Family Medicine Leadership Consortium Minutes

Virtual Meeting – August 13-14, 2021

Please see webpage for all documents:
https://stfm.org/conferences/fmlc/overview/

AAFP: Margot Savoy, MD; Gary LeRoy, MD; Shawn Martin, CAE; Stephanie Quinn; Ada Stewart, MD; Julie Wood, MD; Karen Mitchell, MD; Sterling Ransome, MD
AAFP Foundation: Martin Devine, MD; Rebecca Jaffe, MD, MPH; Heather Palmer; David R. Smith, MD, MPH; Tomas Owens, MD
ABFM: Andrew Bazemore, MD, MPH; Wendy Biggs, MD; John Brady; Bob Phillips, MD, MSPH; Kevin Rode, Warren Newton, MD, MPH
ACOFP: Nicole Bixler, DO; Robert DeLuca, DO; Bruce Williams, DO; Bob Moore, CAE
ADFM: Amanda Weidner; Chelley Alexander, MD; Allen Perkins, MD; John Franko, MD
AFMRD: Wendy Barr, MD; Steven Brown, MD; Kim Stutzman, MD; Deanne St. George; Kathleen Ingraham
NAPCRG: Gillian Bartlett-Esquillant, PhD; Jack Westfall, MD; Julie Sutter, CAE
STFM: Stacy Brungardt, CAE; Aaron Michelfelder, MD; Linda Myerholtz, PhD; Tricia Elliott, MD; Emily Walters; Hope Wittenberg, MA; Sandy Van Tuyl

GUESTS: Mary Theobald, MBA; Danielle Jones, MPH; Melinda Abrams, MS; David Skorton, MD; Peter Long; Marcus Plescia, MD; Liz Fowler, PhD, JD; Susan Hassmiller, PhD, RN; Scott Shipman, MD, MPH; Stacy Potts, MD; Colleen Conry, MD; Leah Hendrick, JD; Nick Minter, MPP; Corinne Lewis, MSW: Peter Eckrich

1. Welcome and Introductions

2. Wicked Problem 1: Advancing the Recommendations from the NASEM High-Value Primary Care Report (Part 1)

Robert Phillips, MD, MSPH, described the task and process for the development of the NASEM High-Value Primary Care Report and reviewed actions and plans for implementation since its release.
Download: **FMLC_Implementing HQ Primary Care Briefing Presentation August 2021**

Lauren Hughes, MD, MPH, MSc gave an update on Primary Care Centers Round Table (PCCRT) Campaign to promote the formation of a Secretary's Council on Primary Care. PCCRT believes the Council would provide appropriate authority and leadership to coordinate and elevate primary care activities and functions across the federal government.
Download: **PCCRT Presentation**

Discussion:

- Important to collaborate and show how primary care workforce issues, including payment & metrics, are tied to GME reform and medical education funding.
- A secretary's council would boost visibility of primary care with both a short-game focus of this administration's priorities and long-game proactive policy approach.

- Strategy for the priority of emphasis for each of the five NASEM report objectives will likely depend on alignment and timing with the current administration's priorities and funding.

Shawn Martin, CAE, presented historical context for the NASEM report as it relates to the new paradigm for primary care financing, PC for America, and the Commonwealth Fund Task Force policy recommendations on payment and delivery system reform.

- The work of the NASEM report builds on primary care and QI reports and actions since the 1960s. Discrepancies between spending and outcomes have been documented for years, in particular the QI/PI industrial complex as a failed solution and burden on PC.
- The NASEM report pulled together overwhelming depth of evidence on the value of primary care and the dysfunction of QI burdens resulting in a decrease in outcomes. We've reached an inflection point showing the economic dysfunction in primary care and the need for payment reform.

Discussion:

- A flaw in prior approaches has been positioning primary care as a solution to political and healthcare problems when it should be seen as a standalone good and the contributor to health. The NASEM report repositions it in those terms.
- Reframe the conversation:
  - Primary care needs a structural payment model redesign completely independent of other health care.
  - Primary care also needs to advocate for enough GME funding to supply the PC workforce shortage.

2. Wicked Problem 1: Advancing the Recommendations from the NASEM High-Value Primary Care Report – External Perspectives (Part 2)

External presenters shared ideas and examples of how their organization is or is planning to advance the recommendations from the report.

Melinda Abrams, MS, Commonwealth Fund, (mka@cmwf.org)

- The Commonwealth Fund is working to reframe primary care as an investment. They're Interested in evaluating innovative payment plans and helping primary care practices to adopt new payment models as alternatives to fee-for-service.

Discussion:

- There are minefields in risk adjustment. Important to be thoughtful about what success looks like. Adjusting for equity, severity of conditions, and other contributors to health. Value-based care adjustments have sometimes been an opportunity to pay less and ask for more.
- Pushing Medicare as a lever to enact change, but work with commercial plans to strategically bring everyone, including middle-class patients on private plans, along.
- Recommend locking arms with other primary care clinicians outside of family medicine to speak with stronger voice.

David Skorton, MD, Association of American Medical Colleges (AAMC)

- AAMC's strategic plan has significant alignment with the NASEM report in its focus on community collaborations, equity & justice, increasing the diversity of the PC workforce, payment reform + EHR interoperability, and telehealth.
- Supports value-based payments, team-based care models, and mitigating inequity through asynchronous telehealth.
  Direct contact with Dr Skorton aamcpresident@aamc.org & Dr Shipman, AAMC sshipman@aamc.org

Discussion:

- Important to acknowledge how the shortages in behavior health can be met with team-based and interprofessional training through primary care. Particularly important especially with addiction burden to train our workforce.

- AAMC is not in alignment with NASEM report with regard to redesign and allocation of GME funding for primary care. Agree with the emphasis on the importance of primary care but not on the specifics of policy to shift GME funding.
- Create accountability in schools to change diversity. This can happen by holding leaders both accountable to change the composition of the workforce toward diversity and accountable for the workforce climate and environment.

Peter Long, Blue Shield of California

- Primary care is the backbone of health care. It's time to switch to a better model with advanced and predictable payments, better outcome metrics, and standardized metrics to pay for value.
- Performance incentives are carefully designed by doctors to simplify targets and ensure that payments are predictable.
- Direct contact peter.long@blueshieldca.com

Discussion:

- Key stipulation of the program that incentive payments go directly to individual physicians and/or providers.
- Important to provide plan for this type of transition so that RVU payments aren't just abruptly dropped, and funding transferred to specialties. Critical to keep primary care as key player in the payment model and award the work they are doing.

Marcus Plescia, MD, Association of State and Territorial Health Officials

- The NASEM report's focus on community medicine and population health would be embraced by the public health sector. Social determinants of health are also a primary focus for public health right now.
- FQHCs and primary care physicians have traditionally been too busy doing clinical work to dig into the research agenda of public health. Due to COVID-related funding that's being used to update and improve public health data collection, there may be key opportunities for collaboration in the immediate future.
    - Public health researchers need better clinical data around race & ethnicity, for instance, to address health disparities.
    - What do physicians need back from public health databases? What types of data sets do physicians need to be able to pull back for their institutions and patient registries – vaccines, etc.

Liz Fowler, PhD, JD, Center for Medicare, and Medicaid Innovation (CMMI)

- Fully supportive of the NASEM report and pleased with the health equity emphasis that aligns with the CMMI strategic goals. Want to invest in tools for closing gaps in healthcare
- Payment model transformation takes time and investment. The payers want to be involved model design process. Many of the models are first tested with more affluent practices, but it's critical to focus on and support payment reform in more diverse practice settings.
- Goal for all practices to be accountable for cost and quality by 2032. CMMI plans to address the issue of innovation uptake by practices that are "better served" vs more underserved.

Discussion:

- Important to include underserved populations thoughtfully, whether rural providers or urban underserved communities. Understand that change fatigue may be a factor in innovation uptake.
- Revisit how we define success with payment models. There's a need to make investments upfront, which is challenging if tasked with staying budget neutral in a short time period. We should think broadly about practice impact and if budget requirements need legislative change.

Susan Hassmiller, PhD, RN, Robert Wood Johnson Foundation

- The future of primary care needs nursing capacity to advance health equity. Important to remove practice barriers and fully support the value of nurses. Support flexible payment of nursing roles in public health.
- Payment reform in NASEM report doesn't mention nurses' contributions that need to be captured in payment system. Nurses can help bridge the gap in access to care.

Discussion:

- There are missed opportunities for smart care with overuse of medical assistants rather than trained nurses. Training in team-based care need to be prioritized across primary care.
- The goal of a more diverse nursing workforce and promoting health equity is being addressed through mentorship, coaching, and awareness at the leadership level.

3. Advancing the Recommendations from the NASEM High-Value Primary Care Report – Ideation and Harmonizing Family Medicine's Efforts (Part 3) Breakout groups focused on harmonizing ideas and identifying potential areas for collaboration among the family medicine organizations.

Attached addendum document with discussion from 5 areas: Payment, Access, Workforce, Digital Health, and Accountability

4. Addressing Antiracism and DEI in Family Medicine: Approach for Collective Action
Moderator Danielle Jones MPH, AAFP Director of Diversity and Health Equity, presented the FM-CAR Charter for discussion and approval.
Download: **Charter**
Download: **Updated actions and efforts**

Discussion: FM-CAR would identify gaps and opportunities for collaboration within the specialty but would not develop its own projects. Opportunity for family medicine to be a leader in the space.

- Communication is part of the work of FM-CAR, so we'll need to be committed to sharing information with consensus and support from the leadership. Consider what elements of plan we should have consensus on from organizations before dissemination.
- It was suggested that the document of FMLC organization actions and efforts be distributed to members internally and incorporate feedback before publishing it in a journal or formal platform. Allow for a certain amount of time for feedback before releasing as an endorsed document.
- Recommend plan for regular updates of the actions and efforts of each FMLC organization, perhaps even on a public or digital dashboard. Highlight early wins. The Graham Center may be able to help with a dashboard.
- It was noted that every organization does not have to be involved in every action listed. Each organization will do their own work. The spirit of FM-CAR and the charter is to enhance information sharing and information but not at the expense of action and moving forward independently as well as collaboratively.

Next Steps:

- Work group will revise the FM-CAR charter based on the discussion and send the revised document to the organizations for approval.
- Contact: Amanda Weidner aweidner@adfm.org, Julie Sutter jsutter@napcrg.org, or Danielle Jones djones@aafp.org with additional comments from an organization.
- Timeline:
  - Anticipate revised FM-CAR charter to be approved in fall 2021 or during January 2022 FMLC meeting.
  - Simultaneously organizations can select representatives. Representatives are ideally one staff and one member from each organization, but this is up to the discretion of each org.
  - Will develop talking points for sharing with members of each organization.

5. Duration of FM Residency Education
Warren Newton, MD, and Karen Mitchell, MD, presented and lead discussion for input on the case re-envisioning the length of training for family medicine training. There was a robust discussion about the issues to consider relative to the length of residency training.

Download: Duration of FM Residency Education

Discussion:

- Consider student debt 3 vs 4 years. Think about the barrier additional debt of a 4th year would create especially for a more diverse population. How would this affect recruitment and the appeal of the specialty?
- Because residency keeps adding but doesn't take anything away, some students are willing to take on the extra debt by enrolling in 4-year programs.
- It is possible that the only way to extend CMS funding is a declaration for 4 years.
- The current model of 3 years cannot just be tweaked but needs to be reimagined and fundamentally changed to deliver the promise of family medicine. The current system isn't delivering the promise of competence and complexity.
- What is the best way to support learning and master adaptive training? Be flexible; formal training for 3 years followed by informal learning in community. Increase self-efficacy and confidence in learning skills on the job.
- What are we training for? Need to describe skill set and measure skills. Scope should include engagement in community, advocacy, system-based practice, and team-based care.
- Straw Poll for desired residency length of training in the long term (5-10 years):
    - Question 1:
        - 69% - preferred 3 years with major reform in requirements
        - 31% - preferred 4-year residency training for all
    - Question 2:
        - 16% - Three years of initial residency followed by fellowships of 6-12 months.
        - 23% - Keep 3-year required residency but support a mentored apprenticeship in the first year of practice
        - 23% - Allow programs to choose 3 or 4 years in length, based on needs and interests of the program
        - 16% - Time variable residency length between 3 to 4 years based upon competency and learner needs
        - 23% - Require all programs to be 4 years in length with robust areas of concentration responsive to community needs

7. Government Relations Update
Peter Eckrich; Hope Wittenberg, MA; Bob Phillips, MD; and Stephanie Quinn provided updates for the ACOFP, CAFM, ABFM, and the AAFP.
Download**:** Joint Gov't Relations Update August 2021

8. Debrief and Closing Remarks
Dr Stewart announced in-person meeting planned for January 14-15, 2022, in Charleston, South Carolina, hosted by the AAFP.

Meeting evaluations will go out and are due back August 30.