Rev PC Summit Annotated Bibliography

This annotated bibliography seeks to provide foundational information and perspectives about why and how to increase the proportion of the health care dollar devoted to primary care and systemic change options. It includes reviews, studies, op/ed pieces, reports and briefs from multiple perspectives. This is not a formal review, but rather a primer to the Rev PC Summit topics. The bibliography is organized according to Summit sessions. Articles that are relevant to more than one Summit session will be noted as such. These summaries were prepared by Antonio Hernandez, a third-year medical student at UC Davis, by summarizing key concepts from the articles and including direct quotations where relevant.

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Expert Committee Session 1: Sharing What Has Been Learned Through Efforts to Optimize the Primary Care Spend

In addition to the articles below you may find articles 14, 27, 28, 29, 30, 31, 32 relevant.

1. **Title:** Spending for Primary Care Fact Sheet
   Topic: Primary Care Spending, Ratio of Primary Care, Healthcare Spending
   Article Type: Fact Sheet
   Citation: Primary Care Collaborative. Spending for Primary Care Fact Sheet. March 2020. https://thepcc.org/resource/spending-primary-care-fact-sheet

   Summary: Despite high levels of U.S. healthcare spending, the proportion spent on primary care is inadequate and inefficient for the country's healthcare needs. This fact sheet provides an overview of the:
   1. current U.S. primary care spending compared to other healthcare costs (varies between 5.8% to 7.7% of total spending by health insurers);
   2. effects of inadequate primary care spending on access to preventive services and the primary care workforce (e.g., decrease in practicing primary care physicians from 44% to 37% between 2005 – 2015); and
   3. evidence that doubling the primary care spend to 10%–12% of the total health care dollar would improve outcomes while covering the increased primary care cost. Research shows that investments in primary care lead to lower costs, higher patient satisfaction, fewer hospitalizations and ED visits, and lower mortality.

2. **Title:** Measuring Primary Healthcare Spending. Technical Brief No. 44
   Topic: Primary Care Spending, Primary Care Measurement
   Article Type: Technical Brief
   Citation: Cohen DJ, Totten AM, Philips RL Jr., Jabbarpour Y, Jetty A, DeVoe J, Pappas M, Byers J, Hart E. Measuring Primary Healthcare Spending. Technical Brief No. 44. (Prepared by the Pacific Northwest Evidence-based Practice Center under Contract No. 75Q80120D00006.) AHRQ Publication No. 24-EHC013. Rockville, MD: Agency for Healthcare Research and Quality; May 2024. https://doi.org/10.23970/AHRQEPCTB44
   (Final reports are located on the Effective Health Care Program search page. iii)

   Summary: This 2024 report provides definitions, data sources, and approaches used to estimate primary care spending in the United States and identifies where consensus exists in measurement methods. It concludes with providing guidance on steps toward a standardized approach to measuring primary care spending. The report relied on a literature search of peer-reviewed and grey literature, responses to a Federal Register Notice, and recommendations from key informants. It found that primary care spending estimates ranged from 3.1% to 10.3% of the total health care dollar. More than 40 definitions of primary care spending were cited; in particular "13 State Governments have developed and/or are implementing measurements of primary care spending." There are similarities among definitions of primary care spending, but significant differences between measurement methods, which prevents comparisons among studies. The report concludes with recommendations for policy leaders,

including creating a primary care clinician database to reduce reliance on CPT codes, developing "a template for transparent reporting of methods used to estimate primary care spending, collaborat[ing] with federal and state agencies to develop shared definitions and estimates of primary care spending, and continu[ing] the development and ongoing maintenance of State All-Payer Claims Databases."

3. **Title:** Revitalizing Primary Care, Part 1: Root Causes of Primary Care's Problems
Topic: Primary Care Reform, Healthcare Reform, Burnout, Primary Care Spending, Panel Size
Article Type: Commentary, Opinion
Citation: Bodenheimer T. Revitalizing Primary Care, Part 1: Root Causes of Primary Care's Problems. Ann Fam Med. 2022 Sep-Oct;20(5):464-468. doi: 10.1370/afm.2858. PMID: 36228065; PMCID: PMC9512560.

Summary: This essay focuses on what Bodenheimer argues are the two primary causes of Primary Care's problems which are:

1. insufficient primary care spending;
2. panel sizes that are too large for the team that manages them.

Using the latest systematic reviews and leaning heavily on personal experiences and professional interactions, Bodenheimer explains why he believes these are the root causes of the problems in primary care. In addition to those two root causes, there is also discussion on access for patients and burnout in primary care. Bodenheimer argues that the lack of primary care spending is leading to large panel sizes that providers struggle to manage as well as discouraging medical students from pursuing careers in primary care, which further exacerbates the size of panels. In the US, the average panel size for a family physician is 2,194 patients while the average panel size in Europe was 1,687 patients (2015). Bodenheimer also makes the case that panel size metrics are not up to date with the current realities of the system. Panel size should consider patient complexity, patient access, comprehensiveness of services offered, and the team that is caring for the panel. Without panels optimized for patient care, there will be decreased patient access and increased burnout for primary care physicians. This overview of the root causes of problems in primary care concludes part one of the essay and prepares readers for part two which focuses on the most promising initiatives.

4. **Title:** Revitalizing Primary Care, Part 2: Hopes for the Future
Topic: Primary Care Reform, Healthcare Reform, Burnout, Primary Care Spending, Panel Size
Article Type: Commentary, Opinion
Citation: Bodenheimer T. Revitalizing Primary Care, Part 2: Hopes for the Future. Ann Fam Med. 2022 Sep-Oct;20(5):469-478. doi: 10.1370/afm.2859. PMID: 36228059; PMCID: PMC9512544.

Summary: In this part 2 essay about the health of primary care in the United States, Bodenheimer presents the limited success of many initiatives to improve primary care. Bodenheimer highlights how many of these initiatives do not address the root causes of primary care problems that he identified in part 1, (insufficient spending on primary care leading to large panel sizes without sufficient workforce support). These initiatives are identified as either diffuse or focused, depending on whether they aim to improve multiple components or a single component of primary care. Diffuse initiatives included

Primary Care Medical Homes (PCMH), Accountable Care Organizations (ACOs), and Comprehensive Primary Care Plus. Focused initiatives included care management, open access, and telehealth. Bodenheimer argues that these initiatives have not addressed the root causes, nor have they had sufficient success improving primary care. From his +50 years of experience, he identifies "bright spot" practices and "far-reaching policy," that can "increase primary care spending and build powerful teams that can assist clinicians in caring for their panels." Bodenheimer shares examples of how state governments can mandate or strongly incentivize increases in primary care spending. Federal incentives, such as decoupling the Relative Value Scale Update Committee from how Medicare determines reimbursement rates, would lead to more accurate reimbursement to often overestimated costs of procedural specialty services. To address the challenge of large panel sizes, Bodenheimer cites examples of interprofessional healthcare teams, improvements to core clinical teams, and opportunities for health care team members to take more autonomy in the management of various patient conditions. "With adequate primary care spending and powerful teams," Bodenheimer believes that "primary care can become accessible to patients and joyful to all".

5. **Title:** The Health of US Primary Care: A Baseline Scorecard Tracking Support for High-Quality Primary Care
Topic: Primary Care Scorecard, Implementation of high-Quality Primary Care, Measuring Primary Care
Article Type: Report
Citation: Jabbarpour Y., Petterson S., Jetty A., Byun H., The Health of US Primary Care: A Baseline Scorecard Tracking Support for High-Quality Primary Care, The Milbank Memorial Fund and The Physicians Foundation. February 22, 2023.

Summary: One of the recommendations from the 2021 National Academies of Science, Engineering, and Math (NASEM) Report on *Implementing High Quality Primary Care* encouraged the development of a scorecard to measure progress toward this implementation. Using five performance indicators that align with recommendations in the NASEM report, this first-of-its kind scorecard covers financing, workforce, access, training, and research. The overall finding for financing: there is underinvestment in US primary care calculated as the proportion of the total of health care spend to the primary care spend, and how that compares with proportional primary care spend of comparable countries. Workforce finding: the US primary care workforce is shrinking, but the distribution of primary care providers varied among states both in terms of primary care providers overall and the composition of providers, such as physicians, nurse practitioners, and physician assistants. Related to this shrinking primary care workforce, the scorecard found that many adults report not having a primary care provider they regularly see, and that this percentage of adults is growing. This issue of access has continued to grow even as rates of uninsurance have been decreasing. Training data is consistent with these workforce issues where too few physicians being trained in community settings. In the final performance indicator, the scorecard found a dearth of primary care research investment; most significantly only 0.2% of NIH funding is allocated to primary care research. It's not well understood what the optimal levels are for the Scorecard indicators, but the authors make the case that the current measurements indicate that not enough is being done to support high-quality primary care. Despite some NASEM measure guidelines,

data limitations challenged the scorecard development and more data infrastructure work is required to get a complete understanding of progress toward the implementation of high-quality primary care. The scorecard finds severe underperformance among all indictors across the United States, but the authors intend for the scorecard to serve as a baseline that the nation and individual states can work from to improve their current efforts supporting high-quality primary care. The report concludes that "monitoring and reporting on national and state progress toward achieving high-quality primary care Is an essential step toward accountability and positive change."

6. **Title:** Primary Care Productivity: Findings from the Literature and Perspectives from a Stakeholder Panel
Topic: Primary Care Productivity, Primary Care Definitions
Article Type: Research Report
Citation: Hempel, Susanne, Idamay Curtis, Stephan D. Fihn, Annie Brothers, Marjorie Danz, Karin M. Nelson, Aneesa Motala, and Lisa V. Rubenstein, Primary Care Productivity: Findings from the Literature and Perspectives from a Stakeholder Panel. Santa Monica, CA: RAND Corporation, 2021. https://www.rand.org/pubs/research_reports/RRA703-1.html

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Summary: Definitions related to primary care vary widely, including definitions of productivity. This RAND report using systematic reviews of available evidence and discussions with expert stakeholders sought to "define productivity, input, and output in primary care; identify tools relevant to primary care productivity; and establish consensus regarding key aspects of primary care productivity." In addition to providing guidance on these definitions, the stakeholder panel endorsed several statements found in the report, these statements emphasized the context dependent nature of any productivity measurements and underscored the need for supports for improving primary care. Results of the study lead to three broad approaches to output which were "throughput," "procedure," and "revenue" which measure productivity in metrics like patients seen, services performed, and financial earnings, respectively. Through this literature review and the stakeholder panel a framework for primary care productivity was developed, this "Primary Care Productivity Measurement Framework" defines inputs by the "labor and capital resources," and the "activities the resources intend to support." Outputs in this framework are splint into three categories, "direct activity products," such as the patients seen or procedures performed, "intermediate activity products," such as quality and comprehensiveness, and "desired outcomes" like quality of life or care experience. Both the inputs and outputs are considered within the context that they exist which includes the type of health care organization, the patient population, the primary care site, and the health care team characteristics. Together these findings help grow consensus regarding definitions in primary care productivity.

7. **Title:** Health Is Primary: Charting a Path to Equity and Sustainability PCC Evidence Report 2023
Topic: Primary Care Supply, Primary Care Demand, Primary Care Workforce
Article Type: Report, Policy Recommendations
Citation: Huffstetler A, Greiner A, Siddiqi A, et al. Health is primary: charting a path to equity and sustainability. Primary Care Collaborative and the Robert Graham Center, 2023. https://www.graham-center.org/content/dam/rgc/documents/publications-reports/reports/pcc-evidence-report-2023.pdf

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Summary: The Primary Care Collaborative first published a 2019 report on the shared principles of primary care. This report continues in the spirit of those principles to evaluate "the current supply capacity for primary care and demand for its use…" The seven shared principles of primary care are "patient centered, comprehensive & equitable, continuous, coordinated & integrated, team based & collaborative, high value, and accessible." Guiding this report are three objectives, understanding the factors that address access, the supply and demand factors that support primary care, and what investments are needed to shift primary care to a public good. Split into 3 sections, this report covers 1) a literature review of the supply and demand on primary care, including the distribution of primary care providers, the population need for primary care, and the expectations for primary care; 2) an evaluation of the primary care workforce, including both physicians and advanced practice practitioners; 3) A set of recommendations and policy implications. These recommendations cover 5 domains: data, payment, workforce, education/training, and employers.

8. **Title:** Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care
Topic: Primary Care Models, Policy Recommendations, Primary Care Workforce
Article Type: Consensus Study Report
Citation: National Academies of Sciences, Engineering, and Medicine. 2021. *Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care*. Washington, DC: The National Academies Press. https://doi.org/10.17226/25983. (McCauley L, Phillips RL Jr., Meisnere M, Robinson SK, eds.)

Summary: This consensus study report by the NASEM provides a vision for the implementation of high-quality primary care. The report includes the history of primary care and the current trajectory, the areas of concern, and where we need to fill knowledge gaps. The report covers these topics in depth through which recommendations for the implementation of high-quality primary care are formed. Undergirding the five implementation objectives is the emphatic assertion that primary care is a public good because, "primary care is the only health care component where an increased supply is associated with better population health and more equitable outcomes." A series of recommendations are based on the following implementation objectives that the committee set "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"

Expert Committee Session 2: What Elements Belong in Optimally Resourced, Relationship Oriented Primary Care Practices, What Do They Cost, and How Should Practices Be Paid to Provide Them?

In addition to the articles below you may find articles 8, 16, 17, 18, 26 relevant.

9. **Title:** Time for Family Medicine to Stop Enabling a Dysfunctional Health Care System
   Article Type: Commentary, Opinion
   Author: Kurt C. Stange, MD, PhD
   Citation: Stange KC. Time for Family Medicine to Stop Enabling a Dysfunctional Health Care System. Ann Fam Med. 2023 May-Jun;21(3):202-204. doi: 10.1370/afm.2981. PMID: 37217333; PMCID: PMC10202512.

   Summary: Stange asserts that primary care physicians are the integrators of a healthcare system designed to disintegrate and these physicians cannot continue to work under the current malfunctioning system. Continued work in a setting where healthcare is treated like a commodity, primary care physicians are propping up the same system that is causing burnout, moral distress, and depersonalization. Rather than continue to ask an under-resourced primary care workforce to uphold a failing healthcare system, he makes the case we should deliver the highest quality personal doctoring feasible under current conditions. From those conditions, the growing patient demand for those services can drive the systemic changes needed. The idea of having a personal doctor doesn't have to be a dream of the past, but instead could be the reality of a foundation for the future of a healthcare system. By focusing on the types of settings and situations in which physicians will practice rather than purely addressing the number of physicians that are trained, we can ensure that physicians can provide the full use of their skills to meet the needs of patients. With these changes, we can address issues like burnout, low student interest in primary care, and compensation. Instances of this vision have been seen in the Direct Primary Care monthly subscription models that allow physicians to assure all primary care for mixed panels. Physician led Accountable Care Organizations (ACOs) have shown some systemic possibilities in improving quality with controlled costs by investing in relationships and targeted use of specialized services. These are signals that productive change is possible. Only by rejecting current conditions can we move toward a system that values and invests in healing and health-promoting relationships with patients and communities.

10. **Title:** Forging a Social Movement to Dismantle Entrenched Power and Liberate Primary Care as a Common Good
    Topic: Coalition Building, Healthcare Reform, Primary Care Reform, Family Medicine, Direct Primary Care, Primary Care for All
    Article Type: Commentary, Opinion
    Citation: Grumbach K. Forging a Social Movement to Dismantle Entrenched Power and Liberate Primary Care as a Common Good. Ann Fam Med. 2023 Mar-Apr;21(2):180-184. doi: 10.1370/afm.2950. PMID: 36973058; PMCID: PMC10042563.

Summary: Despite reforms and advocacy efforts of the last few decades, there have been no fundamental improvements to the field of family medicine or primary care. Although the NASEM 2021 Report, *Implementing High-Quality Primary Car* (bibliography article #8), presents new opportunities through policy recommendations, Grumbach argues that this reform effort will fail to yield transformative change unless the field of family medicine adopts a new theory of change and tactical approach to health care reform. In this essay, Grumbach argues 1) as stated in the NASEM report, high-quality primary care is a common good; 2) market-based health systems are a barrier to primary care as a common good; 3) professionalism has both helped and harmed family physicians' efforts as agents of change for primary care as a common good; 4) family physicians must adopt "counterculture professionalism" to work with patients and a broad coalition of allies to actualize primary care as a common good.

Grumbach presents a vision of primary care as a public good through the concept of "Primary Care for All." This vision imagines a single payer system for all primary care services using a monthly capitation fee model similar to the direct primary care model. Existing insurance programs would continue to provide non-primary care services. Government would fund this program at 10% of the total US health care spend. Reform like this would be made possible through a social movement for primary care that brings a broad coalition of patients, the PCP workforce and other stakeholders. As next steps to build this movement, Grumbach makes three recommendations in the following order: 1) include public members on the boards of family medicine organizations; 2) family medicine should support patients and community members as leaders in the implementation of NASEM recommendations; 3) as equity is paramount, power must be shared with patients and community, as well as with advance practice professionals rather than continue the turf battles that exist today. Only through this broad mobilization of a social movement for primary care can we expect that current reforms will lead to a successful transformation where previous reforms could not.

11. **Title:** Revising the Logic Model Behind Health Care's Social Care Investments
Topic: Healthcare investment, logic models, Social Services, Primary Care, Social Services Navigators, Social Determinants of Health
Article Type: Commentary, Opinion
Citation: Gottlieb LM, Hessler D, Wing H, Gonzalez-Rocha A, Cartier Y, Fichtenberg C. Revising the Logic Model Behind Health Care's Social Care Investments. Milbank Q. 2024 Jun;102(2):325-335. doi: 10.1111/1468-0009.12690. Epub 2024 Jan 25. PMID: 38273221; PMCID: PMC11176407.

Summary: There has been increased focus on the social determinants of health and the influence that social risk has on patient outcomes. There is evidence to show that programs that aim to connect patients to social services do lead to better patient outcomes, but studies have shown that changes in social risk are not mediating these outcomes. Gottlieb et al. argue that the traditional logic model, which states that identifying and addressing unmet social risks through social services will lead to decreased social risk and thus improve health outcomes, is insufficient because patient outcomes are "not solely the result of increased access to social services and reductions in social risk." Rather "emotional

support/healing relationships," "health care services connections," and "tailored clinical care," are also critical, evidence-based pathways that should be integrated into a more expansive logic model for social interventions. These pathways are "not mutually exclusive and may often be interconnected." The authors argue that understanding the impact of social services navigators in this way will allow for better decisions when it comes to cost-effective investments. They make the case that this integrated model provides a more robust approach for better understanding the mediating factors of social services interventions and the development of further logic models. It also helps highlight the new understanding that, even in cases where social service resources are limited, increasing investment in navigators may be "more cost-effective than investments solely focused on one pathway."

12. **Title:** Radical Reorientation of the US Health Care System Around Relationships: Rebalancing the Transactional Model
Topic: Fee-For-Service, Healthcare Reform, Continuity of Care, Provider-Patient Relationships, Administrative Workload, Care Delivery Models
Article Type: Commentary, Opinion
Citation: Sinsky CA, Shanafelt TD, Ristow AM. Radical Reorientation of the US Health Care System Around Relationships: Rebalancing the Transactional Model. Mayo Clin Proc. 2022 Dec;97(12):2194-2205. doi: 10.1016/j.mayocp.2022.08.003. Epub 2022 Oct 4. PMID: 36207152.

Summary: The authors make the case that the "corporatization and commodification of healthcare," has led to a system where the relationships between patients and physicians is deprioritized. Providers are seen as interchangeable between visits and that being seen by any provider is just as good as being seen by their regular provider. This transactional model of healthcare permeates the entire healthcare system in the way that healthcare teams are structured, the additional administrative workload placed on providers, and in the fee-for-service payment model. The authors make the case that the healthcare system can be "radically reoriented around relationships" through "three foundational actions that must be advanced to reorient the care delivery system structure…" Health care systems must:

1) "prioritize continuity of relationships," which include changes like having providers follow in-patients through discharge even if they are no longer on service, work with the same healthcare teams, and support provider conversations to facilitate continuity of care. The authors further clarify that these changes must go beyond being led by individual physician behavior change, but rather this must be supported by "the design of the systems in which they practice," through "staffing models, communication channels, and scheduling systems.
2) "make room for relationships by removing sludge from the system," which includes automating administrative processes, reducing documentation, and aligning the values and goals between administrators and providers. The time and workload savings from these actions should be reinvested into efforts that support relationship building between providers and patients.
3) "realign reimbursement and incentives," which includes encouraging providers to "adopt an owner's mindset in practice" to ensure that the highest value practices are aligned with the needs of patients, and to "align payment in support of relationships," which includes changing

payment systems to reimburse for time spent supporting relationships and reducing the documentation burden associated with those reimbursements.

The authors acknowledge that the biggest barriers to this transformation are that our current transactional medicine system is the norm, which makes it challenging to imagine that change is possible. With the limited resources experienced in healthcare and the perceived lack of substantial change in recent memory, it can be difficult to believe that the healthcare system can be reoriented around relationships. The authors believe that, with a collective effort from all stakeholders including providers, policymakers, and payors, radical reorientation around relationships is possible.

13. **Title:** Health Care Expenditures Attributable to Primary Care Physician Overall and Burnout-Related Turnover: A Cross-sectional Analysis
Topic: Physician Burnout, Health Care Spending, Primary Care Reform,
Article Type: Original Research, Simulation Model
Citation: Sinsky CA, Shanafelt TD, Dyrbye LN, Sabety AH, Carlasare LE, West CP. Health Care Expenditures Attributable to Primary Care Physician Overall and Burnout-Related Turnover: A Cross-sectional Analysis. Mayo Clin Proc. 2022;97(4):693-702. doi: 10.1016/j.mayocp.2021.09.013

Summary: Primary care faces a shortage of physicians, especially as burnout exacerbates overall turnover. Published literature continues to show the importance of maintaining continuity of care in primary care. There is also growing evidence that burnout contributes to "higher rates of physician turnover, more frequent errors, lower quality, and threats to physician well-being." Building a simulation model using cross-sectional survey data (measuring PCP burnout and intention to leave practice) and healthcare expenditure data, Sinksy et al. bridge the gap in evidence on the impact that burnout-related turnover has on health care expenditures. The authors used conservative estimates of percentage of physicians that leave practice, panel size, and panel composition of Medicare/non-Medicare patients to estimate excess health expenditure for patients who lose their PCP. The base model estimated that there is an $86,336 excess health care expenditure per PCP in the first-year-following-leave (regardless of burnout status). Of the nearly $1billion in first-year excess expenditures nationally, $260 million is due to burnout-related turnover (sensitivity analysis ranges between $178M and $444M). The authors make it clear that this turnover cost is distinct from "the estimated $4.6 billion borne annually by health care organizations in costs attributable to burnout related to reduced productivity…."; thus, concluding that "[c]ollectively, these costs would translate to a nearly $5 billion increase in health care expenditures each year due to burnout-related turnover costs." Sinsky et al. identify several limitations in the study but assert that their conservative estimates do not overstate the impact that PCP burnout has on health care expenditures.

Expert Committee Session 3a: Advancing Optimally Resourced, Relationship Oriented Primary Care (Identifying Necessary Research to Attain the Vision)
In addition to the articles below you may find articles 2, 8, 10, 12, 21, 25 relevant.

14. **Title:** Measuring Primary Care Spending in the US by State
Topic: Primary Care Spending, Primary Care Data Transparency, State-Federal Policies, Healthcare Spending
Article Type: Research Brief
Citation: Cohen DJ, Totten AM, Phillips RL, Jabbarpour Y, DeVoe J. Measuring Primary Care Spending in the US by State. JAMA Health Forum. 2024;5(5):e240913. doi:10.1001/jamahealthforum.2024.0913

Summary: Primary care spending by U.S. state was estimated through a search of grey literature, Ovid MEDLINE, and Cochrane Central. From this search, recommendations to standardize state data were identified. The authors identified nine states that estimate primary care spending as a percentage of total health care spending and ten states that estimate primary care spending by payer type. There are a broad range of definitions leading to significant differences in state primary care spending estimates. B*etween 3.1% to 10.2% of total spending was allocated to primary care depending on the definition used*. For example, some states included OBGYN providers, Behavioral Health Clinicians, NPs, and/or PAs in the definition of the primary care workforce. Furthermore, differences in states' total health care spending existed as some states did not include prescription drug costs. Without a standardized method of measurement, it was not possible to determine spending differences across states, time, or in response to policy decisions. The authors note that measuring primary care spending should include all payers and all primary care services provided to all people (including claims and nonclaims payments, patient cost sharing, and charity care). A standardized consistent measurement of primary care spending will allow us to better understand the effects of policies, initiatives, and the associated health outcomes.

15. **Title:** Overcoming Common Anxieties in Knowledge Translation: Advice for Scholarly Issue Advocates
Topic: Knowledge Translation, Policy Advocacy, Movement Building, Policy Implementation
Article Type: Commentary, Opinion
Citation: Kershaw P, Rossa-Roccor V. Overcoming Common Anxieties in Knowledge Translation: Advice for Scholarly Issue Advocates. Milbank Q. 2024 Jun;102(2):383-397. doi: 10.1111/1468-0009.12694. Epub 2024 Feb 16. PMID: 38363871; PMCID: PMC11176404.

Summary: There has been increasing urgency for the academic community to more effectively implement evidence generated from research; however, shortcomings of translating this knowledge into action must be addressed. Kershaw and Rossa-Roccor make the case that that effective Knowledge Translation (KT) will require overcoming "three anxieties" that researchers face in the process of KT. By addressing these anxieties, KT practitioners can avoid "the trappings of the information deficit assumption," in which practitioners assume that their role in KT is to provide evidence that policy makers lack and that the best evidence will always be used by policy makers. For each of the anxieties, Kershaw

and Rossa-Roccor offer a "think and act like a…" recommendation where they complete the sentence with "marketer, lobbyist, movement, or political scientist." The first of these anxieties is that "evidence is not the primary factor influencing human decisions." Values are often what drive decision-making, and the authors make the case for this through the "moral foundations theory" (MFT) which "depicts how morals, intuitions, and emotions guide decision making." The authors' recommendation to address this is to "think and act like a marketer," by instead framing evidence as a call to action. The second anxiety is that "insufficient attention is given to the role of power in obstructing or supporting evidence implementation." The authors recommend that KT practitioners "think and act like a lobbyist or movement," by intentionally directly lobbying those in positions of power and by indirectly influencing decisions through movement building with the public. The third anxiety is that "current theories of policy change in KT are too simplistic" which highlights the case that the "information deficit" model is the current primary theory of change for KT Practitioners. They argue that one must "think and act like a political scientist" by adopting theories of policy change already developed by the political sciences. The authors acknowledge that these recommendations are not without challenges. The politics associated with these strategies can risk criticisms from colleagues who are often operating under the prevailing idea that such strategies undermine the objectivity of academia. Academic institutions need cultural change that incentivizes KT practitioners to take the time to implement these advocacy strategies. Institutions can assign greater weight to KT have --on par with research productivity-- in the determination of academic promotions. Kershaw and Rossa-Rocca argue that the risks associated with these recommendations are minimal compared to the risk of "leaving so much scholarly evidence unimplemented in the world of politics" which has "harmful implications for avoidable morbidity, avoidable mortality, and life expectancy."

16. **Title:** Estimating the Costs of Implementing Comprehensive Primary Care: A Narrative Review
Topic: Implementation Costs, Primary Care Reimbursement, Payment Models, Primary Care Costs
Article Type: Narrative Review
Citation: Martsolf GR, Kandrack R, Friedberg MW, Briscombe B, Hussey PS, LaBonte C. Estimating the Costs of Implementing Comprehensive Primary Care: A Narrative Review. Health Serv Res Manag Epidemiol. 2019 Apr 30;6:2333392819842484. doi: 10.1177/2333392819842484. PMID: 31069248; PMCID: PMC6492354.

Summary: In this systematic review, the authors look at 8 studies to understand the current costs associated with practices implementing and sustaining Comprehensive Primary Care Services. These services go beyond face-to-face visits and include services such as "care management, care coordination, expanded access including after-hours visits, and electronic communication with providers." These studies varied significantly in the costs that were measured, the categorization of comprehensive primary care, and the comparison groups when estimating costs. For example, studies varied on whether they were calculating the costs with becoming a level 3 recognized practice by the National Committee for Quality Assurance, estimating the costs with sustaining services associated with comprehensive primary care, or calculating the costs of implementing new comprehensive primary care services. These studies often had small sample sizes of practices that were selected on

convenience. Findings did suggest that payments for sustaining comprehensive primary care services are likely set within a reasonable range as "five of the studies estimated comprehensive primary care capacity maintenance costs of $2 to $5 per patient per month," which "overlap the range of payments offered by sponsors of recent medical home demonstrations." The heterogeneous designs and limited generalizability of the studies highlight the need for additional research for payers to align their payment models with the actual costs of adopting comprehensive primary care.

17. **Title:** Primary Care Continuity, Frequency, and Regularity Associated with Medicare Savings
Topic: Primary Care Visit Patterns, Healthcare Savings, Primary Care Spending
Article Type: Original Research, Retrospective Cohort Study
Citation: Sonmez D, Weyer G, Adelman D. Primary Care Continuity, Frequency, and Regularity Associated with Medicare Savings. JAMA Netw Open. 2023;6(8):e2329991. doi:10.1001/jamanetworkopen.2023.29991

Summary: There have been associations reported between primary care use and outcomes like "health care savings, lower costs of care, reduced acute care utilization, and improved population-level mortality." However, there is no consensus on the optimal primary care visit patterns to maximize the health care savings. This retrospective cohort study analyzed how the regularity, frequency, and continuity of primary care visits impacted Medicare savings (representative 5% sample of Medicare beneficiaries, with ≤3 primary care visits (2016 to 2018). Outcomes included savings in Medicare expenditures, and the risk-adjusted factors of Medicare expenditures, ED visits, and number of hospitalizations. All three factors of regularity, frequency, and continuity were associated with cost savings and utilization outcomes. The authors found increased savings associated with greater frequency of primary care visits. In aggregate, these savings continued until about 10 visits after which there were no additional savings. They found that greater frequency led to greater savings for more complex patients. Regularity was defined the variance of time between visits. The study created 6 groups, first splitting the sample between those with regular and irregular visit patterns, then these two groups were split into three levels of continuity: high, moderate, and noncontinuous. From these subgroups, the results give insight into the importance of the three factors and how they may impact each other. For example, results showed that "cost savings were only observed for patients in the highly continuous groups…which suggest that continuity may be relatively more important…" The most significant limitation of this study is that the sample was restricted to those with three or more primary care visits which limits insight "…for patients not currently accessing primary care." It's also unclear whether patients with less regular primary care patterns are irregular because their primary care provider is not working to make those visits more regular or whether the patient is not setting up their visit patterns to be more regular. The authors concluded that "optimization of these primary care visit patterns was associated with significant improvement in outcomes."

18. **Title:** The Effect of Primary Care Visits on Total Patient Care Cost: Evidence from the Veterans Health Administration
Topic: Primary Care Visit Patterns, Care Utilization, Healthcare Expenditure, Veterans Health Administration
Article Type: Original Research, Retrospective Cohort Study
Citation: Gao J, Moran E, Grimm R, Toporek A, Ruser C. The Effect of Primary Care Visits on Total Patient Care Cost: Evidence from the Veterans Health Administration. J Prim Care Community Health. 2022 Jan-Dec;13:21501319221141792. doi: 10.1177/21501319221141792. PMID: 36564889; PMCID: PMC9793026.

Summary: Gao et al. highlight the role that Primary Care (PC) has been positioned to have in preventative care and reducing use of other healthcare resources. There is published literature on how primary care has "reduced emergency department visits, hospitalizations and health expenditures." This retrospective study seeks to build on the role of primary care visits to measure the effect that visits have on the total patient care cost. From a sample of "over 5 million patients assigned to a PC provider in the Veterans Health Administration" (2016 to 2019), the author's main outcome of interest was the total annual patient care cost. The risk-adjusted results showed that on average each primary care visit was associated with a total cost reduction of $721. Further analysis showed that the greatest savings occurred with the first primary care visit which saved $3976 on average. These savings were greater for higher risk patients where those among the top tenth percentile showed savings of $16,406. In general, each additional visit showed diminishing returns with one model showing no further cost reductions after the 4th or 5th visit, and another model showing increasing costs after the 10th primary care visit. These results were specific to in-person primary care visits. While the authors performed an analysis of telehealth and phone visits that showed savings of $299.60 and $78.90, respectively, there was "limited number of patients using these services and heterogeneity of the services delivered by these 2 modalities." These results were sustained with sensitivity analysis, leading the others to "suggest that expanding PC capacity can significantly reduce overall health care costs and improve patient care outcomes…"

Expert Committee Session Advancing Optimally Resourced, Relationship Oriented Primary Care (Essential Components of a Logic Model for Funding and Transforming Primary Care)
In addition to the articles below you may find articles 5, 8, 11, 26 relevant.

19. **Title:** Rebuilding the Relative Value Unit–Based Physician Payment System
Topic: Physician Payment System, RVUs, Health Care Reform
Article Type: Commentary, Opinion
Citation: McMahon LF, Song Z. Rebuilding the Relative Value Unit–Based Physician Payment System. JAMA. Published online July 10, 2024. doi:10.1001/jama.2024.8478

Summary: McMahon and Song make the case that the way relative value units (RVUs) are calculated needs to be updated using newer and more objective data sources. Currently, RVUs are determined through a process that involves surveying physicians on estimated work required based on a clinical vignette that describes a patient visit or procedure. This leads to the Resource-Based Relative Value Scale (RBRVS) benefiting some specialties more than others. One evaluation of procedure times found significant variations between survey-derived work estimates and objective measures. These inequalities are further exacerbated by the changing practice landscape with roughly one-third of work in primary care occurring outside of visits or procedures. The authors provide three key recommendations for government agencies: 1) Gather newer and more objective data on physician work; 2) Use updated data to recalibrate the structural equivalency of physician work; and 3) Set the dollars per revised RVU, building in estimates of behavioral responses on volume and site of care based on specialties that benefit more or less from the RBRVS.

20. **Title:** The Promise and Challenge of Value-Based Payment
Topic: Fee-for-service, Value-Based Payment, Physician Payment System, Health Care Reform
Article Type: Commentary, Opinion
Citation: Shenfeld DK, Navathe AS, Emanuel EJ. The Promise and Challenge of Value-Based Payment. JAMA Intern Med. 2024;184(7):716–717. doi:10.1001/jamainternmed.2024.1343

Summary: Value-Based Payment (VBP) models have the potential to shift priorities to quality and cost-lowering over quantity of services. Programs like Medicare's Comprehensive Care for Joint Replacement bundled payment program for hip and knee replacement and Medicare Shared Savings Program have demonstrated proven savings without compromising quality. However, VBP comprises only a small portion of total physician payment. Taking full advantage of VBP will require overcoming challenges with VBP design and adoption. Physician-led accountable care organizations (ACOs) save more than hospital-led ACOs because the savings primarily come from reductions in hospitalizations. Better VBP design will need to consider that hospital-led ACOs are often deciding if the shared savings will outweigh any revenue losses. VBP models should avoid requiring participants to reduce their own revenue to generate savings. Additional improvements in VBP design must address "ghost savings" which are risk-adjusted spending decreases without reductions in Medicare spending. Under these conditions, physicians are incentivized to comprehensively code a patient's chart to increase payments for riskier patients. One potential solution is requiring participants to generate absolute nominal savings. Even when motivated, VBP adoption can be challenging because it requires both quality and cost data and the means of processing the data to take advantage of VBP programs. This type of work is different from the fee-for-service model that physicians understand. To solve this, the authors recommend the development of low-cost solutions that integrate with open-source packages and requiring commercial payers use the same standard data formats. Realizing the benefits of VBP will require solving both design and adoption challenges.

21. **Title:** Physician Compensation Arrangements and Financial Performance Incentives in US Health Systems
Topic: Physician Payment Systems, Value-based payment, Physician Compensation
Article Type: Original Research
Citation: Reid RO, Tom AK, Ross RM, Duffy EL, Damberg CL. Physician Compensation Arrangements and Financial Performance Incentives in US Health Systems. JAMA Health Forum. 2022;3(1):e214634. doi:10.1001/jamahealthforum.2021.4634

Summary: Objective: This original investigation characterized the compensation of US Health system-affiliated physician organizations (POs). Research Approach: As a component of the larger RAND Health System Study, a cross-sectional mixed methods analysis was performed through a combination of compensation document review, interviews, and surveys from the leadership of 40 POs. Major Findings: The most common type of base compensation incentive component was volume-based with 83.9% of PCPs and 93.3% of specialists from POs reporting this type of compensation. This constituted 68.2% and 73.7% of compensation for PCPs and specialists, respectively. Many POs featured quality and cost performance incentives with 83.9% of POs reporting it as a component of compensation for PCPs and 56.7% for specialists, but the compensation percentage was modest with 9% for PCPs and 5.3% for specialists. When asked to name the top 3 actions that physicians can take to increase their compensation, the most cited action was increasing the volume of services. Author Conclusions: Despite opportunities for value-based reimbursement incentives, the compensation of both PCPs and specialists In POs were dominated by volume-based incentives.

22. **Title:** It Takes Two to Tango: Creating an Effective State–Federal Partnership for Primary Care Reform
Topic: Health Care Reform, Federal Policy, State Policy, Policy, Partnerships, Primary Care Vision
Article Type: Issue Brief
Citation: Walker L, Dowler S, Rabson B, Rauner B. It Takes Two to Tango: Creating an Effective State–Federal Partnership for Primary Care Reform. The Milbank Memorial Fund. May 2024. 2-to-tango_federal-agenda_Issue_final.pdf (milbank.org)

Summary: This issue brief recommends seven ways that the federal government can support states in strengthening primary care: 1) Establish accountable leadership– Primary care interacts with countless agencies across the healthcare system. Providing a person or entity to serve as the one responsible for advancing the vision of primary care would create a shared anchor for states to address questions, concerns, and a clearer policy vision; 2) Create a road map with a vision for the future– States can be places of innovation, but without a clear direction they may find themselves backtracking, obsolete, or out of line with federal reforms. An evidence-based roadmap will help states understand where the federal government is going so they can plan for where they may fit in; 3) Establish common definitions of primary care and primary care spending– Primary care covers a wide spectrum of specialties, services, and settings. Federal definitions would reduce the negation of definitions in state policy decision-making and would provide states with a default approach that would enable comparisons across states and entities; 4) Set benchmarks and goals so states can align priorities and measure

success– This would allow comparisons between states and strategies to support federal goals; 5) Provide access to data– Setting interoperability standards and improving access will help states to effectively prioritize resources, remove barriers to integration, and promote informed primary care; 6) Establish a comprehensive workforce strategy– With more primary care physicians leaving each year than we are gaining, the federal government must support both recruitment and retention of clinicians; 7) Provide a strategy to close the gap between states– Some states have built a strong infrastructure from federal grants which has put them into a position to continue growing through further federal grants. The government must create strategies for assisting states that have fallen behind and lack the infrastructure to access additional federal funds.

23. **Title:** Defining the State Role in Primary Care Reform
Topic: State-Federal Alignment, Primary Care Reform, Best Practices, State Role, Coalition Building, Data Infrastructure
Article Type: Issue Brief
Citation: Walker L, Watkins LD, Koller C. Defining the State Role in Primary Care Reform. The Milbank Memorial Fund. May 2024. Defining-the-State-Role-in-Primary-Care-Reform_final.pdf (milbank.org)

Summary: States have an opportunity to lead primary care reform, but states can find it difficult to define their role in the reform process. This article offers six key activities for states to prioritize their resources and use their authority most effectively: 1) Define the current state of primary care at the state and local level– States must provide data transparency to understand gaps, strengths, and variations. Baseline data are necessary to identify policy options; 2) Build a coalition– States must convene stakeholders across health sectors to identify and generate support for primary care policies. The absence of a single organization responsible for primary care makes it necessary for states to bring together a broad coalition of physician organizations, advanced practice practitioner associations, health systems, frontline providers, payers, patient advocates, employers, life sciences leaders, and legislative and executive representatives to support alignment and accountability; 3) Identify policy options– States must assess their alignment with federal programs and policies so that they can best inventory their own initiatives, identify gaps, and select programs that need expansion or modification; 4) Establish consensus priorities– Through the primary care coalition and identification of policy options, a set of recommendations should be given based on areas of greatest concern and the feasibility of the policy options; 5) Identify policy champions– Determining whether an initiative requires legislative action, executive action, or action at the industry level will help identify the appropriate policy champion; 6) Provide an accountability structure– States must create a structure for monitoring policy and program implementation. These structures can include annual reports, policy champions, and reporting on the status of consensus recommendations. This promotes an expectation that primary care initiatives are implemented with diligence. States such as Virginia, New York, and Rhode Island have implemented the first two priorities (e.g., established a state coalition in primary care), and set an example or other states to adopt this approach. The article concludes with a brief case study on coalition building by the Virginia Task Force on Primary Care (VTFPC). The VTFPC was initially established at the start of the COVID-19 Pandemic to address the immediate crisis that primary care

was facing, but now the VTFPC receives ongoing funding to provide recommendations to the state to support primary care including the development of a primary care scorecard and tracking state primary care spending.

24. **Title:** Written Testimony of Christopher F. Koller Before the U.S. Senate Committee on the Budget on How Primary Care Improves Health Care Efficiency
Topic: Primary Care Spending, Clinician Mix, Medicare and Medicaid, Healthcare Reform
Article Type: Government Report, Testimony
Citation: Koller, Christopher F. U.S. Senate Committee on the Budget. "Written Testimony Before the U.S. Senate Committee on the Budget on How Primary Care Improves Health Care Efficiency" March 6, 2024.
https://www.budget.senate.gov/imo/media/doc/mrchristopherkollertestimonysenatebudgetcommittee.pdf

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Summary: In Christopher Koller's testimony on "How Primary Care Improves Health Care Efficiency" to the U.S. Senate Committee on Budget, Koller makes four claims about the healthcare system before concluding with four recommendations to "improve the efficiency and effectiveness of the Medicare Physician Fee Schedule (FPS)." First Koller, presents how the U.S. spends more on health care (16.6% of GDP) than other peer countries and still gets poor outcomes despite the spend (including no better life expectancy). Second, Koller makes the case that the U.S. clinician mix is the reason for this higher spending with poorer outcomes. Peer countries have specialist to generalist ratios of 2:1 compared to the U.S. ratio of over 7:1. Comparatively, higher ratios of primary care clinician supply are "associated with longer life expectancy, fewer hospital visits, fewer emergency department visits, and fewer surgeries." Third, Koller states that it is Medicare's physician fee schedule (PFS) that is the primary cause of the shortage of primary care providers. The PFS in conjunction with the Center for Medicare Services' Relative Value Scale Update Committee have disproportionately valued specialist compensation and services. Even though Medicare is only one-fifth of healthcare spending, Medicare's PFS serves as the reference point for compensation for all payers. The fee-for-service payment structure also prioritizes services that are technical such as procedures and testing, which discourages primary care-oriented services like "patient education telephone consultations, email messaging, [and] care planning." Lastly, reforms to Medicare and other healthcare systems are possible when it comes to primary care. Initiatives such as the Medicare Shared Savings Program, Maryland Primary Care Program and the Center for Medicare and Medicaid Innovation's Comprehensive Primary Care Plus have all shown healthcare savings. In particular, the Medicare Shared Savings program reports that when primary care providers comprise 75% or more of an accountable care organization, they saw double the savings per capita. Measuring the proportion of healthcare spending on primary care is a metric that can help systems understand their orientation to primary care. Koller gives four recommendations to improve the Medicare PFS. The first is to revise the Medicare PFS valuation process to align with recommendations from the National Academies of Sciences, Engineering, and Medicine. This would mean "increasing the payment rates for primary care evaluation and management services by 50% and reducing other service rates to maintain budget neutrality," and "restoring the Relative Value Scale Update Committee to the

advisory nature as originally intended…" Second, "direct CMS to annually report primary care spending levels across all its programs and models." Third, use a hybrid payment model for primary care services that is part FFS and part capitated. Lastly, CMS should waive Medicare Part B cost sharing whenever a beneficiary is provided services from their primary care provider.

25. **Title:** Integration of Primary Care and Public Health (Position Paper)
Topic: Community Oriented Primary Care, Population Health, Public Health
Article Type: Position Paper
Citation: American Academy of Family Physicians. Integration of Primary Care and Public Health (Position Paper). Updated December 2020. https://www.aafp.org/ about/policies/all/integration-primary-care.html

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Summary: This position paper by the American Academy of Family Physicians makes the case that Family Medicine has the opportunity to lead the transformation of primary care into a field that aligns with public health practices. While there is a growing knowledge about how "upstream" factors such as social inequities, institutional inequities, and living conditions play a role in the risk behaviors and diseases that affect populations, there is not enough action being taken by physicians to directly address these root causes. This paper calls for action at the "physician, practice, community leadership, educational, and advocacy level." These types of actions include better infrastructure for data collection on the social determinants of health, create partnerships across government and private sector when it comes to public health, increase educational opportunities to prepare future physicians for the vision of this integrated system, and ensure investments into primary care spending to facilitate the integration with public health. This position paper goes on to define a shared understanding of population health, community-oriented Primary Care (COPC), and the role of the family physician when it comes to integrating primary care and public health. Supporting these efforts will involve ensuring that family physicians build capacity and partnerships beyond the clinical environment. The AAFP concludes by stating that "advocacy efforts, educational reforms, and even the professional culture of family physicians must shift to affirm the board room and not only the exam room…"

Expert Committee Session 4: Attaining Optimally Resourced, Relationship Oriented, High Value Primary Care in California
In addition to the articles below you may find articles 5, 7, 8, 10, 12, 22, 23 relevant.

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26. **Title:** California Public Purchaser Contract Provisions on Primary Care: Multi-Payer Alignment Drives Investment
Topic: Primary Care Spending, Contract Provisions, Recommended Actions, Public Healthcare, Healthcare System Alignment
Article Type: Issue Brief

Citation: Yegian J. (May 2023). California Public Purchaser Contract Provisions on Primary Care: Multi-Payer Alignment Drives Investment. California Health Care Foundation. https://www.chcf.org/wp-content/uploads/2022/04/CAPublicPurchaserContractProvisionsPCMultiPayerAlignment.pdf

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Summary: Contract provisions related to primary care present an opportunity to align efforts throughout the healthcare system. In California, the three largest public purchasers, DHCS, Covered California, and CalPERS have strengthened contract provisions related to primary care measurement, reporting, payment, and investment. These contract provisions are virtually identical when it comes to reporting on primary care spending, consideration of a target on floor for primary care spending, reporting on payment models, increasing adoption of value-based models in primary care, and reporting on payment models for primary care amongst the five largest contracted physician organizations. This alignment has several benefits: driving investment into primary care; signaling the importance of primary care-centric health care system; reducing administrative burden, and enabling transparent compatibility across payers and providers.

27. **Title:** Guiding Principles and Recommended Actions
Topic: Primary Care Coalition, Primary Care Reform, Primary Care Spending
Article Type: Issue Brief
Citation: Primary Care Investment Coordinating Group of California. Guiding Principles and Recommended Actions, California Health Care Foundation, April 2022. https://www.chcf.org/wp-content/uploads/2022/04/PCInvestmentCoordinatingGroupGuidingPrinciples.pdf

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Summary: The Primary Care Investment Coordinating Group of California (PICG) was formed to bring together public and private health care purchasers, policymakers, analysts, improvement specialists, consumer advocacy organizations, and funders of primary care investment. This coalition has five guiding principles through which they developed five recommended actions. The guiding principles are:

1. Access to high-quality primary care is critical for improving population health outcomes
2. Primary care is under-resourced and requires greater investment,
3. Payment for primary care needs to be sufficient to support advanced primary care attributes, 4) Payment models should shift from fee-for-services to value based
4. Multi-payer alignment on investment, measurement, and value-based payment is essential to strengthening primary care.

The Recommended actions are 1) Measure and report primary care spending; 2) Set a target; 3) Pay for advanced primary care; 4) Establish purchaser requirements; 5) Track progress. The PICG set these principles and actions with the intention to generate a collective effort toward increasing resources for improving primary care in California.

28. **Title:** Office of Health Care Affordability Recommendations to the California Health Care Affordability Board: Proposed Primary Care Investment Benchmark
Topic: Primary Care Spending, Spending Ratio, Primary Care Investment
Article Type: Issue Brief

Citation: Office of Health Care Affordability. Office of Health Care Affordability Recommendations to the California Health Care Affordability Board: Proposed Primary Care Investment Benchmark. California Department of Health Care Access and Information. April 2024. https://hcai.ca.gov/wp-content/uploads/2024/04/OHCA-Recommendations-to-Board_Proposed-Primary-Care-Investment-Benchmark.pdf

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Summary: The Office of Health Care Affordability (OHCA) was established in 2022 with the mission that all Californians receive health care that is accessible, affordable, equitable, high-quality, and universal. As part of that mission, OHCA is proposing a primary care investment benchmark to the California Health Care Affordability Board. OHCA is recommending:

1. for each payer, a relative improvement benchmark of 0.5 to 1 percentage point per year increase in primary care spending as a percent of medical expense through 2034, and
2. a statewide absolute benchmark of 15 percent of total medical expense allocated to primary care by 2034.

OHCA's rationale is based on the increasing costs of health care spending and the effects that it has had in causing many Californians to skip or delay care. OHCA outlines their three primary responsibilities to achieve the recommendations: 1) slow health care spending growth through collection and reporting on total health care expenditure data and enforcing spending targets set by the Board; 2) promote high-value health system performance; and 3) assess market consolidation. This recommendation comes as a result of the work of the Investment and Payment Working Group in developing the primary benchmark, measurement, methods, and definitions. These recommendations seek to align California with the share of spending on primary care in high performing health systems internationally which range from 12 to 15 percent.

29. **Title:** Investing in Primary Care: Lessons from State-Based Efforts
Article Type: Report
Citation: Condon MJ, Koonce E, Sinha V, et al Investing in Primary Care: Lessons from State-Based Efforts. Oakland, CA: California Health Care Foundation; Apr 2022. https://www.chcf.org/wp-content/uploads/2022/03/InvestingPCLessonsStateBasedEfforts.pdf

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Summary: Building off the urgency in a report by the National Academies of Science, Engineering, and Math that made the case that investment in primary care increases population health, this report is a guide on the ways that California can move forward to increase investment in primary care. Highlighted in the report is a need for a shared definition of primary care spending. Using survey data from 17 states, the authors categorize efforts in 4 stages of stimulating investment to improve primary care. The stages include: "Practicing, In Process, Getting Started, and Aspirational." The states use up to 3 mechanisms/tools to stimulate investment in primary care: transparency, contracting, and regulation. Transparency mechanism means reporting on the level of primary care investment and publicly committing to increase it. The contractual mechanism includes tools like having both public and private purchasers require health plans to invest in primary care. Regulatory tools include examples such as

state agencies requiring investment in primary care investment through fines "or deny[ing] rate filings when health plans fall short". Three key lessons from the report are 1) establish a shared vision, bringing together a broad coalition of stakeholders that representatives from health systems, commercial health plans, Medicaid, state employee benefits plan, employers, and consumers; 2) conduct annual measurement and reporting across markets based on a common definition of primary care investment; 3) set investment targets and encourage (or require) purchaser commitment through the contractual mechanism.

30. **Title:** Primary Care's Essential Role in Advancing Health Equity for California
Topic: Primary Care Reform, Health Equity, Statewide Healthcare Reform
Article Type: Report
Citation: Rittenhouse DR, O'Malley AS, Wesley DB, et al Primary Care's Essential Role in Advancing Health Equity for California. Oakland, CA: California Health Care Foundation; Mar 2023. https://www.chcf.org/wp-content/uploads/2022/10/PrimaryCareEssentialRoleAdvancingHealthEquityES.pdf

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Summary: This report gives guidance on the role that primary care contributes to advancing health equity and makes recommendations for both shifting the paradigm to ensure that equity is central to these conversations and for next steps on how California can strengthen equity centered primary care. First, the report presents evidence on how the five defining aspects of primary care contribute to health equity. These elements are accessible first-contact care, continuous care, comprehensive care, coordinated care, and accountable whole-person care. Examples of these include how continuity is associated with greater trust, which is important for patients from communities that have historically higher rates of distrust in the healthcare system, and how comprehensive care that integrates behavioral health "may help reduce mental health disparities for Latinos/x." Next, the authors call for a paradigm shift to "ensure these efforts prioritize equity." The authors highlight four key aspects of this shift which include "recognizing high-quality primary care as a common good, embracing the diversity of primary care settings and investing resources according to need with the intentional goal of reducing health and social inequities, proactively applying principles of equity and justice to all decisions, and building accountability for action." The report concludes with 14 recommendations across five domains (community engagement; workforce education and training; clinical practice transformation; payment and spending; and data collection, measurement, and reporting). Case studies and examples of solutions and barriers to primary care health equity are highlighted. The authors conclude with a recommendation that California establish a "primary care equity action forum that would build new partnerships and provide leadership and accountability for this important work."

31. **Title:** Investing in Primary Care: Why It Matters for Californians with Commercial Coverage
Topic: Primary Care Spending, Statewide Reform, Commercial Health Coverage, Health Care Plans, Provider Organizations
Article Type: Original Research

Citation: Yanagihara D, Hwang A, Investing in Primary Care: Why It Matters for Californians with Commercial Coverage Oakland, CA: California Health Care Foundation; Apr 2022. https://www.chcf.org/wp-content/uploads/2022/04/InvestingPrimaryCareWhyItMattersCommercialCoverage.pdf

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Summary: Investing in primary care spending has benefits both in terms of patient outcomes and reducing health care expenditures. This study "sought to understand the level of primary care investment in California and how it varies across health plans and provider organizations." The study reviewed 2018 claims data from 13.9 million (~80%) commercially-insured California adults (HMO, PPO and EPO products). The first analysis found an average primary care spend of 7.5% with a range from 3.5% to 12.7% among 14 health plan-product combinations. The second analysis focused on provider organizations (PO) among Commercial HMOs; at the PO level there was an average primary care spend percentage of 7.6% with a range of 2.8% to 15.4%. Comparing the two analyses, "primary care spending at the health plan level was not consistently associated with better outcomes…" but at the PO level these associations of better outcomes were consistent and statistically significant. To emphasize the potential impact that primary care spending can have on health expenditures and outcomes, if the three lower quartiles had the same performance as the top quartile there would be reductions of health care expenditures of $2.4 billion in addition to better patient outcomes in recommended care, care experience, reduced hospitalizations, and reduced ED visits. The authors state that "health care systems that invest more in primary care as a proportion of their overall budget perform better on measures of quality utilization and cost." The authors suggest that future research should both "explore factors contributing to the variation in primary care spending percentage and its association with performance among provider organizations."

32. **Title:** Considerations for Statewide Advanced Primary Care Programs
Topic: Advanced Primary Care. Statewide Health Reform, Primary Care Spending
Article Type: Report
Citation: Haft H, Jones C. Considerations for Statewide Advanced Primary Care Programs. The Milbank Memorial Fund. March 2024. https://www.milbank.org/wp-content/uploads/2024/03/Haft-Jones-Article_final.pdf

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Summary: More states are working toward implementing statewide Advanced Primary Care Programs with many of them partnering with the Center for Medicare and Medicaid Innovation (CMMI). The report aims to be "categorical and not prescriptive" in its presentation of considerations for states implementing Advanced Primary Care Programs. The report provides background on how states have historically worked with past CMMI models through which there was varying levels of involvement. New models, such as Making Care Primary (MCP) and States Advancing All-Payer Health Equity Approaches and Development (AHEAD), encourage states to control health care costs while addressing health equity through mechanisms such as supporting adoption of global budgets by hospitals, and boosting the primary care infrastructure. The report provides eight areas of considerations for states as they put together "multipayer primary care investment programs.":

1. "Leadership, Governance, and Policy," Governments have an opportunity to take the lead and provide clarity through policy.
2. "Business Case," Statewide primary care models should appeal to stakeholders from a business perspective.
3. "Infrastructure Costs and the Payment Model," Support through staff and program funding
4. "Care Delivery Elements and Model Design," Enhanced care elements will need to fit the needs and resources of each state.
5. "Data and Information," Practices will need "actionable data-derived insights"
6. "Learning and Diffusion Systems," An advanced primary care model will require a network for the diffusion of information to providers, patients, and additional stakeholders.
7. "Program Operations," States will need to ensure that support for primary care models are carefully designed.
8. "Sustainability." Programs should be adaptable and planning for long term continuous of the program even as the dynamics of state governments change.

Discussions in these categories range from strategies to make primary care models financially "attractive to providers, payers, consumers, employers, and state governments," to ensuring that program operation infrastructure is in place to support advanced primary care programs. While the specifics may be different for each state program, these types of considerations will be important for a "sustainable transformation to a health care system built on a strong foundation of advanced primary health care."

33. **Title:** Advancing Health Equity Through Primary Care Policy Priorities and Recommendations for California
Topic: Statewide Health Reform, Health Equity, Primary Care Spending, Health Policy
Article Type: Report
Citation: Rittenhouse D et al. Advancing Health Equity Through Primary Care Policy - Priorities and Recommendations for California. California Health Care Foundation/Mathematica, August 2024. https://www.chcf.org/wp-content/uploads/2024/08/HealthEquityPrimaryCare.pdf

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Summary: In March 2023, the California Health Care Foundation (CHCF) sponsored the report Primary Care's Essential Role in Advancing Health Equity for California, which outlines the large body of evidence demonstrating primary care's essential contribution to advancing health equity and calls for new ways of thinking and acting to collectively strengthen primary care across the state with the intentional goal of reducing health and social inequities. In 2023, to build consensus around policy recommendations, prioritize next steps, and catalyze collective action, a Summit on Primary Care Policy to Advance Health Equity included 30 policy thought leaders, including experts in primary care and health equity from California, such as state officials, consumer advocates, community leaders, providers, and patient representatives. Perspectives from other states with demonstrated success in building primary care capacity and infrastructure in pursuit of equity also were included. Key summit outcomes included consensus reached by the participants on the following:

- Three foundational policies to strengthen primary care. *Foundational Policy #1:* sustainably increase Medi-Cal primary care provider payments to remove financial disincentives to serving Californians with low incomes. *Foundational Policy #2:* increase the proportion of health care spending directed toward primary care and establish transparent and enforceable timebound spending targets for public and private payers. *Foundational Policy #3:* create meaningful engagement of people with lived experiences of discrimination in all California state primary care policymaking and governance bodies to identify impediments to health equity and generate solutions.
- Ten specific high-priority policy recommendations, including two related to engaging the community to share and shift power; four related to enhancing primary care education and training; one each to foster expanded primary care access and to improve data standards and sharing; and two to design payment to achieve equity.
- A three-part approach to increase leadership and accountability to ensure progress:(1) a task force on primary care and health equity, (2) a California state scorecard on primary care and health equity, and (3) an office for primary care within the state government.
  In addition, report Appendix A contains detailed descriptions of the 10 policy recommendations that summit participants collectively identified as high priority for California; Appendix B describes the policy prioritization activity that took place during the summit; and Appendix C identifies the relevant actors for each of the 10 policy recommendations.

34. **Title:** The Curb Cut
    Topic: Targeted Universalism, Health Equity
    Article Type: Perspective
    Citation: Mate KS. The Curb Cut. Am J Med Qual. 2022;37(3):272-275. doi: 10.1097/JMQ.0000000000000022. Epub 2021 Oct 28. PMID: 34724438

Summary: In 1962, Edward Roberts, a wheelchair-using student, became the first severely disabled person admitted to the University of California at Berkeley. Mechanized wheelchairs enabled Roberts and other wheelchair-using students to access the campus relatively unimpeded, but the surrounding urban landscape included then-typical sidewalks with a 6-8 inch drop-off gap, greatly limiting the students' ability to navigate off-campus. Their frustration led them to take to the streets to pour concrete off-ramps at several nearby street corners in Berkeley near the campus, in turn prompting the city council to implement a policy that all sidewalks be designed and constructed to facilitate the movement of disabled persons. The "curb cuts" were recognized also to benefit many non-wheelchair using individuals, such as those pushing baby strollers, older adults, runners, and travelers hauling luggage.

Forty years later, another Berkeley resident, professor john a. powell, described curb cuts as a foundational example of the policy change and communication framework he termed "targeted universalism," which posits that we can best reach universally held societal objectives (e.g., better movement through our cities) by using targeted strategies (e.g., curb cuts) that help provide an

advantage to those that have been systematically disadvantaged. Generally, achieving universal goals requires multiple strategies, targeting the differing or only partially overlapping needs of various groups, so that all can attain or enjoy more of the universal goal. Once the concept of targeted universalism is understood, other "curb cuts" become apparent, such as seat belts (developed to protect children, yet have now saved the lives of countless adults as well) and laws prohibiting smoking in public places (designed initially to protect flight attendants and restaurant and bar workers but now having contributed to a more than 2/3 reduction in tobacco consumption since 1965). Countering long and deeply held societal beliefs, these examples show that "giving an advantage" to one group need not disadvantage the rest ("either-or" framing), and in fact often benefits most or all in society. As such, targeted universalism offers a potential antidote to our climate of extreme polarization (political, economic, and social) – promoting belonging rather than "othering" by highlighting interconnectedness, mutual goals, and the critical role of coalitions assembled from an array of stakeholders, including traditionally marginalized individuals who are afforded legitimacy, agency, and power.

Approaches rooted in targeted universalism are being used by some pioneering health care systems to address health inequities. An example: one health system observed that in their behavioral health units, patients who spoke English as a second language had a length of stay that was double the rate of native English speakers; in response, the unit instituted simultaneous language translation services (a targeted strategy) thereby reducing the length-of-stay difference between the two language groups by 82%. Notably, the intervention increased the capacity of the behavioral health units, which benefited all their patients (regardless of first language). Five common threads observed across such successful pioneering health system efforts are: 1. A purposeful focus on equity, making it a strategic priority; 2. Dedicating resources to collecting the necessary data and leveraging quality departments to focus on inequities; 3. Focusing on specific clinical gaps and seeking to understand the contributing nonmedical social factors such as accessibility and affordability; 4. Speaking openly about racism and the desire to overcome its legacy; and 5. Forming relationships with community partners, recognizing that achieving equity involves addressing issues that health systems do not control directly or at all.

35. **Title:** Targeted Universalism: Policy and Practice
Topic: Policy Framework
Article Type: Primer and Practice Guide
Citation: powell ,ja, Ake, W., & Menendian, S. (2019). Targeted Universalism: Policy & Practice. UC Berkeley: Othering & Belonging Institute. Retrieved from https://escholarship.org/uc/item/9sm8b0q8

Summary: Targeted Universalism is a framework for designing policy that is able to both serve the needs of groups that are not being met and for groups that are in positions of privilege. Targeted and universal approaches to policy are common, but this framework seeks to take the advantages of both approaches while avoiding their respective shortcomings. Targeted approaches, such as food stamp programs, seek to improve outcomes for specific groups. This type of policy is helpful for improving outcomes in those groups, but it can often fail to address the underlying outcome for all of society–that everyone should have access to nutritious food. Universal approaches have broad applications toward a shared goal, but

at the expense of ignoring underlying disparities, such as universal basic income or universal healthcare coverage. These types of policies have the potential to cause exacerbate inequities (e.g., universal health coverage helps people who otherwise did not have healthcare coverage, but doesn't address the potential lack the healthcare resources such as an adequate supply of physicians). Targeted universalism takes grounds these approaches in the pursuit of a shared outcome while incorporating the need for differentiated approaches for various subgroups. This report provides a deeper examination of and practical guide to targeted universalism. The report provides 5 steps for targeted universalism:

1. Establish a universal goal based upon a broadly shared recognition of a societal problem and collective aspirations.
2. Assess general population performance relative to the universal goal.
3. Identify groups and places that are performing differently with respect to the goal. Groups should be disaggregated.
4. Assess and understand the structures that support or impede each group or community from achieving the universal goal.
5. Develop and implement targeted strategies for each group to reach the universal goal.

36. **Title:** The Failing Experiment of Primary Care as a For-Profit Enterprise
Topic: Private Equity, Primary Care Investment, Corporate Primary Care
Article Type: Commentary, Opinion
Citation: Grumbach K, Cohen DJ, Jabbarpour Y. "The Failing Experiment Of Primary Care As A For-Profit Enterprise", Health Affairs Forefront, September 5, 2024. DOI: 10.1377/forefront.20240903.604079

Summary: Grumbach et al. make the case that for-profit corporate primary care models have failed to produce any meaningful improvements in primary care. Their pursuit of short-term financial returns is misaligned with the goals and process in the primary care system thereby disrupting the system. When several large corporations like Walgreens, Amazon, and Walmart purchased primary care providers like VillageMD, One Medical, and Carbon Health, there were opposing perspectives that emerged: an optimistic view that said these investments signaled a recognition of the long-term value in providing primary care and corporations could build on that foundation, and an "…alternative view that was suspicious of the growing capture of health care delivery by investor-owned corporations and private equity…" that would lead to increased costs without any improvements in quality. This alternative view suggested that private interests seek short-term financial gains by taking advantage of opportunities like exploiting Medicare advantage, evading limits on medical-loss ratio, using primary care as a loss leader to boost retail sales, and capitalizing on brick and mortar savings through virtual practices. More recently, Walgreen's, Amazon, and Walmart reduced the number of clinics, employees, and primary care services they provide; in the case of Walmart. they eliminated their entire health care center program. These divestments from the primary care sector, may be a sign that these investments were predicated on short-term returns. Grumbach et al. then make the case for how the primary care field can move forward without relying on corporate investment. The authors focus on "…the need for bold public policy to address primary care payment, infrastructure, and corporate ownership… policy [that] is required to move the nation on a collective path to primary care for all."

37. **Title:** Value-Based Payment and Vanishing Small Independent Practices
Topic: Value-Based Payments, Consolidated Primary Care, Primary Care Infrastructure
Article Type: Commentary, Opinion
Citation: Rooke-Ley H, Song Z, Zhu JM. Value-Based Payment and Vanishing Small Independent Practices. JAMA. 2024;332(11):871–872. doi:10.1001/jama.2024.12900

Summary: Rooke-Lye et al assert that value-based payment models need to recognize and address their effect on small, independent physician practices. Most physicians are employed by hospitals and health systems and value-based payment models have the potential to further accelerate that trend. Small practices, which "…exhibit lower per-patient spending, fewer preventable admissions, and lower readmissions compared to their hospital-owned counterparts," face a lot of resource challenges when competing with larger systems under this model. This is because value-based payment models often require technology infrastructure, population health management expertise, and connections with other segments of the health care delivery system and larger systems can exercise economies of scale. This has put corporate owners in a position where they can "leverage capital, management, and scale," to acquire or affiliate smaller practices. This corporatization carries risks as private investment can lead to "aggressive and potentially fraudulent coding practices and other forms of gaming that increase spending or are untethered to clinical outcomes." Supporting small practices is going to take solutions like subsidizing practices directly through additional payments or indirectly by increasing the fee schedule. Ensuring that value-based payment models do not "unintentionally make independent practices a casualty…" requires eliminating barriers to smaller practices that are willing to participate, such as "simplifying the significant administrative complexity of the value-based payment landscape and shoring up technical assistance."

Additional Resources

The Milbank Memorial Fund and the California Health Care Foundation have selected primary care transformation as their area of focus. We encourage you to explore the respective websites for sources beyond those profiled in this annotated bibliography. Additionally, the Othering & Belonging Institute provided more information about equity and targeted universalism.

Milbank Memorial Fund selected primary care transformation as one of its three focus areas. With a strong emphasis on policy, MMF has been providing a rich resource of non-partisan blogs, briefs, and reports for more than 8 years. I also publishes a scorecard on the health of primary care.

https://www.milbank.org/resources/?fwp_focus_area=primary-care-transformation

California Health Care Foundation has selected primary care as one of its areas of focus ("Primary Care Matters") and has published briefs and reports and created the Primary Care Investment

Coordinating Group of California (PICG) in 2021. For current efforts see: Current Efforts - California Health Care Foundation (chcf.org). Other highlighted reads recommended by Kathryn Phillips include:

- The Case for Investing in Primary Care in California (chcf.org): This report provides a broad look at the value of primary care provider and team relationships, where and why our health care system underinvests in primary care**.** It reviews the definition of primary care, including its central attributes and provider types; briefly summarizes evidence on the value of primary care and the status of primary care payment; and explores the intersection of primary care with three high-priority areas of policy and program development in California — health workforce, coverage expansion, and CalAIM.
- Investing in Primary Care: Why It Matters for Californians with Medi-Cal Coverage (chcf.org): This first-of-its-kind study examines primary care spending by 13 Medi-Cal managed care plans in California, for 5.4 million members, and finds that greater investment in primary care is associated with better quality of care and a higher plan rating.

OTHERING & BELONGING INSTITUTE – UC BERKELEY recommends exploring equity through their website at https://obiu.org/ where they also delve into more detail about targeted universalism.