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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.

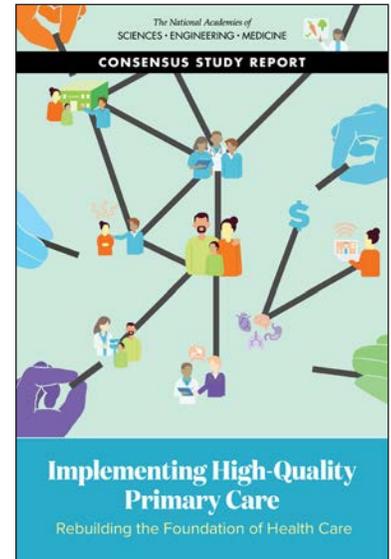
Unequal access to primary care remains a concern, and the COVID-19 pandemic amplified pervasive economic, mental health, and social health disparities that ubiquitous, high-quality primary care might have reduced. Primary care is the only health care component where an increased supply is associated 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

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

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.

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.

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