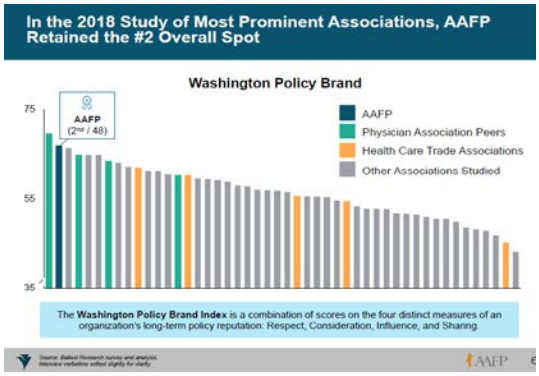
AMERICAN ACADEMY OF FAMILY PHYSICIANS
STRONG MEDICINE FOR AMERICA

AAFP Organizational Update
Working Party – August 2018

ADVOCACY

The AAFP continues to be recognized as one of the top performing and most influential organizations in Washington, DC. In 2017, the AAFP engaged in an evaluation process with Ballast Research to determine the impact of AAFP advocacy. 2018 marks year two of our engagement with Ballast, and we are pleased to report that the AAFP continues to be ranked the second most prominent association in Washington, DC (figure 1). Policymakers continue to seek out input from the AAFP. As noted in figure 4, the AAFP's opinion is more likely to be sought out than any other organization in the study. The other charts show our performance on individual measures of advocacy.

(Figure 1)



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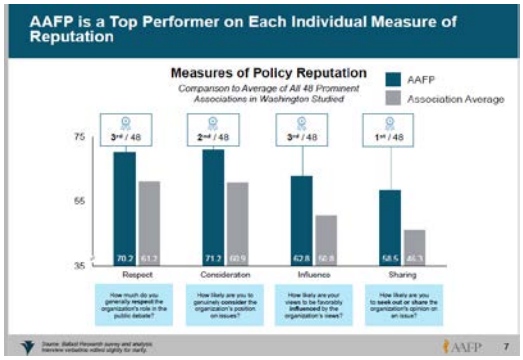

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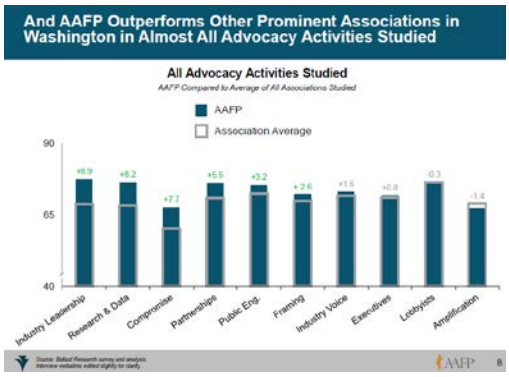

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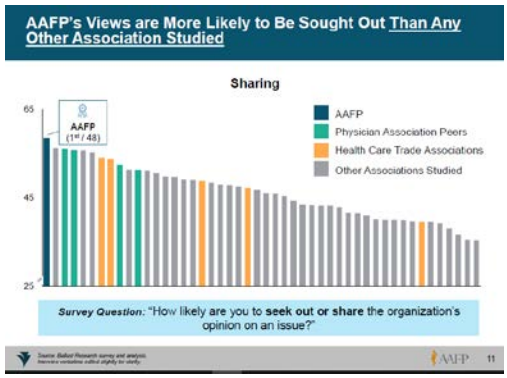


Fighting for Family Medicine

In June, the AAFP launched its Fighting for Family Medicine initiative. FFFM is a set of member communication and advocacy products designed to give family physicians up-to-the-minute information on the comprehensive advocacy work the AAFP is doing on behalf of family physicians and their patients. The new brand represents our commitment to be an organization that stands up and speaks out on behalf of family physicians.

A key component of this new Fighting for Family Medicine initiative will be the "**Fighting for Family Medicine Newsletter**," which goes to all AAFP members every other Tuesday. The FFFM Newsletter offers an overview on a wide variety of advocacy topics, focusing not just on our work in Washington, DC, but also our work with state governments, private insurance companies, patient organizations and other organizations engaged in health care. FFFM Newsletter is anchored by In the Trenches – a blog focused on providing family physicians in-depth and thought-provoking analysis of health policy and politics. You can view this content at Fighting for Family Medicine Hub**.**

In addition to the FFFM Newsletter, the AAFP has launched the Advocacy Insider – a newsletter for members of the Family Medicine Action Network (FMAN). The FMAN provides the most active advocates access to policy briefs, talking points, and up-to-the minute information about what is

happening in Washington, DC or your state Capital. The FMAN also features advocacy engagement resources, enabling family physicians the tools to communicate with their elected officials on key issues impacting your practice, your patients, and our health-care system.

Health-Care Coverage & Financing

The American Academy of Family Physicians (AAFP) is a leading voice on health-care issues in the United States. As a national leader, it is important that the AAFP remain attuned to changes in our health-care system and cognizant of potential changes in policy that would support or hinder our strategic goal of ensuring health care for all. To this end, the AAFP has been working to develop a policy document entitled "Health Care for All: A Framework for Moving to a Primary Care-Based Health-Care System in the United States." This document remains embargoed until action is taken by the AAFP Congress of Delegates, but the AAFP is pleased to report our ongoing work on this important set of issues.

This framework under development emphasizes the need for health-care system reforms that aim to serve all Americans, be foundational in primary care, and work to reduce barriers such as price and accessibility that limit people from obtaining health coverage.

In 2017, the AAFP presented to the Congress of Delegates a policy background document entitled "Discussion Paper on Health Care Coverage and Financing Models." The commissioning and presentation of this work was in response to actions taken by the Congress of Delegates in 2016, which directed the AAFP to "explore" health-care coverage and financing options that could enhance, compliment, or replace our current system.

The "Health Care for All: A Framework for Moving to a Primary Care-Based Health Care System in the United States" is the next phase of our work on these important issues. Building on the informative content of the discussion paper, the AAFP began drafting policy options that would frame our future policy and advocacy work on health care coverage and financing.

This policy framework will provide the AAFP and its Board of Directors policy options aimed at achieving the goal of health-care coverage for all – a goal based upon AAFP policy that recognizes that health is a basic human right for every person and that the right to health includes universal access to timely, acceptable and affordable health care of appropriate quality.

It is intended to provide clearly articulated guardrails that would shape the AAFP's support or opposition to future health-care reform proposals that might come before federal and state governments and the American people. While the document is designed to highlight and promote our policy priorities, it is not intended to be viewed as a self-encompassing, comprehensive policy. Future decisions would be based on the alignment of any proposal with AAFP strategic and policy objectives, political and economic realities, and the need to achieve changes in policy that are consistent with our mission.

Administrative and Regulatory Simplification

The AAFP continues to prioritize the reduction of administrative burden on family physicians in our advocacy efforts. We participated in a closed-door roundtable with House Ways and Means Committee members as part of the "Medicare Red Tape Relief Initiative." At that June 14 session,

AAFP staff engaged in dialogue with legislators about the AAFP administrative-burden agenda. While the first roundtable in March was more formal, this one had unstructured dialogue between legislators and panelists. Health Subcommittee Chairman Peter Roskam (R-IL) led the discussion, and Subcommittee ranking Democrat Sandy Levin (D-MI) also participated. AAFP was one of 10 groups invited to participate. The Committee's plan is to identify as many items as possible that can be achieved without legislation, and use its influence at CMS to accomplish them administratively. This includes accelerating reforms now taking place at CMS (e.g. the revamp of the E&M documentation guidelines). The Committee is expected to move forward later this year with legislative options. Generally, this would involve releasing a discussion draft with legislative text, followed by an opportunity for AAFP to comment.

The 2019 Medicare Physician Fee Schedule, released on July 12, includes many proposals aimed at reducing the documentation and quality reporting requirements for physicians participating in the Medicare program. While the AAFP will be carefully analyzing these proposals, an initial review suggests that the proposed changes to Medicare documentation requirements for the office visit E/M codes could greatly reduce the current documentation burden and help to ensure that the medical record reflects the true nature of the visit and not just 'bullets for billing'. This fee schedule proposed rule (over 1400 pages) will require careful and critical review and the AAFP will respond in due time.

Advanced Primary Care Alternative Payment Model (APC-APM)

On December 19, 2017, the Physician-Focused Payment Model Technical Advisory Committee (PTAC) voted to recommend that the Secretary of Health and Human Services (HHS) pursue limited scale testing of the AAFP's advanced alternative payment model proposal as soon as possible. The PTAC clarified that "limited scale testing" in this context should be on an order of magnitude equal to or greater than Comprehensive Primary Care Plus.

In their deliberations, the PTAC noted some perceived weaknesses in the model. Areas of the proposal identified by the PTAC for additional structure and/or clarity are:

1. Attribution
2. Accountability for quality and cost
3. Structure of cost-sharing for patients
4. Evaluability
5. Risk adjustment

To begin to address issues in those areas, the AAFP convened a small group of health-care policy and delivery system experts in Washington, DC, on February 27, 2018. Those experts provided valuable insight and posed several questions that will help further develop the model and facilitate implementation.

On February 28, 2018, PTAC formally submitted its recommendation to the Secretary of HHS, and on March 19, 2018, the AAFP sent a letter to the Secretary requesting his support for PTAC's recommendation and testing the AAFP's model. If the Secretary accepts PTAC's recommendation, the AAFP will work with staff at the Centers for Medicare & Medicaid Services (CMS) to facilitate testing. Our work with, and in follow-up to, the expert panel noted above will strengthen our work with CMS when that time comes.

On June 12, HHS Secretary Alex Azar issued a letter responding to the PTAC recommendation with feedback on the APC-APM. In his response, the Secretary encouraged the AAFP to further refine several aspects of our model, stating, "HHS believes strengthening primary care is critical to promoting health and reducing overall health-care costs in the nation." He recognized the AAFP for our "strong commitment to innovation and improving health care." With respect to the APC-APM, the Secretary commented, "This proposal from AAFP offers promise because of its emphasis on the expansion of beneficiary access to high-quality primary care and its support of primary care physicians' ability to deliver advanced primary care more effectively."

The AAFP continues to engage with CMS and the Center for Medicare and Medicaid Innovation (CMMI) to identify commonality between the APC-APM and other models that are under development at CMMI.

Primary Care Benefit Legislation

The costs of health care and health-care coverage continue to increase at significant rates. As a result, many individuals, families, and employers are turning to high-deductible health plans (HDHP) as a means of securing affordable coverage for themselves, their families and their employees.

According to a report from Americas Health Insurance Plans (AHIP), in 2017, almost 22 million Americans had enrolled in an HDHP, up from only one million in 2005. All indicators suggest that this rapid growth of HDHPs will continue in individual, small group, and employer-sponsored markets.

The AAFP views HDHPs as innovative structures that allow individuals to secure affordable health-care coverage, which is important. Individuals who have health-care coverage are more likely to have a continuous relationship with a primary care physician, which is a key indicator of health and health maintenance. Put simply, if you have health-care coverage and a continuous relationship with a primary care physician, you are more likely to have better health and better maintenance of your health conditions as compared to those who lack one or both.

The Internal Revenue Service (IRS) defines a HDHP as any plan with a deductible of at least $1,350 for an individual or $2,700 for a family. Consider the real-world impact of high deductibles in the context of a May 2018 Federal Reserve System Board of Governors report entitled Report on the Economic Well-Being of U.S. Households in 2017 that found that *"four in ten adults couldn't cover an unexpected $400 expense without selling something or borrowing."* While HDHPs are playing an important role in expanding access to affordable health-care coverage for millions of people, the deductibles associated with the plans are becoming a hurdle to obtaining health care for millions of people. In fact, a Centers for Disease Control and Prevention (CDC) report: Financial Barriers to Care: Early Release of Estimates From the National Health Interview Survey, 2016 found:

> *"Among privately insured adults aged 18–64 with employment-based coverage, those enrolled in an HDHP were more likely than those enrolled in a traditional plan to forgo or delay medical care and to be in a family having problems paying medical bills."*

These statistics cry out for a policy solution. On May 18, Congressman Brad Schneider and Congresswoman Elise Stefanik (R-NY) introduced the *Primary Care Patient Protection Act of 2018* (H.R. 5858). This legislation aims to assist individuals and families who have secured health-care coverage through a high-deductible health plan (HDHP), but face obstacles to accessing the health-

care system due to their deductibles, secure access to their primary care physicians. The *Primary Care Patient Protection Act of 2018* would create a primary care benefit for all HDHP holders allowing for up to two deductible-free primary care office visits each plan year. If enacted into law, individuals with a HDHP would have access to their primary care physician, or their primary care team, independent of cost-sharing – meaning that the patient could receive a defined set of primary care services prior to meeting their deductible. The company issuing the HDHP to the individual or family would be responsible for providing full payment for the primary care services provided by the physician and cost-sharing requirements would remain in place for all services outside the defined primary care services outlined in the bill.

Medicare Access & CHIP Reauthorization Act (MACRA)

The American Academy of Family Physicians (AAFP) continues to place an enhanced priority on Medicare Access and CHIP Reauthorization Act (MACRA) implementation and compliance. This work focuses on educating family physicians; facilitating practice transformation; influencing regulations; and aligning public and private payers.

Member Education and Resources

The AAFP continues to educate members about the Quality Payment Program (QPP) created by the MACRA. We strive to provide members with resources they need to succeed under value-based payment.

One of the goals of the QPP is to expand participation in advanced alternative payment models (AAPMs). However, the number of AAPMs currently available is limited. Until more AAPMs are available, the AAFP anticipates most of its members will participate initially in the Merit-Based Incentive Payment System (MIPS) track of the QPP. Accordingly, most of the existing resources are focused on guiding physicians through MIPS as they prepare for participation in AAPMs.

Following release of the 2018 QPP final rule, the AAFP reviewed and updated existing resources as well as produced a 2018 MIPS Playbook. The Playbook is a comprehensive resource that provides in-depth information on each of the MIPS performance categories. To simplify the program requirements, the Playbook also includes a checklist with actionable guidance to help members navigate the QPP. This resource is available free to members. Market research is currently underway to guide the development of the 2019 version.

The AAFP continues to publish *FPM* supplements as part of its Making Sense of MACRA series. Recent supplement topics included Medicare care management services, a 2017 performance period recap, and 2018 performance period updates. Since it is important for all physicians, including employed, to understand the impact of the QPP, the AAFP has produced two *Making Sense of MACRA FPM* supplements specifically for the employed physician. The first supplement was published in the fall of 2017 and provides background on how the QPP affects them. The second supplement appeared in the May/June issue of *FPM* and provides the top five questions employed physicians should ask their administration about the QPP. This series in *FPM* will conclude at the end of the 2018 calendar year.

From the launch of MACRA Ready Campaign, AAFP has realized more than 500,000 MACRA web-page views. Since the introduction of the 2017 MIPS Playbook, member engagement with the AAFP's

MIPS resources has increased significantly. Additionally, downloads of the 2018 MIPS Playbook are outpacing downloads of the 2017 version. This may signal that AAFP members understand the need to begin collecting 2018 data earlier since a full-year reporting is required, and they trust AAFP resources to help them avoid negative payment adjustments. Strong and consistent member engagement indicates that the AAFP is delivering on its promise to provide guidance for members transition to value-based payment.

While general MACRA information will decrease as more members have a working knowledge of the law, AAFP education and resource development is expected to emphasize how to optimize scoring under MIPS and how members can position their practice to successfully participate in advanced alternative payment models.

Advocacy

The AAFP remains engaged in advocacy related to MACRA implementation:

1. On March 21, 2018, the AAFP submitted a statement for the record on "Implementation of MACRA's Physician Payment Policies" as part of a hearing on the subject by the House Committee on Ways and Means Subcommittee on Health. The statement re-iterated the AAFP's commitment to the QPP's long-term success and urged the subcommittee to take all possible steps to promote primary care APMs and simplify MIPS.
2. On April 16, 2018, the AAFP joined several other organizations to urge CMS to reduce the 2018 MIPS quality measure reporting period from a calendar year to a minimum of 90 consecutive days. The organizations cited the lack of timely and direct notification by CMS on whether a physician is considered MIPS eligible and a severe delay by CMS in updating the QPP interactive website with 2018 information as justification for shortening the required reporting period.

Direct Primary Care (DPC)

The AAFP is a strong advocate for Direct Primary Care (DPC) at the state and federal level. DPC now has over 25 states with legislation supporting DPC and/or defining it as a medical service outside the scope of insurance regulation. In addition, three states have introduced legislation for DPC pilots. In April, Nebraska passed a bill that establishes a Direct Primary Care Pilot Program within the Nebraska State Insurance Program. The pilot program would begin in 2019 and continue through 2022. The pilot program will include direct primary care health plans in the Nebraska State Insurance Program for state employees in addition to the typical plans found. This is similar to a pilot in New Jersey in which R-Health is providing a DPC plan option to members of the New Jersey State Health Benefits Program (SHBP) and School Employees' Health Benefits Program (SEHBP) and their families. To date, Wisconsin and Missouri have also introduced DPC pilot legislation specifically for Medicaid beneficiaries.

The AAFP has been working closely with the Trump Administration, especially CMS Administrator Seema Verma, on expanding opportunities for the DPC model in Medicare, Medicaid, and the health insurance marketplaces. In December, the AAFP received a request from CMS asking how many AAFP members would be interested in a potential federal demonstration featuring a direct primary care payment methodology. AAFP Practice Advancement staff drafted a survey that was sent to DPC practices and a random sample of non-DPC practices to determine interest. The AAFP took this

opportunity to gather objective data about active direct primary care practice characteristics including the practice size, type, staffing ratios, and patient mix. This information will be used to update educational and advocacy resources around DPC. CMS also convened four small regional focus groups to gather additional stakeholder feedback from active DPC practices.

On April 23, 2018, the CMS released a request for information seeking input on a potential model they called "direct provider contracting (DPC)" to test within the Medicare fee-for-service (FFS) program (Medicare Parts A and B), Medicare Advantage program (Medicare Part C), and Medicaid. The RFI did not contain any details on the model but asks for stakeholder input on how best to design the model. CMS noted the goals of the direct provider contracting model are (1) to enhance access to physicians for beneficiaries; (2) to reduce administrative burden on providers around billing for services; and (3) to set a revenue stream that would be designed to provide more provider flexibility in caring for patients. The AAFP highlighted how the AAFP's APM proposal was designed to meet the same goals. The AAFP also offered insight on its experience and knowledge of members practicing in DPC models, including many of the results from the recent survey mentioned above.

The AAFP supports and educates members on the DPC practice model. The DPC Toolkit continues to help members starting or planning a DPC practice. It is being updated to include additional learning formats, such as educational videos and checklists. Content will be updated to reflect the current environment and add information on how practices can engage employers within DPC. In addition, the AAFP, the American College of Osteopathic Family Physicians (ACOFP), and the Family Medicine Education Consortium (FMEC) co-hosted the 2018 DPC Summit, which was held July 13 - 15, 2018, in Indianapolis, Indiana. The theme centered on how DPC is stretching the boundaries of the movement and being recognized by top officials and employers nationwide. The event garnered strong interest from exhibitors and sponsors.

Clearinghouse Discontinuation

On July 16, 2018, the Agency for Health Care Quality and Research's National Guidelines Clearinghouse (NGC) shut-down. The AAFP is concerned about this decision. The NGC serves as an important purpose. It is the only national repository of evidence-based clinical guidelines. It aligns with the work that takes place within the Institute of Medicine. The AAFP uses the NGC as a resource for our clinical guidelines work, and our family physicians use the information as part of their patient care delivery.

FAMILY PHYSICIAN HEALTH AND WELL-BEING UPDATE

The AAFP continues to make improving member well-being and professional satisfaction a top priority and introduced several well-being resources in the last year. In April 2018, 458 family physicians attended the inaugural Family Physician Health and Well-Being Conference, exceeding expected attendance by 22 percent. We believe this underscores the fact the family physicians are looking for solutions and support. Highlights of the conference included 36 different breakout sessions, morning yoga, a welcome reception, attendee-driven networking opportunities before and after the course, and a highly accomplished faculty group. 98 percent of surveyed attendees felt the conference was excellent or better than average; 95 percent agreed or strongly agreed that they felt encouraged to come up with new and better ways of doing things to improve their professional

satisfaction; and 50 percent stated they plan to attend the conference every year. Planning for the 2019 and 2020 conferences is underway.

Since its launch in September 2017, the Physician Health First Web Portal (www.aafp.org/mywellbeing) has received 29,735 unique visitors. Along with more than 100 well-being articles, videos, and CME sessions, the Portal is home to the Maslach Burnout Inventory (free to all AAFP members and completed by 3,000+ members as of June 2018) and Well-Being Planner (www.aafp.org/myplanner). The Well-Being Planner, launched April 2018, allows members to save articles to a reading list, learn how to address major areas of the family physician ecosystem, set goals, and track and measure their progress. As of June 2018, over 500 members have created plans and/or have added goals to their plans.

Initiative priorities for fiscal year 2018-19 include launching a team documentation product, implementing Physician Health First AFP Chapter Presentations, investigating student and resident member well-being improvement opportunities, and continuing to further refine existing resources. In addition, a well-being Practice Improvement activity module is scheduled to launch in Spring 2019 and may be supported by an ABFM grant if certain specifications can be met.

In June, the 2018 Family Physician Well-Being Research Survey, sent to a sample of 5,000 active members, revealed that 57 percent of members responding reported they would choose to be a family physician again (up 2 percent from 55 percent in 2017, not meeting or exceeding the AAFP's goal of 60 percent). Furthermore, 43 percent of members agreed that the AAFP provides effective resources to improve their well-being (up 19 percent from 24 percent in 2017 and exceeding the AAFP's goal of 40 percent).

The AAFP continues to believe that to meaningfully improve family physician well-being and professional satisfaction, we must accomplish both significant payment reform and dramatically lessened administrative burden, which appear to combine to be root-cause contributors to high levels of family physician burnout. For 2019 and 2020, the AAFP renewed our sponsorship of the National Academy of Medicine Action Collaborative on Clinician Well-Being as a means to leverage system and organizational prioritization of efforts to accomplish meaningful improvements systemically.

STUDENT CHOICE OF FAMILY MEDICINE

The 2018 National Conference of Family Medicine Residents and Medical Students, scheduled for August 2-4, 2018, is on pace to exceed student participation rate for 2017 by 11 percent and 34 percent for 2016*. Our 2018 goal is to register 1,750 medical students. There has been increased effort by medical schools' departments of family medicine and AAFP chapters to promote and provide financial aid to support student attendance. We believe the findings from the University of South Dakota study titled, "Promoting Student Interest in Family Medicine Through National Conference Attendance," published in PRiMER, STFM's open access scholarly journal, has helped departments and chapters to further support sending medical students to the meeting. In addition, AAFP promotion has been increased to attract more MS1 and MS2 medical students.

25 X 2030 Collaborative Kickoff Event

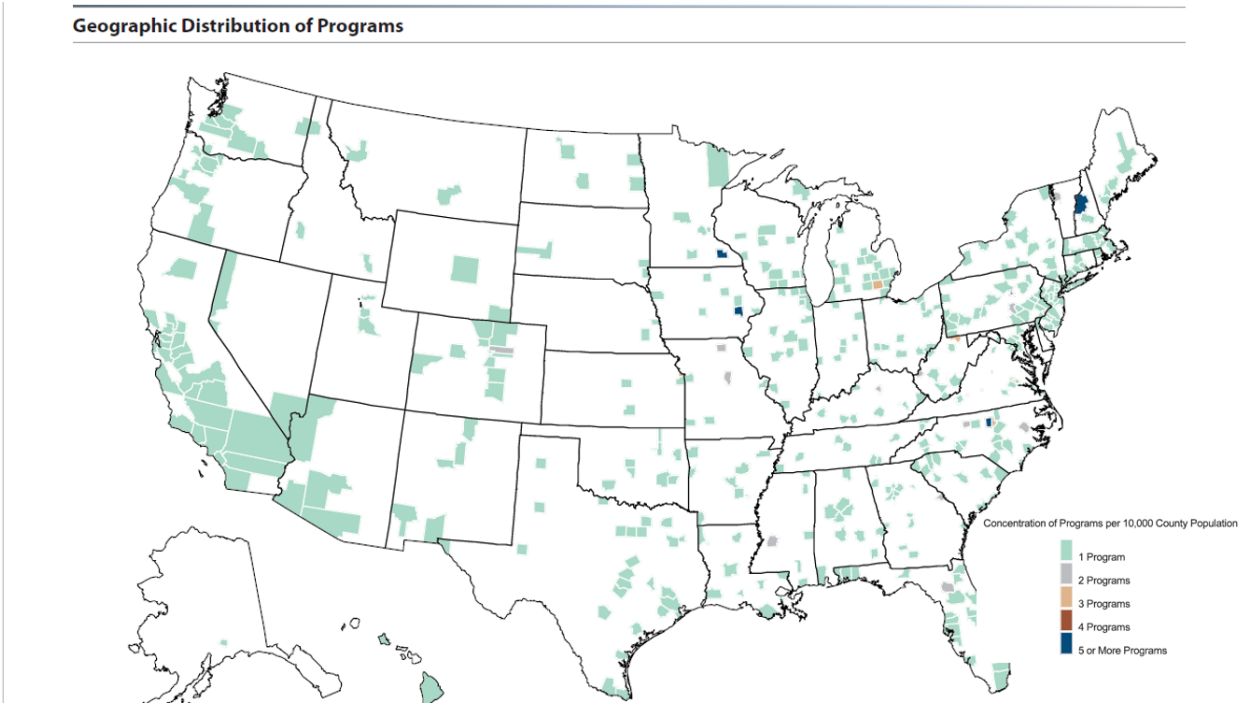
On August 30 and 31, the AAFP will host staff and members from each of the family medicine organizations to kick off the collaborative and coordination of efforts to take bold steps to increase

student choice of family medicine. This collaborative kickoff will lead to efforts that further address the four key drivers of student choice: Pipeline, Process of Medical Education, Practice Transformation, and Payment Reform (and the brand of Family Medicine). One of the first projects the collaborative will work on together is to create the infrastructure to support the Student Choice Learning an Action Network – leveraging the concepts of positive deviance, data to inform and guide improvement and a bias toward action.

Residency Education

The AAFP was invited to participate as an external consultant to the ACGME Work Group on Accreditation for Medically Underserved Areas for its meeting in June 2018. Lead by Kevin Weiss, ACGME Senior Vice President of Institutional Accreditation, the workgroup is charged with constructing an accreditation framework to overcome challenges of starting and sustaining residency programs in rural and urban underserved communities. The AAFP was represented by Jay Fetter from the AAFP Division of Medical Education.

The workgroup presented this map to show the distribution of residencies in the US:



AAFP TASK FORCE ON BOARD CERTIFICATION IN FAMILY MEDICINE

The AAFP continues to work to support our members in addressing their expressed frustrations with the administrative burden and perceived lack of value of the present requirements for Family Medicine Certification, also known as Maintenance of Certification (MOC) or Continuing Board Certification (CBC). In July 2017, the AAFP Board of Directors formed a Task Force on Board Certification in Family Medicine. The Task Force, chaired by President-Elect John Cullen, MD, met in

December 2017 and January 2018. It then submitted five recommendations along with a report on continuing board certification to the AAFP Board of Directors for consideration and action at the April 2018 Board meeting.

The five AAFP Board approved actions are:

1. Adopted a new policy titled "Professional Self-Regulation, Competence, and Certification" that was drafted by the Commission on Continuing Professional Development (COCPD) in 2017 and further refined by the Task Force.
2. Adopted new guidelines titled "Guiding Principles for the Evaluation of Family Medicine Specialty Certifying Boards" that were drafted by the Commission on Continuing Professional Development (COCPD) in 2017 and further refined by the Task Force.
3. That the AAFP begin preliminary evaluation and background for the establishment of a certifying body that would address the needs of our members.
4. That the AAFP identify additional ways to communicate members' concerns regarding continuing board certification.
5. That the AAFP and ABFM work together to recognize that physicians and patients are key stakeholders in the certification process. The common vision should minimize physician burden, improve quality of care, and further the specialty of family medicine. This collaborative work will include discussions about improvements to the continuing board certification process (including alternatives to the proctored exam) as well as AAFP sponsored CME that would qualify for continuing board certification.

In September 2017, the American Board of Medical Specialties (ABMS) convened a Vision Commission to "vision a system of continuing board certification that is meaningful, relevant and of value, while remaining responsive to the patients, hospitals and others who expect that physician specialists are maintaining their knowledge and skills to provide quality specialty care." In February through May 2018, the Vision Commission invited stakeholders to complete an online survey. The AAFP undertook several actions to encourage AAFP members to complete that survey.

The AAFP Board of Directors remains firmly committed to the principles of lifelong learning, continuing professional development, clinical expertise of the health-care workforce, and professional self-regulation, including assessment mechanisms to assure the public that the care they receive is evidence-based and high quality. The AAFP is also committed – by policy and in practice – to advocate that assessment mechanisms, such as those utilized in continuing board certification programs (also known as Maintenance of Certification or Family Medicine Certification) be evaluated and enhanced to maximize their relevance and minimize their cost. We remain committed to advocating for the appropriate use of board certification as only one component of professional self-regulation rather than an absolute requirement in the determination of clinical privileges, credentialing, licensure, payment, and employment.

GUN VIOLENCE

As we know, gun violence in the US is a public health epidemic. Using comprehensive, interdisciplinary approaches, and working in collaboration with other public health professionals, family physicians can play an imperative role in the reduction of gun violence. In April 2018, the AAFP Board of Directors approved a position paper entitled, "Prevention of Gun Violence." https://www.aafp.org/about/policies/all/gun-violence.html

AAFP CENTER FOR DIVERSITY AND HEALTH EQUITY (CDHE) EveryONE PROJECT

The EveryONE Project's Social Determinants of Health Toolkit will be complete and launched at this year's AAFP FMX. Resources currently available include:

- Guide to Social Needs Screening Tool and Resources, https://www.aafp.org/patient-care/social-determinants-of-health/everyone-project/tools.html#patients/

- Addressing Social Determinants of Health in Primary Care: Team-Based Approach for Advancing Health Equity, https://www.aafp.org/dam/AAFP/documents/patient_care/everyone_project/team-based-approach.pdf

The AAFP Neighborhood Navigator tool is currently in final stages of beta testing. This robust tool can be used at the point-of-care to connect patients with community resources. Additional information is being added to the toolkit regarding community advocacy and engagement.

The EveryONE Project website is being updated and will be more user-friendly for locating and utilizing tools and resources. The current website can be found at: https://www.aafp.org/patient-care/social-determinants-of-health/everyone-project.html?cmpid=everyone_hp_hops_cfd_col_fmx

As payment remains a key question, the AAFP developed the following policy: Advancing Health Equity: Principles to Address the Social Determinants of Health in Alternative Payment Models https://www.aafp.org/about/policies/all/socialdeterminants-paymentmodels.html

The AAFP hosted a Health Equity Roundtable on May 30, in Washington DC with 20 organizations in attendance, providing input on the role of family physicians advancing health equity and greatly increasing collaboration with external organizations. The learnings are being incorporated in a comprehensive strategic planning process to determine a strategic plan for the CDHE for the next three-to-five years.

CDHE is partnering with CAFM on a project supported by FMAHealth to implement tools developed by CAFM to support faculty leadership development by women and underrepresented minorities. CDHE is also working with the FMAHealth Health Equity Tactic team with an in-person meeting occurring in April 2018 to coordinate efforts and plan collaboration. CDHE surveyed state chapters of the AAFP for input on their needs and is developing resources that can be used at the chapter level including a speakers' bureau and slide sets.

CDHE has established the Family Medicine Health Equity Advisory Team (FM HEAT) with representation of staff from all the family medicine organizations. Quarterly meetings are planned. FMHEAT serves as the coordination group to foster collaboration and align health equity efforts of the family medicine organizations.

GLOBAL HEALTH SUMMIT

The 2018 AAFP Global Health Summit (previously known as workshop) will be held in Jacksonville, Florida, September 13-15, 2018, with a preconference on September 12.

https://www.aafp.org/events/global-health.html. This is the 15th year of the summit and is the place to network, learn and train with current and global health advocates.

Of special note in 2019, the Summit will be held in Albuquerque, New Mexico, October 10-12, 2019 with the Wonca Rural Health Conference in the same location, October 11-15, 2019. http://www.globalfamilydoctor.com/Conferences/WorldRuralhealthconference.aspx