NASEM Actions and plans as of July 2021

Pay: ***Pay for Primary Care Teams to Care for People, Not Physicians to Deliver Services***

• Payers (ie, Medicaid, Medicare, commercial insurers, and self-insured employers) should evaluate and disseminate payment models based on the ability of those models to promote the delivery of high-quality primary care, not on achieving short-term cost savings.
• Payers using a fee-for-service model should shift primary care payment toward hybrid (part fee-for- service, part capitated) models and make them the default payment model over time.
• The Centers for Medicare & Medicaid Services (CMS) should increase the overall portion of spending on primary care.
• States should implement primary care payment re- form by facilitating multi-payer collaboration and by increasing the overall portion of health care spending in their state going to primary care.

AAFP	Verbal
AAFP Foundation	
ABFM	ABFM supports the advocacy goals of the Family, including payment. Our research and activity support payment adjustment for social deprivation.
ACOFP	ACOFP has one specific advocacy priority related to this action (1.2). Preserve the Family Medicine Model of Care (ACOFP Advocacy Priority 6). • Continue to support DPC arrangements through appropriate tax treatment (e.g., allowing DPCs to be paid for using health savings accounts). Regarding action 1.4, ACOFP has three supporting advocacy priorities: 1. Address the Family Physician Shortage (ACOFP Advocacy Priority 3) • Support policies that equalize reimbursement for primary care and specialty care. • Reward care provided by family medicine through reimbursement policies that are proven to ensure high-quality patient outcomes and patient satisfaction. 2. Improve Outcomes and Reduce Costs Through Primary Care and Support for Family Physicians (ACOFP Advocacy Priority 5) • Support primary care models that empower and reward PCPs who focus on prevention of chronic illness, manage those who have progressed and appropriately use specialists. • Ensure physicians earn compensation for activities that are under the heading of "care coordination," which are essential for improved outcomes and reduction of health care costs. • Recognize the clinical value and cost-savings from physician-led care coordination and establish appropriate reimbursement policies for such activities. 3.Focus on Vulnerable Populations and Address Racial Disparities (ACOFP Advocacy Priority 7) • Preserve and enhance Medicare and Medicaid reimbursement for rural and underserved area physicians, including the facilities where they provide care (e.g., Rural Health Clinics (RHCs), Federally Qualified Health Centers (FQHCs), Critical Access Hospitals (CAHs) and Disproportionate Share Hospitals (DSHs)). Note: While our advocacy priorities as written appear physician centered, they are predicated on the premise of supporting the full primary care team.
ADFM	1) Support departments in efforts to organize by state for collective action (e.g. advocacy for primary care spend, etc.); 2) Encourage efforts to address payment at health system level, share resources and case examples
AFMRD	• Encourage AFMRD members, by providing tools and resources, to advocate locally on behalf of increased primary care spending. • Work with STFM to ensure the development of health systems management curricula that supports residents being trained to advocate for, develop, and work in these new payment models
NAPCRG	
STFM	1. Developed a proposal for a rural hospital bonus payment for hospitals that host training programs to commit to keeping their programs going in light of financial issues due to Covid, encouraging other orgs such as NRHA to support it. 2. Identify and showcase community partnership models and multi-institutional collaborations that advance health equity in communities. 3. Provide STFM members with training and resources to effectively make the case to health systems leaders and legislators that investment in primary care medical education has financial and patient care benefits.

Access: ***Ensure That High-Quality Primary Care Is Available to Every Individual and Family in Every Community***

• All individuals should have the opportunity to have a usual source of primary care. Payers should ask all covered individuals to declare a usual source of primary care annually and should assign nonresponding enrollees. Community health centers, hospitals, and primary care practices should assume and document an ongoing clinical relationship with the uninsured people they are treating.
• The Department of Health and Human Services (HHS) should target sustained investment in creating new health centers (including federally qualified health centers [FQHC], FQHC lookalikes, and school-based health centers), rural health clinics, and Indian Health Service facilities in areas with a shortage of primary care.
• CMS should revise and enforce its fee-for-service and managed care access standards for primary care for Medicaid beneficiaries. CMS should also assist state Medicaid agencies with implementing and attaining these standards, as well as measure and publish state performance on standards.
• CMS should continue to support the COVID-19–era rule revisions and interpretations of Medicaid and Medicare benefits that have facilitated integrated team-based care, enabled more equitable access to telephone and virtual visits, provided equitable payment for non–in-person visits, eased documentation requirements, expanded the role of interprofessional care team members, and eliminated other barriers to high-quality primary care.
• Primary care practices should move toward a community- oriented model.

AAFP	Verbal
AAFP Foundation	• The Family Medicine Care USA grants for free health clinics focus on those clinics that in particular serve the underserved. • The Family Medicine Cares Resident Service Award creates an opportunity for Family Medicine Residents to address health disparities by tackling the health need the underserved in their local communities.
ABFM	ABFM supports a focus on access. Our work to support payments based on social deprivation will support practices in improving access for vulnerable. Our demographic and certification data will allow monitoring of diversity in our workforce and teams, which are necessary for access and health equity. We are developing collaborations with the CDC and the Census to define and monitor social determinants of care at the community level. PRIME and its extension to social determinants provide tools for addressing key access issues, and we are developing national projects to use to assess the status and vitality of rural primary--a key population of concern with respect to access.
ACOFP	Action 2.4: CMS should permanently support COVID-era rule revisions. In general, this is in line with our advocacy priorities. We may want to spell this out more in our plan given where we are in the pandemic. The current advocacy positions are written in a way that may be more appropriate for the middle of the pandemic, not post. (ACOFP Advocacy Priority 1) Action 2.5: Primary care practices should include community members in governance, design, and delivery, and partner with community-based organizations. While not directly aligned with the above actions, ACOFP has an advocacy priority to Focus on Vulnerable Populations and Address Racial Disparities (ACOFP Advocacy Priority 7) which does support the broader recommendation of ensuring high-quality healthcare for all. • Advocate for federal health program policies that assist and support—rather than financially penalize—physicians for unmet patient needs related to social determinants of health. • Develop and advocate for policies ensuring access to equitable and high-quality healthcare. • Encourage Congress to recognize and act on the racial health disparities in our country to improve health outcomes for minority populations.
ADFM	1) support departments in collaboration and advocacy at state and community levels; 2) encourage sharing/find venues for sharing resources on addressing health of populations at an institution level (led or at least championed by DFMs); 3) DFMs may work within their communities to align efforts with community-based organizations, FQHCs, etc. for collective movement toward access for all
AFMRD	• Develop resources to help program directors demonstrate, to health system leaders, the value and contribution the residency program brings to providing community oriented primary care, caring for underserved populations and sustaining clinical relationships with uninsured patients. • Advocated to continue support for COVID-19 era CMS rule changes. • Support development of new residency programs in FQHCs and rural community settings
NAPCRG	
STFM	1. The GME Committee has created a Leadership Training Track for Residents and Early-Career Faculty at the 2021 Annual Meeting. URM Leadership Workgroup has identified topics for an online course on leadership for URM faculty. 2. The work of the STFM Telemedicine Curriculum Task Force is broadly aligned with the access objective. By developing and disseminating a national curriculum to train medical students and residents to perform high-quality primary care via telemedicine, STFM's efforts will enable and advance the shared vision of delivering effective primary care to every individual and family in every community. 3. Launched Health Systems Initiative with multiple tactics around engaging health system leaders. 4. AFMAC continues to advocate for sustained investment in THCs and continued support for the pandemic rule revisions that have facilitated integrated team-based care and payment for non in-person visits, and the training related to those visits.

Workforce: ***Train Primary Care Teams Where People Live and Work***	
• Health care organizations and local, state, and federal government agencies should expand and diversify the primary care work- force, particularly in federally designated shortage areas, to strengthen interprofessional teams and better align the work- force with the communities they serve. • CMS, the Department of Veterans Affairs, the Health Resources and Services Administration, and states should redeploy or augment funding to support interprofessional training in community- based, primary care practice environments.	
AAFP	Verbal
AAFP-Foundation	Provide leadership development training to residents and students for potential impact in their communities and institutions as future family medicine physicians.
ABFM	ABFM supports residency transformation through ongoing work on re-envisioning the residency education of the future; at this stage, the focus is on the ACGME writing group. The recent special issue of Family Medicine laid out many specific major changes: starting with the obligation of meeting the future needs of society, to an emphasis on the practice being the curriculum, a robust involvement in community, competency-based assessment and a broader system that ensures innovation, better standardization, and more social accountability. We are also continuing to engage the ACGME about core faculty time, which is critical to the specialty's future. We believe that it will be important to develop what we mean by team-based care and a key role for personal physicians--and to involve patients and communities at many levels. The ABFM foundation is committed to supporting a major national collaborative project to support residency transformation, once the outlines of the changes become clear. ABFM's graduate survey shows outcomes of residency education; in collaboration with other researchers and AFMRD, we will contribute to the effort to drive improvement in residencies through the use of outcomes data. ABFM certification and demographic data will help monitor and drive changes in workforce scope of practice, team composition and practice transformation across the country; ABFM research has a major focus on health equity in teams, communities, and other settings. The Center for Professionalism and Value in Health Care will engage other specialties, professions, and the public in both development of models of team-based care as well as development of metrics for care that will help to shape the care environment to make it more friendly to robust primary care and the role of personal physicians. CPV will also advocate for commitment to professionalism as an underlying value, which we see as necessary for the future of the health care system. Finally, ABFM is committed to the long-term development of the family medicine workforce through independent assessment and assessment to support education developed by the AAFP and other partners.
ACOFP	Action 3.2 ACOFP has one advocacy priority related to this recommendation: 1. Address the Family Physician Shortage (ACOFP Advocacy Priority 3) • Increase financial support to hospitals, especially those in rural areas, to establish residency programs in family medicine. • Protect and expand medical education funding, including Direct and Indirect Graduate Medical Education funding, and preserve existing alternative Graduate Medical Education programs, such as the Teaching Health Centers Graduate Medical Education program, Title VII and other medical education programs.
ADFM	1) sharing models of team-based care; 2) sharing innovations in GME (e.g. to address community needs) and encouraging GME expansion; 3) advocating for GME expansion opportunities and opportunities for paying for innovations in team-based care;
AFMRD	• Developed DEI milestones for programs to use to assess the DEI status and progress within their program. • Continue to develop diversity related education and resources for AFMRD members with a focus on encouraging diverse workforce with in FMRPs. • Support programs in developing models for interdisciplinary training through NIPDD and other AFMRD programming • AFMRD supports through AFMAC and CAFM advocacy efforts to fund rural GME and THC expansion and permanence • AFMRD supports new program and new program director development so that more programs can be created in diverse locations and communities
NAPCRG	
STFM	1. Health Systems Initiative has aggregated relevant curriculum and is creating new online and in-person curriculum to fill gaps. 2. Working with the VA to deliver faculty development at VA facilities. Work with NRHA and other organizations in support of a rural GME bill. 3. In the early stages of addressing scope of practice issues. 4. Staff and members participate in ongoing meetings of the 25x2030 campaign steering committee and executive committee. MSE Liaison to the 25x2030 initiative asking group for input and providing updates. 5. The URM initiative has liaisons from the AAMC, AAFP, and the Comprehensive Medical Mentoring Program to share ideas and enhance collaborations. 6. STFM/CAFM support for legislation such as our rural GME bill and THC expansion and permanence help to "expand and diversify the primary care work- force, particularly in federally designated shortage areas, to strengthen interprofessional teams and better align the work- force with the communities they serve.

Digital Health: ***Design Information Technology That Serves Patients, Their Families, and the Interprofessional Primary Care Team***	
• The Office of the National Coordinator for Health Information Technology (ONC) and CMS should develop the next phase of electronic health record certification standards to align with the functions of primary care; account for the user experience of clinicians and patients to ensure that health systems are interoperable; ensure equitable access and use of digital health systems; include highly usable automated functions that aid in decision-making; ensure that base products meet certification standards with minimal need for modification; and hold health information technology vendors and state and national support agencies financially responsible for failing to meet the standards. • ONC and CMS should plan for and adopt a comprehensive aggregate patient data system to enable primary care clinicians and interprofessional teams to easily access comprehensive patient data needed to provide whole-person care.	
AAFP	Verbal
AAFP Foundation	
ABFM	ABFM has been funded by the ONC to address the current status of EHR use among the prime registry. This represents an opportunity to influence the future development of EHRS, to reduce burden and improve outcomes.
ACOFP	Action 4.2 In general, ACOFP has three advocacy priorities related to this recommendation: 1.To encourage the appropriate use of telehealth (ACOFP Advocacy Priority 2). • Prioritize telehealth services for the patient's primary care physician. • Ensure care is properly coordinated with the primary care physician, and Congress should provide resources for physicians to effectively coordinate care with other providers. • Reduce administrative burden associated with telehealth, including burdensome state licensing requirements. • Use data and evidence to develop telehealth coverage policy that ensures patients are receiving the highest quality care possible. • Ensure that family physicians have sufficient resources to invest in new technologies to provide effective telehealth services. 2.Reduce unnecessary paperwork requirements (ACOFP Advocacy Priority 4). • Promote EHR interoperability and standardize reporting requirements to reduce time spent on EHRs. • Develop meaningful EHR reporting requirements to replace unnecessary requirements that do not contribute to patient outcomes. • Streamline utilization management policies across payers in a way that all stakeholders can quickly and efficiently address patient needs. 3. Improve Outcomes and Reduce Costs Through Primary Care and Support for Family Physicians (ACOFP Advocacy Priority 5). • Equalize reimbursement across settings of care and between primary care and specialty care so that primary care has the resources to provide the newest technology and to obtain health IT that assists with improving quality and reducing costs.
ADFM	1) help to train learners in UME and GME space on telehealth ; 2) support efforts on "measures that matter" and other ways to move this forward by individual DFMs sharing faculty expertise
AFMRD	
NAPCRG	
STFM	1. Advocated for various telehealth changes under COVID public health emergency to aid rural training and supervision.

Accountability: ***Ensure That High-Quality Primary Care Is Implemented***	
• The HHS secretary should establish a Secretary's Council on Primary Care to enable the vision of primary care captured in the committee's definition. • HHS should form an Office of Primary Care Research at the National Institutes of Health and prioritize funding of primary care research at the Agency for Healthcare Research and Quality, via the National Center for Excellence in Primary Care Research. • Primary care professional societies and consumer groups at the national and state levels should assemble and regularly compile and disseminate a "high-quality primary care implementation score- card," based on the 5 key implementation objectives.	
AAFP	Verbal
AAFP Foundation	
ABFM	ABFM supports a secretary's council and a focus of federal effort on primary care research, along with more funding and prioritization for primary care research. We believe that these are critical to the future of family medicine and primary care, along with the other recommendations of the report.
ACOFP	Action 5.1: The HHS Secretary should establish a Secretary's Council on Primary Care to coordinate primary care policy, ensure adequate budgetary resources for such work, report to Congress and the public on progress, and hear guidance and recommendations from a Primary Care Advisory Committee that represents key primary care stakeholders. ACOFP hasn't yet, but can support this recommendation. Action 5.2: HHS should form an Office of Primary Care Research at NIH and prioritize funding of primary care research at AHRQ. ACOFP hasn't yet, but can support this recommendation. ACOFP would encourage there be the ability to specifically study osteopathic family medicine as part of some research.
ADFM	1) support advocacy efforts for creating a federal group for primary care; 2) support advocacy efforts for creating/funding a research center focused on primary care; 3) push forward the discussion of a research agenda for the discipline
AFMRD	• Support and disseminate AFMAC advocacy efforts related to Secretary's Council on Primary Care, Office of Primary Care at NIH, Primary Care Advisory Committee. • Work with ABFM to increase the use and functionality of the AFMRD and ABFM National Graduate Survey to measure residency program outcomes
NAPCRG	
STFM	1. Train faculty to rigorously assess the effectiveness of their educational tools, methods, and programs. New CERA Fellowship supports this work, fellowship starts May 2021. 2. Project from Practice Management Collaborative: creating an educational curricular resource to improve education in practice management. Quality Improvement Assessment Tool, https://www.stfm.org/media/2203/ucsf-qi-project-assessment.pdf 3. Partner with other organizations to share data on health indicators and the value of workforce development and increasing the primary care spend. 4. AFMAC recommends its member organizations support policy to advance the establishment of a Secretary's Council on Primary Care, the formation of an Office of Primary Care Research at NIH, and increased funding of primary care research at the Center for Primary Care at AHRQ. STFM/CAFM has been actively working for funding of the Center for primary care research at AHRQ since 2017.
PCCRT (Primary Care Centers Round Table)	● The Primary Care Centers Round Table (PCCRT) is a volunteer group of primary care research and policy centers across the US that meets regularly, including the Robert Graham Center, the Eugene S. Farley, Jr., Health Policy Center, the Center for Professionalism and Value in Health Care, the Center for Community Health Integration, the UCSF Center for Excellence in Primary Care, the Larry A. Green Center, the Morehouse National Center for Primary Care, and the OHSU Center for Primary Care Research and Innovation. The main purposes of the PCCRT – which first began convening in fall 2018 – are to maintain a continual focus on research and policy necessary for the future of family medicine and primary care and to foment a primary care movement. ● The PCCRT is leading an effort to drive sustained focus on this NASEM report recommendation, ultimately leading to its implementation at the federal level. This effort includes two components: 1) a "private" strategy that connects primary care leaders within and beyond the PCCRT to Administration officials, legislators, and other health care influencers to have targeted conversations emphasizing key messages around the need for and the value of this Council; and a "public" strategy that identifies PCCRT and other primary care leaders who can author lay press and peer-reviewed articles that communicate the same key messages.