PRIMARY CARE
INTERNATIONAL
CONFERENCE

The Essential Role of Primary Health Care (PHC) for Health Security and Securing Health

An International Conference

Washington, DC July 19-20, 2023

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Executive Summary:

Never has there been a more urgent need to focus US policymakers' attention on the importance of securing primary health care as part of health security. Life expectancy in the US is eroding for the first time in its history, and the gaps in health outcomes are widening. In 2021, the National Academies of Sciences, Engineering, and Medicine (NASEM) published *Implementing High-Quality Primary Care*, to highlight the fundamental role that primary care plays in addressing the nation's most pressing health threats and growing health inequities. In anticipation of a US Primary Health Care (PHC) Action Plan driven by the Office of the Assistant Secretary for Health (OASH), US and international stakeholders came together in July 2023 to discuss the need for global alignment on strengthening PHC around the world, bringing together more than 20 countries, most HHS agencies, other federal agencies with health missions, national primary health care experts, and stakeholder organizations.

The international conference held in Washington DC built on the goals of the *2018 Declaration of Astana* that sought to galvanize global commitment to Primary Health Care and resulted in the world's health ministers declaring, "strengthening primary health care (PHC) is the most inclusive, effective and efficient approach to enhance people's physical and mental health, as well as social well-being, and that PHC is a cornerstone of a sustainable health system." Despite impressive progress in strengthening primary health care in many countries, the global struggle to respond to the COVID pandemic underscores the critical need to recommit to fit-for-purpose primary health care, to better partner with public health, to promote global health

security, and to improve health equity. A strengthened primary health care system is foundational to reducing death, whether from global outbreaks of infectious disease, mental illness, or chronic disease.

The July conference highlighted US and global efforts to prioritize and invest in primary health care. As part of the US government's commitment to primary care, several initiatives have already been launched. In June, the Center for Medicare and Medicaid Innovations (CMMI) announced the *Making Care Primary* initiative and in September they shared details about the *States Advancing All-Payer Health Equity Approaches and Development (AHEAD) Model* to increase investment in primary care and reduce disparities in health outcomes. In December of 2022 the *HHS Roadmap for Behavioral Health Integration* was unveiled, identifying opportunities to expand access to behavioral health by integrating it into primary care settings. In order to support these and other anticipated efforts, the NASEM recently created a *Primary Care Standing Committee* composed of PHC experts and stakeholders who have the statutory authority to support HHS.

In addition to the US government's domestic focus on primary care, the US Agency of International Development (USAID) recently announced a new *Primary Impact Initiative, together with PMI and PEPFAR.* This effort will renew the focus on PHC, building more intentional linkages across USAID's current global health programs and initiatives to further strengthen PHC, beginning in seven low- and middle-income countries. To ensure progress toward meeting the anticipated goals, both USAID and HHS are developing dashboards to track progress on key PHC functions and population health outcomes. The HHS dashboard is responsive to the recommendations of the NASEM report and builds on a *national scorecard developed by the Milbank Memorial Fund.*

The July PHC conference was unique in its expansive focus on primary **health** care (not limiting itself to primary care) and public health, as well as its emphasis on both US and global examples of progress and promise. The conference was rich with examples and engagement about PHC solutions to improving health equity, mental health, pandemic response and preparedness, and public health. Participants offered insights into elements of an anticipated HHS PHC Action Plan, specifically the importance of standards for measuring, monitoring, and prioritizing research into primary health care. The conference helped set the stage for increased collaboration across US agencies and global PHC stakeholders. Given the challenges inherent in the fragmented US public-private health system, federal leadership to prioritize primary care is essential, particularly as it pertains to the coordination of workforce training, safety net funding, payment and benefits policy, health information technology, quality measurement, and research – all called for in the 2021 NASEM report[i].

Nine conference issue briefs, conference slides, and other resource material can be found on the conference *website*. A summary of the key discussions from the conference are provided below.

Conference Issue Briefs

- Astana Declaration Discussion Martinez-Bianchi-Stavdal (pdf)
- Catalyzing Local Primary Health Care Service Delivery-Ariadne Labs (pdf)
- HHS Action Plan to Strengthen PC-L.Hughes (pdf)
- Inseparable – Primary care and mental health integration (pdf)
- NASEM – An objective venue to inform PC policy (pdf)
- Primary Health Care in United States – Closer Than We Might Think-Bitton Finke (pdf)
- Primary Health Care as a Common Good Stange-Etz (pdf)
- Strengthening Primary Care – Public Health Integration-Haft (pdf)
- Primary Health Care's Critical Role in Advancing Health Equity-Rittenhouse (pdf)

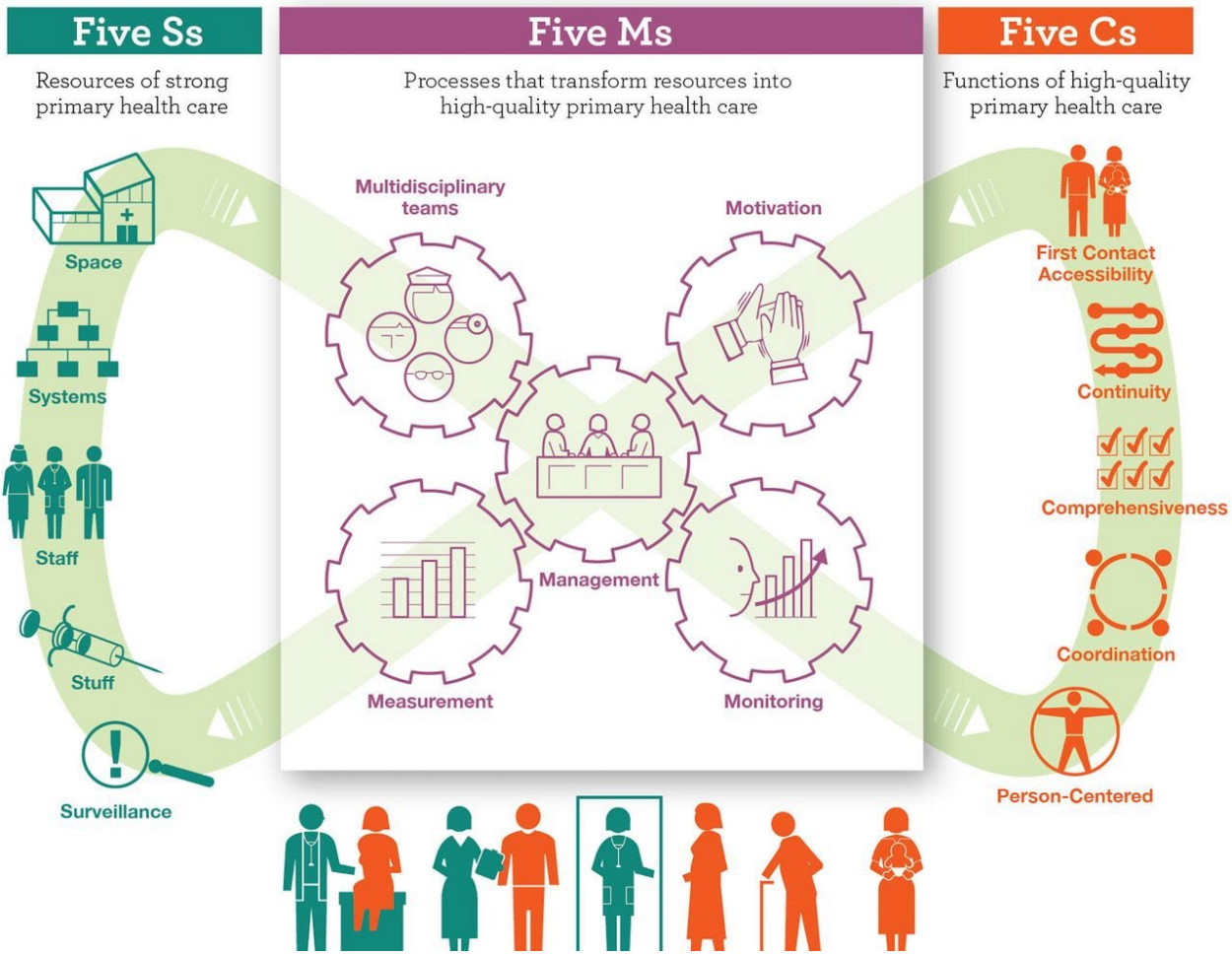
The Essential Role of Primary Health Care for Health Security and Securing Health

Summary of Key Discussions

- The anticipated HHS PHC Action Plan will join a global effort to strengthen primary health care that has been decades in the making, to include the National Academies of Sciences, Engineering, and Medicine (NASEM) published *Implementing High-Quality Primary Care* and the 2018 Declaration of Astana.
- In the US and across the globe, primary health care is severely under-leveraged for securing health, and as a part of health security.
- The US needs a radical reorientation of our primary care (PC) system to one that is based on primary health care.
- Solutions won't be found in any single agency or government. ***USAID, CMS/CMMI, HHS Behavioral Health Plan are leading key elements of the US strategy on primary care*** — but a unified US PHC Action Plan can help to broaden and integrate these efforts clearly and consistently.
- A series of vertical investments cannot adequately address community health. That requires an investment in PHC – a horizontal support that provides foundational, team-based care to improve personal and population health. There is robust evidence that investment in PHC leads to life expectancy improvement.
- Advancing primary health care is the scaffolding on which overall health rests - contact point for people, outreach, and ability to pull people in for the majority of their medical and public health needs.
- We need clear, investable targets to systematically strengthen PHC programs – what are the appropriate metrics and measures to ensure adequate investment and accountability for investing in PHC?
- It can take years to build the trust and relationships to bring people into PHC to get the care that they need.
- How does the US expand its lens from PC to support robust PHC and equity?
    - The public private multi-payer financing system poses a unique challenge for how the US defines value and for PC financing.
    - Maryland and Vermont are the only states with CMS contract for a Total Cost of Care All-Payer Model. Are there opportunities for states that want to do innovate, similar to the community health model in Costa Rica? How can we support the experimentation and dissemination of innovative all-payer models, to include the Making Care Primary multi-payer pilot, and the States Advancing All-Payer Health Equity Approaches and Development (AHEAD) Model?
    - Health systems typically measure value in a reductionist way; there is interest in moving toward more global measures of performance. How can health systems move away from reductionist measures to align clinician/clinic value?
    - The changes that practices must make to shift from fee-for-service to capitation models require up-front resources as the health workforce is required to grow and change.

Practices need implementation and infrastructure support outside of the per patient payment systems.

- Primary care team is central to the care. Telehealth is a key adjunct to the team. It needs to connect the patient to their team. *The ability to contact a clinician or professional on the team by email, chat and video should be integrated into the care model.*
- We need metrics to track our success and create a PHC investment case, for example: (from Atul Gawande's slides)



- Original source: Asaf Bitton, Jeremy H Veillard, Lopa Basu, Hannah L Ratcliffe, Dan Schwarz, Lisa R Hirschhorn (2018). The 5S-5M-5C schematic: transforming primary care inputs to outcomes in low-income and middle-income countries. BMJ https://gh.bmj.com/content/3/Suppl_3/e001020

- Need to bring various disciplines together to address complex problems.
- In the US, value based care empowers a shift away from the hamster wheel of payment codes towards a more relationship-based care model. CMMI's new innovation model is setting goals for having patients in value-based relationships (through ACOs) and a relationship with advanced PC practice.

- Need to overtly address health equity in order to make advances in population health
- Relationship-based care is crucial to building patient trust and engagement
- Most patients go to available emergency departments when there is an urgent need for care. We need to help communities understand that primary care is foundational to health systems that maintaining and protecting health. This reduces crowding in emergency settings and can reduce overall health care costs.
- Primary health care should be viewed as the "Gateway, not gatekeeper" – examples where this is done well include Costa Rica, FQHCs, HMOs/ACOs
- CMMI/government can help set up the structure & provide resources, but implementation and ownership for strong primary health care is local, specific to individual communities, and built on relationships.
- Quote from Admiral Rachel Levine – "All federal agencies & departments are health agencies (everything impacts health)".
- Trading up on efficiency and trading down on trusting relationships prevents us from envisioning a future where mental health is valued as much as physical health = PHC

What is already in motion?

- 2018 Declaration of Astana & Global Conference on Primary Health Care refocused the global community on PHC, many agreements have been made at World Health Assembly since
- 2021 NASEM report on Implementing High-Quality Primary Care offers a blueprint, already used by CMMI, OASH
- 2023 NASEM report on Achieving Whole Health; moving toward 'well-being' and patient-centered health conceptions, on the road toward PHC in the US
- WHO/World Bank announcement of funding for PHC demonstration models in 7 countries across Africa and Asia
- USAID: Primary Impact initiative (2022) designed initially for 7 countries. Development of PHC metrics helps ensures policy and financial investment. There is an opportunity to learn from, adapt and borrow some of those targets for redirection of investment in the US and opportunity to leverage partnership.
- Milbank PC scorecard and HHS PHC Dashboard. Creating measures for national tracking of PHC and Population Health success
    - CMMI's Making Care Primary multi-payer pilot, and the States Advancing All-Payer Health Equity Approaches and Development (AHEAD) Model
- HHS Behavioral Health Integration Roadmap
- HHS Request for Information on on strengthening primary care in the US; anticipated release of PHC Action Plan
    - "Did not start from scratch" - ADM Levine
    - Strong focus on health equity

USAID – Atul Gawande

"In the US, we are experiencing a reduction in life expectancy for the first time since WWII".

-Atul Gawande

"Access is crucial to reaping the benefits of the progress we have made in primary care." USAID supports funding for foreign assistance and diplomatic engagement, and has prioritized advancing health equity around the world by: 1) Preparing for Future Pandemics; and 2) Advancing PHC.

USAID is currently focused on the decline in life expectancy due to COVID-19 Pandemic and delayed access to care: "**We can't address this issue the way we have done it before because everything has broken down; needs to occur by primary healthcare."**

Why is Primary Health Care the Focus?

- PHC delivers 90% of WHO services needed to increase life expectancy
- Evidence that investment in PHC is the way to expand universal to provide essential health services, leading to expanded access to care resulting in improved life expectancy.

How do we pivot to systematically strengthen PHC?

- Critical to learn how lower income countries have been able to show greater success in expanding PHC than we have in the US: **These countries set clear, investable targets**
- Clear metrics are how we make PHC more investable, which is crucial
  - It can't just be about inputs (staff etc), we need to know its managed well and shows outcomes related to coverage
  - USAID is creating new metrics using current data to ensure we have clinics appropriately staffed, people are receiving care in increasing numbers, and ensuring they are achieving equity goals
  - USAID shared a concept for an initial PHC Dashboard, relevant to the HHS PHC Dashboard

Centers for Medicare & Medicaid Innovation – Liz Fowler

The CMS **Center for Medicare and Medicaid Innovation is beginning to implement** elements of a HHS PHC Action Plan by announcing the Making Care Primary program, including a CMMI commitment to Health Equity. CMS has demonstrated this commitment with two new primary care payment models: Making Care Primary and States Advancing All-Payer Health Equity Approaches and Development (AHEAD) Model. As part of the OASH Request for Information on the Initiative to Strengthen PHC, the stakeholder community emphasized the importance of CMS' participation, demonstrating a commitment to make tangible investments in primary care. CMMI has declared primary care and health equity as two of their top priorities.

Panel: Promoting Health Equity by Investing in PHC (Chris Koller; Jim Macrae, Roman Macaya, Purva Rawal)

- **Costa Rica:** 105 health areas in the country, each area has about 10 teams with geographic catchment and accountability. Each Basic Integral Primary Care Team consists of a general practitioner (GP), nurse, medical records clerk, and community health workers (CHWs). The Community is at the Center of their Health System. Basic principle that underlies this structure is equity and use of community health workers to provide outreach. CHWs are able to address health concerns, provide vaccinations, health education, etc. to families in at-home settings as trusted members of the community.
- **US Community Health Centers:** 1,400 health centers around the US, ranging from 2,000 to 200,000 patients; in total around 30 million patients; 90% are below the poverty line. Challenge: Primary care is being asked to do more, and more, and more. We need a model based on community that ensures trust and engagement with the health care system, leading to better outcomes overall.
- **Centers for Medicare and Medicaid Innovation** supports relationship-based, longitudinal, sustained care w/ a PCP and a primary care team. “If you want to work on health equity, you have to work on primary care.” These two things go hand-in-hand. Three main mechanisms to achieve these:
    - Start with the payment, aim to move away from FFS to value - prospective, population-based payments that provide flexibility to bring in different members of the care team based on community needs
    - Bring more safety net providers to the table
    - Need for more resources to support health related social needs, such as food, housing, transportation
    - Sustainable transformation must also be supported by multiple payers (private and public) to reduce administrative burden for providers - alignment of payment and incentives is critical across payers

Keynote: HHS Initiative to Strengthen Primary Health Care - Admiral Rachel Levine

- Fee-for-service payment does not foster comprehensive care, and it hinders our ability to maintain wellbeing across our health care system. The HHS initiative aims to encourage comprehensive care by strengthening PHC, with the goal of emphasizing and improving health equity. Recognizing the social determinants of health are critical to HHS goals (housing, transportation, environment, education, etc); Building community resilience by valuing these social determinants of health.
- Building on policies and programs that already exist across the HHS, but that might not come together without leadership and coordination at the federal level, as anticipated in the HHS PHC Action Plan.

Panel: Addressing the Crisis of Mental Health and Substance Use Disorder and the role of PHC (Ben Miller; Rachel Pryor, Tori Solt, Brenda Reiss-Brennan, John Naslund)

- The main issues that individuals face when needing mental health services are that it is: too complicated, too expensive, and they don't know where to go. PHC can address these concerns by providing an open, trusted door towards healing. This healing is hard to provide without a team. We have made leaps in understanding the science, policy, etc in providing good integrative care, but this is far from the standard of care.

- **Veterans' Health Administration**
    - Veterans are screened for suicidality, substance use, PTSD, etc. when they enter the primary care clinic
        - The primary care clinician does assessment, then sends to primary care integration team
        - They don't send them home in between these things, "warm handoff"
    - The VA sees the patient as a whole person, and VA leadership ask themselves "how can we make a positive difference in this person's life" not "what do they have"
        - Improving competence and confidence in managing comorbid conditions
        - In 2020, there were 350 less veteran suicides than in 2019
        - Trust in the providers by veterans is crucial to this success

- **Intermountain Health**
    - Healthcare is delivered through relationships and mental health integration is crucial to improving the quality of these relationships at Intermountain Health
    - Routine medical care and routine mental health are provided all in the same appointment, same relationships
    - Cost: $22.19/patient, Saved $115/patient per year
- **Example: India**
    - You can train ordinary people to deliver good quality, basic mental health care
    - Needs to be more accessible, relatable, start in the community
- **HHS prioritization of behavioral health is also kickstarting the HHS Action Plan**
    - Momentum for strengthening the US mental health system is unlike, it has ever been before given
    - Why do we know what works, yet its not working?
        - Pushing models, payment models, who is on the care team, etc. Biggest problem is that we haven't integrated mental health into communities
    - It doesn't end with treatment, it involves long-term recovery support

Keynote: Investment, Innovation, and Implementation of PHC for Improved Health Systems Resiliency and Outcomes in the Americas

- According to the World Bank, Latin America was one of the hardest hit areas during the COVID-19 pandemic; The mortality rate of health workers in Latin America was 1.2 x higher than health workers in the US; Maternal mortality rates worsened throughout the pandemic
- PAHO Priorities
    - Emphasizing the importance of the lessons learned from the pandemic
    - Strengthen overall health care by ensuring that PHC can reach everyone
    - Utilizing models adapted to local health conditions

Keynote: Epidemic-Ready Primary Health Care: Preventing and Mitigating the Next Pandemic (Tom Frieden)

- US ranks last in performance rankings on quality and spending
- An increase in blood pressure doubles vascular mortality from age 30-59
- Globally, less than 1/7 people have their blood pressure under control
- Cardiovascular Disease is the leading cause of black-white life expectancy disparities
- WHO-HEARTS offers a model for broader PHC Improvement with focus on
    - Simple, practical protocols
    - Improving purchasing and supply chain management for Medication and Equipment supply
    - Team-Based care
    - Patient-centered services including
        - Improving patient support
        - Reduce/No copayments
        - Improving access and confidence in primary care
    - Information Systems that
        - Provide feedback loops
        - Strengthen data-driven culture of accountability
        - Support quality Improvement

Panel: Progress and Challenges with PC/PHC Measurement (Diana Frymus, Suraya Dalil, Judith Steinberg, Corrine Lewis, Asaf Bitton)

- Commonwealth Fund
    - Main goal is to improve quality of care for uninsured, people of color, low income
    - Commonwealth comparisons of high-income countries provide crucial longitudinal data about primary care. US consistently ranks last on most measures. The focus on collecting patient data adds a critical perspective to help improve US PHC
- USAID
    - Earlier this year Primary Impact was launched- rallied around the need to support LMIC strengthen PHC
    - 7 focus countries (5 in Africa, 2 in Asia), Working to define 2-year action plans
    - Have a measurement framework to inform supporting investments in PHC
    - Strong relationship between PHC and global security, crucial to be prepared for future responses
- HHS
    - HHS Primary Care Dashboard Goals
        - Goal is to monitor health of US PHC and the impact of HHS actions to strengthen PHC
        - Building on Milbank Memorial and Robert Graham Center work
    - Measures must reflect:
        - System wide measures that represent current state of PHC and that PHC investments are reaching PHC
        - The breadth of the HHS Action Plan at the goal level to adequately monitor the impact
        - Health equity (stratifications, demographics, etc.)
        - Measures not too “high level,”

Panel: Research – Assessing the Power of PHC (Luke Allen, Rick Glazier, Laura Sessums, Bob Mash, Kurt Stange)

- Decades-long Research Capacity building in sub-Saharan Africa: PRIMAFAMED
    - Capacity Building
        - Online training program with virtual mentoring
        - Online workshops
        - Face-to-face meeting in different areas
    - Collaboration

        - Setting up global PHC research consortium- identify global questions to investigate (focused mostly on service delivery, role of family physician in regions in relation to PHC, systems of quality improvement, composition of team that can participate in PHC)
    - Communication
        - Dedicated, self-sustaining research journal African Journal of Primary Health Care & Family Medicine (phcfm.org)
        - Engaging with regional policy members- WHO Afro
        - Discussion about developing collaborating centers for PHC in Africa
- Canada is increasing research focus on primary care thanks to leadership of a family physician researcher for their equivalent of the NIH
    - Aiming to increase impact of research, increase population focus, and broaden diversity of researchers
- AHRQ was designated by Congress as primary care research lead, but no funding was assigned to this role until 2022 when it received $2M. Remains less than 0.3% of total federal heath research funding. Besides support and an anemic researcher pool, the good research that is done is not integrated to improve collective understanding of this largest platform for healthcare and health relationships.

Panel: Increasing Sustainable Investment in PHC and Health Systems Around the World (Cicely Thomas, Anna Stavdal, Harsh Bakshi, Loyce Pace)

- Continuous relationships in primary care (continuity) produce trust
    - Longer relationships in primary care are associated with lower hospital admissions, reduced costs, lower mortality - causal relationship with trust
    - Strong primary care provides stability
    - WONCA - world organization of family doctors - 30 by 2030 campaign calls for development partners explicitly to assign 30% of their health funds towards building and improving primary care systems, to deliver integrated, comprehensive primary care services by 2030
- In India, care used to be organized in verticals, focusing on maternity, childhood health, and communicable diseases, but now focus on Comprehensive Primary Health Care
    - Health and wellness centers provide preventative, diagnostic/curative, palliative, and rehabilitative care
    - Community Health Workers, Asha workers (supervised by community health workers), community workers, and others collaborate
    - India's healthcare expenditure - 30% to primary care
    - Moving things that may have been handled in a secondary or tertiary environment in the past in a primary care setting
- Due to financial setbacks, debt, inflation, some countries may have to cut back spending on national healthcare systems; 35 of 36 Global Financing Facility supported countries are not on track to meet maternal mortality requirements

Measurement and Accountability of PHC (Breakout)

- How does primary health care not get second level status, how do we capture its value?
- If WHO could agree on comprehensive measures of PHC could that include the US
- Can we use score cards to affect actionable improvement on a low level
- IHS - maternal health outcomes aren't great - somewhat a result of comorbid conditions but IHS sought to determine the connection between paths to higher levels of maternal care for certain patients and these outcomes - spatially mapped the optimization of comprehensive primary care
- Need to have every patient attributed to a primary care provider in the US
- Primary Care Assessment Tool - from the US and is currently being implemented in some areas of Africa
- Mexico City underserved area - resident/nurse/community health worker - comprehensive measurement - social interactions within the clinic actually improved social connectedness across the community
- Primary care is the core of primary health care - don't forget about primary care within primary healthcare
- USAID and HHS PHC Scorecard are important for national strategy and accountability-how that translates down to clinician and practice assessment needs alignment

Reallocating resources to support PHC (Breakout)

Main takeaways

- Define and measure spending and PHC
- How much money and on what?
- Who are the main targets?
- How to achieve the goals designated for the targets
- How to create motivation and momentum for moving forward with current changes being taken in the U.S.
- What is being done within the states and how actions are impacting PHC
    - What can we learn from the states that are showing 'successful' trends
    - What measures are done to define SUCCESS within primary health care
- Offset trainee debt and reduce wage/payment gap to support primary care workforce
- Spending on PHC
    - Identifying the % of total healthcare spend allocated to PHC to start and identify a plan of action and measurement
    - Estimated at ~25-40% on average in the rest of the Americas
    - U.S. ~5% of spending

    - Defining what PHC means and price the components/functions to understand % spend needed to support adequately
    - Value based health care getting health systems, and payers on the same page with resourcing PHC practices
- PC/PHC Spend Measurement
    - Systems of health accounts using the classification of expenditure and functions to also make assumptions of where money can be allocated
    - Need agreements worldwide on expenditures within different care systems to support comparisons and outcome assessments
- Workforce
    - Payment gap between primary care and subspecialties is harming the workforce
    - Canadian experiment with payment normalization caused a large, sudden workforce effect (increased trainee choice of primary care, reversed emigration to US)
- Loan repayments and reimbursements
- Resourcing primary care to address social determinants with community partners
- Medicare and Medicare Advantage offer ways to lead the payors

PHC workforce (Breakout)

- Specialization is not a problem in and of itself, but an imbalance in specialist-primary care workforce.
- This fuels a larger US Problem which demands a generalist solution – fragmentation.
- Fragmentation is pervasive and accelerating and is a fundamental driver of the unprecedented declining U.S. life expectancy that has been a theme of this conference, declines despite unparalleled investment.
- The U.S. leads the world in specialization and fragmentation, but we're not alone, as these trends are accelerating across the developed world, in contrast to LMIC, where absence of resources hasn't permitted sufficiency in specialized services.
- Generalism is deeply misunderstood, conflated with words like basic/easy instead of complex and critical, and diminished not only in training but payment and in popular media.
- It is critical that we continue to demonstrate the value of generalism and a generalist workforce; back it with numbers (which we know exist in peer review and even lay literature; see David Epstein's "Range").
- It is particularly important that we build evidence based consensus around the need for Generalist-Specialist balance; 50% has demonstrated value (Commonwealth, Starfield).
- A solution comes from elevating rather than diminishing the demonstrated value of generalism and recognize that gatekeeping is not a dirty word.
- And this must come not just at the individual level, but through our PHC teams, which must be funded not only to practice together but to train together (inter professionalism).

- Social Accountability as a framework - community-directed, need driven workforce planning must be addressed in implementation of any successful PHC Action Plan.
- HHS must stand up for the virtue of a balance between generalism & specialization (50-50) support measurement and tracking of its investment in training and workforce. What HHS decides to measure & value as it operationalizes its strategy is what it will get.
- Only with this framework will we achieve community exemplified by PHC but community driven resource allocation.

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

RECOMMENDATIONS

I. PAYMENT REFORM

1. **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.
2. **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.
3. **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.
4. **Facilitate Primary Care Payment Reform at the State Level.** States play an important role in implementing payment reform through policy and action.

II. ENSURE ACCESS

5. **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.
6. **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.
7. **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.
8. **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.
9. **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.

III. TRAIN PRIMARY CARE TEAMS

10. **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.

11. **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.

IV. ADVANCE DIGITAL HEALTH

12. **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.
13. **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.

V. ENSURE IMPLEMENTATION

14. **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.
15. **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.
16. **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.