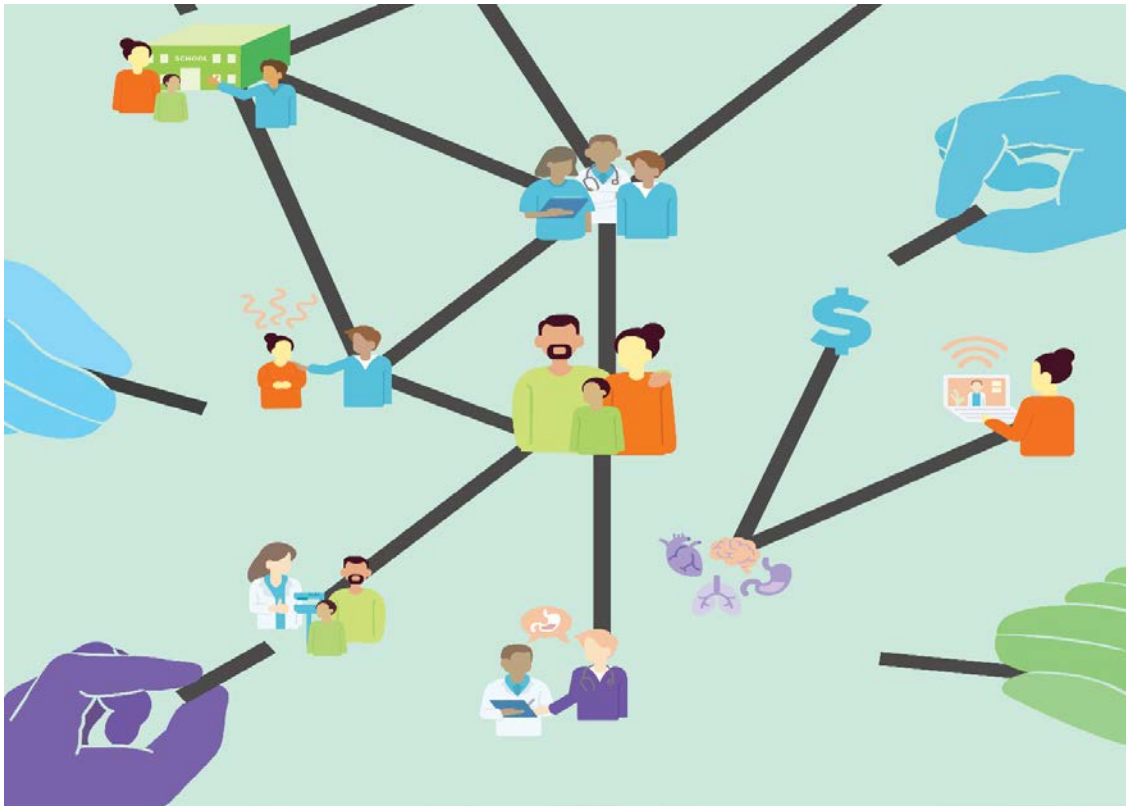


The National Academies of Sciences, Engineering, and Medicine

Strengthening Primary Health Care: A Webinar

March 22-23, 2022 | 10:00 AM - 1:00 PM EST



Link for public to view webinar:

<https://nasem.zoom.us/j/92099231019?pwd=cmFINlhpMENqa3B6MXlvOGxIUlpFUT09>

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Webcast Information for Attendees

Strengthening Primary Health Care: A Webinar

Joining the Webinar

Live Webstream on March 22-23, 2022; 10:00 AM - 1:00 PM EST:

<https://nasem.zoom.us/j/92099231019?pwd=cmFINlhpMENqa3B6MXlvOGxIUlpFUT09>

- We welcome your active participation and input in the webinar.
- Please submit any questions via the “Q&A” function, and include your name and affiliation.
- This webinar is being webcast and recorded. The webcast and presentation files will be archived on the project webpage.
- Also, please note that all biosketches of today’s speakers are available on the project website.
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Strengthening Primary Health Care: A Webinar

March 22, 2022
10:00am– 1:00pm Eastern Time Zone

Primary Health Care: Defining, Measuring, and Strengthening

10:00 am	Welcome from the National Academies of Sciences, Engineering, and Medicine - Robert L. Phillips, Co-chair, NASEM Committee on Implementing High-Quality Primary Care - Victor J. Dzau, President, National Academy of Medicine
10:10 am	Welcome from the Office of the Assistant Secretary for Health Admiral Rachel L. Levine, Assistant Secretary for Health, Department of Health and Human Services
10:15 am	Plenary 1: What is the Desired Model of Primary Health Care? Moderator: - Robert L. Phillips, Co-chair, NASEM Committee on Implementing High-Quality Primary Care Panelists - Maret Felzien, Patient Advocate - James Mold, University of Oklahoma Health Sciences Center - Lloyd Michener, Duke School of Medicine; UNC Gillings School of Global Public Health - Kameron Leigh Matthews, Cityblock Health Q&A with Speakers
11:10 am	Panel 1: How Do We Measure Primary Health Care for Value, Impact, and Investment? Moderator: Kevin Grumbach, University of California, San Francisco Panelists - Rebecca S. Etz, Virginia Commonwealth University School of Medicine - Jack Westfall, Robert Graham Center - Christopher Koller, Milbank Memorial Fund Q&A with Panelists
11:55 am	Break
12:00 pm	Panel 2: What Innovations Could the Federal Government Consider to Strengthen Primary Health Care? Moderator: Melinda Abrams, Commonwealth Fund Panelists - Robert A. Berenson, Urban Institute - Louise Cohen, Primary Care Development Corporation - Patricia (Polly) Pittman, George Washington University - Margaret Flinter, Weitzman Institute Q&A with Panelists

12:55 pm	Closing Remarks Judith Steinberg, Office of the Assistant Secretary for Health
1:00 pm	Adjourn
March 23, 2022 10:00am– 1:00pm Eastern Time Zone State, Territory, Tribal Nation Exemplars, and Partnerships	
10:00 am	Welcome Robert L. Phillips, Co-chair, NASEM Committee on Implementing High-Quality Primary Care
10:05 am	Plenary 2: What are Successful State Innovations? Moderator: Shannon McDevitt, Health Resources and Services Administration, Office of the Assistant Secretary for Health (on detail) Panelists - Howard Haft, Maryland Department of Health - Kathryn E. Phillips, California Health Care Foundation
10:25 am	Panel 3: What Activities are Advancing Health Outcomes, Access, and Equity through Primary Health Care Strengthening in States, Territories, and Tribal Nations? Moderator: Asaf Bitton, Brigham and Women's Hospital; Harvard Medical School Panelists - Neelam Gupta, Oregon Health Authority - Christina Severin, Community Care Cooperative - Crystal Eubanks, Purchaser Business Group on Health - Douglas Eby, Southcentral Foundation Q&A with Panelists
11:15 am	Break
11:20 am	Panel 4: How Can State-Federal Partnerships Improve Health Outcomes, Access, and Equity by Strengthening Primary Health Care? Moderator: Lauren Hughes, University of Colorado Anschutz Medical Campus Panelists - Dominic Hugo Mack, National Center for Primary Care, Morehouse School of Medicine - Kathryn King Cristaldi, Medical University of South Carolina - William (Bill) Burman, Denver Health System - Kelly Hughes, National Conference of State Legislatures Q&A with Panelists
12:10 pm	Panel 5: What Changes are Needed to Support Health Professionals' and Communities' Engagement in Strengthening Primary Health Care? Moderator: Ann Greiner, Primary Care Collaborative Panelists - Shari M. Erickson, American College of Physicians - Brandon G. Wilson, Community Catalyst

	Q&A with Panelists
12:40 pm	Plenary 3: How Can the Department of Health and Human Services Respond to the Challenge? • <i>Andrea Palm, Deputy Secretary, Department of Health and Human Services</i>
12:50 pm	Closing Remarks: Office of the Assistant Secretary for Health Primary Health Care Team • <i>Judith Steinberg, Office of the Assistant Secretary for Health</i>
12:55 pm	Closing Remarks: National Academies of Sciences, Engineering, and Medicine • <i>Robert L. Phillips, Co-chair, NASEM Committee on Implementing High-Quality Primary Care</i>
1:00 pm	Adjourn

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Featured Speakers and Moderators

Melinda K. Abrams, MS

Commonwealth Fund

Melinda K. Abrams, MS, is Executive Vice President for programs at the Commonwealth Fund, where she has responsibility for the development and management of the Fund's grant programs. Since coming to the Fund in 1997, Ms. Abrams has worked on the Fund's Task Force on Academic Health Centers, the Child Development and Preventive Care program, led the Patient-Centered Coordinated Care Program, and most recently was the senior vice president of the Delivery System Reform and International Health Policy programs. Ms. Abrams has served on many national committees and boards for private organizations and federal agencies and is a peer-reviewer for several journals. Ms. Abrams was the recipient of a Champion Award from the Primary Care Development Corporation and a Primary Care Community/Research Leadership Award from the Patient-Centered Primary Care Collaborative. Ms. Abrams holds a B.A. in history from Cornell University and an M.S. in health policy and management from the Harvard School of Public Health.

Robert A. Berenson, MD

Urban Institute

Robert A. Berenson, MD, is an institute fellow at the Urban Institute. From 1998 to 2000, he directed Medicare payment policy and private plan contracting at the Centers for Medicare and Medicaid Services. In the Carter Administration, he served as an assistant director of the Domestic Policy Staff. He was vice chair of the Medicare Payment Advisory Commission and an initial member of the Physician-Focused Payment Model Technical Advisory Committee, created by the Medicare Access and CHIP Reauthorization Act of 2015. He publishes widely in peer review journals, focusing on the issues of payment reform, consolidation and high prices in hospital markets, and Medicare issues, generally. He received an M.D. from Mount Sinai School of Medicine and practiced general internal medicine in Washington, DC, prior to starting his policy career.

Asaf Bitton, MD, MPH

Brigham and Women's Hospital; Harvard T.H. Chan School of Public Health

Asaf Bitton, MD, MPH, is the Executive Director of Ariadne Labs, a health systems innovation center at Brigham and Women's Hospital and the Harvard T.H. Chan School of Public Health. He is an Associate Professor of Medicine and Health Care Policy at both Harvard Medical School and the Harvard T.H. Chan School of Public Health.

A globally-recognized leader in health systems innovation, he leads Ariadne Labs' efforts to design, test, and spread scalable systems-level solutions that improve health care processes, enhance purposeful interactions between patients and their providers, and impact populations at scale. As a practicing primary care physician and expert in primary health care policy, financing, and delivery, he has served as a senior advisor for primary care policy at the Center for Medicare and Medicaid Innovation since 2012. He has helped design and test three major comprehensive primary care payment and delivery initiatives, representing the largest tests of combined primary care payment and clinical practice transformation work in the United States. He currently serves on the Center for Strategic and International Studies Bipartisan Commission on Strengthening America's Health Security, the National Advisory Council for Healthcare Research at the Agency for Healthcare Research and Quality in the U.S., and is an elected member of the International Academy of Quality and Safety. He previously served as director of Ariadne Labs' Primary Health Care Program, leading primary care measurement and improvement initiatives in Central America, Sub-Saharan Africa, and

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Eastern Europe along with previous work at the Harvard Medical School Center for Primary Care directing regional primary care practice learning collaboratives in Massachusetts. He is a core founder and steering committee member of the Primary Health Care Performance Initiative, a partnership that includes more than 20 countries and the World Bank, the World Health Organization, UNICEF, The Global Fund, and Bill & Melinda Gates Foundation dedicated to improving the global provision of primary health care. Dr. Bitton practices primary care at Brigham and Women's South Huntington clinic, a team-based community primary care practice in Boston that he helped found in 2011.

William (Bill) Burman, MD

Public Health Institute at Denver Health

Bill Burman, MD, is a primary care provider for persons with HIV and the former Executive Director of the Public Health Institute at Denver Health. One of the primary strategies used during the 11 years he led the Institute was to develop strong collaborations with the primary care and behavioral care agencies in Denver, particularly Denver Health's Family Medical Centers and School-Based Health Centers. These collaborations were very effective on a range of shared health priorities including tobacco cessation, childhood obesity prevention, and vaccination.

Louise Cohen, MPH

Primary Care Development Corporation

Louise Cohen is the Chief Executive Officer of the Primary Care Development Corporation (PCDC), a not-for-profit community development financial institution dedicated to catalyzing excellence in primary care through strategic community investment, capacity building and advocacy to achieve health equity in disinvested communities. PCDC provides capital and technical assistance to a wide variety of primary care providers, and advocates for improved and increased primary care access, capacity, quality, reimbursement, capital resources, and integration with behavioral health to improve health outcomes, create healthier communities, increase health equity, and reduce overall health care system costs. Prior to assuming leadership of PCDC, she was Vice President for Public Health Programs at one of the nation's largest public health institutes, where she oversaw programs to improve community health through food access and nutrition, women's reproductive health, tobacco control, and child development. Ms. Cohen held successive leadership positions at the New York City Department of Health and Mental Hygiene from 1998-2011 where she led the *Take Care New York*, New York City's first comprehensive health policy agenda, and the Primary Care Information Project, which brought a public health and prevention-oriented ambulatory care electronic health record system to more than 2,500 primary care providers.

Victor J. Dzau, MD

National Academy of Medicine

Victor J. Dzau, MD, is the President of the National Academy of Medicine (NAM), formerly the Institute of Medicine (IOM). In addition, he serves as Vice Chair of the National Research Council. Dr. Dzau is Chancellor Emeritus and James B. Duke Distinguished Professor of Medicine at Duke University and the past President and CEO of the Duke University Health System. Previously, Dr. Dzau was the Hershey Professor of Theory and Practice of Medicine and Chairman of Medicine at Harvard Medical School's Brigham and Women's Hospital, as well as Bloomfield Professor and Chairman of the Department of Medicine at Stanford University.

Douglas Eby, MD, MPH, CPE

Southcentral Foundation

Douglas Eby, MD, MPH, CPE, is a Physician Executive who has worked in support of Alaska Native people for nearly 30 years as they completely redesigned an entire healthcare system around customer-ownership and powerful personal relationships. Southcentral Foundation (SCF) employs nearly 3000 people providing a very wide range of community and

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medical services across southern Alaska and co-manages a medical campus (Alaska Native Medical Center – ANMC) that includes a tertiary hub hospital, along with the full range of medical services. The SCF Nuka System of Care is the only two time healthcare recipient of the national US Presidential Baldrige Award for Excellence – and is sought after by healthcare systems from all over the world for the impressive work done primarily in population health and the complete redesign of Primary Care, Maternal Child Health, Behavioral Health and other community and population based services. He has been faculty for the Institute for Healthcare Improvement for over 25 years and presents nationally and internationally on a range of topics.

Shari M. Erickson, MPH American College of Physicians

Shari M. Erickson, MPH, currently serves as Chief Advocacy Officer and Senior Vice President of Governmental Affairs and Public Policy with the American College of Physicians (ACP). In this role, Ms. Erickson oversees the operations of the Washington, DC office and manages ACP's overall advocacy and policy initiatives relating to Congress and federal regulatory agencies, including the Department of Health and Human Services (HHS), Centers for Medicare and Medicaid Services (CMS), CMS' Center for Medicare and Medicaid Innovation (CMMI), and other federal bodies. Ms. Erickson also oversees ACP's Department of Medical Practice, which is responsible for the ongoing development and maintenance of programs, products, tools, and services to assist medical practices with regulatory compliance and practice transformation. In addition, Ms. Erickson currently serves as Co-Chair of the Primary Care Collaborative's (PCC) Public Policy and Advocacy Workgroup. Before coming to ACP, Ms. Erickson was a Senior Program Director with the National Quality Forum (NQF) in Washington, D.C. where she was responsible for managing an array of projects that support NQF's national strategy for health care quality measurement and reporting. Ms. Erickson received her Master of Public Health degree from the Johns Hopkins Bloomberg School of Public Health and her Bachelor of Arts and Bachelor of Arts-International Studies degrees from Miami University in Ohio.

Rebecca S. Etz, PhD Virginia Commonwealth University

Rebecca S. Etz, PhD, is a Professor of Family Medicine and Population Health at Virginia Commonwealth University (VCU), and Co-Director of the Larry A. Green Center - Advancing Primary Health Care for the Public Good. Dr. Etz has deep expertise in primary care measures, practice transformation, and engaging stakeholders. As faculty at VCU, and previous co-director of the Ambulatory Care Outcomes Research Network, Dr. Etz has been the Principal Investigator of several federal and foundation grants, contracts and pilots, all directed towards making the pursuit of health a humane experience. Dr. Etz leads the Quick COVID-19 survey series regarding the response to and impact of COVID-19 on US primary care practices. This is the only national resource of its kind, and has also been fielded in New Zealand, Australia, and Canada. Dr. Etz led the team and development of the Person-Centered Primary Care Measure, also the first of its kind in the US. The PCPCM has since been translated into 30 languages and piloted in 7 other countries. Most recently she served on the National Academies of Medicine consensus study, *Implementing High Quality Primary Care*.

Crystal Eubanks, MSC Purchaser Business Group on Health

Crystal Eubanks, MSC, is Senior Director of Care Redesign at the Purchaser Business Group on Health (PBGH). She advances strategy and program design and execution, partner engagement and business development within PBGH's Care Redesign and California Quality Collaborative (CQC) programs. She also leads CQC's technical body of work for behavioral health integration and guides technical assistance for provider organizations participating in CQC improvement collaboratives. Prior to this role, Crystal advised and trained health care delivery organizations, their improvement teams and practice coaches in CQC's Transforming Clinical Practice Initiative from 2016 to 2019. She brings quality improvement, clinic operations and leadership experience from on-the-ground work with

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ambulatory/primary care delivery systems. Crystal earned a Master of Science in Healthcare Quality from the George Washington University School of Medicine and Health Sciences.

Maret Felzien, MA

Patient Advocate

Maret Felzien, MA, is a native to northeastern Colorado and recently retired from a long career working to support underserved and underprepared students at the local 2-year college. Currently assist with the daily operations of Felzien Farms, the family dry-land farm and cattle ranch. She became involved with community engagement and Community-based Practice Research nearly 20 years ago through work with High Plains Research Network (HPRN) and the Community Advisory Council. This group informs, advises, and co-creates health research to strengthen primary care across rural eastern Colorado. The research conducted in these rural communities has been fun, meaningful, and successful, and most importantly, has shown positive impact on the health of the communities. Her community engagement work and advocacy has grown from this experience to include work with North American Primary Care Research Group and The Robert Graham Center among others; she continually collaborates on research teams and with projects as a patient/community voice or leader, an advocate, and even sometimes as a co-investigator.

Margaret Flinter, PhD

Community Health Center, Inc.

Margaret Flinter, PhD, is the Senior Vice President and Clinical Director of the Community Health Center, Inc. (CHCI). A family nurse practitioner by training, she has held progressive roles in the organization as both clinician and executive leader. In 2005, she founded CHCI's Weitzman Center (now the Weitzman Institute) as the research and development arm of CHCI and she serves as Senior Faculty of the Institute. She has authored numerous publications focused on advancing primary care, has served as national co-director of the LEAP project, and serves as Chair of the National Nurse Practitioner Residency and Fellowship Training Consortium. Margaret received her BSN from the University of Connecticut, her MSN from Yale University, and her PhD at the University of Connecticut. She is a fellow of both the American Academy of Nursing and the American Academy of Nurse Practitioners, and a former National Health Service Corps Scholar.

Ann Greiner, MCP

Primary Care Collaborative

Ann Greiner, MCP, serves as President and Chief Executive Officer of the Primary Care Collaborative. In this role, she is responsible for leading the overall organizational strategy and fostering strategic partnerships throughout the health care sector nationally. At a critical time in U.S. health policy, Ms. Greiner directs the PCC's policy agenda, working across a diverse stakeholder group of more than 60 executive member organizations to advance an effective and efficient health care system built on a strong foundation of primary care and the patient-centered medical home (PCMH). The PCC's membership includes a broad group of public and private organizations, including payers, providers, non-profits and leading corporations. Working with this membership and the PCC Board, Ms. Greiner is focused on defining and implementing an advocacy, research and education agenda that furthers comprehensive, team-based and patient-centered primary care. Ms. Greiner has dedicated her entire career to advancing the quality of U.S. health and health care. She has more than 25 years of experience, including senior-level positions at prestigious national not-for-profit organizations. Prior to leading the PCC, she served as Vice President of Public Affairs for the National Quality Forum where she increased the visibility and influence of NQF on Capitol Hill. Before working at NQF, Ms. Greiner held high-profile policy, research, and public affairs roles at the American Board of Internal Medicine, the National Academy of Medicine and the National Committee for Quality Assurance (NCQA). In these roles, she pioneered research to help the field and the public understand the extent of the U.S. health care quality problem, helped spearhead the publishing of some of the first-ever quality ratings in health care, and led an effort to integrate the physician certifying

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boards into the CMS accountability framework. Ms. Greiner has a Master's Degree in Urban Planning from the Massachusetts Institute of Technology and a Bachelor of Arts Degree in English Literature from Hobart and William Smith Colleges.

Kevin Grumbach, MD

University of California, San Francisco

Kevin Grumbach, MD, is the Hellman Endowed Professor of Family and Community Medicine and Chair of the Department of Family and Community Medicine at the University of California, San Francisco. He is a Founding Director of the UCSF Center for Excellence in Primary Care and Director of the Community Engagement Program for the UCSF Clinical and Translational Science Institute. He served as Vice President for Population Health for the UCSF Health system from 2015-2018. His research and scholarship on the primary care workforce, innovations in the delivery of primary care, racial and ethnic diversity in the health professions, and community health improvement have widely influenced policy and practice. With Tom Bodenheimer, he co-authored the best-selling textbook on health policy, *Understanding Health Policy - A Clinical Approach*, now in its 8th edition, and the book, *Improving Primary Care – Strategies and Tools for a Better Practice*, published by McGraw Hill. He received a Generalist Physician Faculty Scholar award from the Robert Wood Johnson Foundation, the Health Resources and Services Administration Award for Health Workforce Research on Diversity, the Richard E. Cone Award for Excellence and Leadership in Cultivating Community Partnerships in Higher Education, and the UCSF Chancellor's Public Service Award, and is a member of the National Academy of Medicine.

Neelam Gupta, MPH, MSW

Oregon Health Authority

Neelam Gupta, MPH, MSW, is the Director of the Clinical Supports, Integration, and Workforce Unit at the Oregon Health Authority. She possesses over 20 years of experience as a strategic health care leader in advancing health equity in cross-sector initiatives for Medicaid and safety-net populations. Prior to joining the Oregon Health Authority, Neelam managed and evaluated patient-centered, integrated models of care to promote systems transformation in Los Angeles County and nationally. Her career spans leading programs at a philanthropic foundation, a Medicaid managed care plan, a workforce development agency, a health care apprenticeship center, and a community clinic association. Neelam earned Masters' degrees in Public Health and in Social Welfare from the University of California, Los Angeles.

Howard Haft, MD, MMM, CPE, FACPE

Maryland Department of Health

Howard Haft, MD, MMM, CPE, FACPE, was appointed by Governor Larry Hogan to serve as Deputy Secretary for Public Health Services in the Maryland Department of Health in 2015. Since that time he has also served as the interim Executive Director of the Maryland Health Benefit Exchange as the Executive Director of the Maryland Primary Care program and most recently as Senior Medical Advisor to the Department. During the COVID-19 pandemic, he served as the Senior Medical Planner for the Unified Command and lead on the Vulnerable Populations Task Force and COVID-19 Therapeutics program. Dr. Haft has been licensed to practice medicine since 1974. He received his undergraduate degree at the University of Rhode Island, attended Medical School at Pennsylvania State University, and completed post-graduate Internship and Residencies at Brown University and a Master's degree from Tulane University School of Public Health and Tropical Medicine. Dr. Haft is Board Certified as a specialist in both Internal Medicine and Emergency Medicine. Following his residency at Brown, he held an academic position at the University of California, Davis as an Assistant Professor in the Departments of Medicine and Psychiatry. He is recognized by the American Board of Physician Executives as a Certified Physician Executive (CPE) and as a Fellow of the ACPE. He served as an Adjunct Professor in the McDonough Graduate School of Business and as Assistant Clinical Professor of Medicine at Georgetown University School of Medicine. Dr. Haft was the Founder and the Chief Medical Officer of Conmed Healthcare Management, a

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publically traded company. He served as the President of Maryland Healthcare, a multispecialty clinic in Southern Maryland, as President of the Maryland Foundation for Quality Healthcare, and as Medical Director of Health Partners, Inc. Dr. Haft has also served as Chief Executive Officer of the Ellis Medical Group in New York. Dr. Haft provided emergency medical care for disasters including Hurricane Katrina, the Haitian earthquake, and in remote Caribbean locations. Dr Haft's career has been dedicated to solving complex medical care delivery challenges and implementing programs to serve diverse populations in Maryland and across the Nation.

Kelly Hughes, MPH NCSL

Kelly Hughes, MPH, oversees staff and projects related to health access, costs and coverage policy issues at NCSL. Ms. Hughes brings nearly two decades of professional experience in federal and state government, non-profit, research and health care settings. A graduate of CDC's Public Health Prevention Service fellowship, she also earned her Bachelor of Science from Virginia Polytechnic Institute and State University and Master of Public Health from Emory University.

Lauren Hughes, MD, MPH, MSC, FAAFP University of Colorado School of Medicine

Lauren Hughes, MD, MPH, MSC, FAAFP, is Associate Professor of Family Medicine in the University of Colorado School of Medicine and the State Policy Director of the Eugene S. Farley, Jr. Health Policy Center. In these roles, she leads initiatives to generate and/or translate data for policymakers to inform the design and implementation of evidence-based policy. Her research interests include strengthening rural health care, the future of primary care and public health post COVID-19, and new payment and delivery models that address social determinants of health. Dr. Hughes previously served as Deputy Secretary for Health Innovation in the Pennsylvania Department of Health, where she co-designed and launched the Pennsylvania Rural Health Model, a new payment and delivery model that transitions rural hospitals from fee-for-service to multi-payer global budgets and transforms how they deliver care to better meet community health needs. Dr. Hughes serves on the American Board of Family Medicine, the Rural Health Redesign Center Organization, and the American Medical Student Association Foundation Boards of Directors. She has been a visiting scholar at the CMS Innovation Center, the Commonwealth Fund, and ABC News Medical Unit. She earned her MD from the University of Iowa, her MPH in health policy from The George Washington University, and her master's in health and health care research from the University of Michigan as part of the Robert Wood Johnson Foundation Clinical Scholars Program. She is currently pursuing a master's degree in health care delivery science from Dartmouth College. She completed her family medicine residency at the University of Washington in the Harborview Hospital track. In 2018, she was named a Presidential Leadership Scholar by Presidents Bill Clinton and George W. Bush. In 2021, she was elected Chair-Elect of the American Board of Family Medicine and appointed to the National Academies of Science, Engineering, and Medicine Board on Health Care Services.

Kathryn King, MD, MHS Medical University of South Carolina

Kathryn King, MD, MHS, is the Associate Executive Medical Director for the Center for Telehealth and Associate Program Director for the National Telehealth Center of Excellence. Dr. King has a special interest in taking an innovative, population-based approach to extending the reach of traditional healthcare and directs programs that address population health at the Center for Telehealth. Dr. King began her career at MUSC's Center for Telehealth as the Medical Director for School-Based Health, growing this program from approximately 15 to over 100 schools over the last five years. She continues to direct this program along with a series of other programs that address population health such as Virtual Urgent Care, Remote Patient Monitoring, Institutional Health and Patient Outreach. Dr. King is responsible for overseeing the process of screening requests for telehealth funding from providers across the state and supports a system of telehealth development through the South Carolina Telehealth Alliance. She also works with state

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agencies, the South Carolina Board of Medical Examiners and policy makers to help enhance the widespread implementation of telehealth programming for South Carolina citizens. During the COVID-19 pandemic Dr. King took a lead role in overseeing the continuity of care between 4 major telehealth enabled programs that served the population of South Carolina. As the Associate Program Director for one of two federally designated Telehealth Centers of Excellence, Dr. King helps to lead a team of over 20 researchers who are conducting a rigorous scientific evaluation of a variety of telehealth programs to inform the national telehealth landscape. Dr. King attended medical school at the Medical College of Virginia, completed her pediatric residency training at the Medical University of South Carolina and a general academic fellowship at The Johns Hopkins University, earning a Masters of Health Science at The Johns Hopkins Bloomberg School of Public Health.

Christopher Koller, MA

Milbank Memorial Fund

Christopher Koller, MA, is President of the Milbank Memorial Fund, a 116-year operating foundation that improves population health by connecting leaders with the best information and experience. Before joining the Fund, he served the State of Rhode Island as the country's first health insurance commissioner, an appointment he held between 2005 and 2013. Under Mr. Koller's leadership, the Rhode Island Office of the Health Insurance Commissioner was nationally recognized for its rate review process and its efforts to use insurance regulation to promote payment reform, primary care revitalization, and delivery system transformation. The office was also one of the lead agencies in implementing the Affordable Care Act in Rhode Island. Prior to serving as health insurance commissioner, Mr. Koller was the CEO of Neighborhood Health Plan of Rhode Island for nine years. In this role, he was the founding chair of the Association of Community Affiliated Plans. Mr. Koller has a bachelor's degree (summa cum laude) from Dartmouth College and master's degrees in social ethics and public/private management from Yale University. He was a member of the National Academies' Health Care Services Board from 2014 to 2019 and has served on the Academies' Committees on Essential Health Benefits, Integrating Social Needs Care and Implementing High Quality Primary Care. He has also served in numerous national and state health policy advisory capacities. Mr. Koller is a Professor of the Practice in the Department of Health Services, Policy and Practice in the School of Public Health at Brown University.

Admiral Rachel L. Levine, MD

Admiral, U.S. Public Health Service

Assistant Secretary for Health

U.S. Department of Health and Human Services

Admiral Rachel L. Levine, MD, serves as the 17th Assistant Secretary for Health for the U.S. Department of Health and Human Services (HHS) and the head of the U.S. Public Health Service Commissioned Corps. She fights every day to improve the health and well-being of all Americans. She's working to help our nation overcome the COVID-19 pandemic and build a stronger foundation for a healthier future - one in which every American can attain their full health potential. ADM Levine's storied career, first, as a physician in academic medicine focused on the intersection between mental and physical health, treating children, adolescents, and young adults. Then as Pennsylvania's Physician General and later as Pennsylvania's Secretary of Health, she addressed COVID-19, the opioid crisis, behavioral health and other public health challenges.

Dominic Hugo Mack, MD, MBA

Morehouse School of Medicine

Dominic Hugo Mack, MD, MBA, is a Professor of Family Medicine at Morehouse School of Medicine (MSM) and serves as Director of the National Center for Primary Care (NCPC). Dr. Mack leads NCPC's promotion of health equity and population health through the development of strategies to further research, innovations and trainings that advance primary care systems. NCPC concentrates program development in four areas: Big Data Health Equity Research, Health

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Policy, Substance Use Prevention and Treatment, and Digital Health. He is the Principal Investigator (PI) and Director of the National COVID-19 Resiliency Network (NCRN), an Office of Minority Health cooperative agreement with MSM. Dr. Mack is also founding director of MSM's Georgia Health Connect (GaHC) Health Information Network (HIE), currently known as Hi-Bridge. Dr. Mack also serves as PI on several other domestic and global federally funded grants and cooperative agreements including the HRSA funded Zambia MSM/HBCU collaborative. He currently serves as the Board Chair of the GA Health Information Network (GHIN). Dr. Mack has practiced in Georgia for many years and served in various clinical and non-clinical health-related leadership roles within non-profit and for-profit organizations including many years of service in the US Federally Qualified Health Center system. He is dedicated to the improvement of business practices and the implementation of technological innovations in medical organizations that serve disproportionately impacted communities. Dr. Mack strives to develop national partnerships in rural and urban communities to implement equitable and sustainable community-based interventions for better health outcomes for all people.

Kameron Leigh Matthews, MD, JD, FAAFP

Cityblock Health

Kameron Leigh Matthews, MD, JD, FAAFP, is the Chief Health Officer of Cityblock Health, a transformative, value-based healthcare provider integrating medical, behavioral, and social services for Medicaid and dually eligible and low-income Medicare beneficiaries. A board-certified Family Physician, Dr. Matthews has focused her career on underserved and vulnerable communities, having held multiple leadership roles in correctional medicine, federally qualified health centers, and managed care. Most recently at the Veterans Health Administration, she led transformational efforts focused on integrated, Veteran-centered models of care including the implementation of the MISSION Act of 2018 and the EHR modernization effort. In addition to other non-profit and advisory board positions, she serves as the Vice-Chair of the board of directors of the National Quality Forum. As a passion outside of work, she founded and co-directs the Tour for Diversity in Medicine, an initiative seeking to bring premedical enrichment activities to underrepresented minority high school and undergraduate students across the country.

Shannon McDevitt, MD, MPH

U.S. Department of Health and Human Services

Shannon McDevitt, MD, MPH is a board certified family physician working to promote innovative and effective primary care. Dr. McDevitt is the Federal Partner Lead for the U.S. Department of Health and Human Services Initiative to Strengthen Primary Health Care, which will produce a federal foundation to optimize primary care nationally. She is also a physician in the Bureau of Primary Health Care at the Health Resources and Services Administration (HRSA), where she leads the conceptualization of how funding may be used to advance the Health Center Program, including the network of nearly 1,400 HRSA-supported health centers and the strategic technical assistance partners. Her work advances Administrative priorities, including a pivotal role in developing the Health Center Program response to COVID-19, HIV, the opioid epidemic, digital health, integrated practice models, and precision medicine. Dr. McDevitt is also a co-lead for the Healthy People 2030 Access to Health Services topic area workgroup. She applies her skills in relationship building, critical thinking, technical writing and reviewing, and group facilitation to each new challenge that she is presented. Dr. McDevitt received her Doctor of Medicine degree from Wayne State University School of Medicine and her Master in Public Health from the University of Pittsburgh. She completed family medicine residency training at Moses H. Cone Memorial Hospital and a faculty development fellowship at the University of Pittsburgh Medical Center-St. Margaret.

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J. Lloyd Michener, MD

Duke School of Medicine

J. Lloyd Michener, MD is a family physician who has long worked to link communities, health care and public health to achieve community health. His career has been based at Duke, where he has served as a family practice team leader, medical director, residency director, founder of the division of Community Health and the Duke Center for Community Research, and then Chair of the Department of Community and Family Medicine for more than twenty years. The Department partnered with multiple local organizations to co-design and manage community health and school programs and microclinics, and managed NC Medicaid for the surrounding counties, including its Medical Home program. He now serves as emeritus Professor of Family Medicine and Community Health, Duke School of Medicine; and Adjunct Professor, Public Health Leadership, UNC School of Public Health. Dr. Michener founded and leads the *Practical Playbook*, with the support of the de Beaumont Foundation, CDC and HRSA, helping link diverse communities across the US with health care and public health. He also serves as Chair of the Board of the Foundation for Health Leadership and Innovation, and is a member of the National Academies of Medicine Workgroup on Assessing Meaningful Community Engagement. Nationally, he has served as a member of the (then) Institute of Medicine Committee on Integrating Primary Care and Public Health; the founding Co-Chair of the Community Engagement Steering Committee for the Clinical and Translational Science Awards of the NIH; the NIH Council for Complementary and Alternative Medicine; the Board of Directors of the Association of Academic Medical Colleges; the National Academic Affiliations Advisory Council of the Department of Veterans Affairs; and as President of the Association for Prevention, Teaching and Research. His awards include the Mead Johnson Award from the AAFP and the Duncan Clark Award from APTR. Dr. Michener is a graduate of Oberlin College, Harvard Medical School, and family medicine residency and Kellogg fellowship at Duke.

James Mold, MD, MPH

University of Oklahoma

James Mold, MD, MPH, is a family physician, geriatrician, and practice-based researcher who has developed a person-centered conceptual framework for primary care called goal-oriented care, in which the clear and direct focus of care is on helping individuals clarify and achieve major health-relevant life goals (survival, quality of life, growth and development, and a good death). Dr. Mold received his undergraduate degree from the University of Michigan and his medical degree from Duke University School of Medicine. He completed a residency in Family Medicine at the University of Rochester/Highland Hospital, and a Master of Public Health Degree in Biostatistics at the University of Oklahoma Health Sciences Center. He practiced full-spectrum family medicine in a small town in N.C. before joining the faculty at the University of Oklahoma where he became a geriatrician and a practice-based researcher. In 1991 he proposed a new person-centered conceptual framework for primary care called goal-oriented care, which he has subsequently developed and described in presentations, journal articles, and two books. Since his retirement in 2014, he has served as a consultant to the Oklahoma Clinical and Translational Science Institute and to researchers at the University of North Carolina involved in the implementation of goal-oriented care. Dr. Mold lives in Chapel Hill, North Carolina. He has been a member of the National Academies since 2008.

Andrea Palm, MSW

Deputy Secretary, Department of Health and Human Services

Andrea Palm, MSW, is the Deputy Secretary of the Department of Health and Human Services (HHS). As Deputy Secretary, she is the Chief Operating Officer and is responsible for overseeing the day-to-day operations of the Department. Palm most recently served as Secretary-designee of the Department of Health Services (DHS), overseeing one of the largest state agencies in Wisconsin as a member of Governor Tony Evers' cabinet. In this role, she had responsibility for the state's Medicaid program, its Supplemental Nutrition Assistance Program (SNAP), and behavioral health programs, among others. DHS is also Wisconsin's public health agency, and as such, Palm led the state's response

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to the COVID-19 pandemic. Previously, Palm held a number of policy and operational roles in the Obama-Biden Administration at HHS, including Acting Assistant Secretary for Legislation, Counselor, Chief of Staff and Senior Counselor to the Secretary. During her eight-year tenure, she worked on a variety of Administration priorities, including the Affordable Care Act, as well as providing leadership for the Department's work to combat the opioid epidemic. Palm was born and raised in rural, upstate New York. She holds a Bachelor's degree from Cornell University and a Master's degree from Washington University in St. Louis.

Kathryn E. Phillips, MPH

California Health Care Foundation

Kathryn E. Phillips, MPH, is a Senior Program Officer for the California Health Care Foundation, a private philanthropic organization dedicated to advancing meaningful and measurable improvements in health and healthcare for low-income Californians and strengthening Medi-Cal – the nation's largest Medicaid program. Ms. Phillips leads the foundation's efforts to advance primary care, including modernizing payment for Federally Qualified Health Centers and public hospitals/health care systems, accelerating the adoption of integrated behavioral health, and increasing investment in primary care. She also supports the Foundation's Primary Care Workforce portfolio, including expanding Graduate Medical Education capacity. She is a managing partner of the California Improvement Network and a member of the California Quality Collaborative Executive Committee. Prior to joining CHCF in 2016, Ms. Phillips was the program director for practice transformation at Qualis Health, a quality improvement organization. There she directed regional and national quality improvement initiatives, including The Commonwealth Fund's landmark Safety Net Medical Home Initiative, which developed and tested an evidence-based framework to guide primary care redesign efforts; trained practice coaches in 5 states; and helped 65 primary care safety net sites improve quality, efficiency, and patient experience. Her portfolio also included initiatives to advance care integration and enhance the capacity of primary care practices to deliver behavioral health and oral health services. Ms. Phillips' experience also includes designing evidence-based purchasing guidelines and workplace health promotion programs for the Center for Prevention and Health Services at the National Business Group on Health, a nonprofit membership organization of Fortune 500 employers. She managed public-private partnerships to advance clinical preventive services, maternal and child health, and behavioral health. Ms. Phillips holds a master's degree in public health from the University of Michigan.

Robert L. Phillips, Jr., M.D., MSPH

Center for Professionalism and Value in Health Care

Robert L. Phillips, Jr., M.D., MSPH, is the founding Executive Director of the Center for Professionalism and Value in Health Care. Prior to that, from 2012 to 2018, he was Vice President for Research and Policy where he led the launch of a national primary care clinical registry and a Measures that Matter research and development program for primary care. He is a graduate of the Missouri University of Science and Technology (1990) and the University of Florida College of Medicine (1995) where he graduated with honors for special distinction. He completed training in family medicine at the University of Missouri in 1998, followed by a two-year fellowship in health services research and public health (MSPH, 2000). After fellowship, Dr. Phillips became assistant director of the Robert Graham Center, Washington DC, and from 2004-2012, he served as its Director. Dr. Phillips currently practices part-time in a community-based residency program in Fairfax, VA, and is Professor of Family Medicine at Georgetown University and Virginia Commonwealth University. He served on the American Medical Association's Council on Medical Education and as president of the National Residency Matching Program. A nationally recognized leader on primary care policy and health care reform, Dr. Phillips was elected to the National Academy of Medicine in 2010. He currently serves the NAM on the Membership Committee (Section 08 Chair) and the Action Collaborative on Clinician Well-Being and Resilience: Research, Data, and Metrics (Member). He previously served as NAM Membership Committee Section 08 Vice Chair and as a member of three consensus studies: Committee on Depression, Parenting Practices, and the Health Development of Young Children; Committee on Integrating Primary Care and Public Health; and, Committee on Assessing Progress on Implementing the Recommendations of the Institute of Medicine Report *The Future of Nursing: Leading Change*,

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Advancing. He has also served as a reviewer for several studies and is a frequent participant in NAM/NASEM Workshops and Round Tables. Dr. Phillips was also a member of the NAM Vital Directions writing committee in 2016. He was co-chair of the National Academies' Committee on Implementing High-Quality Primary Care that authored the consensus report, *Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care*.

Patricia (Polly) Pittman, PhD

George Washington University

Patricia (Polly) Pittman is the Fitzhugh Mullan Professor of Health Workforce Equity at the Milken Institute School of Public Health, George Washington University. As director of the Mullan Institute for Health Workforce Equity, Professor Pittman built an extensive research enterprise focusing on policies that enable the health workforce to better address health equity, including protection of labor rights of health workers. Her current portfolio includes directing two HRSA-supported Health Workforce Research Centers, as well as several foundation-supported grants. Trained in medical anthropology and public health, she works with interdisciplinary teams in mixed methods designs. She has published over 50 peer reviewed journal articles and has served as PI on over 40 research grants relating to health workforce policy. These most recently include a background paper commissioned by Robert Wood Johnson Foundation (RWJF) for the National Academies of Medicine Committee on Nursing 2020-2030. She teaches Advanced Health Policy Analysis and Health Workforce Policy.

Christina Severin, MPH

Community Care Cooperative

Christina Severin MPH, is a leading health care executive with more than 20 years of experience and numerous accomplishments in managed care, delivery systems, health insurance, Accountable Care Organizations, quality, public policy, and public health. She has led Community Care Cooperative (C3) since the organization's launch in 2016, leveraging the proven best practices of ACOs throughout the country, building the organization on the collective strengths of its health centers, and growing the organization to better serve MassHealth members throughout the commonwealth. Christina's prior leadership experience includes serving as President and Chief Executive Officer of Beth Israel Deaconess Care Organization and as President of Network Health, a nonprofit Massachusetts health plan. She earned a Master of Public Health with a concentration in Health Services from Boston University School of Public Health, and a Bachelor of Arts in Political Economy from the University of Massachusetts at Amherst.

Judith Steinberg, MD, MPH

U.S. Department of Health and Human Services

Judith Steinberg, MD, MPH, is a Senior Advisor to the Assistant Secretary for Health and lead for the Department of Health and Human Services Initiative to Strengthen Primary Health Care. Dr. Steinberg served as the CMO of the Bureau of Primary Health Care (BPHC), part of the Health Resources and Services Administration, which funds and administers the health center program. There she focused on integration of behavioral health and primary care as a response to the opioid crisis, clinician wellbeing, and improving the prevention and management of chronic diseases, utilizing a multidisciplinary team-based approach to care. She also served as Chief Medical Officer (CMO) of the Office of Infectious Disease and HIV/AIDS Policy (OIDP), part of the Office of the Assistant Secretary for Health. OIDP coordinates the Ending the HIV Epidemic in the U.S. initiative and the development and implementation of our national strategic plans for HIV, viral hepatitis, sexually transmitted infections, and vaccines. Advancing health equity and reducing health disparities are major areas of focus of these efforts. Before joining the federal government, Dr. Steinberg was Deputy CMO and Senior Director of the Office of Healthcare Innovation and Quality at the University of Massachusetts (UMass) Medical School's Commonwealth Medicine division. There Dr. Steinberg and her team supported MA health care reform, contributing to the design and implementation of new healthcare delivery and value-based payment models that included primary care transformation. Dr. Steinberg was an associate professor of medicine,

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and family medicine and community health at UMass Medical School and an assistant professor of medicine at Boston University School of Medicine. She earned her medical degree from the University of Texas, and completed a residency in internal medicine at Beth Israel Hospital in Boston, as well as an infectious disease fellowship at Beth Israel/Brigham and Women's Hospitals in Boston. She was a Commonwealth Fund/Harvard University fellow in minority health policy and received a master's degree in public health from Harvard University.

Jack Westfall, MD, MPH Robert Graham Center

Jack Westfall, MD, MPH, now serves as the Director of the Robert Graham Center which aims to create and curate evidence to inform policies that support primary care. He completed his MD and MPH at the University of Kansas School of Medicine, an internship in hospital medicine in Wichita, Kansas, and his Family Medicine Residency at the University of Colorado Rose Family Medicine Program. After joining the faculty at the University of Colorado Department of Family Medicine, Dr. Westfall started the High Plains Research Network, a geographic community and practice-based research network in rural and frontier Colorado. He practiced family medicine in several rural communities including Limon, Ft. Morgan, and his hometown of Yuma, Colorado. Dr. Westfall was on the faculty of the University of Colorado for over 20 years, including serving as Associate Dean for Rural Health, Director of Community Engagement for the Colorado Clinical Translational Science Institute, AHEC Director, and Senior Scholar at the Farley Health Policy Center. In 2019, he completed two years as the Medical Director for Whole Person Care and Health Communities at the Santa Clara County Health and Hospital and Public Health Department. His research interests include rural health, linking primary care and community health, and policies aimed at assuring a robust primary care workforce for rural, urban, and vulnerable communities.

Brandon G. Wilson, DrPH, MHA Community Catalyst

Brandon G. Wilson, DrPH, MHA, serves as Director of the Center for Consumer Engagement in Health Innovation at Community Catalyst. He joined Community Catalyst following his tenure in federal service as a Public Health Advisor with the Centers for Medicare and Medicaid Services (CMS) Office of Minority Health. He led the Office's efforts on sexual orientation and gender inclusion (SOGI) data collection, policy efforts in post-acute care settings, and social determinants of health. He effectively engaged with federal partners and other CMS stakeholders to advance health equity in regulations, payment policy, models, and demonstrations. He also directed a strategic portfolio designed to strengthen the business case for health equity. Brandon most recently received the CMS Impact Award from CMS Administrator Chiquita Brooks-LaSure for advancing health equity and accessibility in COVID-19 for persons living with disabilities. Prior to joining CMS Office of Minority Health, Brandon led portfolios in CMMI's Accountable Health Communities Model and the Health Care Innovation Awards. At CMMI, he spearheaded and led the Health Equity Working Group, which laid the foundation for CMMI's health equity focus in its strategy refresh. He also headed NIH/NIAD's recruitment and retention approaches for increasing minority screening and enrollment in preventative and therapeutic vaccine clinical trials and participation in NIAID's Community Advisory Board. Brandon also directed culture of patient safety quality improvement projects for the NIH Clinical Center Office of the Director. For his exceptional commitment and dedication in identifying a solution for a global infectious disease threat by advancing a malaria vaccine through a clinical trial, he received awards from NIH's Director, Dr. Francis Collins and NIAID's Director, Dr. Anthony Fauci. Dr. Wilson also brings a wealth of knowledge, skills, and abilities in HIV/AIDS advocacy, policy, and research from national policy organizations as the National Association of People with AIDS. Dr. Wilson completed his Master's in Health Systems Management at George Mason University in 2013 and his Doctor of Public Health at Morgan State University in 2020, where his dissertation was on culturally adapting NIH's PROMIS-29 health-related quality of life profile for and with Black Sexual and Gender Minorities living with HIV/AIDS in the US, using the Rash rating scale model for psychometric validation. He also holds a Health Sciences (Health Administration and Public Health) faculty appointment at Purdue University, where he's taught courses in health economics and policy, community health needs

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assessments, and healthcare marketing. His research interests include using patient-centered and indigenous models of care, health economics outcomes research, policy analysis, and community-based participatory and action research to eliminate health disparities and advance health equity in underserved and disinvested communities.



MAY 2021

Implementing High-Quality Primary Care Rebuilding the Foundation of Health Care

High-quality primary care is the foundation of a high-functioning health care system. When it is high-quality, primary care provides continuous, person-centered, relationship-based care that considers the needs and preferences of individuals, families, and communities. Without access to high-quality primary care, minor health problems can spiral into chronic disease, chronic disease management becomes difficult and uncoordinated, visits to emergency departments increase, preventive care lags, and health care spending soars to unsustainable levels.

Unequal access to primary care remains a concern, and the COVID-19 pandemic amplified pervasive economic, mental health, and social health disparities that ubiquitous, high-quality primary care might have reduced. Primary care is the only health care component where an increased supply is associated with better population health and more equitable outcomes. For this reason, **primary care is a common good**, which makes the strength and quality of the country's primary care services a public concern.

The National Academies of Sciences, Engineering, and Medicine formed the Committee on Implementing High-Quality Primary Care in 2019. Building on the recommendations of the 1996 Institute of Medicine report *Primary Care: America's Health in a New Era*, **the committee was tasked to develop an implementation plan for high-quality primary care in the United States.**

The committee's definition of high-quality primary care (see Box 1) describes what it *should be*, not what most people in the United States experience today. To rebuild a strong foundation for the U.S. health care system, **the committee's implementation plan includes objectives and actions targeting primary care stakeholders and balancing national needs for scalable solutions while allowing for adaptations to meet local needs.**

The committee set five implementation objectives to make high-quality primary care available to all people living in the United States:

1. Pay for primary care teams to care for people, not doctors to deliver services.
2. Ensure that high-quality primary care is available to every individual and family in every community.
3. Train primary care teams where people live and work.
4. Design information technology that serves the patient, family, and the interprofessional care team.
5. Ensure that high-quality primary care is implemented in the United States.



The committee's implementation plan—comprising recommended actions under each objective—calls for appropriately scaled actions by public- and private-sector actors at the macro, meso, and micro system levels (see the full report for details) and creates accountability structures. Below are the implementation objectives with summaries of the recommended actions to achieve them.

OBJECTIVE ONE: PAY FOR PRIMARY CARE TEAMS TO CARE FOR PEOPLE, NOT DOCTORS TO DELIVER SERVICES

- Payers¹ 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 (FFS) model should shift primary care payment toward hybrid (part FFS, part capitated) models, and make them the default over time.
- The Centers for Medicare & Medicaid Services (CMS) should increase the overall portion of spending going to primary care.
- States should implement primary care payment reform by facilitating multi-payer collaboration and by increasing the overall portion of health care spending in their state going to primary care.

Implementing high-quality primary care begins by committing to pay primary care more and differently because of its capacity to improve population health and health equity for all of society, not because it generates short-term returns on investment for payers. High-quality primary care is a common good promoted by responsible public policy and supported by private-sector action.

OBJECTIVE TWO: 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 non-responding enrollees to a source of care. When community health centers, hospitals, and primary care practices treat people who are uninsured, they should assume and document an ongoing clinical relationship with them.
- The U.S. Department of Health and Human Services (HHS) should target sustained investment in creating new health centers (including federally qualified health centers, 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 FFS and managed care access standards for primary care for Medicaid beneficiaries. CMS should also provide assistance to state Medicaid agencies for implementing and attaining these standards, and measure and publish state performance.
- CMS should permanently support the COVID-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.

The COVID-19 pandemic forced payers to enhance the ability of patients to access their primary care teams virtually by video and telephone. These forms of care provide many benefits and CMS should minimize the payment and regulatory barriers to their use. Efforts by primary care teams to build relationships with community organizations

BOX 1. WHAT IS HIGH-QUALITY PRIMARY CARE?

The provision of whole-person,* integrated, accessible, and equitable health care by interprofessional teams who 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.

* Whole-person health focuses on well-being rather than the absence of disease. It accounts for the mental, physical, emotional, and spiritual health and the social determinants of health of a person.

¹ Medicaid, Medicare, commercial insurers, and self-insured employers.

and public health agencies should place patients, families, and community members at the center of the design and accountability of these endeavors.

OBJECTIVE THREE: 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 workforce, particularly in areas that are medically underserved and have a shortage of health professionals, to strengthen interprofessional teams and better align the workforce with the communities they serve.
- CMS, the U.S. Department of Veterans Affairs, the Health Resources and Services Administration (HRSA), and states should redeploy or augment funding to support interprofessional training in community-based, primary care practice environments.

Organizations that train, hire, and finance primary care clinicians should ensure that the demographic composition of their primary care workforce reflects the communities they serve and that the care delivered is culturally appropriate. Developing a workforce able to deliver high-quality care that meets the committee's definition of primary care requires reshaping what is expected of training programs and the clinical settings where the training occurs. The committee recommends adopting alternative financing sources for HRSA-developed, community-based primary care training and that federal support be available to trainees of a broad array of primary care professions.

OBJECTIVE FOUR: 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 (HIT) 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.

HIT creates opportunities to improve care coordination and person-centeredness. The committee supports federal standards-setting but has determined that current certification requirements are a barrier to high-quality primary care. Creating and implementing these changes require new policies and authorizations as well as innovation by vendors and state and national support agencies. However, these changes will greatly assist primary care teams to deliver high-quality care.

OBJECTIVE FIVE: ENSURE THAT HIGH-QUALITY PRIMARY CARE IS IMPLEMENTED IN THE UNITED STATES

- The HHS Secretary should establish a Secretary's Council on Primary Care to achieve the vision of high-quality 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 level should assemble, regularly compile, and disseminate a "high-quality primary care implementation scorecard," based on the five key implementation objectives to track progress in achieving this report's objectives. (View Appendix E of the report for the committee's proposed scorecard.)

CONCLUDING REMARKS

To increase the chances for successful implementation of high-quality primary care, actors should be held publicly accountable for their responsibilities. Evidence abounds for what is needed to achieve high-quality primary care for all, but primary care lacks a unified voice advocating for change. Organizing primary care clinicians, consumer groups, employers, and other stakeholders to assess the implementation of the committee's recommended actions will hold the named actors accountable, increase the likelihood of successful implementation, and catalyze a common agenda to achieve a vital common good—high-quality primary care.

Committee on Implementing High-Quality Primary Care

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Implementing High-Quality Primary Care

Rebuilding the Foundation of Health Care

PAYMENT REFORM

High-quality primary care that is team-based, relationship-oriented, and broadly accessible is critical to improving the health of the nation's population and reducing health disparities. Yet, primary care in the United States is fragile and weakening. The cause is two-fold: systemic underinvestment and a fragmented payment system that reimburses individual clinicians for providing specific services instead of teams for delivering whole-person care.

Due to its direct benefits to society, primary care deserves to be treated as a common good and should be promoted by responsible public policy and supported by the private sector. The report *Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care* outlines objectives to make high-quality primary care available for everyone in the United States.



PAYMENT

Pay for primary care teams to care for people, not doctors to deliver services.

Any effort to implement high-quality primary care must begin with a commitment to **pay for primary care teams to care for people, not doctors to deliver services**. To improve payment for primary care to better meet people's needs, payment should be increased to reflect the outsized benefit primary care has on the health and well-being of society and flexible enough to allow practices to meet the specific needs of the population they serve.

RECOMMENDED ACTIONS

Change the Standard for Evaluating and Supporting Payment Models

Primary care payment models to date have largely been judged based on their ability to generate cost savings. Payment models that support integrated, interprofessional primary care teams working in sustained relationships with patients and families will ensure that high-quality primary care is possible to implement and sustain.

ACTION: 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 and not on their ability to achieve short-term cost savings.

Shift to a Hybrid Payment Model

At present, most primary care in the United States operates under a **fee-for-service (FFS)** model in which insurers pay a given fee for each service. Capitated payment models are less common but provide a fixed amount of money per patient paid in advance to the practice for the delivery of health care services.

ACTION: Medicaid, Medicare, commercial insurers, and self-insured employers should **shift primary care payment toward hybrid (part FFS, part capitated) models**, making them the default method for paying for primary care teams over time. For risk-bearing contracts with population-based health and cost accountabilities, such as those with accountable care organizations, payers should ensure that sufficient resources and incentives flow to primary care.

The hybrid reimbursement model (part FFS, part capitated) should:

- **Pay prospectively** for interprofessional, integrated, team-based care. This includes incentives for incorporating non-clinician team members and for partnerships with community-based organizations.
- Be **risk-adjusted** for medical and social complexity.
- Allow for **investment** in team development, practice transformation resources, and the infrastructure to design, use, and maintain necessary digital technology; and
- **Align with incentives** for measuring and improving outcomes for patient populations assigned to clinicians.

Increase Overall Primary Care Spending

Only a small and declining portion of health care spending is directed to primary care. Underinvestment has perpetuated a system that in most cases is unable to provide high-quality primary care by restricting the ability of interprofessional teams to address the whole-person health needs of individuals and families they serve.

ACTION: The Centers for Medicare & Medicaid Services should increase the overall portion of spending going to primary care by:

- Accelerating efforts to improve the accuracy of the Medicare physician fee schedule by **developing better data collection and valuation tools** to identify overpriced services; and
- **Restoring the Relative Value Scale Update Committee to an advisory nature** by developing and relying on additional experts and evidence.

Facilitate Primary Care Payment Reform at the State Level

States play an important role in implementing payment reform through policy and action.

ACTION: States should implement primary care payment reform by using their authority to **facilitate multi-payer collaboration** and by **measuring and increasing the overall portion of health care spending going to primary care**.

CONCLUSION

Most primary care delivered today is transactional in nature, with payment rendered for services provided. Payment reform that supports and encourages high-quality primary care is fundamental to improving the health of the nation. While primary care payment reform may not result in short-term cost savings, it is a long-term investment that can improve population health and create greater health equity.



What Is High-Quality Primary Care?

High-quality primary care is the provision of whole-person, integrated, accessible, and equitable health care by interprofessional teams who 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.

To download a free copy of the full report and other resources, please visit nationalacademies.org/primarycare.

Implementing High-Quality Primary Care

Rebuilding the Foundation of Health Care

ENSURE ACCESS

High-quality primary care should be person-centered, family-centered, and community-oriented. The nation must also overcome barriers to ensure access to primary care for all communities, particularly underserved populations. The COVID-19 pandemic further highlighted pervasive economic, mental health, and social health disparities that might have been reduced with better access to high-quality primary care.

The report *Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care* outlines objectives to make high-quality primary care available to everyone in the United States. Community-oriented primary care models that are able to meet the specific needs of the population they serve and that partner with public health and community-based organizations—influenced by policy changes and innovative payment models—are central to **ensure that high-quality primary care is available to every individual and family in every community.**



ACCESS

Ensure that high-quality primary care is available to every individual and family in every community.

RECOMMENDED ACTIONS

Provide Access to Everyone

Successfully implementing high-quality primary care means everyone should have access to a regular source of primary care. While this is more likely to happen when everyone has adequate health insurance, there are ways to improve and reinforce access to primary care and support relationships for both the insured and uninsured.

ACTION: To facilitate an ongoing primary care relationship, all individuals should have the opportunity to have a usual source of primary care.

- Medicaid, Medicare, commercial insurers, and self-insured employers should ask all covered individuals to **declare a usual source of primary care annually and should assign non-responding enrollees** to a source of care using established methods, track this information, and use it for payment and accountability measures.
- When health centers, hospitals, and primary care practices treat people who are uninsured, they should assume and document an ongoing clinical relationship with them.

Create New Health Centers

Health centers are a reliable source of high-quality primary care in underserved communities around the country. It is a model worthy of expansion to improve access to high-quality primary care to more underserved populations and facilitate providing a usual source of high-quality primary care to the uninsured.

ACTION: The U.S. Department of Health and Human Services should **target sustained investment in creating new health centers** (including federally qualified health centers, look-alikes, and school-based health centers), rural health clinics, and Indian Health Service facilities in areas with a shortage of primary care.

Revise Access Standards

Medicaid is the second-largest payer in the country, with disproportionate numbers of children and high-needs beneficiaries. Medicaid needs a new strategy to address its documented low rates for primary care paid by state Medicaid agencies and their contractors that limit children's access to high-quality primary care.

ACTION: To improve access to high-quality primary care services for Medicare beneficiaries, the Centers for Medicare & Medicaid Services (CMS) should **revise and enforce its fee-for-service and managed care access standards**. CMS should also provide technical assistance to state Medicaid agencies to implement and attain these standards, and measure and publish state performance.

Eliminate Barriers to Primary Care

The COVID-19 pandemic quickly illustrated that primary care can be delivered outside a traditional office setting, creating options to help eliminate barriers to care and forcing Medicare and other establishments to quickly scale their ability to access primary care teams virtually by video and telephone.

ACTION: CMS should **permanently support COVID-era rule revisions** and Medicaid and Medicare benefits interpretations 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.

Build Relationships

Having primary care teams embedded within communities and partnering with public health and community-based organizations are crucial to build health-improving relationships with patients, families, and community members.

ACTION: Primary care practices should **move toward a community-oriented model** of primary care by including community members in their governance and practice design and partnering with community-based organizations.

CONCLUSION

Everyone in the country should have access to high-quality primary care that is person-centered, relationship-oriented, and responsive to the needs of the community.

Personalized, prioritized, and coordinated care for all people and families in communities will require a system that develops and sustains strong relationships in primary care with community organizations and public health agencies, and works to ensure universal access to high-quality primary care.



What Is High-Quality Primary Care?

High-quality primary care is the provision of whole-person, integrated, accessible, and equitable health care by interprofessional teams who 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.

To download a free copy of the full report and other resources, please visit nationalacademies.org/primarycare.

Implementing High-Quality Primary Care

Rebuilding the Foundation of Health Care

TRAIN PRIMARY CARE TEAMS

High-quality primary care is critical to addressing the unique needs and preferences of individuals, families, and communities but the current number of trainees entering primary care professions is inadequate. In recent years, the proportion of health care trainees choosing to enter primary care has decreased. In addition, funding for training the primary care workforce is inconsistent and insufficient, with training tending to occur in hospital settings instead of in the communities where most primary care takes place.

The report *Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care* outlines objectives to make high-quality primary care available to everyone in the United States. For primary care teams to address race- and ethnicity-based treatment disparities, their members should reflect the lived experience of the people and families they serve. Organizations that train, hire, and finance primary care clinicians should ensure that the demographic composition of their primary care workforce reflects the communities they serve and that the care delivered is culturally appropriate. High-quality primary care is also best done by a professionally diverse team whose members each bring unique skills in addressing the needs of the patients, families, and communities they serve.



WORKFORCE

**Train primary
care teams
where people
live and work.**

It is essential to **train primary care teams where people live and work**. This will require reshaping training programs and aligning a payment and financial system that provides incentives and rewards to create effective, integrated primary care.

RECOMMENDED ACTIONS

Expand and Diversify the Primary Care Workforce

Black, Hispanic, American Indian and Alaska Native, and Native Hawaiian and other Pacific Islander people are currently underrepresented in nearly every clinical primary care occupation. To provide everyone with high-quality primary care, care teams should reflect the diversity of the communities they serve.

ACTION: Health care organizations and local, state, and federal government agencies should **expand and diversify the primary care workforce**, particularly in areas that are medically underserved and have a shortage of health professionals, to strengthen interprofessional teams and better align the workforce with the communities they serve.

- Public and private health care organizations should ensure inclusion, support, and training for family caregivers, community health workers, and other informal caregivers as members of their interprofessional primary care team.

- The U.S. Department of Education and the U.S. Department of Health and Human Services (HHS) should partner to expand educational pipeline models that would encourage and increase opportunities for students who are underrepresented in health professions
- The Health Resources and Services Administration (HRSA), state and local government, and health care systems should redesign and implement economic incentives, including loan forgiveness and salary supplements, to ensure that interprofessional care team members, especially those who reflect the diverse needs of the local community, are encouraged to enter primary care in rural and underserved areas.
- Health systems and organizations should develop a data-driven approach to customizing interprofessional teams to meet the needs of the population they serve.

Increase Funding and Expand Settings for Training

While training individual primary care clinicians in inpatient settings is commonplace, it is not where primary care occurs and will not develop a workforce able to deliver high-quality primary care to everyone. Current funding to support the training of interprofessional primary care teams is inconsistent and insufficient.

ACTION: The Centers for Medicare & Medicaid Services, the U.S. Department of Veterans Affairs, HRSA, and states should **redeploy or augment funding to support interprofessional training** in community-based, primary care practice environments. The revised funding model should be sufficient in size to improve access to primary care and ensure that training programs can adequately support the primary care needs of the future.

- HRSA funding, via Title VII and VIII programs, for other health professions training should be increased and prioritized for interprofessional training.
- HHS should **redesign the graduate medical education (GME) payment** to:
 - Support training primary care clinicians in community settings.
 - Expand the distribution of training sites to better meet the needs of communities and populations, particularly in rural and underserved areas.
 - Prioritize effective HRSA models for existing GME funding redistribution and sustained discretionary funding.
 - Modify GME funding to support training all members of the interprofessional primary care team, including nurse practitioners, pharmacists, physician assistants, behavioral health specialists, pediatricians, and dental professionals.

CONCLUSION

The ability to deliver high-quality primary care depends on the availability, accessibility, and proficiency of interprofessional primary care teams to meet the health care needs of all individuals, families, and communities.

Those who train, hire, and finance primary care teams should ensure that the demographic composition of their interprofessional primary care workforce reflects the communities they serve. Developing a workforce able to deliver high-quality care requires reshaping what is expected of training programs and the clinical settings where the training occurs.



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Implementing High-Quality Primary Care

Rebuilding the Foundation of Health Care

ADVANCE DIGITAL HEALTH

Well-designed health information technology (HIT) is essential to making high-quality primary care more accessible, convenient, and efficient for patients, families, and interprofessional care teams. The digital tools routinely used in primary care, such as electronic health records (EHRs) and patient portals, collect health information to help primary care teams make diagnoses, coordinate and deliver care, track progress, and communicate among team members. Despite their potential, today's electronic health data present challenges. Primary care teams must spend long hours documenting care and reviewing and gathering information from specialists, hospitals, pharmacies, and other sources.

The report *Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care* outlines objectives to make high-quality primary care available to everyone in the United States. To improve care coordination and advance HIT for primary care, changes are needed to **design digital health that serves patients, their families, and the interprofessional primary care teams**.



DIGITAL HEALTH

Design information technology that serves the patient, family, and interprofessional care team.

RECOMMENDED ACTIONS

Develop the Next Phase of Digital Health

Well-designed digital health tools should improve the care delivery experience of patients and primary care teams. For example, EHRs should serve as the hub of patient information, make it easier for people to receive care, and seamlessly provide clinicians with the information they need to deliver the right care at the right time, but there is room for improvement. Vendor policies, inconsistent data storage and architecture, and limited mechanisms for efficient data transfer limit EHRs interoperability and the current dominance of the market by a few informatics vendors has locked clinicians and practices into existing systems and stifled innovation.

ACTION: The Office of the National Coordinator for Health Information Technology (ONC) and the Centers for Medicare & Medicaid Services (CMS) should **develop the next phase of digital health**, including EHR, certification standards to:

- Align with the functions of primary care, supporting the relationship among clinicians, care teams, and patients;
- Account for the user experience of clinicians and patients to ensure that health systems are truly interoperable;
- Ensure equitable access and use of digital health information systems that support equitable care and deliver national standards;
- Include highly usable automated tools that make sense of data, identify clinically important data, and inform care;

- Ensure that base products meet certification standards with minimal need for local modification to meet requirements; and
- Hold HIT vendors and state and national support agencies financially responsible for failing to meet the standards.

Comprehensive Patient Data System

A national, comprehensive, and aggregated patient data system would enable primary care clinicians, teams, patients, and families to easily access the comprehensive data needed to provide whole-person care. Creating and implementing this change will require new policies and authorizations as well as innovation by vendors and state and national support agencies.

ACTION: ONC and CMS should **plan for and adopt a comprehensive aggregated patient data system** to enable primary care clinicians and interprofessional teams to easily access comprehensive patient data needed to provide whole-person care.

- This data source needs to be usable by any certified digital health tool for patients, families, clinicians, and care team members.
- ONC and CMS could accomplish this through a centralized data warehouse, individual health data card, or distributed sources connected by a real-time, functional health information exchange.

CONCLUSION

Digital health technology creates opportunities to improve care coordination and support primary care relationships among individuals, families, clinicians, and communities.

The use of telemedicine and other technologies during the COVID-19 pandemic highlighted the benefits of digital health, improving primary care access and offering more scheduling flexibility. However, changes to the marketplace, aggregated comprehensive patient data, and revised federal standards are needed to strengthen the role of HIT to support the implementation of high-quality primary care.



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Implementing High-Quality Primary Care

Rebuilding the Foundation of Health Care

ENSURE IMPLEMENTATION

The report *Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care* outlines objectives to make high-quality primary care available to everyone in the United States.

Successfully implementing a plan to create high-quality primary care requires assigning accountability. No federal agency currently has oversight of primary care, and no dedicated research funding is available. The current measures applied to primary care are not aligned with its purpose and function and fail to adequately assess its quality and ensure accountability.

Clear and meaningful measures of care, ongoing research, and leadership from the federal government are all necessary to **ensure that high-quality primary care is implemented in the United States**.



ACCOUNTABILITY

Ensure that high-quality primary care is implemented in the United States.

RECOMMENDED ACTIONS

Assign Accountability

The federal government plays an active but uncoordinated role in primary care. The COVID-19 pandemic further highlighted this lack of coordination. Congressional COVID-19 relief did not specifically support primary care and primary care was not included in federal epidemic strategies before or during the pandemic. Senior secretary–level coordination of federal primary care activity in workforce training, safety net funding, payment and benefits policy, health information technology, quality measurement, and research is necessary to ensure the implementation of the report’s recommendations with the goal of achieving high-quality primary care for everyone in the United States.

ACTION: The Secretary of the U.S. Department of Health and Human Services (HHS) should **establish a Secretary’s Council on Primary Care** to enable the vision of primary care captured in the committee’s definition.

- Council members should include the Centers for Medicare & Medicaid Services Administrator; the Directors of the Center for Medicare & Medicaid Innovation, the Health Resources and Services Administration, and the Agency for Healthcare Research and Quality (AHRQ); the Assistant Secretary for Planning and Evaluation at HHS; and the National Coordinator for the Office of the National Coordinator for Health Information Technology.
- The council should coordinate primary care policy across HHS agencies with attention to the following responsibilities:
 - Assess federal primary care payment sufficiency and policy;
 - Monitor primary care workforce sufficiency, including training, financing, production, and preparation; incentives for federally designated shortage areas; and federal clinical assets/investments;

- Coordinate and assess the adequacy of the federal government’s research investment in primary care;
- Address primary care’s technology, data, and evidence needs, including interagency collaboration in the use of multiple data sources;
- Promote the alignment of public and private payer policies in support of high-quality primary care; and
- Establish meaningful metrics for assessing the quality of primary care that embrace person-centeredness and health equity goals. Additionally, the council should coordinate implementing the committee’s recommended actions that target federal agencies.
- As part of its coordination role, the council should verify adequate budgetary resources are allotted in respective agencies for filling these responsibilities.
- The council should annually report to Congress and the public on the progress of its implementation plan and performance.
- The council should be informed through regular guidance and recommendations provided by a Primary Care Advisory Committee created by the HHS Secretary under the Federal Advisory Committee Act that includes members from national organizations that represent significant primary care stakeholder groups.

Create a Primary Care Research Agenda

While primary care research is instrumental to address questions that are critically important for primary care outcomes and a population-based understanding of illness and disease, it is in need of a significant boost in support and funding. At present, no federal agency is funded to advance a robust primary care research program. While AHRQ was designated by Congress to steward primary care research, no funding was allocated for this task. Similarly, primary care research currently receives less than 0.4 percent of the National Institutes of Health’s (NIH’s) research funding.

ACTION: HHS should **form an Office of Primary Care Research at NIH and prioritize funding of primary care research at AHRQ** via the National Center for Excellence in Primary Care Research.

Track Implementation Progress

An implementation plan needs a set of metrics to track its progress and assess whether its objectives are achieved over time. To that end, the report proposes a scorecard (see Appendix E) of selected measures that could be managed by one or more of the sponsoring organizations, federal agencies, or other interested stakeholders.

ACTION: To improve accountability and increase the chances of successful implementation, primary care professional societies and consumer groups at the national and state level should **assemble and regularly compile and disseminate a “high-quality primary care implementation scorecard,”** based on the five key implementation objectives to track progress in achieving this report’s objectives. One or more philanthropies should assist in convening and facilitating the scorecard development and compilation.

CONCLUSION

Primary care is the only health care component where an increased supply is associated with better population health and more equitable outcomes, making it a common good. The strength and quality of the country’s primary care rely on having a plan that accounts for the complexity of the U.S. health care system in both the public and private sectors and affirms the fundamental responsibility of the federal government to lead this process. Ensuring that the nation can successfully implement this plan for high-quality primary care requires coordinating primary care activities at the federal level, assigning accountability, establishing effective measurement, and prioritizing funding of primary care research.



What Is High-Quality Primary Care?

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Office of the
Assistant Secretary
for Health

HHS Initiative to Strengthen Primary Health Care

Improving access to health care, advancing health equity, and improving the health of the nation are top priorities of the Biden-Harris Administration and the Department of Health and Human Services (HHS). Strong primary health care is important to achieving these goals.

- Primary health care has been shown to improve health outcomes and health equity and is critical for addressing the pressing health needs of our day.
- The COVID 19 pandemic has highlighted the importance of integrating public health and primary care to improve access to COVID 19 testing, care, and vaccination.
- Integration of primary health care and behavioral health improves access to mental health care, substance use disorder treatment and overdose and suicide prevention.
- Strong primary health care can lead to improved maternal and child health and wellness and help reduce the alarmingly high maternal mortality rates and disparities in our nation.
- Increasingly, primary health care and community-based organizations are partnering to support the health and wellbeing of individuals, families, and communities by addressing social determinants of health and bringing care and resources to where people are.

Unfortunately, many people lack access to primary health care and ongoing, trusting relationships with a primary care provider and team; primary health care is under-resourced; the workforce is shrinking and like other disciplines, struggles to maintain well-being; and the COVID 19 pandemic significantly threatened the financial stability of primary care practices.

With the leadership of Secretary Becerra and Admiral Levine, the Assistant Secretary for Health, the **HHS Initiative to Strengthen Primary Health Care** was launched in September 2021. OASH is coordinating the development of an HHS action plan for strengthening primary health care, working with HHS agencies and other federal offices and departments. The recently released National Academies of Sciences, Engineering, and Medicine Report, [*Implementing High Quality Primary*](#)

[*Care: Rebuilding the Foundation of Health Care*](#), will inform the development of the HHS Plan. OASH is also engaging diverse stakeholders and subject matter experts, including patient, family, and community advocates, to learn about innovative approaches, needs and challenges, to inform the HHS plan. OASH aims to develop this plan by summer 2022.

The Initiative to Strengthen Primary Health Care aims to achieve a federal foundation for high quality primary health care for all to improve the health of individuals, families, and communities, and improve health equity.

Policies to Transform Primary Care: The Gateway to Better Health and Health Care



More people receive care from a primary care provider each month than any other health professional. Primary care providers often serve as an entry point in the health care system - connecting patients to the other specialists, treatment options and even social services needed to get and stay healthy. Additionally, we know that primary care is associated with better health outcomes and lower costs – particularly for patients with complex health needs. But even given all this, consumers must still overcome significant obstacles to access high quality primary care. For example:

- Affordability barriers
- Locating and accessing a primary care provider
- Finding care that meets their needs
- Significant disparities in the quality of care patients receive

Because primary care is the gateway to the health system, a transformed health system that meets the health needs of all people must start with re-envisioning how we deliver primary care. If we can utilize primary care to catch chronic health issues or social needs early and address those needs in a coordinated and comprehensive way, it is possible to lower health care costs, improve health outcomes and patient satisfaction, and begin to tackle health disparities. Advocates and policymakers who are working towards a truly patient-centered health system must begin addressing the legislative, administrative and cultural barriers standing in the way of a primary care policy agenda that will move us closer to this vision.

Addressing the problems with primary care access and quality will require a multifaceted approach at the federal and state levels. The menu of policy options presented in this accompanying chart, when taken together, would move us towards a health system that centers high quality, accessible, person-centered primary care. For more details about the problems facing primary care today and the policy solutions needed to address these problems, see our full report: [Policies to Transform Primary Care: The Gateway to Better Health and Health Care](#).



Sally and Edna's story embodies the problems caused by a lack of communication and coordination in primary care. Learn more: healthinnovation.org/work/stories

Steps to a Transformed Primary Care System

Remove financial barriers	Change the way care is paid for	Reform the way primary care is delivered	Build out connections between primary care and social services	Improve access to primary care by expanding the primary care infrastructure	Experiment with non-traditional primary care models
Do away with Medicare co-pays for primary care services	Revise policies for determining Medicare primary care payment	Improve Medicare access to home-based primary care	Promote social needs screening and referrals	Expand scholarship and loan forgiveness programs	Advance multi-payer medical home models
Require first-dollar coverage of primary care services in high-deductible health plans	Advance innovative and value-based payment models in primary care	Allow same day billing for different providers in Medicaid	Strengthen the Health Home to address the social determinants of health	Improve and strengthen the Conrad 30 J-1 visa waiver program	Advance Universal Primary Care initiatives
Close the Coverage Gap	Pass legislation requiring measurement/minimum levels of primary care spending	Promote co-location of behavioral health and oral health services within primary care	Promote models that directly integrate of primary care and social services at a single site	Establish a “pipeline” program to encourage students to enter into primary care professions	Promote the delivery of primary care as part of comprehensive, community-based models
Ensure safety-net coverage for immigrant populations		Advance Community Paramedicine initiatives		Expand the number of Graduate Medical Education (GME) slots for primary care	Promote member/patient owned primary care models
				Expand Medicaid reimbursement for Community Health Workers	Allow for reimbursement across payers for virtual primary care platforms

Community Care Cooperative: Harnessing the Power of FQHCs to Drive ACO Success

Christina Severin, MPH, Community Care Cooperative

Community Care Cooperative (C3) is a non-profit Accountable Care Organization whose mission is to leverage the strength of federally qualified health centers (FQHC) to improve the health and wellness of their communities. C3's President and CEO, Christina Severin will be presenting on the organization's efforts to harness the power of FQHCs to drive ACO and health center success including the history of the company, its financial infrastructure and funds flow as well as its successful Flexible Services program.

C3 was created in early 2016 by a group of nine community health centers to play a leading role in the redesigned Massachusetts Medicaid program. The ACO was launched in 2018 with 15 members health centers and over 110,000 members. In 2022, the organization has grown to 18 health centers serving over 170,000 members in three risk contracts. C3 has also created Community Pharmacy Cooperative and Community Technology Cooperative, two subsidiaries that scale health centers by banding together to buy and operate services including in house pharmacy and the Epic electronic health record. Currently in its last year of the ACO contract with MassHealth, the organization is looking forward to renewing its contract, adding several new FQHCs and moving toward primary care capitation in 2023.

C3 has a complex internal risk model that is designed to achieve three goals: meaningful incentives for health centers, responsible and actuarially valid risk sharing, and ensuring management and repayment of the risk that is taken. Health centers choose from three different risk tiers – low, medium, and high – and work with the C3 team to determine what the best choice is. This arrangement provides pooling and risk transfer to mitigate impact of high-cost claimants and assist with budget setting process at the health center level. The organization also has a budget reconciliation total cost of care model with MassHealth in which fee-for-service claims are billed and paid. At the end of the year, all claims are debited against the total cost of care budget and incorporating with the ACO's quality performance to determine final performance. This performance creates gains or losses for the ACO.

One of C3's biggest successes has been in the MassHealth Flexible Services program where they are a standout leader throughout the Commonwealth. The Flexible Services program provides food, nutrition and housing supports for eligible members in partnership with several social service organizations. Since its launch, the program has served approximately 7,000 members with over \$8.4M spent for goods and services including food vouchers, home delivered meals, household items, move-in costs, and home modifications. These services have improved outcomes for members with 25% fully food secured after 6 months in the program and more than 400 moved into houses and reporting housing stability. The Flexible Services program has also seen a reduction in total cost of care for members enrolled as well as a reduction in emergency department utilization. The program has been key to addressing social drivers of health for health centers and their members.

Strengthening Primary Care – the SCF Nuka System Solution

Douglas Eby, MD, MPH, CPE, Southcentral Foundation

The Southcentral Foundation (SCF) Nuka System of Care has spent the past 25 years building a powerful and capable Primary Care system while redesigning the entire healthcare system around it and accomplishing the Quadruple Aim, becoming the only healthcare organization to win the U.S. Malcolm Baldrige National Quality award twice. Our customer-driven design orders significantly fewer labs, radiology, and medications and much fewer specialty referrals, ED use, and hospitalizations, while moving our entire population from the bottom 5%ile to the top 25%ile (based on HEDIS benchmarks) for clinical performance/outcomes. We have done this while producing high staff and customer satisfaction levels – and at a total cost well below US national averages – in a very high risk/high complexity population. Nuka is high on personnel/human staff costs but low on total costs generated from Primary Care.

1. Relationships – The entire system is based on personal, first name, trusting, long term relationships. Tens of thousands of people are ‘empaneled’ by entire family/household to a PCP team (PCP – Primary Care Provider) and have been guaranteed same day access (for 22 years) by the communication means of their choice directly to these individuals (PCP, Case Manager, CMA, and CMS – Case Management Support), who then pull in additional expertise to join this trusted team relationship as needed. Nuka is about life-long trusted personal partnering.
2. Mind/Body/Spirit in context – Nuka Primary Care includes behavioral, medical, and social care/support all together in whatever mix is needed.
3. Integrated Team – Every clinic is ‘right-sized’ to include 5-6 PCP teams with shared 2-3 Behaviorists, 1 Clinical Pharmacist, 2-3 midwives, 1 Social Worker, and Dietician.
4. Co-Located – Shared across several clinics, but co-located right in Primary Care are multiple Psychiatrists, Chronic Pain Specialist physician, Chronic Pain expert psychologist, Palliative Care, HIV expert, Child Complexity expertise, Adult Complexity expertise, Lactation Consultants, and a range of home-visiting clinical staff, all of whom support Primary Care needs.
5. Specialists – Most specialists and sub-specialists in the larger system understand that their main function is to join (in real time) the PCP teams to add their particular expertise into the ongoing long-term Primary Care partnership.
6. Infrastructure – Highly developed data mall capability, improvement capability (SCF has many Improvement Advisors and Improvement Specialists), annual planning cycle and cascade, and commitment to workforce development/training are critical to the system’s success.
7. Customer-driven through exceptional leadership – SCF leadership spend 10-40% of their time in any given month in the community and meeting with/listening to individuals and advisory councils, and leaders in the community. We are truly customer-driven. We are a service industry and as such, provide our expertise when, where, and how the customer wants it.
8. Leadership – We make a huge effort in leadership development at all levels, with a particular commitment to developing Alaska Native leaders from the communities we support.
9. Hiring – We prioritize hiring from within the communities we support.
10. Coaching – Our entire system is based upon our ability to connect deeply in human terms and then influence people to take actions that further their health and management of their chronic conditions. This means we train deeply in self-knowledge, coaching, partnering, and supporting people in their journeys, based on their values and goals and beliefs.

This proven Primary Care and whole healthcare system design can serve as a model for everyone.

The Maryland Primary Care Program: Successful State Innovation

Integrating Primary Care and Public Health

The Maryland Primary Care Program (MDPCP), a partnership between the Maryland Department of Health and the Center for Medicare and Medicaid Innovation (CMMI), is demonstrating that sufficient strategic investments in primary care can enable the delivery of high-value care that improves health equity while reducing costs. This advanced primary care program launched in 2019; within two years of its onset, 2/3rds of all eligible primary care practices (525) had enrolled and Program Year three (PY3), 88% of participating practices have transitioned to the advanced level of the program, signifying delivery of advanced primary care.

MDPCP has achieved this success through four key strategies:



INCREASE IN PRIMARY HEALTH CARE INVESTMENT

See [NASEM Report](#)

A successful Advanced Primary Care program needs to provide sufficient resources to meet the needs of the patient population. In MDPCP, this means supplying adequate financial funding to support team-based care and providing additional state resources available that support the goals of population health. The Medicare non-visit-based payments made to MDPCP participants in 2021 averaged ~\$31 per beneficiary per month (PBPM), which approximately doubles the average overall payments. Even after accounting for this level of financial support, [a study done by the Maryland Health Services Cost Review Commission](#) using a difference-in-difference methodology and risk adjusted comparison group estimated that MDPCP practices had a net savings over the first two years of the program of \$16 million even after accounting for the additional investments.



PRIMARY HEALTH CARE DASHBOARDS

Early on, MDPCP worked with Chesapeake Regional Information System for Our Patients (CRISP), the state health information exchange (HIE), to develop dashboards, reports, and other tools for practices. These tools allow for data-driven practice transformation and include:

- Alerts when patients are seen in Emergency Departments (ED), admitted, and discharged from hospital
- Claim-based utilization data parsed by race, ethnicity, sex, and age
- Area Deprivation Index (ADI) by patient, Hierarchical Condition Category (HCC) score by patient
- Comparison data to other MDPCP and non-MDPCP practices
- Prevention Quality Indicator (PQI) reports
- An AI tool Prevent Avoidable Hospital Events (Pre-AH) that ranks patients on probability of an avoidable ED/hospital event in the next 30 days
- Online bidirectional referral to Community Based Organizations (CBOs)

When the pandemic began, MDPCP worked with partners to develop a vaccine tracker. This tracker provides practices with an accurate record of vaccine status and includes a dashboard, detailing demographics for the patient population, a critical step in examining the equity of vaccine access and delivery. In addition the practices were provided with a COVID-19 Vulnerability Index in order to prioritize equitable care.





RISK ADJUSTMENT AND EQUITY

Equity is a major focus of MDPCP's mission. The state provides data tools and educational resources to assist practices in stratifying data to understand disparities, identify beneficiaries with the highest level of unmet needs, and refer patients for social needs. Key examples of MDPCP's health equity focus are below.



Pioneering payment stream that directs funding to target social needs:

Beginning in 2022, MDPCP practices receive the [Health Equity Advancement Resource and Transformation \(HEART\)](#) payment to provide additional resources to support social needs of high-need patients. The payment provides \$110 PBPM for Medicare beneficiaries who are considered high-risk clinically and who have high neighborhood-level socioeconomic disadvantage (measured through Area Deprivation Index). This payment directs more resources to the highest need patients, and it is pioneering as a payment to primary care based on beneficiary social risk level.



Emphasis on social needs screening and referrals: Primary care practices in the advanced MDPCP track are required to screen patients for unmet social needs and refer to community-based resources. MDPCP and CRISP are supporting this work through:

- A bidirectional referral tool within CRISP to refer to community-based resources
- Providing technical assistance on best practices for screening for social needs and incorporating screenings into EHRs and workflows



PUBLIC HEALTH INTEGRATION

Primary care plays a prominent role in addressing the COVID-19 pandemic. MDPCP, along with State public health partners, led a unified response to COVID-19 that included pandemic data, clinical guidance, and resources to strategically respond to patient needs.

MDPCP's well established communication system, direct relationship with practices, and integration with public health infrastructure served as essential building blocks in the overall success in pandemic response. With these resources, practices were able to provide vaccines, test patients, and refer for therapeutics in a coordinated, statewide approach throughout the pandemic. As noted in a [2021 Milbank study](#) comparing MDPCP participation status and COVID-19 outcomes, MDPCP participation was significantly associated with fewer COVID-19 cases, hospitalizations, and deaths.

GLOSSARY

- | | | |
|---|---|---|
| • ADI - Area Deprivation Index | • FFS - Fee-for-Service | • MDPCP - Maryland Primary Care Program |
| • CBOs - Community-Based Organizations | • HCC - Hierarchical Condition Category | • PBPM - Per Beneficiary Per Month |
| • CMMI - Center for Medicare and Medicaid Innovation | • HEART - Health Equity Advancement Resource and Transformation | • PY3 - Program Year Three |
| • CRISP - Chesapeake Regional Information System for Our Patients | • HIE - Health Information Exchange | |

Steps that Can Be Taken Today to Advance Goal-Oriented Primary Care

James Mold, MD, MPH, University of Oklahoma

- 1) Fund development of educational programs for all levels of clinicians and clinicians in training to help them adopt and implement goal-oriented care
- 2) Encourage and support interdisciplinary team residency training models**
- 3) Support development of degree program for primary care administrators**
- 4) Support goal-oriented training for nurse practitioners and physician assistants
- 5) Develop and test a comprehensive primary care logic model to guide research and policy
- 6) Encourage the development of quality indicators that are process- and goal-oriented
- 7) Encourage inclusion of size of impact estimates in future guidelines
- 8) Encourage development of EHR interfaces and decision-support aids designed to help clinicians and patients document and track achievement of key goals**
- 9) Make sure that new payment models adequately support the primary care functions, goal-oriented care, continuous quality improvement, and investments in innovation.
- 10) Encourage development of research methods and studies that allow for individualization of interventions (e.g., processes) and outcomes (e.g., prespecified)
- 11) Make it easier for clinicians to include all levels of prevention (including chronic disease management, e.g.) during Medicare Annual Wellness Visits**
- 12) Encourage and support comprehensive AWWs for Medicaid enrollees**
- 13) Support further development and use of comprehensive health risk assessment and other clinical modelling tools to guide preventive care
- 14) Improve the accuracy of cause of death determinations by encouraging more virtual autopsies and better training of clinicians and public health officials**
- 15) Support long-term studies of preventive strategies including prevention of future disability
- 16) Incentivize implementation of high-impact preventive strategies
- 17) Encourage implementation of evidence-based IT interventions to support behavior change
- 18) Reward clarification of needs, values, and priorities prior to deciding on interventions
- 19) Encourage development and use of tools to help patients clarify needs, values, and priorities
- 20) Support development of residency curricula in human growth and development
- 21) Encourage development of methods to assess and track lifespan growth and development
- 22) Encourage advance directive discussions during Medicare and Medicaid AWWs
- 23) Support reintegration of urgent care, home care, long term care, and palliative care**

Value Of Non-Billable Services and the Cost of Providing Comprehensive Primary Health Care

John (Jack) M. Westfall, MD, MPH, Director, Robert Graham Center

- Primary care practices get most of their revenue from patient clinical visits – billed services.
- Primary care clinicians, teams, and practices do lots of clinical visits.
- Primary care clinicians and their practice teams do lots of other activities to provide care for their patients
- Provider and practice activities beyond the clinical visit (partial list)
 - Lab/imaging review, communicating results, - may be bundled into visit fee
 - Patient communication – emails, portals, phone calls, synchronous and asynchronous
 - Triage, treatment, management
 - Prospective outreach for prevention and chronic care management, reminder emails
 - Community programs and engagement
 - Nurse, staff communication, outreach, refills, education
 - Social services, referrals for SDOH,
 - Behavioral health
- Patient Spend – Out of Pocket
- Payer – Structured payments
 - Non-fee-for-service payments applied to primary care services. Capitated payments, per-member-per-month payments. Non-claims payments may include “value-based” pay-for-performance bonuses or withholds; shared savings relative to a benchmark; or other type of non-fee-for-service payment
- **Potential Research to answer this question**
 - Observe primary care to determine all the activities and services provided in and by a primary care team practice and determine what parts are billable and all the components that are not billable
 - Study 3-5 states that have legislated support for high quality advanced primary care and determine what increased payment models pay for. Rhode Island would be a great first state to evaluated.
- **Primary health care and public health integration**
 - Sometimes primary care is necessary but not sufficient
 - Sometimes public health is necessary but not sufficient
 - Primary care and public health reside in the context of community social assets.
- Community Health Index (CHI) provides a small area measure of public health, primary care and social assets. The CHI reveals local, state, and national policy levers to improve population health. The CHI could be used for community risk adjustment of payment (medical care, public health, social investment)
- **Potential Research to answer this question**
 - Identify counties with high CHI and low CHI to evaluate their collaboration and integration, mitigation efforts, and opportunities.
 - Study 10-20 counties to identify the opportunities for PC-PH integration. “bright spots”
 - Identify the variety of models for Primary Care and Public Health Integration



Kelly Hughes, MPH, NCSL

Role of State Legislatures in Health Care Access

State legislatures play critical roles in strengthening the health care safety net and ensuring public health. As the policymaking and appropriations branch of state government, legislatures develop and fund health care safety net programs, support data collection and use data to make decisions, allocate resources toward state needs and populations experiencing disparities, and foster collaboration between agencies and organizations.

State Legislative Efforts to Strengthen Primary Health Care

State legislatures have long played an important role in bolstering access to high quality, affordable health care services, including primary care. And as the country confronted the COVID-19 pandemic, health care access has only become more vital.

Improving access to care—or the timely use of personal health services to achieve the best health outcomes—can be achieved through many policy avenues, including:

- Payment Reforms (e.g., alternative payment models, value-based payment models)
- Delivery Reforms (e.g., telehealth, licensing)
- Scope of Practice (particularly among nurse practitioners and physician assistants)
- Workforce Pipeline (e.g., career pathways, training)
- Coverage

NCSL Resources

- [Innovations in Health Care: A Toolkit for State Legislators](#) (July 2019)
- [The Telehealth Explainer Series: A Toolkit for State Legislators](#) (Policy Toolkit, July 2021)
- [Scope of Practice Policy Website](#)
- [Improving Rural Health: State Policy Options for Increasing Access to Care](#) (Policy Report, June 2020)
- [Health Innovations Database](#): Tracks enacted legislation across all 50 states, D.C., and territories on topics to increase access to care, control costs, and improve coverage options.
- [COVID-19 State Legislation Database](#): Tracks all introduced and enacted legislation across all 50 states, D.C. and territories related to and responding to COVID-19.

About NCSL

Established in 1975, the [National Conference of State Legislatures \(NCSL\)](#) is a bipartisan organization that serves the 7,383 legislators and more than 25,000 legislative staff members across all 50 states, commonwealths and territories. Its mission is to advance the effectiveness, independence and integrity of legislatures and to foster interstate cooperation and facilitate the exchange of information among legislatures.

**Successful State Innovations: California's Multi-Stakeholder Engagement
(March 23, 2022: Plenary 2)
Kathryn E. Phillips, MPH, California Health Care Foundation**

Our Approach

- Invest in the primary care workforce
- Increase resources: set and enforce a primary care spending target and align payment models
- Build state-specific evidence on the value of primary care
- Monitor primary care access; hold leaders accountable

Key Takeaways (for State Action)

- Look for evidence, apply lessons
- Engage stakeholders
- Set clear expectations
- Make the case relevant to your state's priorities
- Hold leaders accountable

Examples of Federal government policy steps to help California (and other states) further strengthen primary care

Workforce	• Reform graduate medical education financing. • Move primary care training out of hospitals and into communities. • Finance and support interdisciplinary training. • Make the Health Resources and Services Administration's (HRSA's) teaching health center program permanent.
Primary care investment	• Set a Medicare target for primary care spending; provide resources and encouragement to state Medicaid programs to follow suit. • Ensure Medicare participates in state-led efforts to measure, monitor, and increase primary care spending. • Reinstate federal support for primary care practice improvement; focus resources on private/independent practices, rural practices, and in primary care shortage areas. • Allow states more flexibility in Centers for Medicare & Medicaid Services Innovation Center models.
State-specific evidence	• Embrace the National Academies of Sciences, Engineering, and Medicine primary care scorecard recommendation; support nested state scorecards that reflect state priorities (e.g., language concordance). • Fund the Agency for Healthcare Research and Quality to conduct primary care research that recognizes variations in state-specific needs and policy. • Align primary care data definitions and measures across payers and markets (Uniform Data System, Healthcare Effectiveness Data and Information Set, etc.).
Accountability	• Support state efforts to monitor and address disparities within Medicaid and between Medicaid and other insured populations. • Establish common methodology for measuring network adequacy for primary care. • Enforce Early and Periodic Screening, Diagnostic and Treatment provisions.

Additional Resources

Investing in Primary Care: Lessons from State-Based Efforts

Recognizing the urgent need to strengthen primary care, more than one-of US states and several of the nation's largest public and private purchasers have prioritized shifting more of the health care dollar to primary care. This report provides a detailed review of their primary care investment, payment innovation, and care delivery transformation strategies.

Email kphillips@chcf.org for advanced copy (not yet publicly available). Will be posted to Primary Care Matters Website (chcf.org), April 18, 2022.

Meeting the Demand for Health: Final Report of the California Future Health Workforce Commission

California does not have enough of the right types of health workers in right places to meet the needs of its growing, aging, and increasingly diverse population. In 2019, the California Future Health Workforce Commission issued its recommendations for closing California's growing workforce gaps with emphasis on primary care, behavioral health, and healthy aging.

- [Full report](#) / [At a Glance](#) / [Results](#)

Primary Care Matters: Resource Collection

Noted resources will be available on a new website, April 18, 2022.

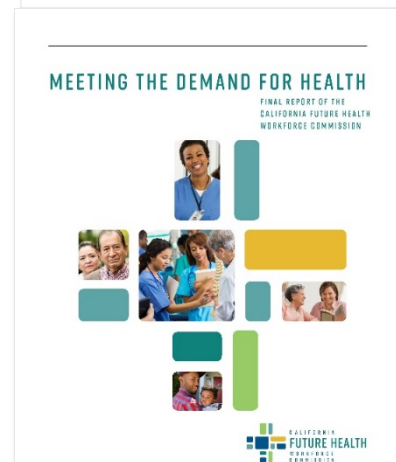
To be added to the distribution list, contact kphillips@chcf.org.



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NASEM Strengthening Primary Health Care Webinar

Panelist Summary – Louise Cohen, CEO, Primary Care Development Corporation

March 22, 2022

Independent primary care providers are essential, but they are in increasingly short supply. Small, independent practices provide 60 percent of primary care in the United States and are associated with positive health outcomes.¹ However, due to demographic factors such as a growing, aging population, there is an escalating shortage of primary care providers in many communities across the country – a primary care physician shortage between 21,400 and 55,200 is anticipated by 2033.¹ Such shortages will only exacerbate existing conditions, as an estimated 62 million people already experience inadequate or no access to primary care because of shortages of physicians in their communities.²

Investment in primary care is necessary. Primary care saves lives, leads to improved individual and community health, and is unequivocally central to health equity. Yet it is continually undervalued and underfunded, with these effects being felt most acutely by marginalized communities. Investment to improve access to and quality of primary care services is needed change to build a more healthy and equitable healthcare landscape in the United States. An increase in primary care spending could allow independent providers to increase staff, update technology, participate in key trainings and improve patient care.³

Primary care practices are small businesses with a fractured web of resources. The healthcare industry remains among one of the primary receivers of Small Business Administration (SBA) loans, which are partially guaranteed by the United States SBA and issued by participant lenders (usually banks). In addition to such loans, primary care practices can also borrow necessary capital through CDFIs, banks, both local and national, and credit unions. This complicated web of funding sources, partnered with a history of disinvestment and underfunding in primary care, leave many practices with a complex territory to navigate when seeking needed capital. To further complicate the funding need, the COVID-19 pandemic left most primary care providers – particularly independent practices – facing challenges such as cash flow disruptions, decreases in patient volume, and shortages in necessary supplies and equipment to effectively treat patients.⁴

PCDC provides needed capital. Primary Care Development Corporation (PCDC) is a nationally recognized 501(c)(3) organization and community development financial institution (CDFI) that uses a variety of financial instruments to provide loans to practices that help update, modernize or expand their operations to better serve their patients. PCDC has a 28-year history of investing in communities through this strategic capital investment and providing technical assistance to increase access to quality primary care and advance health equity.

¹ Association of American Medical Colleges, *The Complexities of Physician Supply and Demand: Projections From 2018 to 2033*, June 2020, available at <https://www.aamc.org/system/files/2020-06/stratcomm-aamc-physician-workforce-projections-june-2020.pdf>.

² National Association of Community Health Centers. *Community Health Center Chartbook*. 2020. <https://www.nachc.org/wp-content/uploads/2020/01/Chartbook-2020-Final.pdf>

³ Primary Care Development Corporation. *The intersection of COVID-19 and chronic disease in New York City: underscores the immediate need to strengthen primary care systems to avoid deepening health disparities*. Points on Care Series, 2020. <https://www.pcdc.org/wp-content/uploads/Points-on-Care-Issue-3-COVID-FINAL.pdf>.

⁴ Health Affairs Forefront. *Independent Primary Care Practices are Small Businesses, Too*. May 2020. <https://www.healthaffairs.org/doi/10.1377/forefront.20200518.930748/full/>

FQHCs are key to the safety net. Federally Qualified Health Centers (FQHCs) deliver comprehensive, culturally competent, high-quality primary health care services to the nation's most vulnerable individuals and families, including people experiencing homelessness, agricultural workers, public housing residents, veterans, and elderly patients. FQHCs reduce health disparities by integrating access to services for pharmacy, mental health, substance use disorders and oral health. Proximity to these health centers can lead to better health outcomes – studies have demonstrated that uninsured people living close to a community health center are less likely to postpone or delay seeking needed care and less likely to visit an emergency room compared to other uninsured individuals.⁵

Well-designed value-based payment can help primary care be successful. By designing value-based payment systems with equity in mind, primary care practices can be better enabled to serve patients and address health inequities. Upfront reimbursement with no downside risk is most effective in equipping primary care practices. Other methods of assisting primary care practices include:

- Capital
- Grants
- Alignment of programs
- Training and technical assistance
- Workforce development
- Multi-payer alignment
- Reduced measures, reporting and administrative burden

Federal-level changes are needed to advance health equity through improving primary care. Compared to other developed nations, the United States has an inefficient payment structure, with secondary and tertiary services receiving the most funding. This contributes to a partnership of overwhelming costs and poor health outcomes.⁶ To address this, there are several changes needed at the federal level. Most importantly, a shift towards a primary care-centered system, with an increased proportion of the healthcare dollar going towards to primary care will provide necessary change for United States healthcare landscape. Other recommendations include promoting global prospective payments, reducing the income gap between primary and specialized care providers through salary restructuring and value-based payment models, incentivizing primary care training programs and promoting diversity across the profession. Through these policy initiatives, legislators can reshape the infrastructure of primary care funding, improving health outcomes and addressing disparities.

⁵ Julia B. Nath, *Access to Federally Qualified Health Centers and emergency department use among uninsured and Medicaid-insured adults: California, 2005–2013*, available at 26 Acad. Emerg. Med. 129 (2019), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6370496/>.

⁶ Papanicolas, I., Woskie, L. R. & Jha, A. K. (2018). Health Care Spending in the United States and Other High-Income Countries. JAMA, 319(10). <https://jamanetwork.com/journals/jama/article-abstract/2674671>

Community Engagement – A Core Component of Primary Care

J. Lloyd Michener, MD, Duke School of Medicine (Lloyd.michener@duke.edu); March 22, 2022

Key Points:

- Communities differ – in their histories, cultures, strengths, and challenges
- Primary care is most effective when it is engaged with and responding to its communities, as part of larger partnerships for health

Effective steps in community engagement - which need to be supported by federal programs:

- Partner with local community organizations to identify priorities, co-design solutions
- Use a health equity lens
- Find/use local data
- Go 'upstream' to look for causes
- Bring primary care to where people are
- Use teams, including CHWs
- Support coordinated cross sector interventions
- Build community capacity

A federal policy office that coordinates efforts of federal agencies to support these steps would be enormously helpful!

Research Questions:

- What are the types/models of community engaged primary care? For instance:
 - Practice networks engage collectively (urban/suburban)
 - Individual practices engage/are sponsored (rural, ethnic, sexual orientation...)
 - Health systems engage, including primary care (regional)
- What are the key metrics for success?
 - Community health equity
 - Resilience
- What is the learning curve for engagement?
 - Outreach – Consultation – Involve – Collaborate – Shared Leadership
- Who are the key partners, and what does each contribute?
 - Local health dept; CBOs
- What are the needed tools and supports to enable and sustain effective models?
 - Local data, IT tools that support bidirectional communication with partners
 - Trusted convenor/facilitator
- What funding is needed for primary care to help communities be equitably healthy
 - Time for planning, evaluation

More information:

- The Practical Playbook II: Building Multisector Partnerships that Work. Michener JL, Castrucci BC, Bradley DW, Hunter EL, et al. New York, NY: Oxford University Press; 2019.
Available online (at no cost) at <<https://www.practicalplaybook.org/page/ppb2-table-contents>>
- Clinical and Translational Science Awards Consortium., United States., National Institutes of Health (U.S.), Centers for Disease Control and Prevention (U.S.), United States, & Clinical & Translational Science Awards Consortium. (2011). *Principles of community engagement*
https://www.atsdr.cdc.gov/communityengagement/pdf/PCE_Report_508_FINAL.pdf
- Organizing Committee for Assessing Meaningful Community Engagement in Health & Health Care Programs & Policies. 2022. Assessing Meaningful Community Engagement: A Conceptual Model to Advance Health Equity through Transformed Systems for Health. *NAM Perspectives*. Commentary, National Academy of Medicine, Washington, DC. <https://doi.org/10.31478/202202c>.
<https://nam.edu/assessing-meaningful-community-engagement-a-conceptual-model-to-advance-health-equity-through-transformed-systems-for-health/>

What Do Patients Want from Primary Health Care?

Maret Felzien
March 22, 2022
Strengthening Primary Care
NASEM

Primary care “strives to achieve: ‘... strengthening the physician–patient relationship by replacing episodic care based on illnesses and patient complaints with coordinated care and a long-term healing relationship.’¹

Primary health care should:

- Build relationships and partnerships –
 - that include respect and trust and whole-person care
 - use a “with” not “at” or “for” philosophy
- Seek quality at multiple levels –
 - the right care at the right time, and enough time when necessary
 - access to evidence-based science and participate in research
 - patient advisory boards embedded for quality improvement and assessment
- Provide coordination and continuity of care at various levels –
 - partner for self-education
 - across the spectrum of care
 - team-based care with as many services as possible in one place
- Be accessibility and integrated –
 - care that is local, responsive to community needs, strengths, and trends
 - improves community-level impacts social determinants of health
- Feel permanent with –
 - clinics and clinicians who can thrive and have a tolerable patient load
 - a career track promoting primary care
 - a robust educational pipeline that recruits early and often from within communities
- Be affordable and easy to navigate.

“Everyone, I mean, EVERYONE, should have a great primary care provider.”

-Ed B., PaCE Member

1. Camille Allison (MD), Linda Zittleman (MSPH), Marc Ringel (MD), Maret Felzien, Christopher Bennett, Shirley Cowart, Martha Flores, Rafael Flores, Mike Hernandez, Ned Norman, Mary Rodriguez, Norah Sanchez, Sergio Sanchez, Kathryn Winkelman, Steve Winkelman, Christin Sutter, Susan Gale & John M. Westfall (MD) (2014) Translating the medical home into patient-centred language, *London Journal of Primary Care*, 6:6, 124-130, DOI: 10.1080/17571472.2014.11494363.

OASH Initiative to Strengthen Primary Care

Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care

What Innovations Could the Federal Government Consider to Strengthen Primary Health Care?

Panel Presentation on March 22, 2022

Margaret Flinter, APRN, Ph.D., c-FNP, FAAN, FAANP

Senior Vice President and Clinical Director, Community Health Center, Inc.

**Senior Faculty Member and Founder Emeritus, Weitzman
Institute**

**Chairperson, Board of Directors, National Nurse Practitioner Residency and
Fellowship Training Consortium**

**Co-Principal Investigator, National Technical Training and Assistance Project on
Clinical Workforce Development**

Middletown, Connecticut

Thank you for the opportunity to share my insights and recommendations on the critical issue of **Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care, and specifically, what the Federal Government Could Do to Strengthen Primary Health Care.** I know firsthand that high-quality primary care is possible and exists today, but as the NASEM report notes, it is not what most people in the U.S. experience today. I will address three areas: 1) how to scale the use of interprofessional team models, including technical assistance and training 2) how to scale e-consultation models for improved primary health care and specialty access and care coordination and 3) the need to coordinate HHS awards and initiatives across agencies, including braided funding.

Scaling the Interprofessional team model: The good news is that we have very well established, evaluated, and replicable models of interprofessional team-based care already in place. This model is found in many of the nation's federally qualified health centers, as well as in Veteran Affairs primary care practices. The LEAP (Learning from Effective Ambulatory Practices) Project that I co-directed several years ago found sporadic evidence for interprofessional team-based care in other types of practices, both large and small. There are two distinct elements to having a successful interprofessional team model: the education and training of individual members of the team to their specific role and discipline as part of their preparation for practice, and the practice/organization's definition and choreography by policy, procedure, and practice of the function of the team as a whole. I offer three models that my organization has developed: 1) NIMAA (National Institute of Medical Assistant Advancement), an accredited school for medical assistants which partners with host FQHCs in 14 states to train medical assistant students in high performing, team-based community health centers throughout their entire course of study (www.nimaa.edu) 2) Postgraduate NP Residency Training in FQHCs that train new NPs specifically to a model of integrated and interprofessional team-based care supported by clear accreditation standards (www.nppostgradtraining.com); there is a corresponding postdoctoral clinical psychology residency that is very similar as well and 3) HRSA funded Cooperative Agreement on Clinical Workforce Development that offers organizations an opportunity for intensive, coached, learning collaboratives made up of multiple health centers in implementing the full team-based care model in their practices (www.chcl.com/nca). The NASEM report appropriately identifies the need for support for each of these models from HRSA and CMS.

Scaling eConsultation models for improved primary care and specialty access: What was once one of the most vexing challenges for primary care providers—access to specialty consult when needed in settings with significant uninsured, underinsured, or geographically isolated populations-- has largely been addressed through the development, refinement, and now scaling of eConsults. Originally developed by Dr. Mitch Katz for public clinics in San Francisco, the model was further refined and studied by the Weitzman Institute of CHCI, with consistent findings of quality, safety, reduced costs-- and a need for follow up face to face (synchronous) specialist-patient consultation less than 20% of the time for most specialty areas. EConsults are now a covered service by Medicaid in many states and Medicaid managed care plans; my organization has a non-profit subsidiary, CeCN (Community eConsult Network), devoted to advancing this work through its ConferMED program. Technical assistance and training for primary care providers and practice on how to effectively find and utilize an eConsult service is essential, along with health care policy requiring both public and private payers to establish payment for this service.

Coordinating HHS awards and initiatives across agencies to support these models: As the NASEM report documents, each of these initiatives can be taken to scale and more widely implemented across multiple systems as part of a national strategy towards full implementation of high-quality primary care. For example: Loans and scholarships for individuals from underrepresented communities would provide the opportunity for medical assistants to train in the NIMAA model. HRSA's BHW now funds approximately 36 postgraduate NP residency training programs, but there is demand for many more programs. HRSA's BHW could also designate specific funding for postgraduate clinical psychology residencies to FQHCs and other organizations that demonstrate advanced, integrated team-based models of care. CMS should direct state Medicaid authorities to cover eConsults at an appropriate level. There are opportunities for other divisions of HHS to collaborate in each of these areas towards a common goal of ensuring high-quality primary care, particularly for

vulnerable populations such as individuals with HIV, Substance Use, and Behavioral Health Disorders.

In addition, we would encourage the following:

- Expand and replicate HRSA's successful National Cooperative Agreement on Clinical Workforce Development to provide intensive technical assistance and training specifically focused on advancing a team-based model of primary care for Health Centers and other primary care organizations that can demonstrate they have the leadership commitment to make the necessary changes in policy, staffing, roles and responsibilities, leadership, and facilities. Provide specific support and funding for up to one year to support organizations with intensive coaching, change management, and compensated time by role to offset revenue lost from direct patient care during the transition.
- Identify organizations that can demonstrate that they have achieved a high performing, team-based care primary care practice and support them financially, through payment or incentives in becoming recognized as teaching/educational practices for pre-licensure or certification student experiences across multiple roles and disciplines, including medical and dental assistants, registered nurses, CHWs, social workers, therapists, NP/PA students, medical and dental students.
- Build on the Readiness to Train Assessment Tool of the Bureau of Health Workforce to help organizations self-assess their readiness to embrace health professions training, and to assess their progress towards interprofessional team based care. There are significant costs to creating and supporting students and trainees in organizational staff and facilities. Build on the success of HRSA's ANE-NPR initiative to fund additional primary care organizations to establish postgraduate NP residency and fellowship programs to expand the current number and permanently authorize such programs
- Consider funding additional postgraduate residencies for other members such of team such as chiropractors and pharmacists, and fund the creation of Dedicated Education Units for undergraduate nursing students to introduce them to the role and practice of primary care nursing. Currently, there is no required primary care clinical practice experience or exposure for BSN students.
- Establish and fund administrative, operational, performance improvement, and data/technology fellowships and internships in high-performing primary care organizations adhering to a team-based model to provide intensive training in these critical areas that underline and support team-based primary care models.



PURPOSE: In 2020, the Virginia Center for Health Innovation (VCHI) partnered with the Commonwealth of Virginia to create the Governor's Task Force on Primary Care to ensure that:

- the viability of primary care practices is safeguarded
- primary care payment is predictable and tied to meaningful performance measurement in order to advance better health care value, and;
- primary care is less susceptible to changes in the economy.

DESIGN: VCHI gathered a group of experts representing clinicians, public and private payers, hospital executives, employers, and patients to discuss primary care in the Commonwealth. The Task force was divided into three subcommittees: Infrastructure; Data Validity and Performance Measurement; and Payment Reform. Each developed specific objectives and action plans.

DATA VALIDITY AND PERFORMANCE MEASUREMENT

YEAR 1: COMMITTEE MEMBERS WERE ASKED, "WHAT IS IMPORTANT IN PRIMARY CARE?"

In response to that question, seven measurement categories were identified as most important.

Seven Measurement Categories:

1. Person-Focused Primary Care Measure (Access, Continuity, Comprehensiveness, Coordination)
2. Person-Centric Diversity and Health Equity Measure (Barriers of Race, Ethnicity, Language)
3. Person-Centric Health Literacy Measure (Individual confidence in managing health)
4. Patient Reported Cost Burden Measure (Co-pays, deductibles, medications)
5. Primary Care Clinician Measure (Administrative burden, Data Access, Burnout)
6. Accountability Measure between Employers and Health Plans (Network, Plan designs, Educational tools)
7. Clinical Competency Assessment (Training, Licensing, and Certification vs. Other)

Note: The Infrastructure subcommittee was tasked with identifying a social determinants of health measure and a total cost of care measure

YEAR 2: RECOMMEND SPECIFIC MEASURES BASED ON THE MEASUREMENT CATEGORIES

The subcommittee has now recommended specific measures to utilize based on these seven measurement categories.

1. Health plans limit required reporting of quality measures to those taken from the CQMC Consensus Core set and mutually agreed upon by the Health Plan and the Hospital System/Clinician.
(Measurement Category 7)
2. Pilot the Person Centered Primary Care Measure + What Matters Index as a streamlined instrument.
(Measurement Categories 1,2,3,4)
3. Use the Physicians' Perception of Autonomy. (Measurement Category 5)
4. Develop an Accountability Measure between Employers and Health Plans. (To be developed)

Note: To encourage adoption and create a baseline, these measures would not initially be tied to payment.

CURRENT - END OF DECEMBER:

- Continue designing measurement pilot with input from data subgroup members and potential partners.
- Identify and secure commitments from pilot partners: Health systems/Providers & Health Plans



GUIDANCE FOR DEVELOPING PRIMARY CARE MEASURES

STARFIELD SUMMIT III CONFERENCE BRIEF



Why This Matters

Measurement of primary care can improve performance, reflect shared parameters of improvement, foster learning, set aspirational targets, and reflect shared understanding of what is valuable. Such assessment must be guided by criteria for what makes for a good measure based in a shared understanding of the purpose(s) of measurement.

What We Know

Primary care measures “allow us to consider what is being done well, what might be better left undone, what needs to be changed, and what is essential and therefore needs to remain unchanged”.¹ The purpose of primary care measures is to:

- Monitor the care provided to patients and families
- Evaluate performance of primary health care and primary care practice settings
- Guide self-assessment and continuous learning within primary care settings
- Estimate alignment of care delivered with the needs/expectations of those who receive and provide it
- Inform decision making for primary health care practice, policy, and investment
- Foster aspirations for improvement

What Needs to Change

A new measurement paradigm might be unleashed by new assumptions:

- Primary care is more than a basket of easily defined and commoditized goods and services. Services offered within primary care exist within relationship-based interactions in a personalized setting.
- When done well, primary care enables the right care to be delivered in the right way, at the right time, and in the right place (defined by both the clinician and patient and informed by relevant information.)
- Efficient process is not synonymous with effective care. Care that is not effective is not efficient. The fastest means to a narrow end using the fewest resources may presume the ability to isolate individual services associated with predictable outcomes given certain actions. This is misaligned with the complex, contextual nature of primary care.
- Individual measures do not drive care – they are each part of a larger picture. Measures done well offer guidance and evaluation of the extent a larger vision is being accomplished. When a measure itself becomes a target, it is no longer an effective means for evaluation.² Payment models that encourage narrow and singular measure-directed care motivate a shrinking sense of professional responsibility.
- The maxim “if it isn’t measured, it won’t happen” often causes a maladaptive chain reaction: a narrow interest in doing what is measured, leading to a multiplication of measures to ensure everything gets done, leading to measures of activity and process, rather than measures related to health, healthcare, performance, or quality. Measures reflecting how primary care provides value are needed to complement the easier, narrow measures sometimes needed to serve external interests. Measures are best when they provide guidance and direction, not specific activity mandates.
- Measures should inform and support accountability, not enforce it. That is, primary care measures track what is important about primary care and are not centered on how to pay people and hold them accountable. Payment and “enforcement” are important “off-label” uses of primary care measures, but too often constrain measure development, distracting from measurement purpose. Measures are unlikely to reflect a one-to-one relationship between an individual clinician’s actions and an individual

patient's or population's outcomes. Health and illness are social conditions beyond the direct impact of any one individual. Measures must be responsive to this basic fact. Environments are needed in which measures are used to identify how to support valuable primary care functions and relationships.

- Measures of care of diseases and specific problems are part of the picture, but do not by themselves add up to measurement of primary care. Rather than allow measurement to be dominated by diseases and organs or life expectancies and what we already know how to count, we should reorient measures to include alignment with how we live, how we experience, what makes for quality care, and what is valuable about primary care to persons.

How This Informs Starfield III

The measurement enterprise incorporates many needs, some of which are tangential to the core purpose of primary health care (e.g., proof of service delivery; ability to differentiate practice settings). Measures that focus on these needs serve a function, are useful in many settings, and to a variety of stakeholders. However, these same measures can do harm if considered, all by themselves, an evaluation of the primary care function, the quality of care provided there, or the experience of those who go there. Though necessary and useful, measures developed to meet external needs should not be mistaken for core measures of primary care performance, even if some measures are able to do both jobs. *Primary care measures*, i.e., those intended to assess primary health care function and value, must satisfy the need of the platform and its future.

Primary care measures should be parsimonious – the smallest meaningful set based on the needs of those within the system.³ The description and building of this vital set of primary care measures will be supported at Starfield III by a commonly held set of guidance.

Guidance for Developing Primary Care Measures

Development of the guiding attributes below began before the conference and this development will continue during Starfield III and after. These items are *guidance*, not universal mandates. They will not all be appropriate in all settings and at all times. The need to assess must always be balanced with the purpose, burden, necessity, and use of the information collected. Based on previous research^{1,3} and the contributions of Starfield III attendees thus far, meaningful and useful primary care measures are ones that:

1. Are meaningful – to patients, families, health systems, policy makers, and clinicians
2. Assess primary care as defined, practiced, experienced, and co-created between patients and clinicians
3. Assess the intended outcomes of primary care, e.g., achievement of health and health goals, illness prevention and health promotion, healing, avoidance of unnecessary pain and suffering, and equity
4. Balance the tensions endemic to primary health care: standardization along side customization, predictability along side ambiguity
5. Are flexible – adaptive to size (roll up and down), life span (infant to elderly), health state (changing health status), and individual differences (context, family, and preferences)
6. Provide evaluation and improvement information actionable at the local, regional, and national level
7. Support self-assessment, self-learning, and aspiration
8. Are feasible, reliable, and without undue data collection burden
9. Point out and establish the importance of things that cannot yet be counted
10. Inform evaluation of a broad vision that understands health and illness exist within a social and cultural framework.
11. Reflect the complexity of the discipline – the whole is more than an additive sum of parts. Embrace interconnectivity, reject reduction to cause and effect of individual elements, assess and support emergence – where just adding up what happens to parts (diseases, individuals) doesn't equal the whole (people, populations)

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Summary: NASEM Webinar on Strengthening Primary Health Care

March 22, 2022

Judith Steinberg

- Setting the stage, we heard about the NASEM Primary Care report and the HHS Initiative to Strengthen Primary Health Care. Today and tomorrow's webinars were designed to inform the implementation of the NASEM report's recommended actions and the development of the HHS Plan.
- We began where we should begin – what do people, families and communities need and desire from primary health care? Key messages are the desire for a respectful, trusting, ongoing relationship with their primary care provider and team, attention to who they are and the context in which they live and work and their goals – what matters to them.
- Primary care should be advised by the patients and communities served, and should work in partnership with them. The examples that Dr. Lloyd Michener gave about listening and working with communities to improve health and health care are so instructive. Then we heard about a model, Cityblock Health, that embodies and operationalizes these principles. I loved this summary: to engender trust: primary care should listen and do something
- Change always begins with measurement. You can't change what you don't measure. So we heard from measurement experts on how to measure primary health care: Some key messages:
- Primary care measurement should be streamlined and should be used to hold the system accountable for ensuring the resources needed to achieve the goal. I think the distinction between clinical measures (for example, screening, blood pressure control) and performance measures - whether primary care is delivering or able to deliver on its promise - was also very instructive.
- We heard alarming workforce data trends during the COVID 19 pandemic and the challenges of measuring the full complement of activities of primary health care, not just those that are billable.
- States are beginning to track primary care investment and set targets for increasing that investment. A key message was the need to standardize the definition of primary care and its measurement

- Then we moved on to innovations that lend detail to the NASEM report's recommended actions:
 - Innovations in how we pay for primary care - how a hybrid payment model – (combining a prospective payment with fee for service), might be implemented through the current CMS physician fee schedule process and/or through the Shared Savings program. And how telehealth services are best paid for through a hybrid payment model.
 - We heard how primary care practices, as small businesses, have a need for upfront investment and capital financing in order to achieve the model that our plenary speakers described. A message: the need to coordinate and measure federal funding for primary health care.
 - Payment change is critical but so is addressing the primary health care workforce. Key messages include the need to fund a national health workforce policy commission, suggestions on how to optimize government funded workforce programs, such as training grants and the National health Service Corps and how to begin to change graduate medical education to better address our workforce shortages. This begins again, with measurement and accountability and coordination across federal and state funders.
 - And we heard about how we can best use increased investment in primary care, new payment models and government funded programs by developing the skills and capacity of interprofessional teams and improving coordination between generalists and specialists using technology.
 - And the need to bring these payment models and workforce programs to scale. A very important message

- So, in closing, let's consider these take aways as we, as a collective, take action to strengthen primary health care for the health of all people. families and communities across our nation.

- And stay tuned for tomorrow's webinar when we will hear about innovations in primary health care that are happening in states, territories, and tribal nations and the importance of state-federal partnerships.

Summary: NASEM Webinar on Strengthening Primary Health Care

March 23, 2022

Judith Steinberg

- We focused today's webinar on the innovations that are happening across our country in states, territories, and tribal nations. States and other jurisdictions have already figured out solutions to thorny challenges in strengthening primary health care. They are the laboratories for what could be done in other states and at the federal level.
- First I want to highlight that Maryland's Primary Care Program a multi-payer program has saved lives during the COVID 19 pandemic – there it is – the evidence of the impact of a strong primary health care system on the pressing health issues of our day - a pandemic.

Key themes that I heard were:

The need for state leadership and for convenings of broad coalitions and collaboratives, often with accountability to the state:

- the primary care investment coordinating group in CA
- a required primary care spending report to the legislature in OR on primary care spending by health plans and CCOs
- a primary care payment reform collaborative in OR
- convening a broad coalition in CA to scale an effective model of primary care, and standardizing a parsimonious measure set, a hybrid payment model and the attributes of primary care practice
- the South Carolina collaborative on telehealth
- State offices for value-based care – some of which are requiring a certain percentage of total cost of care spent on primary care

Also the importance of true and effective community engagement and really, empowerment, and partnership with public health

- the community ownership and focus of South Central Foundation
- community involvement in PBRNs and the National Center for Primary Care at Morehouse
- Great slide on key elements in building effective collaborations between primary care and public health – take a look at this
- Using public health data to target interventions to improve health, conducted in partnership with primary care practices
- PA's Community Choice Program designed with input from the community

Other key innovations:

- Risk adjustment model that is used to allocate payments to practices so that they have the resources to help address patients' social determinants of health a comprehensive data dashboard in MD
- Flowing down the capitation dollars and incentives to their primary care practices to strengthen the investment in their network practices and population health.
- The Flexible Service Program in MA - a fantastic evidence-based innovation made at the state level for ACOS to use in getting social service resources to patients and families. This is a program to look at.
- A focus on continuous improvement for example in OR to address outstanding barriers to access and equity and in the National Center for Primary Care and its PBRN
- Meaningful and parsimonious measure sets
- Fully cross generational care
- Use of synchronous and asynchronous virtual interactions between patient and provider team reducing the need for in person visits
- Interstate medical licensure compacts to advance telehealth

Here are some great statements:

- Public health and primary care were born of the same mother, separated for a time and our now rejoined. (Howard Haft)
- This is about pulling resources to where people are and delivering services on their terms. The owners of the system i.e., the consumers, drive the design (Doug Eby)

What can the federal government do? Comments from speakers. (time did not permit me to state these)

- Better align Medicaid and Medicare and other payers.
- Lead a national effort to adjust allocation of payment by social risk factors,
- Blow up the measure set and measure primary care's value,
- increase support for state-based models and advance state and federal partnerships.
- Adjust rules and regulations to bring industry on board
- Other needs are enhanced data on race and ethnicity for use in focusing care and for accountability
- Medicaid should pay for correctional care

We closed this webinar as we started yesterday, with perspectives from the patients served by primary health care and also the workforce – primary care providers (time did not permit me to state these)

- There are significant disparities in consumers' experience and quality of care
- Desire for ongoing long-term relationship, one stop shopping and attention to them as a whole person
- Need for payment reform but with variable design to meet a diversity of practices capacities
- Need to reduce unnecessary administrative burden of ffs
- Focus on wellbeing of the workforce
- True community partnership and empowerment
- Sharing the burden through partnerships

Convergence of perspectives was very evident

These have been an incredible two days of learning. The webinar series provided a lot of information for us to now delve more deeply into as we consider the actions we will take in our purview to strengthen primary health care – all of us.

- For the Initiative to Strengthen Primary Health Care, these actions will be at the federal level, building on the expanse of activities that federal agencies and departments have already put into place or are planning for the coming year to strengthen primary health care. The Initiative has just completed this exercise – assessing the current state. Now we will be considering some pivotal actions to be taken in an initial HHS plan, guided by the NASEM report. And, as ADM Levine noted yesterday, we intend those actions to include setting up the infrastructure in HHS to continue its leadership role in overseeing the strengthening of primary health care to ensure high quality primary health care for all. This includes an infrastructure to ensure ongoing community and stakeholder engagement in this effort.
- Thank you to the speakers, moderators, and our audience members for this wonderful and inspiring discussion we have had over the last two days. And thanks to NASEM for a fantastically organized event. I can't say enough about that.