

This PDF is available at <http://nap.nationalacademies.org/25983>



BUY THIS BOOK

FIND RELATED TITLES

Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care (2021)

DETAILS

448 pages | 6 x 9 | PAPERBACK

ISBN 978-0-309-68510-8 | DOI 10.17226/25983

CONTRIBUTORS

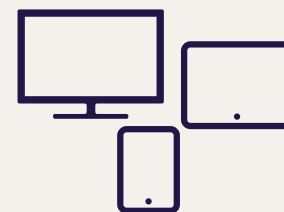
Linda McCauley, Robert L. Phillips, Jr., Marc Meisnere, and Sarah K. Robinson, Editors; Committee on Implementing High-Quality Primary Care; Board on Health Care Services; Health and Medicine Division; National Academies of Sciences, Engineering, and Medicine

SUGGESTED CITATION

National Academies of Sciences, Engineering, and Medicine. 2021. *Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care*. Washington, DC: The National Academies Press. <https://doi.org/10.17226/25983>.

Visit the National Academies Press at nap.edu and login or register to get:

- Access to free PDF downloads of thousands of publications
- 10% off the price of print publications
- Email or social media notifications of new titles related to your interests
- Special offers and discounts



All downloadable National Academies titles are free to be used for personal and/or non-commercial academic use. Users may also freely post links to our titles on this website; non-commercial academic users are encouraged to link to the version on this website rather than distribute a downloaded PDF to ensure that all users are accessing the latest authoritative version of the work. All other uses require written permission. ([Request Permission](#))

This PDF is protected by copyright and owned by the National Academy of Sciences; unless otherwise indicated, the National Academy of Sciences retains copyright to all materials in this PDF with all rights reserved.

Summary

High-quality primary care is the foundation of a high-functioning health care system and is critical for achieving health care's quadruple aim (enhancing patient experience, improving population health, reducing costs, and improving the health care team experience). Primary care provides comprehensive, person-centered, relationship-based care that considers the needs and preferences of individuals, families, and communities. Primary care is unique in health care in that it is designed for everyone to use throughout their lives—from healthy children to older adults with multiple comorbidities and people with disabilities. Absent access to high-quality primary care, minor health problems can spiral into chronic disease, care management becomes difficult and uncoordinated, visits to emergency departments increase, preventive care lags, and the nation's health care spending soars to unsustainable levels. People in countries and health systems with high-quality primary care enjoy better health outcomes and more health equity.

Yet, 25 years since the Institute of Medicine (IOM) report *Primary Care: America's Health in a New Era*, this foundation remains weak and under-resourced, accounting for 35 percent of health care visits while receiving only about 5 percent of health care expenditures. Moreover, the foundation is crumbling: visits to primary care clinicians are declining, and the workforce pipeline is shrinking, with clinicians opting to specialize in more lucrative health care fields.

In addition, unequal access to primary care remains a concern, and the COVID-19 pandemic amplified pervasive economic, mental health, and social health disparities that ubiquitous high-quality primary care might

have reduced. The pandemic also pushed many primary care practices to the brink of insolvency, with most practices uncertain about their financial viability.

Nonetheless, primary care is the only health care component where an increased supply is associated with better population health and more equitable outcomes. For this reason, primary care is a common good, making the strength and quality of the country's primary care services a public concern.

THE STUDY CONTEXT AND CHARGE

The 1996 IOM report made comprehensive recommendations to improve primary care, although many were never implemented. As a result, in 2019, the National Academies of Sciences, Engineering, and Medicine formed the Committee on Implementing High-Quality Primary Care. Building on the recommendations of the 1996 report, the committee's task was to develop an implementation plan for high-quality primary care in the United States.¹

WHAT IS HIGH-QUALITY PRIMARY CARE?

High-quality primary care is 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.

The committee based this definition on the following concepts:

- integrated, whole-person health;
- interprofessional care teams;
- foundational, sustained relationships between the interprofessional care team and patients and families;
- the critical role of communities in providing primary care;
- the importance of equitable access to primary care; and
- the diversity of settings and modalities used to deliver primary care.

This definition describes what high-quality primary care *should be*, not what most people in the U.S. experience today. The committee identified seven facilitators (see Box S-1) to help realize this definition of high-quality primary care and ensure that it is accessible to all.

¹ The complete Statement of Task is presented in Chapter 1 of this report.

BOX S-1 Facilitators of High-Quality Primary Care

1. **Payment Models.** Payment models that support integrated, interprofessional teams working in sustained relationships with patients will ensure that high-quality primary care is possible to implement and sustain.
2. **Accountability and Improving Quality.** Effective measurement that is not onerously burdensome and holds primary care accountable will facilitate improvement over time.
3. **Digital Health Care.** An equitable use of technology can make care more accessible and make the primary care experience more efficient, higher quality, and convenient for people and the interprofessional care team.
4. **Interprofessional Care Teams.** Care provided by teams of clinicians and other professionals fit to the needs of communities, working to the top of their skills, and in coordination leads to better health.
5. **Research.** Building the empirical evidence of the epidemiology, organization, and provision of primary care will facilitate continuous improvement within the field.
6. **Leadership.** Coordination among primary care leaders will provide a unified voice on critical issues that will guide decisions of health care organizations and government while increasing accountability.
7. **Policy, Laws, and Regulations.** Federal and state policy and regulations that are compatible with locally tailored care can enable primary care stakeholders to implement needed changes.

IMPLEMENTATION PLAN

To rebuild a strong foundation for the U.S. health care system, the committee's implementation plan includes objectives and actions targeting primary care stakeholders and balancing national needs for scalable solutions while allowing for local fit.² The implementation plan includes five objectives to make high-quality primary care available for everyone in the United States:

1. Pay for primary care teams to care for people, not doctors to deliver services.
2. Ensure that high-quality primary care is available to every individual and family in every community.
3. Train primary care teams where people live and work.
4. Design information technology that serves the patient, family, and interprofessional care team.

² The committee's implementation plan assumes the current realities of the U.S. insurance marketplace.

5. Ensure that high-quality primary care is implemented in the United States.

The committee’s implementation plan—comprising recommended actions under each implementation objective—builds on a three-element implementation strategy:

- 1. An implementation framework, with three levels of change that accounts for the complexity of the U.S. health care system and its public- and private-sector actors (see Table S-1).
- 2. An accountability framework that establishes a structure and process for assessing the adequacy and completeness of implementation activities.
- 3. A public policy framework that prioritizes developing government policy to implement high-quality primary care, consistent with its status as a common good.

TABLE S-1 The Committee’s Implementation Framework

System Level	Public		Private	
	Example Actor	Example Actions	Example Actor	Example Actions
Macro	Federal/state legislative branch	Policies; laws; funding	Coalitions; associations	Policy advocacy; Public accountability; professional standards
Meso	Federal, state, local executive branch; federal payers; public delivery systems; educators	Regulations; contracting; payment; administrative practices; training	Private delivery organizations; private payers; corporations; institutions; educators	Management policies and practices; training
Micro	Individuals and interprofessional teams delivering care in public and government health systems; individuals and families seeking care	Self-education; quality assessment and improvement; behavior practice	Individuals and interprofessional teams delivering care; individuals and families seeking care	Self-education; quality assessment and improvement; behavior practice

These elements are fundamental for overcoming barriers to implementing high-quality primary care, with supportive public policy being most important. Health care is not a functioning market in the United States, and resource allocation is subject to the concentration of political and economic power.

The current environment creates the window for such policy. While most Americans are satisfied with their own health care, they remain concerned with the system's future. As the nation recovers from the COVID-19 pandemic and considers the weaknesses it revealed, the policy response should include public health investments, health care system strengthening, pandemic preparation and resiliency, and economic recovery. Recovery and rebuilding can constitute the political imperative required to advance the committee's policy recommendations, if skillful and committed champions in positions of influence can communicate the missed potential for primary care to assist in the pandemic and capitalize on public concerns about the future sustainability of our health care system.

For policies requiring expenditures, the relatively small proportion of health care expenses spent on primary care today becomes an opportunity. A small absolute increase in primary care spending for policies this report identifies, redistributed from the large expenses across the rest of the system, can have a high proportional effect on primary care and work to stabilize the health system overall.

The committee's implementation plan calls for appropriately scaled actions by public- and private-sector actors at the macro, meso, and micro system levels³ and creates accountability structures to ensure the work gets done. The value of primary care is beyond dispute, with extensive research identifying policies and practices that facilitate high-quality primary care. The activities within this plan will promote and effectively scale those policies and practices.

Objective One: Pay for primary care teams to care for people, not doctors to deliver services.

Action 1.1: Payers—Medicaid, Medicare, commercial insurers, and self-insured employers—should evaluate and disseminate payment models based on the ability of those models to promote the delivery of high-quality primary care, as defined by the committee, and not on their ability to achieve short-term cost savings.

³ See Appendix D for a table that organizes the committee's recommended actions by system level and actor.

Action 1.2: Payers—Medicaid, Medicare, commercial insurers, and self-insured employers—using a fee-for-service (FFS) payment model for primary care should shift primary care payment toward hybrid (part FFS, part capitated) models, making them the default method for paying for primary care teams over time. For risk-bearing contracts with population-based health and cost accountabilities, such as those with accountable care organizations, payers should ensure that sufficient resources and incentives flow to primary care. Hybrid reimbursement models should:

- a. pay prospectively for interprofessional, integrated, team-based care, including incentives for incorporating non-clinician team members and for partnerships with community-based organizations;
- b. be risk adjusted for medical and social complexity;
- c. allow for investment in team development, practice transformation, and the infrastructure to design, use, and maintain necessary digital health technology; and
- d. align with incentives for measuring and improving outcomes for attributed populations.

Action 1.3: The Centers for Medicare & Medicaid Services should increase the overall portion of spending going to primary care by:

- a. accelerating efforts to improve the accuracy of the Medicare physician fee schedule by developing better data collection and valuation tools to identify overpriced services, with the goal of increasing payment rates for primary care evaluation and management services by 50 percent and reducing other service rates to maintain budget neutrality; and
- b. restoring the Relative Value Scale Update Committee to the advisory nature as originally intended by developing and relying on additional independent expert panels and evidence derived directly from practices.

Action 1.4: States should implement primary care payment reform by:

- a. using their authority to facilitate multi-payer collaboration on primary care payment and fee schedules and
- b. measuring and increasing the overall portion of health care spending in their state going to primary care.

Implementing high-quality primary care requires committing to pay primary care more and differently given its capacity to improve population health and health equity for all society, not because it generates short-term returns on investment for payers. High-quality primary care is not a commodity service whose value needs to be demonstrated in a competitive

marketplace but a common good promoted by responsible public policy and supported by private-sector action. Implementation of primary care spending policies should attend to the characteristics and practice of what constitutes high-quality primary care in accordance with the committee's definition. As the nation's largest payer, Medicare offers payment policies that set the standard for other payers and merit priority. In exchange, primary care should be accountable for developing additional capacities consistent with the committee's definition.

The committee's recommended actions are not untested. Hybrid capitation and fee-for-service (FFS) arrangements, paired with practice transformation resources and aligned across payers as described in Action 1.2, build primary care capacity consistent with the committee's definition. Medicare fee schedule changes have been recommended previously and are within the purview of the U.S. Department of Health and Human Services (HHS).

Many health systems providing primary care services through employed or contracted models have accepted global capitated payments but continue to operate and compensate primary care on an FFS model, blunting the effects of models intended to strengthen primary care. Health systems in these arrangements should honor the intentions of payers and evidence of superior performance, seeing that new payment models allocate sufficient management authority and resources to the practice of primary care.

Because primary care accounts for a small proportion of health care spending, the service price reductions noted in Action 1.3 will be minimal, help equilibrate compensation between primary care and other specialties, and make primary care a more attractive choice for medical graduates. Medicare fee schedule changes are necessary because capitation, budget rates, and compensation within health care systems, as well as relative prices set by other payers, typically rely on fee schedule calculations. States and local markets that have implemented Action 1.4 have achieved reduced cost trends and improved quality. More states should follow their lead.

Self-insured employers with in-state employment bases should follow the lead of their home states and participate in these efforts. Employers with a geographically dispersed workforce should follow Medicare's lead and prioritize and pay for high-quality primary care.

The recommended actions have not been scaled and implemented widely for two reasons. First, payment reform innovations have been evaluated against short-term savings rather than the promotion of high-quality primary care. Repeated testing of new primary care payment models in search of short-term savings has left most primary care clinicians in underpaying FFS arrangements with the wrong incentives. Attention should focus on moving more clinicians to existing models rather than testing new ones.

Second, budget neutrality or premium stability requirements mean increasing the investments in primary care, redistributing funds, and prioritizing it over other health care services. This is what the committee calls for in designating primary care as a common good. This rebalancing requires leadership, particularly in the public sector. The COVID-19 pandemic's further weakening of U.S. primary care has opened a policy window and leadership opportunity for the Centers for Medicare & Medicaid Services (CMS), employers, and more state officials to act without delay.

Objective Two: Ensure that high-quality primary care is available to every individual and family in every community.

Action 2.1: To facilitate an ongoing primary care relationship, all individuals should have the opportunity to have a usual source of primary care.

- a. Payers—Medicaid, Medicare, commercial insurers, and self-insured employers—should ask all covered individuals to declare a usual source of primary care annually and should assign non-responding enrollees using established methods, track this information, and use it for payment and accountability measures.
- b. Health centers, hospitals, and primary care practices should assume and document an ongoing clinical relationship with the uninsured people they are treating.

Action 2.2: To improve access to high-quality primary care for underserved populations, and to facilitate empanelment of uninsured people, the U.S. Department of Health and Human Services, enabled by congressional appropriations, should target sustained investment in the creation of new health centers (including federally qualified health centers, look-alikes, and school-based health centers), rural health clinics, and Indian Health Service facilities in federally designated shortage areas.

Action 2.3: To improve access to high-quality primary care services for Medicaid beneficiaries, the Centers for Medicare & Medicaid Services should:

- a. Revise and enforce its fee-for-service (section 1902) and managed care (section 1937) access standards for primary care for Medicaid beneficiaries, ensuring them adequate access to primary care as defined by the committee, and
- b. Provide technical assistance resources to state Medicaid agencies for implementing and attaining these standards, and measure and publish state performance on these standards.

Action 2.4: The Centers for Medicare & Medicaid Services should permanently support the COVID-era rule revisions and Medicaid and Medicare benefits interpretations that have facilitated integrated team-based care, enabled more equitable access to telephone and virtual visits, provided equitable payment for non-in-person visits, eased documentation requirements, expanded the role of interprofessional care team members, and eliminated other barriers to high-quality primary care.

Action 2.5: Primary care practices should move toward a community-oriented model of primary care by:

- a. Including community members with lived experience in their governance, practice design, and practice delivery and
- b. Partnering with community-based organizations.

Accreditation bodies should encourage practices to be more community oriented by revising their standards to facilitate these changes.

Successfully implementing high-quality primary care means everyone should have access to the “sustained relationships” primary care offers. The committee recognizes that this access is more likely to happen when everyone has adequate health insurance with no financial barriers to primary care. Absent that, payers can improve access by encouraging, formalizing, and supporting existing relationships between enrollees and primary care teams. Aligned payer action will reinforce the value of primary care as a common good and reduce beneficiaries’ misperceptions that any one payer is limiting access to specialty care. While private primary care practices are not obligated to treat the uninsured, those that do and are able should assume an ongoing clinical relationship with them.

The Health Resources and Services Administration’s (HRSA’s) Health Center Program serves 1 in 11 Americans and merits additional scaling, as it improves access to high-quality primary care for people without insurance or in federally designated shortage areas.

As the nation’s second-largest payer, with disproportionate numbers of children and high-needs beneficiaries, Medicaid needs a primary care strategy that addresses the low rates state Medicaid agencies and their contractors pay for primary care, which limits children’s access to it. CMS should lead this strategy, and its state partners should implement and enforce it. Reforming Medicaid to mirror Medicare’s payment standards may be the most straightforward path to ensuring equitable access to high-quality primary care for its beneficiaries. Short of that, modifying federal access-to-care standards for state Medicaid programs can catalyze state and managed care organization payment and coverage policies to prioritize high-quality primary care. Meeting federal and accrediting bodies’ access standards will

require states and their contracted managed care organizations to take the necessary actions, including increasing Medicaid rates for primary care and expanding primary care provider networks as needed.

Primary care accessibility should not be limited by the walls of the practice. The COVID-19 pandemic forced Medicare and other payers to scale the ability of patients to access their primary care teams virtually by video and telephone. The benefits of telemedicine are many, and CMS should minimize the payment and regulatory barriers to their use.

Finally, much of what improves health has little to do with medical care, and efforts by primary care teams to build relationships with community organizations and public health agencies should be fostered. These efforts should place patients, their families, and community members at the center of the design and accountability efforts for successful implementation.

Objective Three: Train primary care teams where people live and work.

Action 3.1: Health care organizations and local, state, and federal government agencies should expand and diversify the primary care workforce, particularly in federally designated shortage areas, to strengthen interprofessional teams and better align the workforce with the communities they serve.

- a. Public and private health care organizations should ensure inclusion, support, and training for family caregivers, community health workers, and other informal caregivers as members of the interprofessional primary care team.
- b. The U.S. Department of Education and the U.S. Department of Health and Human Services should partner to expand educational pipeline models that would encourage and increase opportunities for students who are under-represented in health professions.
- c. The Health Resources and Services Administration, state and local government, and health care systems should redesign and implement economic incentives, including loan forgiveness and salary supplements, to ensure that interprofessional care team members, especially those who reflect the diverse needs of the local community, are encouraged to enter primary care in rural and underserved areas.
- d. Health systems and organizations should develop a data-driven approach to customizing interprofessional teams to meet the needs of the population they serve.

Action 3.2: The Centers for Medicare & Medicaid Services, the U.S. Department of Veterans Affairs, the Health Resources and Services Administration (HRSA), and states should redeploy or augment funding to support interprofessional training in community-based, primary care practice environments. The revised funding model should be sufficient in size to improve access to primary care and ensure that training programs can adequately support primary care pipeline needs of the future.

- a. HRSA funding (via Title VII and Title VIII programs) for other health professions training should be increased and prioritized for interprofessional education.
- b. The U.S. Department of Health and Human Services, enabled by Congress as needed, should redesign the graduate medical education (GME) payment to support training primary care clinicians in community settings and expand the distribution of training sites to better meet the needs of communities and populations, particularly in rural and underserved areas. Effective HRSA models (e.g., Teaching Health Centers, Rural Training Tracks) should be prioritized for existing GME funding redistribution and sustained discretionary funding.
- c. GME funding should be modified to support the training of all members of the interprofessional primary care team, including but not limited to nurse practitioners, pharmacists, physician assistants, behavioral health specialists, pediatricians, and dental professionals.

Black, Hispanic, American Indian and Alaska Native, and Native Hawaiian and other Pacific Islander people are currently under-represented in nearly every clinical health care occupation. For care teams to address race- and ethnicity-based treatment disparities, their members should reflect the lived experience of the people and families they serve. Organizations that train, hire, and finance primary care clinicians should ensure that the demographic composition of their primary care workforce reflects the communities they serve and that the care delivered is culturally appropriate.

Developing a workforce to deliver the committee's definition of primary care requires reshaping training program expectations and the clinical settings in which that training occurs. Training primary care clinicians individually in inpatient settings will not accomplish this. Examples of team-based training in community settings exist, but scaling them requires recalibrating financial incentives to support all primary care team members. Recognizing the significance of this task, the committee recommends adopting alternative financing sources for HRSA-developed, community-based primary care training.

Objective Four: Design information technology that serves the patient, family, and interprofessional care team.

Action 4.1: The Office of the National Coordinator for Health Information Technology and the Centers for Medicare & Medicaid Services should develop the next phase of digital health, including electronic health record, certification standards to:

- a. Align with the functions of primary care—supporting the relationship between clinicians, care teams and patients; providing access and continuous contact over time; collecting and understanding the patient’s story; and focusing on the patient and family rather than the disease;
- b. Account for the user experience of clinicians and patients (e.g., clicks and time spent using system, data transferred without manual review, and improvements in care delivery and health outcomes) to ensure that health systems are truly interoperable;
- c. Ensure equitable access and use of digital health systems that support equitable care and deliver national standards, including guidelines, measures, and decision-making functions, while allowing local tailoring;
- d. Include highly usable sensemaking functionality, such as automated tools that make sense of data, identify clinically important data, and inform care;
- e. Ensure base products meet certification standards with minimal need for local modification to meet requirements; and
- f. Hold health information technology vendors and state and national support agencies financially responsible for failing to achieve benchmarks.

Action 4.2: The Office of the National Coordinator for Health Information Technology (ONC) and the Centers for Medicare & Medicaid Services (CMS) should plan for and adopt a comprehensive aggregate patient data system to enable primary care clinicians and interprofessional teams to easily access comprehensive patient data needed to provide whole-person care.

- a. This data source needs to be usable by any certified digital health tool for patients, families, clinicians, and care team members.
- b. ONC and CMS could accomplish this through a centralized data warehouse, individual health data card, or distributed sources connected by a real-time, functional health information exchange. Each approach has its own challenges, and an initial effort would need to decide on the right national approach.

Digital health, and electronic health records in particular, create opportunities for improving care coordination and person-centeredness. However, digital health is a major source of professional dissatisfaction and clinician burnout. The committee supports federal standards setting but current certification requirements are a barrier to high-quality primary care. The recommended elements for new certification requirements will require additional planning before adoption along with new policies and authorizations to enforce standards. Aggregated patient data systems can benefit primary care's coordinating functions and reduce the chances of data being used for personal or organizational profit. The experience of local and regional health information exchanges can inform this effort. Creating and implementing these changes requires innovation by vendors and state and national support agencies, and accomplishing these goals will not be easy to ascertain.

Objective Five: Ensure that high-quality primary care is implemented in the United States.

Action 5.1: The U.S. Department of Health and Human Services (HHS) Secretary should establish a Secretary's Council on Primary Care to enable the vision of primary care captured in the committee's definition.

- a. Council members should include the Centers for Medicare & Medicaid Services Administrator; the Directors of the Center for Medicare & Medicaid Innovation, the Health Resources and Services Administration, and the Agency for Healthcare Research and Quality; the Assistant Secretary for Planning and Evaluation at HHS; and the National Coordinator for the Office of the National Coordinator for Health Information Technology.
- b. The council should coordinate primary care policy across HHS agencies with attention to the following responsibilities: (1) assess federal primary care payment sufficiency and policy; (2) monitor primary care workforce sufficiency including training financing, production and preparation, incentives for federally designated shortage areas, and federal clinical assets/investments (health centers, rural health clinics, the Indian Health Service, and the U.S. Department of Veterans Affairs); (3) coordinate and assess the adequacy of the federal government's research investment in primary care; (4) address primary care's technology, data, and evidence needs, including interagency collaboration in the use of multiple data sources; (5) promote alignment of public and private payer policies in support of high-quality primary care; and (6) establish meaningful metrics for assessing the quality of primary care that embrace person-centeredness and health equity goals. Additionally,

the council should coordinate implementing the committee's recommended actions that target federal agencies.

- c. As part of its coordination role, the council should verify adequate budgetary resources are allotted in respective agencies for fulfilling these responsibilities.
- d. The council should annually report to Congress and the public on the progress of its implementation plan and performance on each of these six responsibilities.
- e. In all its work, the Secretary's Council on Primary Care should be informed through regular guidance and recommendations provided by a Primary Care Advisory Committee, created by the HHS Secretary under the Federal Advisory Committee Act, that includes members from national organizations that represent significant primary care stakeholder groups, such as patients, certifying boards, professional organizations, health care worker organizations, payers, and employers.

Action 5.2: The U.S. Department of Health and Human Services should form an Office of Primary Care Research at the National Institutes of Health and prioritize funding of primary care research at the Agency for Healthcare Research and Quality, via the National Center for Excellence in Primary Care Research.

Action 5.3: To improve accountability and increase chances of successful implementation, primary care professional societies, employers, consumer groups, and other stakeholders should assemble, and regularly compile and disseminate a "high-quality primary care implementation scorecard," based on the five key implementation objectives identified in this report. One or more philanthropies should assist in convening and facilitating the scorecard development and compilation.

Appendix E contains the committee's proposed scorecard, which aggregates a small number of already compiled state- and national-level measures for each implementation objective in this report.

Successfully implementing recommendations rests in part on clear accountability. Lack of accountability hampered efforts to implement many recommendations in the 1996 IOM report. Thus, the committee's task would be incomplete without recommending an accountability system for implementing the above actions, for which federal leadership and responsibility are essential. As the nation's two largest payers, Medicare and Medicaid shape the nation's health care delivery system. Medicare payment policy's incompatibility with high-quality primary care has weakened

primary care. In addition, federal payments and policies determine priorities for health care workforce training and medical and health care services research.

A Secretary's Council on Primary Care at HHS is the appropriate entity for coordinating the federal role and agency activity called for in these actions. The council should be accountable for monitoring and aligning private-sector activities that support primary care and ensuring that federal policy supports the committee's vision. Senior Secretary-level coordination is necessary given the widespread agency-level activities affecting primary care, including HRSA's workforce training and safety net funding, CMS's payment and benefits policy, health information technology within the Office of the National Coordinator for Health Information Technology, and the Agency for Healthcare Research and Quality's (AHRQ's) health services research. No one agency can shoulder the task of coordination, which would continue to be in the public interest beyond the scope or term of a special task force, another accountability mechanism the committee considered and rejected.

The HHS Secretary should give this council authority to ensure the appropriate agencies devote adequate spending to implement the actions in this report. A key task for the Secretary's Council will be overseeing the establishment of accountability measures for providing primary care consistent with the committee's definition. These measures can change expectations for what constitutes high-quality primary care as defined by the committee, if done judiciously and with stakeholder input, and they can facilitate learning and improved population health. Public reporting will also increase accountability.

Primary care research funding has suffered relative to other health services, so the committee recommends establishing a National Institutes of Health Office of Primary Care Research, with functions similar to its Office of Emergency Care Research. This new entity, coupled with funding for AHRQ's National Center for Excellence in Primary Care Research, could foster a system of learning and improvement that would help make the committee's vision of high-quality primary care a reality for all.

To increase the chances for successful implementation, actors should be held publicly accountable for their responsibilities. Evidence abounds for what is needed to achieve high-quality primary care for all, but organized support for this work is lacking. The professional diversity of high-quality primary care teams is their clinical strength but political and economic weakness, for while other health care services have a single voice advocating for public policy change, primary care lacks a similar voice. The committee's recommended Federal Advisory Committee to the Secretary's council on primary care could serve this function. Organizing primary care

clinicians, consumer groups, employers, and other stakeholders (from the variety of settings in which primary care is delivered) to assess implementation of the activities the committee recommends will hold the named actors accountable, increase the likelihood of successful implementation, and catalyze a common agenda to achieve a vital common good.

The nation deserves nothing less than high-quality primary care for all, but creating such a system requires leadership, accountability, and clear steps to accomplish this work. The committee hopes the work captured in this report realizes this vision sooner rather than later.