Proceedings of The Summit on Revitalizing Primary Care (Rev PC)

University of California–Davis | October 16-18, 2024

Acknowledgments

Recognizing the tenuous state of primary care and being motivated by the growing national momentum toward responding to the primary care crisis, faculty from the University of California, Davis School of Medicine planned and convened the Summit on Revitalizing Primary Care at UC Davis, October 16-18, 2024. Co-chairs Drs. Anthony Jerant, Courtney Lyles, and Richard Kravitz are indebted to their planning committee colleagues, Deborah Cohen, MD; Joshua Fenton, MD; Beth Griffiths, MD, Kevin Grumbach, MD; Mark Henderson, MD; Christopher Koller; Kathryn Phillips MPH, and Dominique Ritley, MPH. The co-chairs are also grateful for the superb support from UC Davis staff members Bill Daehler, Julia Fleuret, Bethney Bonilla-Herrera, Marykate Miller, Eleanor McAuliffe, Gabrielle McAuliffe, Carolyn McConville, Shannon McSmith, Katrine Padilla, Kelcie Rogriguez, Natalie Scoggan, Gina Sperling, and Brenda Terry. Ashley Hay, RN contributed as the Summit scientific writer. In addition to the Expert Committee members identified in Appendix B, the Summit co-chairs appreciate the participation of more than 100 people during the public sessions, including researchers presenting their posters (Drs. Janice Bell, Brittany Chatterson, Allison Elder, Lisandra Franco, Kara Kuhn-Riordon, Heather Martin, Anisha Srinivasan, Melody Le Tran-Reina, and Sara Teasdale). The event was co-sponsored by the UC Davis Department of Family and Community Medicine (DFCM) and the Center for Healthcare Policy and Research, and co-funded by the DFCM and a UC Davis School of Medicine 2024 Impact Symposia Matching Award.

Access to Summit slides and session recordings can be found here: https://tinyurl.com/aatuucus

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Contents

Introduction

It is abundantly clear to an increasingly broad array of stakeholders that primary care is in crisis in the United States (U.S.), at great detriment to individual and population health and to the cost-effectiveness of health care.[1-9] Less clear are the highest priority steps that should be taken to address the crisis, so that high quality primary care built on a foundation of longitudinal, trusting clinician-patient-family relationships will be readily available to all. Delineating those high priority steps was the focus of the Summit to Revitalize Primary Care (Rev PC), convened by faculty at the University of California Davis School of Medicine, October 16-18, 2024.

This report briefly summarizes the context for and activities of the Summit, and provides the recommended actions and activities generated by the experts convened at the Summit to guide primary care revitalization efforts. Readers seeking more details regarding Rev PC are directed to Appendices A through D, which provide, respectively, the full Summit agenda, the Expert Committee member and plenary speaker bios, and summaries of the plenary sessions and Expert Committee sessions.

Why Primary Care Has Been "Slowly Dying"[1]

In the landmark 2021 National Academies of Science, Engineering, and Medicine (NASEM) report *"Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care,"* the report ad hoc committee affirmed that robust, relationship-centered primary care is the foundation of an optimally efficient and effective health care system.[1] Research from several countries indicates greater exposure to primary care is associated with better population health and longevity, and more equitable care.[4,5]

DEFINITION OF HIGH-QUALITY PRIMARY HEALTH CARE

"….the provision of whole person*, integrated, accessible, and equitable health care by interprofessional teams who are accountable for addressing the majority of an individual's health and wellness needs, across settings and through sustained relationships with patients, families, and communities."[1]

National Academies of Science, Engineering, and Medicine, 2021

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

For this reason, the NASEM report also designated primary care as a *common good* that delivers benefits to society and individuals that other elements of the health care system do not.[1,2] However, the committee also noted their definition of primary care was "in many ways aspirational," since most practices in the U.S. lack one or more of the core attributes.[1]

The NASEM report further indicated primary care in the U.S. is "slowly dying," due to a nexus of factors including chronic and severe under-resourcing by health insurers and health systems, inadequate payment models to support it, and inattention in health care workforce planning and policy efforts.[1]

Low Spending on Primary Care Limits Its Value, Undermines Population Health, and Increases Total Health Care Costs

> "Insurance is to protect for unexpected and catastrophic outcomes. Primary Care is neither unexpected nor catastrophic. And maybe what we need to think about is divorcing health insurance from primary care and delivering it as a public good."
>
> *~Illana Yurkiewicz, MD, Stanford University*
> *Author, Fragmented: A Doctor's Quest to Piece Together American Health Care*

Nationally, spending on primary care services is less than 5 cents out of every dollar spent on health care and declining, even though 35 of all health care visits and more than 50% of outpatient visits annually are to primary care clinicians and primary care influences the majority of other health care costs through related referrals, testing, procedures, and hospitalizations.[3,9] The prevailing fee-for-service model of health care payment is another problem, supporting care for discrete patient visits with clinicians rather than the whole-person, primary care team model (e.g., community liaisons, social workers) needed to provide top-quality care (per the NASEM definition).[10] One reason a fee-for-service model is inadequate to support primary care is the limited representation of primary care physicians on the American Medical Association's Relative Value Scale (RVS) Update Committee (RUC), which advises CMS in assigning Relative Value Units (RVUs) for different types of clinical work.[11] Under-representation on the RUC has meant that the RVUs assigned for primary care services are much lower than for subspecialty (particularly surgical and procedural) services, and inadequate to generate enough practice margin to fund non-RVU generating practice elements.[11] These payment structures contribute to primary care practices often failing to deliver optimal care and achieve the best patient outcomes.[12] Partly for these reasons, population health is poorer in the U.S. than in comparable industrialized nations, which spend less on health care but considerably more on primary care as a proportion of total health care spending.[7]

Low Payment of Primary Care Clinicians, Spiraling Administrative Burdens, and Poor Workforce Planning Contribute to an Inadequate Primary Care Base

The low valuation of primary care services by the RUC has also led to the salaries of family physicians, general internists, and pediatricians being among the lowest for all specialties.[13] This creates a strong disincentive for trainees to pursue primary care, given that most medical students accrue significant educational debt.[13,14] Among those already in the primary care workforce, low payment relative to other medical specialties, coupled with high administrative burdens resulting from poor electronic health record (EHR) interfaces, testing and treatment prior authorization requirements, and other factors have led to all-time low job satisfaction ratings and high rates of burnout.[8,15,16] This is prompting increasing numbers of primary care clinicians to limit their spectrum of practice, go part time, leave clinical medicine for other roles, or retire early.[17,18] Such choices are further worsening the already acute shortage of primary care clinicians, both directly and through indirect effects, as medical trainees hear about and observe the disenchantment of primary care clinicians and elect to pursue other specialties.[3,19-21] Together, these issues are further exacerbating a longstanding shortage of primary care clinicians, which is unchecked because the Centers for Medicare and Medicaid (CMS) and the Veterans Administration, which fund most

graduate medical education (GME), have no accountability to ensure the production of an appropriately sized primary care workforce.[22]

The net impact of these issues has been a sharp rise in the number of Americans who lack a usual source of health care, with medically under-served individuals in urban and rural areas most affected, further worsening population health and threatening health equity.[3] Among patients who do have primary care, many are dissatisfied with the timeliness of access and quality of care. This is not surprising given that many clinicians are severely over-empaneled, limiting patient access and necessitating short visit lengths, and lack the practice resources to provide robust primary care.[23-25]

The Time is Right for a Primary Care Recovery

Although the outlook for primary care may seem dire, considerable hope remains. Stemming from the NASEM report and other efforts, there are signs that three separate "streams" have come together in the U.S. to create the necessary conditions for meaningful policy change aimed at revitalizing primary care:[26]

1. A general recognition that primary care is in crisis, and understanding of key contributing factors among government officials, experts, and the public.
2. The availability of potential solutions that would be feasible to implement.
3. The political will to apply those solutions to address the crisis.

Legislative and regulatory efforts are underway in over one-third of States and at the Federal level to revitalize primary care by pushing for a greater allocation of health care spending to primary care and more appropriate payment models to support robust, relationship-centered primary care consistent with the aspirational NASEM definition.[6,27-32] Many of these efforts have been coupled with initiatives to slow the rate of growth in total health care spending, which is unsustainably high. Concurrently, State and federal policy initiatives aim to increase the number of medical trainees pursuing primary care, particularly in communities with least access.[21,33] While these developments create a more hopeful outlook for primary care, clearly there is much more to do.

The Summit to Revitalize Primary Care (Rev PC)

Recognizing the pressing need for solutions to address the key drivers of the primary care crisis, and motivated by growing state, federal, and broader societal momentum toward engaging on this topic, a team of clinical scientists at the University of California Davis School of Medicine convened the Summit on Revitalizing Primary Care (Rev PC). The goals were to educate, build interdisciplinary connections, and most of all generate recommendations and actions to repair the frayed primary care system. The two foundational elements of the Summit were:

- Six open-to-the-public sessions —five plenaries plus one session with brief comments from a California State Assemblymember active in health care legislation. The topics and speakers for the plenary sessions were chosen to help broadcast and ensure a common understanding of:
  a) Key contributors to the primary care crisis
  b) Potential ways of addressing it
  c) Important yet poorly understood issues and unanswered questions that, unless attended to, will hinder progress in revitalizing primary care.

- Five closed Expert Committee sessions convening approximately 30 highly accomplished and nationally recognized primary care thought leaders representing health plan, purchaser, health system, clinician, researcher, advocate, and economic perspectives, drawn from both the public and private sectors. In the Expert Committee sessions, the members deliberated key issues contributing to the primary care crisis, generated recommendations for addressing them, and identified pressing unanswered questions representing a high priority agenda for future research and evaluation studies.

Recommendations from the Summit

Seven broad, high priority recommendations emerged to inform efforts to revitalize primary care, each with related sub-recommendations, as outlined below. As others seeking to influence aspects of health care policy have delineated, there are many potential actor groups that may influence primary care and its revitalization. These include, but are not necessarily limited to the following:

- Public agencies and political leaders
- Health care purchasers (e.g., large employers, Medicaid, unions, etc.)
- Payers and health plans
- Health systems
- Clinicians and provider groups/associations
- Health workforce education and training providers
- Patient and consumer advocacy groups
- Philanthropists and private foundations
- Academic researchers

RECOMMENDATION 1 – INCREASE THE PROPORTION OF SPENDING ON PRIMARY CARE, COUPLED WITH INITIATIVES TO SLOW THE GROWTH IN TOTAL HEALTH CARE SPENDING

Sub-recommendations:

- Encourage the development and consistent use of a uniform definition of primary care in which *continuity* and *comprehensiveness* of care are emphasized, and incorporated in tracking spending on primary care
- Set and enforce higher primary care spend rate targets: at least double the current average spending, commensurate with the primary care spend rates in comparable industrialized countries, which have better population health outcomes and lower total health care spending[7]
    - Employ a gradual implementation approach to attaining primary care and total health care spending targets, providing enough time so that most or all health plans and health systems in the relevant region can attain them.
- Establish and enforce primary care spending accountability mechanisms, including by:
    - Developing and implementing a public dashboard of health plan and health system primary care spending, to foster transparency and encourage adherence,

- Empowering oversight and regulatory bodies to levy fines and develop payer performance improvement plans if primary care spending targets are not met, and
- Requiring health systems to report on the flow of money earmarked for primary care through health systems, to help ensure it reaches intended targets rather than being diverted to other services.

RECOMMENDATION 2 – PAY PRIMARY CARE CLINICIANS AND PRACTICES USING MODELS THAT SUPPORT CARE TEAMS IN DELIVERING HIGH QUALITY, EQUITABLE, RELATIONSHIP-CENTERED PRIMARY CARE

Sub-recommendations:

- Develop and implement hybrid payment models in which an increased proportion (at minimum 60%) of payment is provided as per member per month capitation and decreased proportions are fee-for-service payments
  - Ensure hybrid payment models are risk-adjusted to guide the determination of appropriately sized patient panel sizes for clinicians, and to assure sufficient support for care teams designed to meet the needs of the populations served
  - Consider the need for unique hybrid payment models for three categories of practices: (1) Small, independent practices; (2) community clinics (e.g., Federally Qualified Health Centers); and (3) Larger practices within integrated networks (see p. 39 for rationale).
- Ensure a reliable and meaningful means of attributing patients to primary care practices, of critical importance under hybrid payment models with per member per month (PMPM) capitation.
- Consider establishing state primary care stabilization funds, funded by all payers and sequestered from the larger health system budget, to fund all primary care services.
- Reform or replace the American Medical Association's Relative Value Scale Update Committee (RUC) to achieve greater primary care physician representation and increased Relative Value Unit (RVU) assignments for primary care services.

RECOMMENDATION 3 – ASSIST PRACTICES IN TRANSFORMATION TO ADVANCED PRIMARY CARE MODELS AND ASSESS THE IMPACTS ON CLINICIANS, PRACTICES, PATIENTS, AND COMMUNITIES

Sub-recommendations:

- Incentivize and hold practices and health systems accountable for delivering high quality primary care while minimizing the reporting burden by:
  - Prioritizing practice monitoring of over-arching metrics that reflect core attributes of primary care including:
    - Patient access to care, via multiple modalities (e.g., in-person visits, asynchronous and synchronous telehealth, artificial intelligence [AI] platforms), and

        - Continuity, comprehensiveness, and patient-centeredness of care.
    - Selecting and monitoring a manageably small number of condition- focused quality metrics that also reflect core primary care attributes. For example, related to depression:
        - Services available (e.g., presence of on-site mental health treatment, community mental health workers),
        - Services received (e.g., percent of patients with depression that received treatment), and
        - Effects on outcomes (e.g., percent of patients with depression who attained remission based on symptom scores).
- Monitor the impact of advanced primary care practice at the broader community level (e.g., acute care utilization, mortality, cost of care).
- Provide up front funding and technical consultation and assistance to help practices effectively and rapidly implement advanced primary care models including:
    - Training and leveraging extended primary care team members such as lay health workers to increase the reach of practices and support health and wellness in the communities they serve,
    - Adopting artificial intelligence (AI) and other technologies to reduce clinician administrative burden around charting, coding, and clinical decision-making, and
    - Integrating behavioral health services, of paramount importance given the level of unmet in the U.S. and the impracticality of meeting the need via other channels.
- Monitor well-being and burnout among and the retention of all primary care team members.

RECOMMENDATION 4 - MAXIMIZE THE IMPACT OF PRIMARY CARE AS A LEVER FOR EQUITABLY ADVANCING POPULATION HEALTH

NOTE: *The recommendation for a doubling of spending on primary care (see Recommendation 1, p. 4), if realized, would itself foster equitable improvements in population health.*

Sub-recommendations:

- Establish universal population health goals and employ multiple strategies in pursuing them, targeted to specific health system and societal structural barriers adversely impacting on health and health care (see Plenary 5 p. 30 for rationale).
- Develop, implement, and enforce mandates for all ambulatory practices (primary care and subspecialty care) to participate in the care of patients with Medicaid insurance
    - Explore the provision of additional payments (e.g., determined by risk adjustment) to practices that disproportionately care for the medically underserved.
- Remove cost sharing (copays and deductibles) for primary care services.
- Ensure that risk adjustment methodologies account for both clinical factors and social influences on health.

- Ensure adequate information technology and infrastructure (e.g., data exchange capabilities between relevant entities) to support ongoing measurement, monitoring, and public reporting of health equity-related data (e.g., primary care access, health disparities).

RECOMMENDATION 5 – ADVOCATE FOR THE TRAINING OF AN APPROPRIATELY-SIZED PRIMARY CARE PHYSICIAN WORKFORCE THAT MIRRORS THE DIVERSITY OF THE COMMUNITIES IT SERVES

Sub-recommendations:

- Advocate for:
    - Centers for Medicare and Medicaid Services to develop and publicly report on adherence to policies that ensure distribution of their graduate medical education (GME) funding across regions is proportionate to community needs,
    - States governmental use of Medicaid funds to support GME in ways that better meet the needs of all communities, such as funding training in ambulatory facilities (e.g., Federally Qualified Health Centers) in medically underserved areas, and
    - Community governance structures that hold GME funders accountable for ensuring that primary care workforce needs are met in all regions.

RECOMMENDATION 6 - EXPAND RESEARCH RESOURCES AND INFRASTRUCTURE TO FACILITATE STUDIES ADDRESSING QUESTIONS OF PRESSING RELEVANCE TO PRIMARY CARE AND ITS REVITALIZATION

Sub-recommendations:

- Greatly increase federal and other funding to support primary care research, with a focus on new funding streams to support rigorous examination of topics that reflect the full complexity and cross-cutting nature of primary care.
- Broaden the reach, scope, applicability, and impact of primary care research by developing:
    - Hub and spoke geographic networks of participating practices and investigators, and
    - A national longitudinal registry of primary care practices and core practice data elements.
- Develop and disseminate robust gold standard measures of patient-centeredness, primary care team-centeredness, and primary care practice characteristics (such as panel sizes), to increase validity within studies and comparability across studies.
- Develop and consistently apply more advanced approaches analytic (e.g., parallel mixed methods, rigorous risk adjustment) in addressing complex primary care research questions.
- Build more effective strategies to disseminate research evidence-supported primary care research into clinical practice, such as the Primary Care Extension Program authorized by the Affordable Care Act and tested by the Agency for Healthcare Research and Quality.

RECOMMENDATION 7 - ENGAGE, EDUCATE, AND COLLABORATE WITH A BROAD ARRAY OF SOCIETAL STAKEHOLDERS IN MESSAGING THE VITAL IMPORTANCE OF ROBUST PRIMARY CARE TO POPULATION HEALTH AND HEALTH EQUITY

Sub-recommendations:

- Engage, educate, and facilitate the building of coalitions among the various actors (stakeholders) listed on p. 4 of this report.
- Develop a robust communication strategy which clearly conveys that *all* in the U.S. are poorly served by primary care in its current state, though some groups are more poorly served than others.
- Create a library of evidence-based primary care marketing resources and disseminate the resources via a hub and spoke model, to provide more consistent and more powerful messaging about primary care to the U.S. population.
- Consider efforts to increase health care and primary care literacy at the population level (e.g., via elementary through high school educational programs).
- Strongly encourage community governance structures for all primary care practices.

Conclusion

The recommendations in this report resulted from the activities of the Summit on Revitalizing Primary Care, which facilitated deliberations among approximately 30 national experts and thought leaders in primary care, a group with literally hundreds of years of relevant, collective experience. Still, it must be underscored that most of the recommendations reflect thinking on current best practices, stemming from this combined wisdom, rather than firmly evidence-based strategies.

As reflected in Recommendation 6 in this report (see p. 7), there remains a pressing need for research and evaluation projects to examine:

a) the abilities of governmental entities, regulatory bodies, health systems and practices to successfully pursue the recommendations; and, once pursued,
b) the effects on care team and patient outcomes, population health, and health care spending.

Perhaps this report will spur such projects and prompt funders to develop mechanisms to support them.

In the meantime, it is hoped that the recommendations in this report will be disseminated and adopted widely and will further accelerate the growing momentum toward appropriately supporting primary care —the foundation of health care. Only in this manner will primary care finally achieve its vast yet unrealized potential to equitably advance population health while helping to control escalating health care costs. The human and financial health of the United States depends on healthy primary care.

Appendix A: Summit Agenda

Summit on Revitalizing Primary Care to Recenter Relationships and Enhance Health (Rev PC)

Wednesday, October 16, 2024 Hyatt Place – Davis Executive Meeting Room, Davis Campus	
4:00-5:00 PM	Registration and Opening Reception
5:00-5:30 PM	**Welcome, Opening Remarks, Overview –** Anthony Jerant, MD, Professor and Chair, Family and Community Medicine, UC Davis (UCD) School of Medicine (SOM)
5:30-6:00 PM	Working Dinner
6:00-7:15 PM	Expert Committee Session 1 – Panel/Large Group Discussion Sharing What Has Been Learned Through Efforts to Optimize the Primary Care Spend Panel Discussants: - Wayne Altman, MD, Professor and Chair, Family Medicine, Tufts School of Medicine - Robert L. Phillips, MD, MSPH, Executive Director, The Center for Professionalism & Value in Health Care, American Board of Family Medicine Foundation - Russell Phillips, MD, Professor and Director of the Harvard Medical School Center for Primary Care - Diane Rittenhouse, MD, MPH, Senior Fellow, Mathematica and Professor, Family Medicine and Health Policy, UC San Francisco - Monica Soni, MD, Chief Medical Officer, Chief Deputy Executive Director, Covered California
7:15-7:30 PM	Session summary and closing
Thursday, October 17, 2024 Walter A. Buehler Alumni Center, Davis Campus	
7:20/7:30 AM	Escort to Alumni Center (meet in Hyatt lobby at either time)
7:30-8:00 AM	Public Registration and Breakfast
8:00-8:30 AM	Welcome *(AGR Hall)* **Opening Remarks –** David Lubarsky, MD, MBA, Vice Chancellor, Human Health Sciences and Chief Executive Officer, UCD Health; Susan Murin, MD, MSc, MBA, Interim Dean, UCD SOM **Summit Introduction and Overview –** Anthony Jerant, MD, Professor and Chair, Dept. of Family and Community Medicine, UCD SOM
8:30-9:15 AM	*Plenary 1* *(AGR Hall)* **Primary Care is Deteriorating One "Fragment" at a Time: Reorienting from Transactions to Relationships** Ilana Yurkiewicz, MD – author of the book Fragmented: A Doctor's Quest to Piece Together American Health Care

9:15-10:00 AM	*Plenary 2* *(AGR Hall)* Addressing the Elephant in the Room: Optimizing the Primary Care Spend to Recenter Relationships and Enhance Value in Healthcare *Christopher Koller – President, Milbank Memorial Fund*
10:00-11:15 AM	Poster Session with refreshments: Optimizing Primary Care (*Alumni Ctr Lobby*) Showcasing UCD Research Relevant to Recentering Relationships and Enhancing Value in PC
11:15 AM-12:45 PM	Expert Committee Session 2 – Small Group Breakouts with report back (*AGR Hall*) How Should Practices be Paid to Provide Optimally Resourced, High-Quality, Relationship- Oriented Primary Care?
12:45-1:30 PM	*Lunch* *(AGR Hall)*
1:30-3:30 PM	Concurrent Expert Committee Session 3 – Advancing Optimally Resourced, Relationship Oriented Primary Care *3a:* Identifying the Research that Must Be Conducted to Attain the Vision (*Founders' Board Rm*) *3b:* Inputs to Impact: Traversing the Gap Between Primary Care Funding and Transformation (*West & Allewelt Conference Rms*)
3:30-4:00 PM	Debrief and Reflections Sessions 2, 3a, and 3b (*AGR Hall*)
4:00-5:45 PM	Break
5:45-6:00 PM	Escort back to Alumni Center for evening event (meet in Hyatt lobby)
6:00-7:15 PM	Evening social event with dinner (*AGR Hall*) Guided Wine Tasting – Dr. Hoby Wedler
7:30 PM	Dinner (*AGR Hall*)
Friday, October 18, 2024 Hyatt Place – Davis Executive Meeting Room, Davis Campus	
7:30-8:00 AM	Public Registration and Breakfast
8:00-8:15 AM	Welcome **Introduction and Overview –** Anthony Jerant, MD, Professor and Chair, Dept. of Family and Community Medicine, UCD SOM
8:15-9:00 AM	Plenary 3 **The New California Office of Health Care Affordability (OHCA) Primary Care Investment Benchmark.** Elizabeth Landsberg, JD – Director, California Department of Healthcare Access and Information (HCAI)
9:00-9:15 AM	Plenary 4 **Implementing Primary Care Investment Policies: Ensuring Accountability, Impact, and Equity** Kevin Grumbach, MD – Professor of Family and Community Medicine, University of California, San Francisco
9:15-9:45 AM	Plenary 5 **Targeted Universalism: An Equity 2.0 Approach to Primary Care Policy Development and Communication.** john a. powell, JD – Founding Director, Othering & Belonging Institute and Professor of Law, African American Studies, and Ethnic Studies, University of California, Berkeley
9:45-10:00 AM	Break

10:00-10:30 AM	A California Legislative Perspective: Remarks from Assemblymember Mia Bonta *Mia Bonta – Chair, Assembly Health Committee*
10:30-Noon	Expert Committee Session 4 – Small Group Breakouts with report back: Leveraging the OHCA Increased Primary Care Spending Target to Advance Health Equity in California
12:00-12:30 PM	Summit closing - review next steps
12:30 PM	Networking lunch

Appendix B: Summit Expert Committee Members and Plenary Speakers Biographies

Dr. Wayne Altman
Tufts University

Dr. Altman is Professor and Chair of Family Medicine at Tufts University School of Medicine. He has received 35 teaching awards and citations during his 25 years at Tufts. He has also been recognized as a Boston Top Doc 14 times. Dr. Altman practices at Family Practice Group (FPG) in Arlington where he is President and co-owner of the practice.
Dr. Altman is the founder of MAPCAP (MA Primary Care Alliance for Patients) which advocates for anti-racist health policy that features an emphasis on Social Determinants of Health, health equity, a prospective global payment for primary care, and the doubling of primary care investment. Dr. Altman is a Massachusetts Academy of Family Physicians Board member and serves as their Legislative Committee Chair. He was presented the 2023 Advocacy Award by the Massachusetts Academy of Family Physicians. Dr. Altman is also Chair of the Advocacy Committee for the Association of Departments of Family Medicine.

Palav Babaria, MD
California Department of Health Care Services

Dr. Palav Babaria was appointed Chief Quality & Medical Officer and Deputy Director of Quality and Population Health Management of the California Department of Health Care Services in March 2021. In that role, she and her team are responsible for the quality and equity of care and population health for more than 14 million Medi-Cal members across the state of California. As a part of DHCS' CalAIM Population Health Management program, Dr. Babaria has led a primary care and prevention-centered approach to DHCS' PHM strategy, including strengthened primary care investment and quality withhold alignment across public purchasers Covered California and CalPERS, as well as local integration between public health and Medi-Cal managed care plans as a part of their community health assessments.

Susannah Bernheim, MD, MHS
Center for Medicare and Medicaid Innovation

Dr. Susannah Bernheim is Chief Quality Officer and Acting Chief Medical Officer for the CMS Center for Medicare & Medicaid Innovation. She was previously an Associate Professor at Yale University School of Medicine and Senior Director of Quality Measurement at the Yale-New Haven Hospital Centers for Outcomes Research and Evaluation (CORE). Dr. Bernheim completed her undergraduate degrees at Yale University and her medical degree at the University of California, San Francisco. Dr. Bernheim was a fellow in the Robert Wood Johnson Clinical Scholars program at Yale University, earning a Master's degree in Health Sciences Research.

Margareta Brandt, MPH
California Department of Health Care Access and Information (HCAI)

Margareta Brandt is the Assistant Deputy Director for Health System Performance at the Office of Health Care Affordability (OHCA) at the California Department of Health Care Access and Information (HCAI). She oversees the development and implementation of OHCA's efforts to promote a value-based health care system by measuring quality, equity, adoption of alternative payment models, investment in primary care and behavioral health, and workforce stability alongside implementing spending growth targets to improve health care affordability. Margareta leads the Office's development of a primary care spending definition and statewide primary care investment benchmark to build and sustain primary care infrastructure and capacity and promote improved outcomes for primary care. Margareta was previously the Quality Improvement Manager for Covered California, where she led engagement with health plans to improve health care quality and implement delivery system and payment reforms. Before joining Covered California, she worked at a nonprofit coalition of public and private health care providers and community organizations where she facilitated a collaborative quality improvement initiative for twelve community clinics. Margareta has a master's in public health from the School of Public Health at the University of California, Berkeley.

Dr. Alice Hm Chen, MD, MPH
Centene Corporation

Dr. Alice Hm Chen, MD, MPH, is the executive vice president and chief health officer for Centene Corporation, the largest Medicaid and Marketplace managed care organization in the country. Dr. Chen is responsible for Centene's strategies, policies and programs in support of improving population health for Centene's members. A primary care internist by training, her career has focused on improving access, quality and equity of care for under-resourced communities. Prior to joining Centene, Dr. Chen was chief medical officer at Covered California, the state's health insurance marketplace, where she was responsible for health care strategy focused on quality, equity and delivery system transformation. She previously served as deputy secretary for policy and planning and chief of clinical affairs for the California Health and Human Services Agency, where she led signature health policy initiatives including the development of the Office of Health Care Affordability and played a leadership role in the state's response to the COVID-19 pandemic. Dr. Chen was also a professor of medicine at the University of California San Francisco School of Medicine, based at Zuckerberg San Francisco General Hospital, where she served as its chief integration officer, founding director of the eConsult program and medical director of its primary care internal medicine clinic.

Deb Cohen, MD
Oregon Health Sciences University

Dr. Cohen is a professor and Vice Chair of Research in OHSU Department of Family Medicine. She is an implementation scientist and an expert in qualitative and mixed methods. She spent 25 years studying primary care practices, including primary care staffing and workforce, and the factors that influence innovation in this setting. Most recently, Dr. Cohen led an AHRQ-funded contract that examined how primary care spending is measured in the United States. She is currently conducting a study to identify the workforce configurations in advance primary care practices and what it costs to delivery this care. Dr. Cohen was a member of the committee that prepared the NASEM whole health report. Finally, primary care payment, financing and workforce are also salient topics for the NASEM PC Standing Committee on which she serves.

Aimee Eden, PhD, MPH US Agency for Healthcare Research & Quality

Aimee R. Eden is the Director of the National Center for Excellence in Primary Care Research at the Agency for Healthcare Research & Quality. She is a medical anthropologist and qualitative and mixed methods researcher, with research focusing on issues facing the primary care workforce and the role of primary care in perinatal care. Prior to AHRQ, Dr. Eden was a Senior Research Scientist, Medical Anthropologist with the American Board of Family Medicine. She serves on the editorial review boards of the Annals of Family Medicine and the Journal of the American Board of Family Medicine.

Josh Fenton, MD, MPH
University of California, Davis

Joshua Fenton, MD, MPH is Professor of Family and Community Medicine at UC Davis. He completed a family medicine residency at San Francisco General Hospital and was a Robert Wood Johnson Clinical Scholar at the University of Washington. Dr. Fenton conducts health services research focused on the intersection of primary care and public health with current projects focusing on opioid prescribing, overdose prevention, cancer screening, and patient-doctor communication. Dr. Fenton is on the Editorial Board of the Journal of the American Board of Family Medicine.

Erik Fernández y García, MD, MPH, FAAP
UC Davis Health

Dr. Fernández y García is Professor of Clinical Pediatrics at UC Davis Health. He was born and raised in the South Sacramento neighborhood of Meadowview. He received his MD at Charles Drew/University of California Los Angeles and his MPH. at UCLA. He completed his pediatric residency and academic pediatric fellowship with a focus on Multicultural Health at Children's Hospital Oakland. He came back home in 2005 to practice general pediatrics and pursue research at UC Davis Health. His research focuses on designing, testing, and implementing intergenerational behavioral and mental health interventions ins pediatric primary care settings. These interventions focus on parental depression, parenting, general pediatric health services, and pediatric behavior and development for all families, but especially those most at risk of experiencing inequities in health and healthcare. In addition, he is the Co-Chair of the Department of Pediatrics Committee on Inclusive Excellence and Pediatric Health Equity and co-leads the UC Davis Health Office of Population Health's System-Wide Health Care Equity Collaborative. Outside of UC Davis Health, Dr. Fernández y García is also a Fellow of the American Academy of Pediatrics and a Commissioner on the Sacramento County First 5 Commission. He is an academic coach in the UC Davis Health Office of Medical Education for the TEACH-MS track (focus on serving underserved communities) of medical students.

Lisa Folberg, MPP
California Academy of Family Physicians (CAFP)

Lisa Folberg is CEO of the California Academy of Family Physicians (CAFP), which represents more than 10,000 family physicians across California. In this role, she guides CAFP's advocacy, policy, and membership efforts and oversees the CAFP Foundation. She previously served as CEO of the California Medical Association (CMA) Foundation, a 501(c)(3) nonprofit. Prior, Ms. Folberg served as Vice President at CMA where she managed the day-to-day operations of CMA's policy development and regulatory advocacy, and as Associate Director of Government relations. She joined CMA from the California Legislative Analyst's Office, where she provided the Legislature with analyses on a variety of health and social services budget issues. Ms. Folberg's more than two decades in health policy and advocacy has largely focused on health system financing and reform, health care workforce, public health and expanding access to primary care. She has served as Chair of the California Information Partnership and Services Organization (CalHIPSO) and as a member of the California Department of Public Health's Office of Health Equity Advisory Board among others. Ms. Folberg holds a master's degree in public policy from Georgetown University.

Beth Griffiths, MD, MPH
University of California, San Francisco

Dr. Beth Griffiths is an associate professor of clinical medicine and an internal medicine physician who provides primary care to adults and teaches medical students and residents in primary care clinic. As Co-Associate Director of Training and Policy Programs at the Philip R. Lee Institute for Health Policy Studies and Education Lead for the CTSI IMPACT Core, she collaborates with researchers to translate their work into policy change. In addition, she teaches health policy, advocacy, and community engagement to medical students, residents, and researchers from around the world. She has written about and advocated for expansion of primary care training programs and enhanced primary care spending, particularly noting the importance of ensuring that health systems actually devote enhanced primary care spending to primary care.

Kevin Grumbach, MD
University of California, San Francisco

Kevin Grumbach, MD is Professor of Family and Community Medicine at the University of California, San Francisco. He served as Chair of the UCSF Department of Family and Community Medicine from 2003 to 2022 and is a Founding Director of the UCSF Center for Excellence in Primary Care and Director of the Community Engagement Program for the UCSF Clinical and Translational Science Institute. Dr. Grumbach currently serves on the California Health Workforce Education and Training Council and the Investment and Payment Work Group for the California Office of Health Care Affordability, and co-chairs the California Academy of Family Physicians Task Force on Primary Care for All. He was elected to the National Academy of Medicine in 1997 and currently serves on the NASEM Standing Committee on Primary Care. He cares for patients at the family medicine practices at San Francisco General Hospital and UCSF Health. (*Plenary speaker*)

Mark Henderson, MD
University of California, Davis

Dr. Mark Henderson is Professor of Internal Medicine and Associate Dean for Admissions at the UC Davis School of Medicine. He previously served as Internal Medicine Residency Program Director at the University of Texas Health Science Center San Antonio and at UC Davis. For the past 18 years, he has led UC Davis's efforts to become one of the most diverse medical schools in the US. He is co-principal investigator of the Accelerated Competency-based Education in Primary Care (ACE-PC) program, a 3-year medical school track for students committed to primary care careers, funded by the American Medical Association.

Sandra R. Hernández, MD California Health Care Foundation

Sandra R. Hernández, MD, is president and CEO of the California Health Care Foundation. Prior to joining CHCF, Sandra was CEO of The San Francisco Foundation. She previously served as director of public health for the City and County of San Francisco. In February 2023, Sandra was appointed by Governor Gavin Newsom to serve on the state's Health Care Affordability Board. From 2018 to 2023, she served on the Covered California board of directors, after having been appointed by Governor Jerry Brown. In 2019, she was also appointed by Governor Newsom to the Healthy California for All Commission. During her time at the San Francisco Foundation, she cochaired San Francisco's Universal Healthcare Council, which designed Healthy San Francisco. It was the first time a local government in the US attempted to provide health care for all of its constituents. Sandra practiced at San Francisco General Hospital in the HIV/AIDS Clinic from 1984 to 2016 and was an assistant clinical professor at the UCSF School of Medicine. In 2024, UCSF awarded Sandra its highest honor, the UCSF Medal. Currently, Sandra also serves on the board of the company 23andMe. Sandra is a graduate of Yale University, the Tufts School of Medicine, and the certificate program for senior executives in state and local government at Harvard University's John F. Kennedy School of Government.

Anthony Jerant, MD University of California, Davis

Dr. Jerant joined the UC Davis Department of Family and Community Medicine in 1998 and was appointed Chair in January 2018. He strives to embody the servant leadership philosophy, maintaining a primary focus on cultivating the growth and well-being of the people in the Department and the patients and communities it serves. Before becoming Chair, he was the Department's Vice Chair for Research. Dr. Jerant's research has a strong focus on studying how different aspects of healthcare delivery, including home telecare and computer technology-enhanced office visits, are associated with patient and provider experiences and care outcomes. He has developed and studied patient-facing individualized (personally tailored) interventions to enhance clinician-patient interactions and increase patient activation in care. Additional studies examined how various features of primary care practices are associated with health outcomes, including mortality. Other influential studies concerned the associations of medical school admissions approaches with physician workforce diversity and primary care specialty choice.

Christopher Koller
Milbank Memorial Fund

Christopher F. Koller is President of the Milbank Memorial Fund and Publisher of the Milbank Quarterly. The Fund is a more than 100-year-old operating foundation that improves population health and health equity by connecting leaders with evidence and sound experience. Before joining the Fund in 2013, he served the state of Rhode Island for eight years as the country's first health insurance commissioner. Prior to that, he was CEO of Neighborhood Health Plan of Rhode Island. He has served in numerous national and state health policy advisory capacities and was elected to the National Academies of Science Engineering and Medicine in 2023. Mr. Koller is also a professor of practice in the School of Public Health at Brown University. (*Plenary speaker*)

Richard Kravitz, MD
University of California, Davis

Richard Kravitz, MD, MSPH, is distinguished Professor of Internal Medicine at the University of California, Davis and is co-chair of the 2024 UC Davis Revitalizing Primary Care Summit. As a primary care physician and researcher, Dr. Kravitz has spent his career deeply involved in studying the disruption of the primary care system and proposing strategies for needed reform. Examples of his research includes the causes and consequences of physician behavior; improving care for mental health conditions in primary care settings; and identifying the relationship between patient mix, utilization of health care services, physician specialty and the system of care. His research has also examined patients' expectations for care, how physicians respond to patients' requests for services, and how direct-to-consumer advertising of prescription drugs influences physician decision making in depression. Other summit-relevant leadership positions that Dr. Kravitz as held include serving as a commissioner to the National Commission on Payment Reform (2013) and Co-Editor-in-Chief of the Journal of General Internal Medicine (2009-2017).

Elizabeth A. Landsberg
Department of Health Care Access and Information (HCAI)

Elizabeth A. Landsberg was appointed Director of the Department of Health Care Access and Information (HCAI) by Governor Newsom in December 2020. She is committed to the varied work the HCAI team does to support access to affordable, equitable, quality health care for all Californians as part of 24+ years advocating for the needs of health care consumers. Previously, Director Landsberg was a Deputy Director at the Department of Managed Health Care (DMHC) where she oversaw the Help Center program that assists consumers and providers with healthcare complaints. Before joining the DMHC, Director Landsberg was an advocate for healthcare consumers in the nonprofit realm for more than 16 years. She was the Director of Policy Advocacy for the Western Center on Law & Poverty, where she focused on health reform implementation, Medi-Cal, Covered California and other issues affecting low-income Californians and the Supervising Attorney at the Health Rights Hotline. (*Plenary speaker*)

Courtney Lyles, PhD
UC Davis Center for Healthcare Policy and Research

Courtney Lyles, PhD, is the Director of the UC Davis Center for Healthcare Research and Policy (CHPR). A trained health services researcher, Dr. Lyles has expertise in health equity, digital health/informatics, and implementation science. Her research portfolio designs and evaluates new programs and platforms to support patients and families as well as clinical workflows, with an emphasis on participant- and community-engaged methods and chronic disease prevention and treatment.

Robert (Bob) Phillips, MD
American Board of Family Medicine Foundation

Bob Phillips is Executive Director of the Center for Professionalism & Value in Health Care,
American Board of Family Medicine. He has led health policy centers in Washington, DC for more than two decades, working at the interface of evidence and policy. In 2018, he founded the Center for Professionalism & Value in Health Care (CPV) which aims to study relationships between professionalism and value, promote their alignment, recommend ways to reduce burden, and better support outcome and quality improvement. Dr. Phillips is a practicing family physician in a community-based residency program and is a member of the National Academy of Medicine.

Russell Phillips, MD

Harvard Medical School

Russell S. Phillips is a professor and Director of the Harvard Medical School Center for Primary Care and a practicing general internist at Beth Israel Deaconess Medical Center. He has been a leader in innovation in practice and payment evaluation in primary care, implementing new care models for patients with chronic illness and, using micro-simulation, evaluating the revenues available to support innovations in care and the level of patient coverage required for global payment to lead to changes in practice that enhance value. He was also involved in evaluating the effect of increased primary care payment in Rhode Island on total medical costs and quality. Dr. Phillips has served on a Massachusetts Health Quality Partners Advisory Group on the future of primary care and nationally, is a member of the Primary Care Centers Round Table, representing the HMS Center for Primary Care. In Massachusetts and nationally, he is an advocate for improved access to primary care, and primary care innovation supported by global payment for primary care. He also served on a Primary Care Collaborative Advisory Committee on Oral Health Integration.

Kathryn E. Phillips, MPH
California Health Care Foundation

Kathryn E. Phillips, MPH, is the associate director of Improving Access to Care for the California Health Care Foundation, a private, independent philanthropic organization dedicated to strengthening the Medi-Cal program and improving access to care, health care experiences, and health outcomes for Medi-Cal members and other underserved populations across California. Kathryn develops strategic priorities and new initiatives to build the future health care workforce in California, including efforts to expand pipeline and pathway programs; modernize education and training in medicine, nursing, and pharmacy; and create growth opportunities for current healthcare workers. Kathryn joined the Foundation in 2016 and has led portfolios on advanced primary care, behavioral health integration, and population health; she continues to lead the Foundation's efforts to improve health equity by fostering greater investment in primary care systemwide. Previously, Kathryn worked for a non-profit population health consulting firm where she designed and evaluated national technical assistance initiatives on patient-centered care and care integration and advised state Medicaid agencies on payment reform. She began her career in Washington, DC at the National Business Group on Health where she advised large public and private employers on evidence-based benefit design in partnership with the federal government, consumer advocates, and philanthropy.

Amie Pollack, PhD
Center for Primary Care, Harvard Medical School

Amie Alley Pollack, PhD is Director of Research at the Center for Primary Care, Harvard Medical School providing leadership, strategic direction, partnership engagement, and oversight of the Center's research activities. Amie also leads the Center's behavioral health integration efforts. She is a co-PI on the *Investing in Primary Care* study investigating how provider organizations, practices and payers are investing in advanced primary care services and the impacts of those investments. Amie is also an Investigator for TTELP+, a HRSA-funded project focused on strengthening primary care in rural health systems through an ECHO-based technology-enabled learning and capacity building model, and she is an Investigator on health outcomes research related to open loops, factors related to open loops, and innovations for closing loops (R18, AHRQ). Prior to joining the Center in 2022 Amie was a Senior Research Associate at Vanderbilt University and Visiting Foreign Professor at Vietnam National University focused on strengthening mental and behavioral health research and implementation capacity in Vietnam and Cambodia. Her work in SE Asia was supported by a Global Health Postdoctoral Scientist Award from the Fogarty International Center, and by the NIH and UNICEF. Amie earlier focused on mental health program development and implementation in low-resource communities as a research associate with Judge Baker Children's Center, Harvard Medical School and as a post-doctoral fellow at The Trauma Center of Boston University. Amie earned a BS from The College of William and Mary and a PhD in Clinical Psychology from Bryn Mawr College.

Dominique Ritley, MPH
UC Davis Center for Healthcare Policy and Research

Ms. Ritley is a senior health policy researcher at the UC Davis Center for Health Care Policy and Research. Areas of research focus include health care quality measurement, health care finance and delivery, and health policy. Ms. Ritley is the UC Davis team coordinator for the California Health Benefits Review Program, which provides medical effectiveness and public health impact analyses of health insurance legislation to the California State Legislature. She has co-authored more than 35 CHBRP reports on topics such as telehealth, doulas, continuous glucose monitors, pediatric hearing aids, violence prevention services, and substance use disorder. Dominique also co-directed, with Dr. Richard Kravitz, the California State Policy Evidence Consortium, a pilot program that responded to state legislative committee requests for non-partisan, evidence-based reports about committee topics of interest. Prior to joining CHPR in 2006, Dominique supported the health policy office of the U.S. Senate Health, Education, Law and Pension Committee chaired by Sen. Edward M. Kennedy.

Diane Rittenhouse, MD, MPH
Mathematica; University of California, San Francisco

Dr. Rittenhouse is a Senior Fellow with Mathematica and Professor of Family Medicine and Health Policy at UCSF. She has two decades of experience researching primary care organization, delivery, finance, and workforce – and translating that research into policy. She has been recognized in the United States and Europe as a leading primary care researcher. Currently she leads several projects focused on optimizing the primary care team workforce; developing policy priorities for California to strengthen primary care and advance health equity; diversifying the physician and nursing workforces; understanding and supporting independently owned physician practices; and highlighting exemplary primary care practices participating in federal primary care payment demonstrations. She serves as an expert advisor for the development of the Health of U.S. Primary Care Scorecard recommended by the National Academies of Sciences, Education and Medicine. Dr. Rittenhouse is a family physician by training and practiced for 10 years in a community-based faculty practice at the University of California, San Francisco.

Dylan Roby, PhD
UC Irvine Joe C. Wen School of Population & Public Health

Dylan Roby is a professor and Chair of Irvine Department of Health, Society and Behavior, UC Irvine Joe C. Wen School of Population & Public Health. He is also a faculty associate of the UCLA Center for Health Policy Research. Dr. Roby is a health services researcher with expertise in safety net provider operations and payment, with a focus on federally-qualified health centers and public hospitals. He has led or contributed to several evaluations of Medicaid Demonstration Waivers in California and New York, and has experience with evaluating the impact of patient-centered medical homes on spending and patient experience. Prior to coming to UC Irvine, Dr. Roby was an associate professor and associate chair of Health Policy and Management at the

University of Maryland School of Public Health. His graduate training is in public policy at the George Washington University and he earned his undergraduate degree in Geography from UCLA.

S. Monica Soni, MD
Covered California

Dr. Soni is Covered California's Chief Medical Officer and Chief Deputy Executive Director of the Equity and Quality Transformation Division. She is also Associate Clinical Professor at UCLA and Associate Professor of Internal Medicine at Charles R. Drew University. Covered California has been at the forefront of purchaser initiatives aimed at enhancing advanced primary care, recognizing its crucial role in improving patient outcomes and cost. Covered California has implemented a robust framework of contract requirements including requiring primary care assignment for HMO as well as PPO/EPO, tracking primary care spend for health plans and setting targets, and including penalties for health plans that fail to meet specified performance metrics related to primary care spend. This approach incentivizes health plans to prioritize investments in primary care. Furthermore, Covered California utilizes a comprehensive claims database to track primary care utilization, continuity of care, and spending patterns. This data-driven strategy enables Covered California to monitor compliance with contract requirements, assess the effectiveness of deployed policy levers, and identify areas for future improvement and interventions across purchasers and the state of California.

Lemeneh Tefera MD, MSc Department of Health Care Access and Information (HCAI)

Dr. Lemeneh Tefera is Chief Medical Officer and Deputy Director for Clinical Innovation of the Department of Health Care Access and Information (HCAI). Dr. Tefera received his M.D. degree from the University of Southern California Keck School of Medicine and completed an emergency medicine residency at Kings County Hospital in Brooklyn. Among Dr. Tefera's numerous prior roles of relevance to health care redesign and improvement was his position as Medical Officer-Value Based Purchasing and Merit-Based Incentive Payment System Program (MIPS). Centers for Medicare and Medicaid Services Center for Clinical Standards and Quality.

Raymond Tsai, MD MS
Purchaser Business Group on Health

Dr. Raymond Tsai is a Family Medicine physician serving as Vice President of Advanced Primary Care for Purchaser Business Group on Health, a non-profit coalition of around 40 private employers and public entities nationally that collectively spend $350 billion annually purchasing health care services for more than 21 million Americans and their families. He is currently working with PBGH to help employer and purchaser members identify high quality advanced primary care that meet purchaser standards, as well as enabling easy contracting of identified clinical partners of assured quality. Prior to PBGH, he worked to establish advanced primary care clinic on behalf of a private employer and saw the effect their advanced primary care model in improving

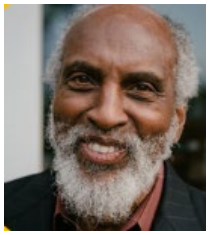
health outcomes, patient experience, provider experience, health equity, and health care spend for agriculture workers in Central Valley California.

Ilana Yurkiewicz, MD
Stanford University

Dr. Yurkiewicz is a Clinical Assistant Professor of Primary Care and Population Health, Department of Medicine and a practicing primary care physician at Stanford Medicine. She authored the book, *Fragmented: A Doctor's Quest to Piece Together American Health Care*. Board certified in internal medicine, oncology, and hematology, she is Co-Director of Stanford's Primary Care for Cancer Survivorship program, an innovative clinic that provides comprehensive primary care for patients with cancer and those at elevated risk, as well as Co-Director of Stanford Internal Medicine East, the largest primary care residency clinic at Stanford. Dr. Yurkiewicz splits her time between practicing medicine and as an award-winning medical journalist. Her book, *Fragmented*, defined fragmentation in medicine as the root cause of the U.S. health care system's failings. She writes and speaks widely about how we can move past fragmented primary care for media outlets such as TIME, NBC News, NPR, and at many academic conferences. (*Plenary speaker*)

Additional Plenary Speakers

john a. powell, JD
UC Berkeley



john a.powell, Professor of Law and African American Studies, the Robert D. Haas Chancellor's Chair in Ethnic Studies, and the founding director of the Othering & Belonging Institute at UC Berkeley. Professor powell is internationally recognized for his work in the areas of civil rights, civil liberties, structural racialization, racial identity, fair housing, poverty, and democracy. The Othering & Belonging Institute he founded brings together scholars, community advocates, communicators, and policymakers to identify and eliminate the barriers to an inclusive, just, and sustainable society and to create transformative change toward a more equitable world.

Mia Bonta, Ed.M, JD
Assemblymember, District 8

Assemblymember Mia Bonta. Since her election in August 2021, Assemblymember Bonta has represented Assembly District 18, which encompasses the East Bay area of Northern California, including a large portion of the city of Oakland and the cities of Emeryville and Alameda. As a dedicated public servant, Assemblymember Bonta has been at the forefront of initiatives aimed at supporting the healthcare workforce to ensure that all communities have access to timely, appropriate, and equitable care. Her leadership has been instrumental in shaping policies that address the systemic barriers faced by historically medically underserved and marginalized people.

Appendix C: Plenary Session Summaries

Plenary 1: Primary Care is Deteriorating One "Fragment" at a Time: Reorienting from Transactions to Relationships – *Ilana Yurkiewicz, MD*

Dr. Yurkiewicz detailed how problems with supporting ***technology***, care ***teams***, and ***time*** availability contribute to fragmented primary care delivery and offered potential solutions for restoring a focus on enduring relationships between individuals, families, and primary care teams. Such relationships facilitate optimal management of health issues and timely delivery of preventive services, maximizing the beneficial impacts of primary care.

> "The secret sauce of primary care is the (clinician-patient) relationship."
> *~Monica Soni, MD*
> *Chief Medical Officer*
> *Covered California*

Regarding ***technology***, problems with EHRs strongly contribute to fragmentation in primary care. There is limited interoperability among EHR brands, often precluding electronic access to prior records and requiring use of archaic parallel technologies (e.g., fax machines). Additionally, physicians face a heavy burden in accessing and manually entering data in EHRs due to poor interface design. Regarding ***teams***, under-financing of primary care means practices cannot build extended care teams allowing clinicians to delegate non-clinician level (e.g., administrative) tasks, worsening clinician burden and contributing to burnout. Pertaining to ***time***, prevailing health care payment models, particularly fee-for-service reimbursement, incentivize episodic, transactional office visits with a procedural focus and disincentivize longitudinal, continuous, relationship- and team-based care with a cognitive focus that extends beyond office visits.

Dr. Yurkiewicz outlined potential solutions to care fragmentation, drawing on her experiences in an innovative primary care practice at Stanford. One promising approach is to adopt alternative payment models to fee for service, such as up front global payment from insurers to cover all practice elements including non-clinician team members. With adequate investment by insurers, global payment can support a shift to smaller patient panels, creating more clinician capacity for follow-up and urgent visits with continuity patients, facilitating continuous relationships, enhancing patient and clinician satisfaction, and reducing burnout. Greater attention to EHR interoperability and clinician involvement in EHR interface design will also be important, along with broader efforts to reduce clinician and practice level administrative burdens.

Plenary 2: Addressing the Elephant in the Room: Optimizing the Primary Care Spend to Recenter Relationships and Enhance Value in Healthcare – *Christopher Koller*

Mr. Koller focused on State level efforts to date to increase the primary care spend rate, since the Federal government has only recently begun engaging on the issue of optimizing payment for primary care, exemplified by the Congressional bipartisan Whitehouse-Cassidy Pay PCPs Act (S.

4338). He began by outlining the "theory of change" underlying most prior and present efforts to increase spending on primary care:

- Primary care is undervalued
- Measuring and reporting on the primary care spend rate illustrates the undervaluing in an easily comprehensible way
- Establishing and measuring progress toward attaining higher primary care levels is an evidence-supported approach, encourages a systemic view, and is an effective political organizing tool
- Setting public policy to reach specified primary care spending targets addresses the failure of the health care "market" to appropriately value primary care.

Beginning with Rhode Island in 2009, 19 states have launched organized efforts to increase the primary care spend rate with essentially all tied to concurrent efforts to slow the growth of total health care spending.[34] Some States only initiated *measuring* and *reporting on* primary care spend rates; several others went further in also *recommending* increased primary care spending targets; while only four (Rhode Island, Oregon, Colorado, Delaware) have initiated *mandated* increases in primary care spending. Collectively, the State-level initiatives have yielded important lessons:

- Despite the efforts, primary care has continued to weaken nationally, with flat or declining state primary care spend rates and numbers of primary care physicians per capita and an increasing proportion of individuals (nearly a third of Americans) without a usual source of care
- Measuring, reporting on, and seeking to increase the primary care spend can be a particularly powerful organizing tool in States that are already relatively more advanced in their efforts to revitalize primary care (e.g., Massachusetts, Virginia).
- There is reasonable evidence that *within* a given State, payers, physician organizations, and integrated care delivery systems spending more on primary care have better outcomes than those spending less.
- There is not yet parallel *between*-state evidence, with no robust studies yet examining whether states with higher primary care spend rates have better primary care access or health outcomes than do states with lower spend rates.

There is a pressing need to address key unresolved issues and challenges that continue to hamper the impact of primary care revitalization efforts. These include:

- Lack of consensus on what services and team members should be encompassed in the primary care spend rate and on how best to measure primary care spending. Koller noted these issues have been taken up by the Agency for Healthcare Research and Quality (AHRQ).[35]
- Lack of clarity on who is accountable for ensuring primary care spending targets are met (e.g., Insurers? Healthcare delivery systems?), and a related lack of enforcement mechanisms and oversight structures with engaged stakeholders, including primary care clinicians and the public.
- Lack of alignment of efforts across all payers in a region (e.g., commercial, Medicaid, Medicare), limiting the impact of primary care revitalization efforts

- Difficulty ensuring that in complex multi-specialty health systems, increased spending earmarked for primary care reaches the clinicians and practices, rather than being siphoned off to fund other activities.
- The deeply flawed yet still prevailing fee for service payment model, which disincentivizes practices to adopt team-based care due to lack of financial support for non-RVU generating elements and activities

These issues illustrate that while increasing the primary care spend is *necessary*, it will not be *sufficient* to revitalize primary care. Koller suggested that it is important to "remember the why" behind primary care revitalization and communicate it frequently and consistently to all stakeholders. He emphasized that the aim of reinvigorated primary care is not near-term cost savings ("return on investment"), but rather improved population health and health equity, per the NASEM report designation of primary care as a "common good." Koller then underscored the need to think about the health care system more broadly as part of primary care revitalization, and to carefully consider what is meant by "the health care system": Is it the national health care milieu? The State-level system? Existing health care organizations? Economically aligned care delivery systems and patient populations (e.g., mature Accountable Care Organizations)? Regardless, the flaws in each of these systems also must be addressed.

> "It will be hard to rebuild primary care, the foundation of the delivery system, without changing the rest of the structure."
>
> *~Christopher Koller, President*
> *Milbank Memorial Fund*

Plenary 3: The California Office of Health Care Affordability (OHCA) Primary Care Investment Measurement and Benchmark – *Elizabeth Landsberg, JD*

This plenary focused on the efforts of the California Department of Health Care Access and Information (HCAI) and its Office of Health Care Affordability (OHCA) to revitalize primary care in the State. HCAI Director Landsberg began by outlining a separate but related charge for her Department: to slow the growth in *overall* health care spending in California while promoting high value health care for its population. Since 2020, annual growth in total health care expenditures in the State has been about 5.4% per capita, outpacing the national rate, with $405 billion spent in 2023. Most economists, legislators, policymakers, and other stakeholders view this rate of growth as unsustainable. Seeking to address this issue, in April 2024 California's Health Care Affordability Board established a base target of 3% growth in total per capita health care spending for performance year 2029, to be approached incrementally over five years with successively smaller growth targets.[34] Under regulatory mandate, health plans, hospitals, and physician groups are now required to submit spending data to the State annually. Further, beginning in 2029, OHCA will have progressive enforcement authority including enforceable Performance Improvement Plans for entities that fail to meet the target and fines for violation of the Plans. The new enforceable target signals the principle that total health care spending should not grow faster than the income of California families.

Landsberg then noted that a key strategy for OHCA in this effort is to push health plans to direct a higher proportion of their spending to high value elements of the health care system – meaning services that can improve individual and population health and advance health equity at relatively low cost – and a lower proportion to higher cost, lower population health impact services that have little or potentially detrimental impact on health equity. OHCA recognizes primary care as a foundational and particularly high value element of health care, yet one that has struggled to deliver on its full promise due to chronic and severe under-investment. In 2019-2021, California commercial plans devoted only 7.3-9.9% of their total spending to primary care services, while Medicare Advantage plans similarly had only 7.7-10.6% of their overall spending on primary care. Recognizing these issues, OHCA has legislative mandates to:

> "So, our theory of change is to increase investment in primary care in ways that reduce low value care and waste, that we then free up more dollars that can be invested into primary care. And we've heard the research that supports that notion."
>
> *~ Elizabeth Landsberg, JD*
> *Director, California Department of Health Care Access and Information*

- Measure the percentage of total health care expenditures (including both claims and non-claims-based payments) allocated to primary care and set spending benchmarks that consider the current and historic underfunding of primary care
- Build and sustain methods of reimbursement that shift some resources away from specialty care and toward primary care and behavioral health
- Promote better outcomes for and sustained systemwide investment in primary care
- Include an analysis of primary care spending and growth in their annual report
- Consult with State departments, external organizations promoting investment in primary care, and other entities and individuals with expertise in primary care

In October 2024, just ahead of the Rev PC Summit, the Health Care Affordability Board adopted a new primary care investment benchmark. By 2034, across all health plans, 15% of total medical expenses should be allocated to primary care services.[34] To facilitate gradually attaining this goal, from 2025-2033, health plans are expected to increase their spending on primary care by 0.5-1.0% of total medical expense per year. OHCA's approach reflects three basic principles:

- Among similar efforts in other States, the most successful have gradually reallocated spending to primary care
- Sustainable delivery transformation requires multi-payer investment to support all populations in accessing high-value primary care
- Increases in total cost of care hinder benchmark success, since as total cost of care increases, achieving primary care benchmarks based on percentage of total medical expense becomes increasingly difficult

At present, the OHCA primary care investment benchmark is a recommendation, not an enforceable legislative or regulatory mandate. Nonetheless, accountability levers include measurement and public reporting by OHCA of progress toward the benchmark and, eventually, the incorporation of progress in Performance Improvement Plans for health plans that fail to meet the spending growth target.

In closing, Landsberg reviewed other critical challenges facing primary care that, unless also addressed, will limit the impact of the new primary care spending benchmark. These include worsening shortfalls in the primary care clinician workforce, particularly in medically under-served urban and rural communities, and limited diversity of the workforce. Many patients lack a usual source of care and clinician panel sizes have ballooned, contributing to high rates of burnout in primary care and fostering health inequities. HCAI is working to address these issues through its Workforce Program Area.

Plenary 4: Nourishing Primary Care: Teeth, Pies, Alimentation, and Nutritional Balance – *Kevin Grumbach, MD*

Dr. Grumbach outlined potential approaches to ensuring that burgeoning initiatives to revitalize primary care will realize their intended impact, with a focus on California and the new OHCA primary care spending benchmark but with broader implications. The new OHCA benchmark was underscored as highly ambitious and important, given increasing primary care spending is a "first order issue": something that *must* occur, yet will not alone be sufficient to revitalize primary care. Grumbach related the results of a study he co-led in which members of the public were asked what percentage of health care spending is currently devoted to primary care services, with a median response estimate of 50%, far greater than the actual percentage.[36] This finding suggests the public intuits the foundational role and scale of primary care yet is crucially unaware of its under-resourcing.

Employing nutritional analogies, Grumbach then outlined four "second order goals" to pursue to help restore appropriate "nourishment" of primary care:

- The need to put "teeth" in primary care spending targets, moving from recommended targets with measurement and public reporting on progress to regulatory or legislative mandates with enforceable penalties for non-compliance. Engaging and educating the public on the importance of primary care revitalization could mobilize broader support and help to hold payers and health systems accountable to meeting spending targets.
- The need to ensure that all "pieces of the pie" are addressed, meaning all payers are held accountable to attaining primary care spend rate targets. Grumbach highlighted challenges to Delaware's pioneering statutory approach to revitalizing primary care: since the private insurance plans beholden to the statute accounted for only 10% of healthcare spending in the State, the impacts on total health care and primary care spending were limited. A similar risk exists in California, since OHCA lacks authority over Medicare and employer-sponsored health plans, suggesting the need to consider innovative primary care payment models. One such approach, part of the Massachusetts legislative effort discussed previously by Dr. Wayne Altman, is to consolidate payments from all health plans into a State primary care stabilization fund (or "trust") to support all primary care services, sequestered from the larger health care budget. All elements of primary care would be supported out of the fund, including non-RVU-generating activities. Federal waivers to support Medicare innovation programs aimed at increasing support for primary care also have promise.

- The need to ensure that increased spending earmarked for primary care makes its way through the health system "alimentary canal" to reach primary care practices. Grumbach asserted that in modern complex health systems, there are many "parasites" along the canal from primary care claims to the practice level. In gauging whether increased primary care spending reaches the practices for which it is intended, it will be important to employ and publicly report on measures that capture improvements in frontline primary care.
- The need to better support the severely "malnourished" urban and rural primary care practices that disproportionately serve historically marginalized patient populations and communities. The longstanding under-resourcing of such practices has perpetuated and worsened sociodemographic and geographic heath inequities. Grumbach asserted the necessity of proportionate primary care spending targets that account for the widely differing baseline levels of resources and burden across practices, to ensure the unique needs and challenges of practices in under-served communities are met. For example, Medi-Cal (California's Medicaid program) spends less on healthcare overall per capita than other payers, meaning 15% of the Medi-Cal spend going to primary care would be considerably less than 15% of the private insurer spend. This signals the need for additional ways of enhancing payment to practices with large Medi-Cal populations.

Plenary 5: Targeted Universalism: An Equity 2.0 Approach to Primary Care Policy Development and Communication – *john a. powell, JD*

> "Typically, we are hard on people and soft on structures; instead, we should be hard on structures and soft on people."
>
> *-john a. powell, JD*
> *Professor, UC Berkeley*
> *Founder, Othering and Belonging Institute*

Professor powell (who spells his name with all lower case letters) introduced the concept of Targeted Universalism, which he developed, as a promising implementation and communication framework to employ in efforts to improve health while making health care and its impacts more equitable.[37] Sometimes referred to as "Equity 2.0," Targeted Universalism involves setting a *universal policy goal* for all groups that is sought through *a range of strategies targeted to different structural factors* that influence the goal. The approach accounts for the fact that we are all situated within *non-neutral structures* (cultural, social, physical) that unevenly distribute benefits and burdens among groups and interact in ways that produce differential outcomes and can foster disparities. Targeted Universalism acknowledges that for most goals, *all* groups have considerable room for improvement, and that a range of strategies is required to target an array of structural impediments. By contrast, the prevailing conceptual approach to equity issues – "Equity 1.0" – focuses on closing gaps between groups that are faring better and those faring worse. This is problematic when none of the groups are doing as well as they should be, as is the case for health outcomes in the U.S. which are suboptimal for all groups. Also, in a "gap-focused" approach, disparities can narrow not because the groups faring worst improve but because the groups that were faring best experience setbacks.

Further, focusing on improving outcomes for the most marginalized creates tension and a feeling of being "othered" among other groups, leading to competition for resources and limiting the formation of coalitions for change. Othering is a sociological process whereby groups of individuals are afforded less respect, attention, and dignity based on various characteristics (e.g., race, sexual orientation, disability), with adverse effects on all facets of life including health. Othering is widespread globally, driven by the rapid amount and pace of change humanity is experiencing, leading people to worry they will no longer "belong" in the world. This anxiety, in turn, is driving what powell called "a stressful health crisis that cannot be fixed at a personal level," and the increasing use of "breaking" stories by politicians, in which constituents are told "You will only belong if you get rid of these 'others'" (e.g., immigrants). Targeted Universalism offers an alternative communication strategy to "breaking" stories, being focused on structures and grounded in fairness, bridging, and abundance.

In contrast to "othering," belonging entails the process of co-creation and co-owning of the environment and its structures, in turn requiring that all participants have voice, agency, dignity, and shared power and responsibility. Research demonstrates that having a greater sense of belonging is associated with benefits to mental and physical health. powell has observed in his collaborations with health care systems that they have many built in hierarchies that can work against creating a feeling of belonging among patients and employees. However, he also noted that the core attributes of optimal primary care – including person-centeredness, individualization and continuity of care, and clinician-patient power sharing – embody Targeted Universalism and can promote a sense of belonging among all parties. "The challenge," he noted, "Is to build health care systems and structures that maximally leverage and create *more* such opportunities."

A California Legislative Perspective: Remarks from Assemblymember Mia Bonta, *Chair, Assembly Health Committee*

Assemblymember Bonta began her remarks by emphasizing the imperative to protect accessible and quality healthcare in California and identifying the essential role primary care clinicians play in that effort. She acknowledged the steps California is taking to bolster primary care through its recent adoption of the voluntary primary care spend target but called out the lack of enforcement mechanisms necessary to achieve the Office of Health Care Affordability's 15% primary care spend rate goal. She underscored the high human and financial costs of inaction in health care, especially around the primary and secondary preventive care that avoids or minimizes the impact of acute and chronic conditions, especially for those who, like herself, are susceptible to individual and systemic bias and discriminatory practices.

Assemblymember Bonta highlighted the importance of primary care clinicians' participation in shaping health care policy, noting she believes there is legislative appetite to support and protect primary care. Health care professionals need to be present and vocal in the legislative process. Effective tactics for health care providers pursuing legislative support include sharing their experiences and stories with legislators to influence policy decisions. As chair of the Assembly Health committee, Bonta welcomes partners to help her bolster a representative healthcare workforce and improve primary care delivery in California.

Appendix D: Expert Committee Sessions

The Rev PC Summit convened an Expert Committee of 30 nationally recognized thought leaders in primary care (researchers, policy makers, payers and purchasers, health system representatives, and advocates) drawn from medicine, public health, law, and economics. During five small-group sessions closed to the public (to encourage candid discussions), the members deliberated on key issues contributing to the primary care crisis and generated recommendations for addressing them. The committee members also identified pressing unanswered questions representing a high priority agenda for future research and evaluation studies. To help ensure a shared understanding of the current state of primary care and revitalization efforts, plenary attendees and Expert Committee members were offered an annotated bibliography. Detailed biographical details for the Expert Committee members appear in Appendix C.

Expert Committee Session 1: Sharing What Has Been Learned Through Efforts to Revitalize Primary Care

Background. In the Summit's first Expert Committee session, five discussants shared experiences and observations about primary care revitalization, and an informal, moderated discussion followed the remarks, affording members the opportunity to react to and expand on others' comments.

Summary of remarks from panelist Wayne Altman, MD

Dr. Altman's brief remarks detailed aspects of his work in Massachusetts as lead agent for Primary Care for You (PC4YOU), a State legislative effort (Senate bill No. 750), detailing aspects of the legislative process which offers lessons for those considering undertaking such efforts. Altman's effort was inspired by prior legislative efforts to increase spending on primary care in Rhode Island led by fellow Expert Committee member Christopher Koller, who was then-insurance commissioner of Rhode Island. PC4YOU has several interrelated aims: (a) Double primary care spending as a proportion of total healthcare spending across payers; (b) Shift the funding model for primary care from fee for service to a prospective monthly payment to practices, provided from a state primary care trust that collects money from commercial payers; (c) Eliminate primary care cost sharing for patients, including co-pays and deductibles; and (d) Financially incentivize primary care practices to adopt a range of primary care transformers from a list of 17 they define, which include the incorporation of integrated behavioral health and addiction treatment services, use of community health workers, and incorporation of home visits.

Altman noted that a state senator championed the legislation early on, which helped it get out of committee on first attempt, which is unusual for a bill of this magnitude and potential impact. However, the senator also felt it very unlikely a bill "this big" would pass on first session and suggested they "pluck something substantive" out of the larger bill to gain some initial momentum, as a springboard toward future legislative sessions. Following this guidance, Altman and his collaborators wrote initial legislation focused on one element of the original bill, establishing a

State primary care task force. This legislation came close to passing in July 2024 but failed at the final hour and will continue to be pursued. Altman remains optimistic that the larger PC4YOU legislation will eventually pass, having obtained endorsements from 13 different major organizations including the American Academy of Family Physicians (AAFP), the Massachusetts Chapters of the American College of Physicians and American Academy of Pediatrics, and the Massachusetts Medical Society. However, he noted that it has taken six years of effort to reach its present status and anticipated it may take another two to four years to finally pass the legislation.

Summary of remarks from panelist Russell Phillips, MD

Dr. Russell Phillips summarized what he called "a series of unanswered questions" or challenges relevant to efforts revitalize primary care:

- **The challenge of determining the "right" proportion of health care spending that should go to primary care**. There are disparate primary care spend rates among states (e.g., 15% in California, 12% in Rhode Island and Oregon). Phillips and other Expert Committee members are conducting research to determine the true costs of delivering robust primary care, which would help to guide benchmarking of primary care spend rates. The findings so far raise concerns that existing spending targets may be too low to attain the desired impacts of reinvigorated primary care such as slower growth in total health care expenditures and better health equity.

- **A lack of consensus on which care elements should be included in "primary care spending," and on how progress in spending will be tracked over time.** Both are critical issues, the latter because primary care spending definitions almost certainly will undergo periodic adjustment at the regulatory and/or legislative levels.

- **The high degree of variability among practices in numerous aspects, including services, staffing, patient populations, and baseline performance.** There is uncertainty about how best to account for and address such variability in revitalization efforts while still holding all practices accountable for improvement. Phillips cited the example of high variability in the social needs of patients across practices and need to develop corresponding practice level-adjusted primary care spending targets and outcome assessments, since caring for vulnerable populations requires a relatively larger care team and other additional resources.

- **The need to incentivize practices and health systems to improve *health outcomes* and shift emphasis away from "quality metrics" and "cost savings."** Phillips cited his group's research suggesting that higher numbers of primary care physicians per capita in a region are associated with lower levels of disability in the region. This compliments prior studies that showed a positive association between primary care physicians per capita and longevity. He suggested such outcomes should be prioritized in gauging the benefits of increased spending on primary care.

- **The need for more work to determine the incremental impacts and costs of different elements of proposed models of robust, comprehensive primary care.** Phillips commented

on the high complexity of such work, while also underscoring it would help in prioritizing the use of a higher primary care spend rate.

- **The importance of developing approaches to ensure that increases in funding earmarked for primary care reach the practices for which they are intended, rather than being diverted for other purposes within large, complex health systems.** This will require greater transparency in tracking spending attributed to primary care. Otherwise, it is possible that spending attributed to "primary care" will increase at the level of insurance claims, satisfying primary care spend benchmark targets on paper, but with few or no benefits at the practice level.

- **The need to determine the best payment approach for primary care services.** While there has been much discussion about global or hybrid global/fee for service payment, identifying the most optimal approach remains an empirical question, and the answer is likely to vary across practices and practice settings.

- **The importance and challenges of creating multi-payer coalitions with all members committed to increasing primary care spending**. Phillips called out the recent success in creating such a multi-payer coalition in California. When only some payers participate, the impact of primary care spending enhancement is blunted, since only relatively small subsets of patients are impacted, in turn creating a disincentive for health systems to develop and appropriately resource robust, comprehensive primary care practices.

- **The need to determine how best to help primary care practices provide truly comprehensive primary care services once funding levels are increased.** Primary care has long been under-resourced, forcing practices to scale down and provide mostly brief, problem-focused visits and refer more complex, time-consuming issues to specialists. National generalist physician societies and others may need to invest in practice consultants to help restore comprehensiveness to generalist practice to reap the full benefits of better-resourced primary care.

- **The need to determine who will pay for the increase in primary care funding.** Will payers be expected to cover the entire cost? And if so, will they pass on the cost to purchasers of insurance, or patients via increased premiums? These rhetorical questions underscore the need to dovetailing efforts to increase primary care spending with concurrent efforts to slow the growth in total health care costs. This could free up more funding for primary care and avoid cost-shifting to consumers.

Summary of remarks from panelist Robert Phillips, MD, MSPH

Dr. Robert Phillips underscored the importance of addressing ongoing primary care payment and workforce development and planning challenges to attract more physicians to pursue and remain in primary care practice. Regarding payment, he noted that the Milbank Memorial Fund (MMF) responded to one of the recommendations in the 2021 NASEM report on primary care by partnering

with The Physicians Foundation and the AAFP's Robert Graham Center to create an annual Health of U.S. Primary Care Scorecard, with metrics including primary care spend rates reported by State, freely viewable online. Phillips then indicated that the U.S. Department of Health and Human Services (DHHS) is developing a Primary Care Dashboard, an effort for which Rev PC Expert Committee member Dr. Diane Rittenhouse is a consulting subject matter expert. The DHHS Dashboard will include two key indicators not included in the Health of U.S. Primary Care Scorecard - *continuity of care* and *comprehensiveness of care* – an important advance since prior studies indicate both attributes are associated with lower total health care costs and reduced mortality risk.

Phillips then highlighted the critical issue of a too small and declining primary care workforce – including physicians, nurse practitioners, and physician assistants. For at least a decade, only about 15% of all U.S. medical school graduates annually have pursued primary care, and the proportion of physicians in in primary care practice has fallen from 32% to 28%, with similar declines for primary dare Nurse Practitioners and Physician Assistants. Phillips then noted that $23 billion dollars are spent annually to support physician graduate medical education (GME) training, mostly funded by Medicare, Medicaid, and the Veteran's Administration, none of whom currently have legislative or regulatory accountability to ensure an appropriate proportion of their funding is directed to meet the current and projected worsening shortfall in the primary care workforce. He also discussed the growing trend of international medical graduates (IMGs) being allowed to practice in the U.S. without having to complete a U.S. residency training program. Eleven states have now passed laws permitting this approach, to help meet shortfalls in the primary care workforce. He pointed out that while many IMGs are well-trained and skilled physicians, currently there are no state or federal oversight and accountability processes in place to verify this at the individual level, and no processes to provide onboarding and acculturation to the U.S. health care system. He closed by encouraging California and other states to consider how state-level funding of GME and accompanying accountability processes can best be leveraged to increase the production of primary care clinicians.

Summary of remarks from panelist Diane Rittenhouse, MD, MPH

Dr. Rittenhouse focused on the nexus of primary care and health equity, citing her own and other work demonstrating that robust primary care plays a crucial role in advancing health equity, including in California. She noted the need to "broaden the tent" of stakeholders who understand this nexus, given her experiences indicating even equity advocates often lack such understanding. With this goal in mind, Rittenhouse recently led a Summit to develop prioritized policy recommendations for strengthening primary care while concurrently advancing health equity.[5] She convened a wide array of stakeholders, including equity advocates from outside the health care field and people with lived experiences of the detrimental effects of socio-demographically based discrimination manifested in prior health and health care policymaking efforts. She employed what she termed a "quite a democratic process" for the Summit, important in conducting the "difficult work" of broader societal engagement, which takes

> "There is no path to health equity that doesn't go through primary care."
>
> ~ *Diane* Rittenhouse, MD, MPH
> Senior Fellow, Mathematica
> Professor, University of California San Francicso

time and sustained attention to building trustful relationships.

The full Summit report contains numerous policy recommendations and useful related materials. In her remarks, Rittenhouse relayed the three most foundational policy recommendations which, unless followed, will greatly impair progress in health equity:

- Adjust (increase) payments to primary care providers who see patients with Medi-Cal insurance, to incentivize such care.
- Increase the primary care spend rate
- Incorporate the voice and representation of people with lived experience of discrimination in health and health care policymaking and decisions.

Rittenhouse then asserted that there is "a lot of work to do in the house of primary care," with the need for consistent and intentional centering of health equity in all planning and decisions we make, rather than delegating all responsibility to stakeholders outside of primary care. She noted the importance of the development of the DHHS Primary Care Scorecard, for which she was a consulting content expert, as a tool to "track (our progress) and be held accountable." She also endorsed the importance of assembling non-governmental, primary care task forces, akin to one in Virginia. In closing, Rittenhouse underscored the critical need for "ongoing, thoughtful, comprehensive leadership around primary care policy" to keep equity concerns at front and center of our work.

Summary of remarks from panelist Monica Soni, MD

Dr. Soni also spoke to primary care revitalization as a health equity lever, but with a focus on statewide agency level efforts. She echoed Dr. Russell Phillips' comments in noting that California is fortunate to have a strong multi-payer coalition committed to better resourcing of primary care, which includes three entities that purchase coverage for nearly half of all people in the State: the Department of Health Care Services (which houses Medi-Cal, California's Medicaid program), CalPERS, and Covered California. These entities have adopted unified approaches to assigning patients to primary care providers and practices, shared alternative payment models, and common methods of monitoring primary care spending. They have also agreed on a limited set of care quality measures, easing the burden of reporting and improvement work for practices.

However, Soni also commented on analyses she has overseen in her role with Covered California indicating that some policy decisions made around insurance coverage and insurers in the State have not had the intended positive impacts on primary care or the patients it serves. She then reviewed the difficulty at the state regulatory level of determining the validity of health plan reports regarding which clinicians are practicing primary care. Many reported as being primary care clinicians would not qualify when using a definition that requires demonstration of continuity of care. As a result, the health plans' reported primary care spend rates are higher than they would be if the plans were held to a definition of primary care incorporating and emphasizing the central importance of continuity. The plans have been resistant to proposals of a requirement to provide data demonstrating continuity of care, and State purchasers of insurance have not added such a requirement in their contracts with payers. Soni emphasized this is unfortunate, since if health plans are not held accountable for supporting continuity clinician-patient relationships, there will likely be less impact from efforts to revitalize primary care.

Expert Committee Session 2: How Should Practices be Paid to Provide Optimally Resourced, High-Quality, Relationship-Oriented Primary Care?

Background. This session considered issues related to hybrid payment reform in primary care. Corrosive impacts of the prevailing fee-for-service payment model have been identified, such as incentivizing practices to generate a high volume of clinician visits rather than focusing on the most optimal approaches to delivering care (possibly with *fewer* visits), with detrimental impacts on clinicians and trainee interest in pursuing primary care.[1] Hybrid payment models, in which practices derive a large proportion of revenue from per-patient-per-month capitation, could create more reliable income streams and allow practices to manage patients in a more individualized, holistic way, with less focus on visit volume. Yet concerns exist regarding the equitability of adopting hybrid payment models without carefully considering the wide variation among current practices in baseline capacities for change and practice improvement. After briefly reviewing these issues and other contextual factors, the Expert Committee members considered two key questions related to hybrid primary care payment models, as presented below. For deliberations, the Expert Committee was divided into groups of five or six members, each of which considered both questions. The groups were instructed to assume the perspective of a hypothetical committee representing payors, policymakers, and primary care clinicians charged designing hybrid payment models for dissemination into primary care. Several themes and recommendations emerged from the small group discussions, which are summarized below.

> "The conversations we've had over the last day and a half really reinforced how critical continuity is to primary care. I think we shy away from trying to measure it or achieve it because it's hard. It's clear that it is measurable. It is also clear that it's achievable if it is resourced, supported, and incentivized. While not a new idea, it changed how I think about our measure set. Measuring primary care continuity must be at the heart of it."
>
> *~Palav Barbaria, MD*
> *Chief Quality & Medical Officer*
> *California Department of Health Care Services*

<u>Question 1:</u> How can hybrid payment models best be designed to help practices deliver high-quality primary care consistent with the 2021 NASEM report aspirational definition?

The Committee endorsed the need for and importance of the following:

- **Robust hybrid payment models for primary care, in which at least 60% of the funding is provided prospectively to practices.** Based on demonstration projects and prior experience with managed care, members believed that hybrid models involving a smaller proportion of the patients or a lower percentage of total revenue will not be effective in changing primary care practices.[38]

- **Financial incentives for practices to achieve high quality primary care, with parsimony in quality metrics (i.e., no more than 5-6 total) that focus on core attributes (continuity,**

comprehensiveness, patient-centeredness) and high priority clinical indicators (e.g., blood pressure control). Several members endorsed potential use of the Person-Centered Primary Care Measure to capture continuity, whole-person orientation, comprehensiveness, and patient experience.[39] Some members also endorsed quality metrics that would create downside financial risk for practices, such as avoidable emergency room or hospital utilization, or persistent racial/ethnic disparities in targeted quality measures.

- **Risk-adjustment in hybrid payment models, particularly if practices were exposed to downside risks.** Several challenges to risk adjustment exist within a hybrid system, including that risk adjustment in a fee-for-service system typically utilizes claims data, and claims volume may decline with hybrid payment implementation. Some suggested risk adjustment could be performed using geographic or small-area measures of deprivation, which correlate to chronic disease prevalence. However, concerns were raised about how this could adversely impact academic health centers, which are not necessarily situated in higher risk geographic areas but nonetheless tend to draw the highest risk members from larger regions.

- **Upfront funding from payers for practices to implement desired transformation, such as integration of behavioral health care, and for an ongoing larger proportional allocation of total healthcare funds to primary care.** Both could help practices to rapidly build and sustain high-functioning primary care teams, and eventually, enhance patient trust and confidence in primary care.

- **Reliable and meaningful means of attributing patients to primary care clinicians** will be particularly important under hybrid payment models. Patients might be required to register or select a specific practice or clinician, and ideally patients would feel meaningfully connected to primary care clinicians, and clinicians would feel empowered to impact the care trajectories of most of their patients.

Members also acknowledged some potential barriers to the impact of implementing robust primary care models. In many locales, patient access to primary care is limited. Further, many patients lack confidence that primary care can fulfill their care needs, leading them to use emergency or specialty services. For patients with multiple health conditions, care is often fragmented across specialties, with an ill-defined role for primary care and, therefore, little coordination.[40,41] The members considered that societal confidence in primary care may shift in a positive direction if payment reforms lead to sustained improvements in practices such as greater comprehensiveness of care, in turn enhancing patients' access to and benefits from primary care.

<u>Question 2</u>: How can fairness and equity across practices be ensured under hybrid payment for primary care, given substantial baseline differences in practice characteristics and patient populations?

The Committee members identified the following points:

- **Distinct hybrid payment models, different from those used for most practices, may be required for three categories of practices: (1) small, independent practices; (2) Federally Qualified Health Centers; and (3) larger practices within integrated networks.** Incentives for practice enhancement under hybrid payment, such as integrated behavioral health or social work services, should differ for each type of practice. Smaller practices may be unable to provide such services directly but might be incentivized to join networks of smaller practices to provide beneficial services to attributed patients. By contrast, practices within large vertically integrated organizations may be well-positioned to adapt quickly to a new hybrid payment model with specific incentives for quality or access.

- **Considerable upfront investments will be necessary for many practices to develop capacity to deliver high-quality care in a prospective payment model.** Initial lump-sum payments may be required to support appropriate staffing and training, health care or information technology infrastructure, and programs or collaborations to enhance behavioral health care and address social determinants of health. Practices might also be assigned to different tiers at baseline. For example, practices with less baseline capacity to manage their attributed population would have less initial exposure to prospective payment and associated downside risk initially, with an increase in prospective payment over time as capacity to manage their population improved. The Making Care Primary demonstration project was discussed as a potential model for this approach.[42]

- **Rigorous risk adjustment will be needed to ensure fairness and equity in prospective payments.** Patients with Medicaid insurance are typically grouped within practices that largely do not serve patients with other insurance types. Such segregation by payor across practices is itself a root cause of inequitable care. New policy initiatives are needed to integrate the care of Medicaid patients across practices. Under hybrid payment, it would be crucial to provide substantially higher prospective payments to practices serving a disproportionate share of Medicaid patients, due to the greater care management needs of this population.

Expert Committee Session 3a: Advancing Optimally Resourced, Relationship-Oriented Primary Care - Identifying Research that Must Be Conducted to Attain the Vision

Background. This session involved consideration of three different although interrelated topics specific to the future of primary care research.

<u>Discussion topic 1</u>: Reviewing the strengths and gaps in the existing primary care research base. Questions presented in this segment of the session were:

- What are the most important primary care research findings to date?
- Do certain studies or findings from the studies have any more or less relevance or impact than others?

- Are there concrete examples of real progress with primary care transformation and revitalization that were driven by research evidence?

From consideration and discussion of these Topic 1 questions, the following key themes emerged:

- **The existing research base has repeatedly identified clear benefits of greater patient and population level exposure to primary care – including but not limited to longer life expectancy/reduced mortality, less disability, and more receipt of evidence-based preventive care services.** Members also pointed out that some of these studies have demonstrated that the benefits of primary care are associated specifically with exposure to certain core attributes of primary care, namely the specific benefits of continuity and comprehensiveness of care.

- **Research also has repeatedly demonstrated beneficial impacts of primary care on equity outcomes.** There is clear evidence that primary care is associated with more equitable access to care and health outcomes. Research also has shown the benefits of core primary care values, processes, and structures on equity outcomes, exemplified by the FQHC model and, more broadly across primary care, the purposeful centering of patients' and communities' social needs.

- **Another area of success is the wide array of datasets and other infrastructure that can readily be leveraged and expanded to further support primary care research.** Examples noted included the PRIME registry and other American Board of Family Medicine databases; electronic health record (EHR) and clinical claims datasets (e.g., OptumLabs Data Warehouse); and several prior and ongoing research funding mechanisms offered by federal (e.g., a new R01 announcement from the Agency for Healthcare Research and Quality) and private foundation sources.

Discussion topic 2: Gaps in and challenges for future primary care research. Questions considered in this segment were:

- What are the major gaps in the primary care research base to date?
- Which settings, methods, and topics have been the most challenging?

Several key themes emerged from this Topic 2 discussion:

- **The challenge of the highly complex nature of many research questions relevant to primary care.** Examples included:
  - Assessing the impact of changes in care delivery models or primary care funding increases are often difficult to disentangle. For example, a new funding target at the macro level results in multiple changes at the at the population, health system, individual practice, and patient levels, which may be specified in research studies differently or not linked together across all levels.
  - Similarly, the more complex primary care becomes (e.g., coordinating traditional primary medical care as well as social needs), the more multi-faceted the analyses need to become in a research study.

- **Interrelated challenges around measurement in primary care research:**
  - The lack of a broadly endorsed, reliable, and well-validated global (e.g., non-reductionist) measure of "high quality primary care" or "whole person care."
    - The widespread use of easily measurable constructs with relevance to primary care, such as trusting clinician-patient relationships and continuity of care (which have many current definitions, some of which are complex to measure from real-world data).
  - The need for clear research designs that simultaneously examine the Quadruple Aim metrics (as opposed to a primary care outcome alone).
    - A subtheme here was the tendency for funders and health systems to anticipate "cost savings" stemming from primary care improvement efforts as the primary outcome of interest. This is at odds with the concept of primary care as a common good, and often unrealistic given research indicating that optimizing individual and population health through exposure to primary care will typically come at some additional incremental cost. The key issue is the incremental cost of primary care-based approaches is likely to be lower than for alternative (e.g., subspecialty-dominated) pathways.

- **The existence of key gaps in the primary care data infrastructure.** These include:
  - A lack of robust data on primary care practice elements and on the primary care workforce, and declining response rates to surveys in these realms, undermining the reliability and validity of findings from related studies.
  - Very scant data on how primary care intersects with parallel, largely siloed care models like urgent care systems (e.g., Minute Clinics).
  - Lack of granularity in claims data, including a lack of or incomplete data on patient assignments (i.e., attribution) to specific primary care clinicians.

- **The considerable degree of mismatch between the foregoing identified research gaps and the stated priorities of current funders of primary care research and their specific funding opportunities.** Specific examples noted were:
  - The longstanding lack of funding for global primary care interventions that transcend diseases and patient categories, driving primary care researchers to instead focus on disease-specific interventions to obtain funding through the National Institutes of Health and other sources, whose funding opportunities are structured almost entirely by diseases or organ systems.
  - A relatively limited amount of research funding earmarked for real-world implementation and evaluation studies versus other types of research.
  - The recent decline in funding for primary care research training hubs to grow the next generation of primary care researchers tackling complex research questions.
  - Inattention to creating funding opportunities to support work simultaneously addressing pediatric and adult primary care issues, to generate knowledge more applicable to providing care across the lifespan.

Discussion topic 3: Re-envisioning primary care research for the future.

To close the session, the Expert Committee members generated ideas for the re-envisioning of primary care research. They were asked to picture their ideal state – mentally removing current restrictions and limitations such as the nature and amounts of current funding opportunities – and then work backwards to potential ways of achieving the ideal state. To help in this task, they were specifically asked to consider an idealized future state for each of the following related to primary care research: (1) datasets; (2) methods; (3) outcomes and measures; (4) collaborations; and (5) funding priorities.

The Topic 3 discussion identified three focus domains for re-envisioning primary care research:

- **Need for additional infrastructure.** There was unanimous agreement that the current state of <1% of federal health care research dollars spent on primary care research is grossly insufficient. Clear tracking as well as a core target metric for the proportion of the federal research portfolio on primary care is necessary.

- **Need for a standard set of measures from clear underlying data sources to understand the impact of changes in primary care on a wide range of care processes and outcomes.** A bold agenda was proposed for more precisely defining and then broadly disseminating gold standard measures of patient and care team-centeredness and practice characteristics, to facilitate comparison of findings across studies. Also identified was the need for a national longitudinal registry of primary care practices that could be leveraged to conduct larger, more powerful, and more broadly representative and impactful studies.

- **Need to develop and consistently apply more advanced analytic methods for the highly complex primary care research questions.** Examples mentioned included parallel mixed methods research and implementation science approaches, as well as methods to examine multiple outcomes simultaneously in health services research.

Expert Committee Session 3b: Advancing Optimally Resourced, Relationship-Oriented Primary Care: Inputs to Impact - Traversing the Gap Between Primary Care Funding and Transformation

Background. In this session, the Expert Committee members first discussed their perceived priority targets for increased primary care spending. Then in two subgroups, subsets of members discussed, respectively: (a) potential approaches to ensuring that increases in primary care spending reach and benefit the intended targets; and (b) persuasive and political influence approaches that could help in ensuring greater health system accountability to the public.

Discussion topic 1: Prioritizing the use of increased primary care spending. The Expert Committee first assembled as a single group to consider the following question: Assume that the

primary care spend rate in your community has doubled from 7.5% to 15% overnight. What are your top 5 priorities for spending the new money?

Ideas were collected in a round-robin fashion, with each member contributing over two rounds while trying to avoid duplication of previously mentioned ideas. As summarized below, responses were sorted into four broad categories of factors:

- **Practice Organization factors**
  - Continuity based, co-located teams
  - Geographically based primary care (e.g., in neighborhoods, schools)
  - Integration of patients and community groups into primary care governance
  - Hub and spoke models for small practices

- **Care Team and Training factors**
  - Inservice training for care navigators (a potential role for medical assistants)
  - Lifestyle education and counseling
  - Scribes (human or artificial intelligence [AI])
  - Community health workers and social workers (available on site for warm handoffs)
  - Integrated behavioral health care

- **Data and Measurement factors**
  - Equity measures and linkages between different relevant data sets
  - Bidirectional data systems (i.e., data pulled in automatically and easy to extract)

- **Payment factors**
  - Prospective payment for quality
  - Resources to limit clinician panel sizes
  - Tuition waivers or loan forgiveness for clinicians pursuing primary care
  - Increased levels of reimbursement for primary care services
  - Increased salaries for primary care clinicians, ideally to reach at least 70% parity with subspecialist physicians and thereby increase the attractiveness of primary care to medical students

Following this discussion, the Expert Committee was divided into two subgroups, each of which considered one of the following issues.

- **Subgroup 1: Focus on Accountability.** This subgroup considered the question: What should we be *measuring and monitoring* to determine whether new resources aimed at primary care transformation are making their way from payers to health plans to primary care practices and are ultimately benefiting patients and communities and supporting the primary care workforce?

After silent deliberation, the subgroup generated approximately 15 ideas which were then consolidated through further group discussion into 10, listed in no specified order below:

  - Ensuring transparent financial accounting, so that health systems are unable to engage in “gaming” reporting
  - Measuring retention, well-being, and burnout of care team members

- Measuring continuity, comprehensiveness, patient-centeredness of care
- Measuring patient access (e.g. the ability to get a same-day appointment for urgent issues, time to third available slot for new patients).
- Ensuring accountability for providing advanced primary care services (care that is person and family centered, relationship-based, accessible, comprehensive, team-based, integrated, coordinated, and equitable)
- Monitoring trends in primary care clinician salaries
- Monitoring chronic disease outcomes, focusing on high-prevalence, high-morbidity conditions)
- Monitoring care team members (e.g. availability of a pharmacist, dietician, or social worker)
- Monitoring trends in disparities and inequities in health and health care
- Monitoring the provision of low-value care

Next, the subgroup members listed from the above priorities their top 5 in rank order from 5 to 1, such that the top choice was assigned 5 points, their next highest choice 4 points, and so on. **Of the 10 central ideas, the following three received 20 or more points and can therefore be viewed as consensus high priority accountability targets:**

- **Ensuring transparent financial accounting (31points)**
- **Measuring continuity, comprehensiveness, and patient-centeredness of care (30 points)**
- **Ensuring accountability for providing advanced primary care services (20 points)**

Two other ideas received 9 points each, suggesting they represent still important but second level accountability targets:

- Measuring retention, well-being, and burnout of care team members
- Measuring patient access

- **Subgroup 2: Focus on Political Coalition Building.** This subgroup considered the question: What political and persuasive strategies on the local, state, and national levels should be adopted to maximize the probability that the 15% spending target is not derailed and that the new resources available to primary care will result in a more accessible, satisfying, and defragmented experience for patients and health care professionals?

After a period of silent deliberation, the subgroup generated 8 non-overlapping ideas about strategies, voiced through a round-robin process:

- Streamlining of quality measures
- Encouraging primary care clinicians to serve in roles that govern resources or enact regulation (e.g., State assembly, county boards, Dept. of Managed Health Care)
- Developing community governance structures for primary care
- Funding and conducting comparative effectiveness research
- Organizing to advocate for the sustainability of funding increases
- Building coalitions with business, labor, and other community groups

- Developing a robust communication strategy about the population health and cost benefits of well-supported primary care, and the current severe under-funding of primary care
- Creating a primary care spending dashboard to enhance transparency

Next, the members listed their top 5 priorities in rank order, such that their top choice was assigned 5 points, their next choice 4 points, and so on**. Four of the 8 ideas received 10 or more points and can be viewed as high priority issues:**

- **Developing a robust communication strategy (37 points).**
- **Creating a primary care spending dashboard to enhance transparency (30 points).**
- **Building coalitions with business, labor, and other community groups (24 points).**
- **Developing community governance structures for primary care (17 points).**

Subgroups session summary. While the two subgroups pursued different questions, both strongly endorsed the importance of transparent financial accounting and reporting around primary care spending. Without it, holding health plans and health systems accountable for delivering increased resources to primary care would be impossible. Additionally, coalitions seeking to build greater support for primary care need to know what plans and systems are spending on such care, ideally via a public, freely accessible dashboard. Both subgroups also expressed broad support for the concept of value-based payment for primary care. Subgroup 1 emphasized that measures of "value" should map to core attributes of high-quality primary care – access, continuity, comprehensiveness, patient-centeredness, and coordination. Subgroup 2 underscored the need for measures and measurement processes to be streamlined as much as possible, to reduce practice burden and allow for clearer messaging to the public about the benefits of primary care.

Expert Committee Session 4: Leveraging the Office of Healthcare Affordability's Increased Primary Care Spending Target to Advance Health Equity in California

Background. For this California-focused session (albeit with broad applicability), the Expert Committee was divided into four subgroups of 3-6 members each. Each subgroup had a pre-designated facilitator chosen from the Committee, who started the session by posing the following question (i.e., all groups considered the same question): What will need to happen for the new Office of Health Care Affordability (OHCA) increased primary care spending benchmark to lead to the improvements in health care and health that essentially all Californians need, while also reducing or eliminating the State's most pressing health and health care disparities?

The facilitators then clarified that the question relates to proactive, purposeful actions that may fall broadly into one of two categories: (a) Best practices, demonstrated by experience or research to be helpful in attaining these kinds of goals; or (b) Areas of uncertainty or disagreement regarding how to most effectively attain goals, including largely or fully untested but promising approaches, representing research gaps to be addressed with appropriately designed studies

Each of the four subgroups deliberated separately using a nominal group process method:

- First, participants individually and silently wrote down their ideas on large sticky notes (one idea per note)
- Second, the notes were stuck on a large easel flip chart and initially grouped according to apparent overlap under the guidance of the facilitator.
- Third, the facilitator led the subgroup in discussion to clarify ideas and examine the pros and cons of each

Three of the four subgroups also separately completed a fourth step in the process, whereby the members each identified the five ideas they viewed as having highest priority, such that their top choice was assigned 5 points, their next choice 4 points, and so on. However, due to technical issues, the rankings from this step were incompletely captured for two of the subgroups. Additionally, the fourth subgroup elected to abandon the ranking step, given the conviction that all the generated ideas were important and that each individually would be insufficient to attain desired health equity improvements from increased primary care spending.

Given these developments, in the following summary of output from this session, the listing of ideas was sorted based on consideration of both the available (albeit incomplete) ranking data and on the number of subgroups that generated the idea:

- **Ensure both the implementation and the enforcement of OHCA's new increased primary care spending benchmark (53 points, listed by 3 of 4 groups).** Expert Committee members view this as an essential step, given research underscoring the inherent equitability of primary care, but by no means sufficient to optimize health equity. Individual groups identified the following subthemes:
    - The need for a pot of increased funding to support primary care practices in identifying and addressing patients' social needs, which would be separate from the pot providing increased funding for traditional primary care clinic services**.** This reflected the concern that if both categories of spending came from one pot, the amount would be insufficient to support either category of services.
    - The need to extend the authority of OHCA, so they not only "recommend" and track and publicly report on primary care spend rates but could enforce a target and levy fines for non-compliance

- **Develop increased transparency mechanisms to ensure the increased spending earmarked for primary care makes its way to and benefits primary care practices, clinicians, and patients (30 points, listed by all 4 groups).**

- **Increase investment in efforts parallel to the OHCA benchmark to produce a more appropriate (in size, skills, and diversity) primary care workforce (22 points, listed by 2 of 4 groups).**
    - Some groups emphasized the importance of the funding sources for workforce development efforts being unique from the funding for increasing the primary care spend rate.

- **Ensure appropriate information technology and data infrastructure (including better data exchange capabilities between relevant entities) to support measurement and monitoring of equity-related outcomes (e.g., care access, disparities) over time (17 points, listed by all 4 groups).**

- **Develop mechanisms to assist practices and health systems in transitioning to high-quality, equity-focused primary care. (15 points, listed by 3 of 4 groups).**
    - Specific ideas generated included developing and offering facilitation, coaching, technical assistance and "best practices" collaboratives for primary care practices and relevant health system (e.g., "C-suite") personnel

- **Require all primary care practices to engage in the care of Medi-Cal patients and address barriers to this occurring (9 points, listed by 3 of 4 groups).**
- **Make the benefits of primary care to achieving health equity clear to the public, through education and public praise for organizations with high primary care spending and strong outcome metrics (8 points, listed by 2 of 4 groups).**
    - One group mentioned that primary care marketing campaigns will not be enough and called for "health care system literacy" education from elementary school through high school

- Target higher levels of spending to primary care practices serving rural and urban disadvantaged populations, via risk stratification or other approaches (0 points, listed by 3 of 4 groups).

- Improve linkages between practices with a strong focus on care of the underserved and high demand subspecialty care resources (3 points; listed by 1 of 4 groups). Specific ideas for doing so generated in various groups were:
    - Expand telecare linkages and employ asynchronous e-consults
    - Incentivize practices to minimize low yield referrals and thereby maintain specialty access for those most in need
    - Promote more diversity in the healthcare workforce - since people from medically underserved/underrepresented backgrounds who become subspecialists may be more willing to participate in underserved care

- Reduce barriers to the integration of behavioral health into primary care (2 points; listed by 2 of 4 groups).

- Incorporate lay community health workers (e.g., promotoras) into all practices (2 points; listed by 1 of 4 groups).

- Create a separate state-managed primary care fund (e.g., as proposed in Massachusetts) to provide payment to primary care practices, carved out of the main health care budget (1 point; listed by 1 of 4 groups).

- Engage employers and other purchasers of health insurance as allies to primary care, which they typically appreciate and value for its comprehensiveness, effectiveness, and equitability (0 points; listed by 1 of 4 groups).

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