VIEWPOINT

Implementing High-Quality Primary Care
A Report From the National Academies of Sciences, Engineering, and Medicine

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Twenty-seven years ago, the Institute of Medicine launched a primary care consensus study that, at the time, seemed highly aligned with the country's appetite for health reform and managed care.[1] *Primary Care: America's Health in a New Era* produced a primary care definition still used around the world; however, the report's recommendations received no traction in the US. Similarly, a 2012 Institute of Medicine report on the integration of primary care and public health largely went unheeded.[2] While primary care is uniquely positioned to support COVID-19 testing, tracing, and vaccination and to help address pervasive health and social inequities, primary care was not considered in congressional relief packages in 2020 and many practices may be closed when they are needed most.

A new consensus report by the National Academies of Sciences, Engineering, and Medicine[3] emphasizes that while primary care in the US provides more than one-third of all health care visits and more than half of all outpatient visits, it receives a relatively small proportion of resources, has no federal coordinating capacity, has no dedicated research support, has a declining workforce pipeline, and remains inaccessible to large portions of the population.

Since 1996, research has continued to bolster the case for the robust association between primary care and lower costs, better utilization patterns, and reduced mortality. Better support for primary care partly explains health outcome differences across developed countries.[4] International studies have estimated that most developed countries spend an estimated 12% to 17% of total health care expenditures on primary care, whereas the US spends an estimated 5.4%.[5,6]

The National Academies committee was tasked with examining the current state of US primary care and developing an implementation plan to build on the 1996 report, strengthen primary care services (especially for underserved populations), and inform primary care systems around the world. The implementation plan considered barriers and enablers of innovation and change, integrated services, the role of primary care in improving health equity and population health, future workforce needs, digital innovations, and access for rural and other underserved populations. The evolution and sustainability of primary care payment models is a major emphasis, along with approaches to measure and improve primary care. The implementation plan emphasizes the need for a federal coordinating function and an evaluation and reporting infrastructure for report recommendations and their influence on health outcomes in the US.

The committee began by reassessing the definition of primary care from the prior report with the goal of stating what high-quality primary care should be, not what is currently experienced by most people in the US. In the new report, the revised definition emphasizes comprehensive care by teams but in the context of relationships: "High-quality primary care is the provision of whole-person, integrated, accessible, and equitable health care by interprofessional teams that 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."[3]

The committee's implementation plan is based on a foundational logic that (1) primary care is unique among health services for its contribution to health and equity, making it a desirable, common good for society and (2) common goods are stewarded by the government, particularly the federal government. However, federal stewardship for primary care is lacking, resulting in inactivity by state and private sectors.

The committee's implementation includes 5 overarching objectives, each with a set of specific actions and accountable actors. The plan balances national needs for scalable solutions while allowing for locally tailored care.

Pay for Primary Care Teams to Care for People, Not Physicians to Deliver Services

- Payers (ie, Medicaid, Medicare, commercial insurers, and self-insured employers) should evaluate and disseminate payment models based on the ability of those models to promote the delivery of high-quality primary care, not on achieving short-term cost savings.
- Payers using a fee-for-service model should shift primary care payment toward hybrid (part fee-for-service, part capitated) models and make them the default payment model over time.
- The Centers for Medicare & Medicaid Services (CMS) should increase the overall portion of spending on primary care.
- States should implement primary care payment reform by facilitating multipayer collaboration and by increasing the overall portion of health care spending in their state going to primary care.

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 nonresponding enrollees. Community health centers, hospitals, and primary care practices should assume and document an ongoing clinical relationship with the uninsured people they are treating.

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- The Department of Health and Human Services (HHS) should target sustained investment in creating new health centers (including federally qualified health centers [FQHC], FQHC 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 fee-for-service and managed care access standards for primary care for Medicaid beneficiaries. CMS should also assist state Medicaid agencies with implementing and attaining these standards, as well as measure and publish state performance on standards.
- CMS should continue to support the COVID-19–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.

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 federally designated shortage areas, to strengthen interprofessional teams and better align the workforce with the communities they serve.
- CMS, the Department of Veterans Affairs, the Health Resources and Services Administration, and states should redeploy or augment funding to support interprofessional training in community-based, primary care practice environments.

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 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.

Ensure That High-Quality Primary Care Is Implemented

- The HHS secretary should establish a Secretary's Council on Primary Care to enable the vision of 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 levels should assemble and regularly compile and disseminate a "high-quality primary care implementation scorecard," based on the 5 key implementation objectives.

Conclusions

The US should reaffirm its commitment to a strong foundation of high-quality primary care as a common good that is accessible to everyone, and should make implementation of high-quality primary care a priority for government and the private sector. The US is increasingly falling behind peer nations in addressing health equity, and high-quality, accessible primary care is an essential solution. A window is opening for government action to enhance and sustain primary care, as it is for other critical parts of the US infrastructure. The new National Academies report charts the path for this work.[3]

ARTICLE INFORMATION

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