NATIONAL ADVISORY COMMITTEE MEETING

BY JACK WESTFALL, ROBERT GRAHAM CENTER

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BACKGROUND

The recent National Academies of Science, Engineering, and Medicine (NASEM) report *Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care* laid out five major recommendations for the advancement of primary care in the United States. The NASEM report called for an annual primary care scorecard to provide a regular update on the progress towards these objectives.

The Robert Graham Center and HealthLandscape will work closely with the Milbank Memorial Fund and The Physicians Foundation to support the development and deployment of a scorecard on the health of primary care. Relying heavily on the recent NASEM report for the intellectual foundation and strategic recommendations, the primary care scorecard will provide an annual snapshot of the nation's commitment to and deployment of primary care.

An external National Advisory Committee was convened to review NASEM's proposed primary care scorecard elements, review the Robert Graham Center's proposed analytic plan, and provide input and advice on final measure choice, data sources, narrative, and messaging.

MEETING AGENDA, MARCH 21, 2022

10:00 a.m.	Welcome and introductions including brief comments from committee members: Why is a stronger primary care system important to you?	Chris Koller Eric Schneider
10:30	Why create a scorecard on the health of primary care? Perspectives from NASEM committee members	NASEM primary care report committee members
11:30	Review advisory committee charge, project management roles and responsibilities	Chris Koller Eric Schneider
12:00 p.m.	Lunch	
12:30	Review proposed measures and data sets including gap analysis and recommendations	Robert Graham Center staff
2:30	Next steps: data analysis and report, interactive website	Milbank Memorial Fund and Robert Graham Center staff
3:00	Closing remarks and adjournment	Chris Koller Eric Schneider

MEETING REPORT

This report provides a brief overview of the National Advisory Committee meeting on March 21, 2022. This report aims to reflect the conversations from the five-hour meeting, along with notes and emails, and conversations held after the meeting.

This report's structure follows the meeting agenda, focusing mainly on the robust conversation from the afternoon review of the proposed primary care measures. For each measure these notes are into four categories: Consensus, Outliers, Requests and Questions, and Parking Lot. **Consensus** is the general sense of the group on the measure and data necessary to report that measure. **Outliers** are the comments and concerns raised by individuals or several attendees that deserve attention but may not be possible to implement.

Requests and Questions are specific questions from attendees that need immediate attention or short-term attention. The **Parking Lot** contains items that deserve further attention and consideration but are not within the efforts to create a primary care scorecard by fall 2022.

OVERVIEW OF THE NASEM REPORT ON HIGH-QUALITY PRIMARY CARE

Members of the NASEM Committee on Implementing High-Quality Primary Care provided a background on the report, the foundational values of primary care, and the call for measuring and reporting on the health of primary care in the United States.

Payment

- High-quality primary care is a good itself, not because of its ability to save money in the short term
- Incremental implementation and change — we should not focus on perfect if it gets in the way of good or better
- Fee-for-service payment is a problem and should decrease or phase out
- Particular attention to Medicare—Medicare sets the stage for other payers
- Role of states is one of the subobjectives — include states when possible

Access

- Everyone should have a primary care practice and/or clinician
- Focus on the large component of patients who are underserved
- Primary care needs to be community based and responsive

Workforce

- Fill in gaps in primary care shortage areas through a variety of health career pathways, education, training, and incentives
- Develop mechanisms and funding for team-based interdisciplinary/transdisciplinary/ integrated workforce

Digital Health

- Digital health and information technology (IT) should serve the patient, the practice, and the clinician
- Apply pressure to IT vendors to create and adapt their IT platforms and tools to support patients and practice teams
- Create and regulate mechanisms for patient data to be available at any point of service

Accountability

- The NASEM report includes implementation, not just observing the problem

- Establish a secretary's council on primary care

- Prioritize funding of primary care research through an office of primary care research at the National Institutes of Health (NIH)

Consensus

- The NASEM report is a seminal work coming at a time that is ripe for health care reform that focuses on primary health care. The report is more than just an observation of the problem and includes a robust challenge for change and implementation.

- The NASEM report recommended a primary care scorecard consisting of reliable, parsimonious, national and state, clinically relevant and policy-relevant measures.

Outliers

- Is the NASEM report destined for the echo chamber of stagnant U.S. policy?

Requests and Questions

- There is a lot of venture capital flowing into primary care, mostly for-profit primary care. How does the NASEM report discuss this phenomenon and how might this influence the primary care scorecard?

- What was the role of the patient and community voice in the NASEM report?

Parking Lot

- Who is the audience for the NASEM report and, hence, the audience for the primary care scorecard?

- Why is this primary care scorecard important?

META-MESSAGES FROM THE DAY

These meta-messages are the general themes that emerged throughout the day. They are the executive summary of digested individual comments, interstitial conversations, questions, concerns, hot takes, and opinions expressed by attendees and collated and curated by the Robert Graham Center team.

- **Attendance.** Everyone showed up. Thanks for showing up, in person, in DC. I think this reflects the importance of this work. The scorecard may amplify the NASEM report. We hope that the national advisory committee will stay engaged, participate, help interpret, and strengthen dissemination of the NASEM report and the need to invest in primary care.

- **Data.** The data are the data. There is a quote in my office: "Yelling and stomping your feet won't make data appear, I know, I've tried." There were lots of comments and questions about the data sources for the selected measures. There are concerns. Are the data valid? Do they represent all the people in the US? Do they offer race category disaggregation? Are they available at the state level? Do they measure the thing we really want? And is the proposed measure really what we want? The conversation frequently ran full circle: This is not perfect data … how might we answer the question we really want? … is there any other data available? … well, this seems like it may be good enough data. Of course, the Robert Graham Center will continue to scour the earth for data, and we welcome your discoveries and recommendations.

- **Audience.** Who is the audience for this report? Lots of folks *should* care about this scorecard. Let's start with 330 million Americans. An understanding of the health of primary care might be interesting to the public. There are 535 federal elected officials. There are 50+ governors and thousands of state elected officials. There are primary care organizations, foundations, and funders and their leadership. And there are specialty and hospital-based organizations and systems that should know about this scorecard. The data are the data; messaging in summer and fall 2022 can target the messages about the data to the specific audience.

- **Why are these measures important?** While the group all know why the primary care scorecard matters, it may be crucial to create a brief, three- to five-sentence elevator speech that any and all can use to answer the question. This will be a bit of homework for the advisory committee members.

- **Do we need a fixed definition of primary care?** Lots of conversation about this. Narrow, broad, extended, team. This timeless question may not be answerable in the context of this scorecard. And a fixed definition may not be necessary to create a primary care scorecard. We can describe the definition used for the scorecard and state that it is dependent on the available data and that some elements of the scorecard are not direct primary care measures but proxy measures for high-quality primary care, access, and accountability.

- **How do we engage primary care allies?** Primary care relies on our allies to support our efforts to implement high-quality primary care. The primary care scorecard may be a tool to engage primary care allies with messages and materials that they can use to support primary care.

- **What is the balance between creating new measures and strengthening current measures?** Not all the measures are perfect. And some are not available for every state. What is the balance between creating new measures, developed and implemented specifically for primary care, and strengthening current measures so they are better aligned with primary care activities?

- **Health information technology is a big deal and is fraught with implementation, cost, and equity issues.** The digital health and IT conversation generated lots of heat. How does primary care interact with IT? How does IT support patients? How does IT support clinicians and practices? Is IT an equity issue? Well, yes, it is. So, how do we identify the best measure that is reliable, available, and equitable? This discussion may change the proposed scorecard measure and is under review by the Robert Graham Center team. More to come on this.

- **Team matters.** Objective 1 calls for a team approach to primary care. Several other measures focus on physicians and physician residency training and don't include as much about the primary care team. A team approach is difficult to measure. Because most national data rely on claims, certification, and licensure, assessing all the team members is not possible. Creating long-term data collection that includes the broad practice and community primary health care team will be important and may be a priority issue for advanced advocacy efforts.

- **Where is the patient voice in this effort?** Lots of folks asked about how the measures are patient-centered or person-centered. Perhaps it is time to add a patient expert voice to the research team and/or the national advisory committee.

- **Primary care is a mitigator of inequity.** Narrative of the scorecard must use an equity lens. There was a robust conversation about the role of health equity, primary care, the scorecard, and the measures. There is not a specific health equity measure included in the primary care scorecard. However, it may be that primary care, in and of itself, is a mitigator of health inequity. Access to primary care, a usual source of primary care, focused training in community settings, and equitable health IT may be a sufficient approach to equity within the construct of a primary care scorecard. Undoubtedly, the narrative and messaging of the scorecard will need to use an equity lens.

- **Primary care resides in the context of the community, more than just the exam room.** Primary care provides crucial services in the exam room. But the primary care team provides so much more than diagnosis and treatment. The practice team is crucial. The practice activities and efforts that occur outside the practice walls are also an important element of primary care. Yet, funding focuses on the exam room encounter. How do we measure the broader practice and community activities and support payment for these? And how do we measure this broad, clinician/team/practice/community approach that is high-quality primary care?

- **Public health.** There is an effort to build collaboration and integration between primary care and public health. There are conditions for which primary care is necessary but not sufficient. How might we measure the relationship between primary care and public health, and should there be a measure for primary care–public health integration?

- **What's in a name?** The term "primary care scorecard" comes across as a measure of primary care itself. The goal is to score the national commitment to and investment in primary care. We do not want to set up the scorecard as an immediate affront to primary care clinicians and practices. This is not a trivial nuance. The first impression of this scorecard will have a major impact on its reception.

NASEM REPORT PRIMARY CARE SCORECARD OBJECTIVES AND MEASURES

While the conversation included each of the five NASEM objectives and measures, the Robert Graham Center identified six specific questions that needed more committee discussion. These specific questions were addressed in the review and discussion for each of the five specific objectives and measures. Of course, the group took the opportunity to address many other objectives and measures. The time allotted to each objective was more of a general guideline rather than a strict time limit.

Specific questions for the committee:

- **Objective 1: Capitation: What is meant and how to measure it?**

- **Objective 2: Usual source of care: narrow definition (person, not facility) or any usual source of care?**

- **Objective 2: Who is included in primary care? Physicians, nurse practitioners (NPs), physician assistants (PAs)?**

- **Objective 4: Digital health: Patient portals? Health information exchange?**

- **Objective 5: Medical Expenditure Panel Survey (MEPS)–primary care relationship measure, Office of the Assistant Secretary for Health progress report.**

- **Extra: What about health equity?**

Objective 1: Pay for primary care teams to care for people, not doctors to deliver services.

	Measure	Calculation	Source	Percentage of States with Data
1.1	Percentage of total spending going to primary care: **commercial insurance**	(Numerator is office-based + outpatient expenditures toward primary care; denominator is total annual health care expenditures) times 100	MEPS	58%
1.2	Percentage of total spending going to primary care: **Medicare**			
1.3	Percentage of total spending going to primary care: **Medicaid**			
1.4	Percentage of primary care patient care revenue from **capitation**	100 minus practice reimbursement via fee-for-service		

Consensus

- Everyone struggles to measure the application and impact of capitated funding.

- State all-payer claims data (APCD) may be appropriate for state primary care scorecards but is not currently feasible for national and multi-state comparisons.

- It is important to measure primary care spending that may support non-billable services and non-billing staff (social services, nutrition, paraprofessionals, community health workers, educators, etc.). What are examples of all the non-billable services and activities that might be supported by non-fee-for-service payment models?

Outliers

- Is MEPS really the best data source? Is MEPS representative of the United States?

Requests and Questions

- Does MEPS include vulnerable populations? **Yes,** MEPS includes all levels of income and access and oversamples vulnerable populations to ensure adequate representation.

Parking Lot

- What is the impact of expanding venture capital in primary care? How much? What is it paying for and creating?

Objective 2: Ensure that high-quality primary care is available to every individual and family in every community.

	Measure	Calculation	Source	Percentage of States with Data
2.1	Percentage of adults without a usual source of health care	Respondents who identify a person as the usual source of care (not facility)/total population	National Health Interview Survey (NHIS)	100%
2.2	Percentage of children without a usual source of health care			
2.3	Primary care physicians per 100,000 people in medically underserved areas	(Numerator is the physician count located within a medically underserved area [MUA] based on HPSA at census tract level; denominator is the total population) times 100,000	National Plan and Provider Enumeration System (NPPES), Medicare physician and supplier payment data, and Health Professional Shortage Areas (HPSAs)	
2.4	Primary care physicians per 100,000 people in areas that are not medically underserved			

Consensus

- Everyone should have a primary care clinician. Universal access to usual source of care.

- Usual source of care may be an individual clinician or a practice.

- Optimal usual source of care is not an emergency room, pharmacy, or health system.

- PAs and NPs working in primary care should be included. Just as specialist physicians are not included in primary care workforce, PAs/NPs working in specialty settings will not be included in primary care workforce estimates.

- Identify the geographic and community gaps in primary care access to support policies and incentives for practicing in HPSAs, in medically underserved communities, and within vulnerable populations.

- Primary care is community based.

- Primary care is a team activity. But it is difficult to measure who all is on the team. Clinicians that can bill are easy to identify, but the non-billing staff are not captured in claims data.

Outliers

- There are cultural factors that may make the emergency room a preferred usual source of care. Who gets to decide what constitutes an acceptable or preferred usual source of care?

- Empanelment may be politically controversial. "If you like your doctor, you can keep your doctor."

Requests and Questions

- Should usual source of care be a deficit-based measure (percentage without a usual source of care) or an asset-based measure (percentage with a usual source of care)? While important for messaging, the scorecard will report those with a usual source of care.

- Clarification of usual source of care. There is wide variation in usual source of care across types of care, patient demographics, and states.

- What is the comparison between the Behavioral Risk Factor Surveillance System (BRFSS) usual source of care measure and the MEPS measure? Robert Graham Center is exploring.

- For Measures 2.1 and 2.2, what is the comparison between NHIS and MEPS?

Parking Lot

- How do we specify equity? Does it adequately include people who are lower income? Does it include race?

- The narrative around the measure matters. There is a wide range of teams around the primary care clinician. Side box of this is "what the world looks like."

- How do community health centers (CHCs) exemplify components of the scorecard? Could there be a study that essentially scores CHCs on these measures?

- How can we capture all the non-billing team members in a primary care practice?

Objective 3: Train primary care teams where people live and work.

	Measure	Calculation	Source	Percentage of States with Data
3.1	Percentage of physicians trained in rural areas and medically underserved areas	Based on the location of sponsoring residence institution	American Medical Association (AMA) with Accreditation Council of Graduate Medical Education (ACGME) companion + TBD	100%
3.2	Percentage of physicians, nurses, and physician assistants working in primary care	(Numerator is Robert Graham Center's novel imputation method to assign field of practice; denominator is all active physicians) times 100	NPPES	
3.3	Percentage of new physician workforce entering primary care each year	(Numerator is count entering primary care; denominator is total new workforce) times 100	American Osteopathic Association (AOA) and AMA with ACGME companion	
3.4	Residents per 100,000 population by state	(Numerator is the count of PGYs; denominator is the total population) times 100,000	NPPES, ACS	

Consensus

- It is important to measure the community setting for graduate medical education. This should include both primary care residency training and specialty training.

- However, this report should focus on primary care residency training.

- While it is important to consider state comparisons, we must use caution in interpreting where primary care clinicians are trained vs. where they practice as there is great state-to-state variability in graduate medical education residency training sites. For instance, Pennsylvania has nine medical schools and dozens of primary care residency programs. Wyoming has no medical schools and just a few residency programs.

Outliers

- None.

Requests and Questions

- What is the effort to describe the diversity of primary care clinicians, teams, and practices?

Parking Lot

- How do we ensure measurement of primary care team diversity including race/ethnicity/language and sexual orientation/gender identity?

Objective 4: Design information technology that serves the patient, family, and interprofessional care team.

	Measure	Calculation	Source	Percentage of States with Data
NA1	Percentage of patients who access a practice **patient portal** in the past year	(Numerator is office-based primary care physicians with specific attribute; denominator is the count of all office-based primary care physicians) times 100	National Electronic Health Records Survey (NEHRS)	100%
NA2	Percentage of office-based physicians who participate in **health information exchange** with other providers and public health agencies			

Consensus

- Digital health and IT should be equitable. And the best measurement of health IT should be equitable.

- In the current context of fee-for-service payment, patient portals are widely felt to be a significant burden on primary care clinicians, with minimal value, and high risk to exacerbate clinician burnout.

- If payment models included attention to asynchronous patient–clinician communication, there might be more widespread support for patient portals.

- Patient portals are not widely available or used by patients, who may prefer text messaging and other communication methods.

- Effective health information exchange might solve some of the problems associated with venture capital, access, relationship-based care, and communication.

Outliers

- Some attendees reported a positive experience with patient portals and their opportunity to provide documentation of asynchronous communication.

Requests and Questions

- Is there a dataset on patient-clinician-practice text communication? **Robert Graham Center is searching for data.**

- What is the cost for a provider to join a health information exchange?

Parking Lot

- Time spent in electronic health record (EHR): How might we measure the time spent on EHR chart work as a measure of health IT that supports the primary care clinician and practice?

- Is health IT a place for clinicians and practices to access population-level health information?

- How can we ensure that patients are able to take their own "health data" with them or access it anywhere they go?

- How might we advocate for a regulatory requirement for EHR vendor reporting on EHR process data? For instance, if an EHR vendor has more than 1000 clinicians on their product, they must report average time for chart completion, patient portal use, preventive care reminder and completion, coding and billing.

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

	Measure	Calculation	Source	Percentage of States with Data
5.1	Investment in primary care research by the National Institutes of Health (NIH) in dollars spent and percentage of total projects funded	Both absolute value and percentage (numerator includes R, K, U, P, T, G, S grants to departments of family medicine; denominator is total annual NIH extramural funding dispersed) times 100	NIH RePORTER	100%
NA2	Ensure high-quality clinical care	MEPS–primary care relationship – standardized sum of 11 patient-reported measures	MEPS	58%
NA	Progress on creation of the Health and Human Services (HHS) Secretary Council on Primary Care and its work	Ratio of outputs produced by process to resources consumed by the process	TBD	NA

Consensus

- The point of the scorecard is to contribute to and amplify the message of the NASEM report and the need to implement primary care from a federal office.

- The primary care scorecard should support and evaluate the creation and deployment of the HHS Secretary Council on Primary Care.

- Primary care research should include more than just family medicine. However, family medicine might serve as a proxy measure for NIH investment in primary care research.

- Include other federal funders in calculating primary care research investment (NIH, Agency for Healthcare Research and Quality, Patient-Centered Outcomes Research Institute, Health Resources and Services Administration, Centers for Disease Control and Prevention, etc.).

Outliers

Requests and Questions

- What is the workload to re-create the RAND Health Services and Primary Care Research Study report findings annually or on a regular basis?

- Robert Graham Center will send out information about the MEPS–primary care relationship measure.

Parking Lot

- What is the Person-Centered Primary Care Measure and when will it be widely available to incorporate into the primary care scorecard?

HEALTH EQUITY

Consensus

- There was a robust conversation about health equity and the primary care scorecard. Should health equity be a separate measure within the scorecard? Or is primary care a mitigator of health equity itself? While the group agreed that health equity is a crucial lens for any narrative and messaging around the scorecard, health equity is not a specific measure within the primary care scorecard.

- CHCs are a tool for improving health equity, and calling out CHCs in the scorecard might be important.

- How does primary care identify social determinants of health in their patient population and address the social and community resource needs?

Outliers

- CHCs provide care for less than 10% of the population of the United States, so while they are an important element of health equity, they represent a small portion of primary care.

Requests and Questions

- What is the prevalence of primary care ascertainment of patient social needs — for instance, through ICD-10 Z codes?

Parking Lot

- Should the scorecard measures be reported by race/ethnicity, socioeconomic status, and other patient, practice, geographic variables?

- We need a repository of states' experience and activities related to health equity, so policy makers don't have to start from scratch. With whom and where might this repository of successes, failures, lessons learned, and policy language reside?

- Should state health equity policy align with a national strategy on health equity?

- How do we ensure measurement of primary care team diversity including race/ethnicity/ language and sexual orientation/gender identity?

- What small area measures of access and equity might be appropriate for use in the scorecard: HPSAs, MUAs, social asset and deprivation indices (Social Deprivation Index, Area Deprivation Index, etc.), Community Health Index?

OVERALL PARKING LOT

- This section includes all the parking lot items from above and some additional parking lot items that were not specific to scorecard objectives or measures.

- Who is the audience for the NASEM report and, hence, the audience for the primary care scorecard?

- Why is this primary care scorecard important?

- What is the impact of expanding venture capital in primary care? How much? What is it paying for and creating?

- How do we specify equity? Does it adequately include people who are lower income? Does it include race?

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- What is the Person-Centered Primary Care Measure and when will it be widely available to incorporate into the primary care scorecard?

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- What small area measures of access and equity might be appropriate for use in the scorecard: HPSAs, MUAs, social asset and deprivation indices (Social Deprivation Index, Area Deprivation Index, etc.), Community Health Index?

- How should telehealth be incorporated into the scorecard? Access? Equity? Usual source of care? payment models? Clearly telehealth is a big deal, so should it be a measure?

- Consider a supplemental section of the scorecard to capture state-generated data. Consider options for who might take the lead on maintaining an up-to-date state policy catalog.

- Create a comprehensive list of potential audiences for the primary care scorecard and the unique messaging necessary to engage each audience. What is the narrative and nuance that will get attention?

- Should the scorecard include a comparison between U.S. primary care and other countries (OECD)?