are exciting because they seem to unleash the power of team-based primary care. However, they do so at the cost of segregation of care by insurance plans and differential costs of care—creating both economic and moral consequences that may be inconsistent with the values of family medicine. More broadly, capitation is still relatively uncommon, at least in sufficient market concentration to support needed innovation in practice. Capitation does tend to shift the focus of dialogue to populations, but the specifics matter: how much reimbursement is provided upfront? How much per covered life, with what risk adjustments? How much of the market is capitated? And critically, how is revenue actually distributed through health systems—ie, to what extent does system revenue go to support primary care and its necessary wraparound services, such as analytics, care coordination, and ancillary onsite services? The University of Michigan NICE (New Innovative Clinical Experience) and the University of North Carolina internal primary care capitation plan are now underway with planned evaluation of impact on clinical outcomes, patients, and staff. Our clinical leaders and researchers need to seek out, evaluate, and report such innovations.

Few family physicians will disagree with promoting access to care, which is the subject of the second set of recommendations in the NASEM report. Definitions of access, however, are critical. Many health systems today define access as the ability to go to their closest urgent care with extended hours. But urgent care—typically 1 problem at a time, without a doctor-patient relationship, and with higher rates of diagnostic testing, antibiotic prescribing, and referrals to emergency departments—is not the right long-term solution. In this context, our specialty needs to prioritize integrating in-person urgent care and telehealth into continuity of care. Importantly, family physicians often perceive tension between access and continuity, especially those who are over paneled and have bloated schedules. Yet, primary care practices have demonstrated support of both continuity and open access[3], and some states (eg, Virginia) have formally facilitated telehealth integration into the patient-centered medical home. The priority for family medicine is to learn from clinical models that support both open access and continuity.

The clinical model described in the NASEM report also emphasizes the value of interprofessional teams' support of sustained relationships over time:

> "High-quality primary care is the provision of whole-person, integrated, accessible, and equitable health care by interprofessional teams that are accountable for addressing the majority of an individual's health and wellness needs across settings and through sustained relationships with patients, families, and communities."

This emphasis on team-based care is important and reflects the reality of clinical care in today's complex care system, with increasing burden of disease and the contributions of social determinants of health. Many different professionals are needed to contribute to high-value primary care. The growth in numbers of new nurse practitioners and physicians' assistants as well as the advent of new roles, such as integrated behavioral health practitioners, care managers and community health workers, underscore the need to broaden the team to better serve patients. Starfield's core functions of primary care—first contact care, continuity, comprehensiveness, and coordination of care—endure over time. But, teams, the community context, and the need for supporting healing relationships are emphasized.[4] ABFM believes that it is now time for family medicine to develop its model of team-based care, including continued refining of care models, roles within a high-functioning team, and ongoing career development for all members of the team. We are confident that this can occur without diminishing the role of personal physicians. The relationship a patient has with their personal physician remains critical as multimorbidity and costs increase. At the same time, we know that the nation needs a system that provides *both* personal physicians *and* team-based care.

Ensuring continued commitment to comprehensiveness and coordination—the other Starfield pillars—is also critical. ABFM data demonstrate that most family physicians are not able to describe their panel size. Yet panel size greatly influences access to care, ability to maintain continuity, and assessment of effectiveness of clinical interventions. Panels also allow framing of important questions for development of a health system with primary care as its foundation: How do we identify and respond to community needs? Which types of team members are essential, and should they best fit in? How do we integrate behavioral health, telehealth, care management, and shared decision making into ongoing care? As a specialty, we have a responsibility to develop, evaluate, and share clinical innovations that support the NASEM recommendations. These innovations must occur across a variety of practice types and geographies—rural, urban, independent, employed, community health centers, VA PACT offices and academic practices—so that we learn what works and what changes are needed to achieve optimal function.

With respect to workforce, the number of family medicine residencies has increased more rapidly than any other specialty in recent years. The report calls for the training of primary care teams in communities; teaching health centers and rural residencies have demonstrated that training residents in underserved communities helps place many graduates in those settings. A major disappointment has been the slow growth of selection of family medicine as a specialty, despite significant growth in medical schools and class sizes. ABFM hopes that the NASEM report will itself catalyze changes in the clinical environment and payment models that enhance the attractiveness of family medicine among medical students; new federal funding for Teaching Health Centers and greater social accountability for GME[5] will help.

The next step for the specialty is residency redesign. A major effort over the last year engaged a variety of stakeholders to reenvision family medicine residency education for the future.[6] As this editorial is being written, an Accreditation Council on Graduate Medical Education (ACGME) writing group is drafting new standards for residency training. ABFM believes that an explicit focus on the clinical learning environment, greater community engagement, and innovation around areas of concentration and duration of residency training have the potential to result in attracting more medical students to family medicine. ABFM also hopes that the new standards will encourage integration of training of other professions in family medicine centers; a visible effort to create interprofessional teams to meet community needs may also help attract a new generation of students. Finally, improving the social accountability of the GME and publicizing outcome metrics can contribute importantly to public dialogue.[7]

Family medicine and primary care cannot succeed without digital systems that support access and continuous care over time and bring analytics to the frontlines of practice in a way that effectively supports continuity and shared decision making.[8] The NASEM policy recommendations—including emphasizing interoperability, the user experience, the accountability of venders—are important. Given the explosion of new IT applications, the specialty should now help curate products that support the core functions of primary care and can be integrated into new clinical models. Telehealth will be a core component of primary care, but care needs to be taken that telehealth does not produce greater fragmentation of care or divert resources away from struggling rural communities. As with other clinical innovations, organized evaluation and sharing both successes and failures will be important.

The final NASEM recommendation emphasizes governmental accountability. A key insight is that without public visibility and accountability, the common good that primary care represents will suffer, as has happened with the pandemic.[9] ABFM is supportive of the HHS Secretary's Council described in the NASEM report, which can have benefits not only for clinical care and infrastructure, but also on workforce policy necessary to support primary care as the foundation

of US health care. Additionally, an important contribution of such a council, along with an NIH Primary Care Research Council would be to better support research relevant to family medicine[10] and support the transformation of primary care described by the NASEM report. Our hope is that academic organizations and policy researchers will take on advocacy for this, including developing and promulgating scorecards for social accountability of clinical care, education, and research. In addition, significant health care innovation and reform is occurring at the state level, where AAFP state chapters, departments, and residencies have opportunities to advocate for adequate primary care spend,[11] consistency and relevance of quality measures across insurers,[12] and expansion of training opportunities for family physicians and other primary care team members.[13] Sharing lessons learned will be important as we travel this journey together.

Moving forward, as we all appreciate, the COVID pandemic has significantly increased the challenges faced by our specialty and the communities we serve. The NASEM report provides hope and a comprehensive roadmap forward. The recommendations are appropriate, they are interrelated, and all family medicine organizations should work together to bring the change we want to see. ABFM looks forward to working with all of you.

Warren P. Newton, MD, MPH, (WNewton@theabfm.org), American Board of Family Medicine (ABFM); Department of Family Medicine, University of North Carolina (Emeritus); Elizabeth Baxley, MD, ABFM; Andrew Bazemore, MD, MPH, ABFM; Michael Magill, MD, ABFM, Department of Family and Preventive Medicine, University of Utah

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STFM SOCIETY OF TEACHERS OF FAMILY MEDICINE **From the Society of Teachers of Family Medicine**

Ann Fam Med 2021;19:566-567. https://doi.org/10.1370/afm.2405.

FROM STFM: STFM SOLIDIFIES ANTIRACISM INITIATIVE

Recent Task Force Formation, Tactic Development, and Grant Funding for Learning Collaborative

Guided by a 5-year strategic plan, the Society of Teachers of Family Medicine's (STFM's) new antiracism initiative seeks to advance racial equity and reduce the prevalence of racism in academic family medicine. This initiative was developed in alignment with the STFM policy against discrimination with the following objectives of:

- Engaging in partnerships that contribute to the health equity of communities through medical education
- Increasing the skill set of family medicine faculty related to health equity
- Increasing the diversity of family medicine faculty and the diversity of learners interested in teaching
- Modeling antiracism and providing support to STFM members in their efforts to transform family medicine educators, learners, and their institutions to be more antiracist

The action plan for the Antiracism Initiative is aligned with STFM strategic objectives, and the work will be led by an STFM antiracism task force.