

Background

Defining Primary Care

Primary care, widely identified as the cornerstone of the health care system, serves as a usual source of care focused on both acute and chronic disease detection, management, treatment, and prevention.¹ Primary care is consistently shown a positive impact on individual and population health.² In a report from the Primary Care Collaborative, the authors note that “*consistent and growing evidence shows that primary care-oriented systems achieve better health outcomes, more health equity, and lower costs.*”³ Early studies in the 1990s found an association between a higher ratio of primary care physicians at a state-level and population-level health outcomes such as lower all-cause mortality and mortality from heart disease, cancer, stroke, as well as infant mortality.⁴ Availability of primary care providers is also associated with increased life span and reduction in infant low birth weight, and better overall patient experience.^{5,6}

Unfortunately, access to regular, high-quality care is a challenge for many people. These issues with access are due to a multitude of factors including workforce.⁷ This lack of access holds true in Washington State as well. Further, reimbursement for primary care is low compared to specialty care, with the United States spending between 5-7% of total health care expenditure on primary care and Washington State spending between 4.4% to 5.6% of total expenditure on primary care.^{3,8}

Efforts to define primary care start with a broad scope of services and general attributes. The concept of primary care was first introduced in the 1920s and described by the Institute of Medicine (IOM) in 1978 as being “*accessible, comprehensive, coordinated, continuous, and accountable.*”⁹ Barbara Starfield further describes primary care as being characterized by first-contact care and being longitudinal and comprehensive.¹⁰ Primary care can further be defined as including advocacy, taking place in the context of a community context and family, including goal-oriented care and health promotion, being integrated, and being based on a relationship.¹¹ In many studies, primary care is defined by four Cs: first-contact care that is comprehensive in addressing a wide variety of issues from sprains to behavioral health to prenatal care, is continuous with multiple touch-points over time, and is coordinated. In order to know whether primary care spend is increasing in the state, Washington must first develop an agreed upon definition of primary care that will allow for accurate measurement.

The IOM categorizes possible definitions into care provided by certain clinicians, a particular set of activities, a level or setting of care, the attributes themselves, or as a strategy for organizing a system.¹² More simply, primary care can be defined broadly as consisting of the care provided by a subgroup of medical providers, the set of functions that providers within and outside of that subgroup perform, and/or a general orientation of a health delivery system.¹³ A family medicine physician may order a thyroid test which would be considered part of primary care while an endocrinologist ordering that

same test may not necessarily be considered primary care. These provider, service, and system categories have been expanded by Millbank into:¹⁴

- Provider: All the services delivered by pre-defined primary care providers in an ambulatory setting.
- Service: Services that meet particular definitions including being: comprehensive, first-contact for a wide variety of (not limited) conditions, coordinated, and taking place over time (longitudinal).
- Service: All office visits and preventative services within a category independent of the provider type.
- Service and Provider: Based in claims, specific set of pre-defined services delivered by pre-defined primary care providers not limited to an ambulatory setting.
- Health systems: Primary care delivered at a system level, useful for capitated systems but most difficult to measure.

Measurement

Measurement is limited by available data, which is predominantly claims data. Developing a mechanism to measure primary care using the four Cs described above (first contact, comprehensive, continuous, and coordinated) is difficult using claims data as these aspects are not evidence in the codes that are billed. Further, the lack of a nationally accepted definition of primary care is a major impediment to assessing and increasing the primary care expenditures. The Washington State Office of Financial Management (OFM) report, mandated by legislation and published in December 2019 notes that comparisons between Washington's percent expenditure and either the national average or other states' reported expenditures are likely misleading due to differing definitions of primary care. For example, Washington does not currently include non-claims-based care (e.g., care coordination activities) in its measure of primary care, but Oregon and Rhode Island do; this may artificially lower Washington's numbers.⁸

In order to develop a proxy for what would be true primary care measurement, groups have operated on various assumptions. If defining by provider, the assumption is that a group of subspecialists (i.e., family medicine) always offers primary care and that other groups of subspecialists never provide primary care (i.e., emergency medicine). This assumption holds true for some but not all disciplines. Advance registered nurse practitioners and physician assistants practice in a multitude of settings, including surgical care, which is not reflected in a claim. Washington state has no roster of primary care providers. The 2019 OFM report adjusted the total claims from ARNPs and PAs by 41% and 34%, respectively. Further, a specialist such as a cardiologist may order a basic lab test.

The OFM report presents narrow and broad definitions of primary care, differing based the types of providers who are assumed to be providing primary care. The narrow definition only includes providers who are traditionally considered to perform primary care while the broad definition includes a wider range of provider taxonomy codes includes behavioral health providers, clinical nurse specialists, registered nurses, midwives, and a host of other providers who are not typically considered general

practitioners.⁸ The OFM stakeholder group also reviewed procedure codes and created both narrow and broad definitions of services qualifying as primary care. Only claims which met both the provider and service definitions of primary care were counted toward the state’s total expenditure, with the narrow definition yielding 4.4% and the broad 5.6%.⁸

However, the OFM report noted that deficiencies inherent to the WA-APCD claims database, combined with lack of a firm definition for primary care, limit the report’s accuracy in some regards. Claims data does not capture, for example, whether or not the location of services provided was a primary care clinic. As was mentioned earlier, Washington lacks a way to measure non-claims-based expenditures. The OFM report mentions a number of other systemic impediments to accurate measurement that may need to be addressed in order to calculate an accurate primary care expenditure percentage for the state.⁸

Type of Provider

First Contact – Do you and your team assess and triage a patient’s new health or health care issues?

Comprehensive – Do you or your team address multiple organ systems?

Continuous – Have you or your team had at least X visits, in-person, email, or telehealth, or X in the last 12 months?

Coordinated – Do you and your team take responsibility for a patient’s care through managing their care plan in coordination with a multidisciplinary team or with offsite referrals?

Appropriate – Do you practice evidence-based, patient-centered medicine?

Provider Type	Yes	No
Family Practice	x	
General Internal Medicine	x	
General Practice	x	
Pediatrics	x	
Geriatrician	x	
Adolescent Medicine	x	
NP - Family	x	
NP - Adult	x	
NP - Pediatric	x	
<i>NP – Female embedded</i>	x	
<i>Psychologist embedded</i>	x	
<i>Social Worker embedded</i>	x	
<i>Naturopath embedded</i>	x	
<i>OB/GYN</i>		x
<i>Midwife</i>		x
<i>Homeopath</i>		x
<i>Chiropractor</i>		x
<i>Emergency Physician</i>		x
<i>Hospitalist</i>		x
<i>Psychiatrist</i>		x

Recommendation Framework

The workgroup's goal is to foster a common understanding of primary care in order to increase primary care accessibility and availability.

Current Primary Care Definition	Millbank: Based in claims, specific set of pre-defined services delivered by pre-defined primary care providers not limited to an ambulatory setting.
Aspirational Primary Care Definition	Millbank: Services that meet particular definitions including being: comprehensive, first-contact for a wide variety of (not limited) conditions, coordinated, and taking place over time (longitudinal)
Components of Primary Care with Large Impact	
Primary Care Spend	

- A common definition, current and aspirational, for primary care services including behavioral health (i.e., providers of, components of, locations of service)
- Components of primary care with the largest impact on individual and population health
- A mechanism for measuring primary care spend

Decisions for attribution:

unit of analysis (patient versus episode of care); signal for responsibility (professional costs versus number of evaluation and management visits); number of physicians that can be assigned responsibility (single physician versus multiple); and minimum threshold for assigning responsibility (majority of visits or costs versus plurality of visits or costs).¹⁵

Examples from Shared Decision Making Report

Patients and Family Members

- Think about your broad health and wellness-related goals (e.g., being able to attend an upcoming family wedding).
- Where different options are available, like the areas noted in this document, give your provider(s) information about your values and preferences and discuss options, tradeoffs, and implications of a decision together.
- Ask about whether a patient decision aid is available.
- Ask your care provider about the test or treatment options available, including the option of “doing nothing” or “watchful waiting.”

Health Care Delivery Organizations and Systems

- Work with your clinical champion(s) to educate providers about the value of shared decision making and how to have a good conversation that uses the patient decision aid or references the patient decision aid if the aid will be distributed to patients prior to the visit.
- Select one of the 10 clinical areas to pilot (e.g., breast cancer screening).

Providers

- Participate in skills training. Shared decision making is a learned skill-set that is supported by patient decision aids.

Health Plans and/or Professional Liability Carriers

- Incorporate shared decision making requirements as standards for value-based models (e.g., Centers of Excellence).

Employers

- Incorporate shared decision making requirements as standards for value-based contracting (e.g., Centers of Excellence, Accountable Care Organizations).
- Talk to your health plan about the importance of shared decision making and how to report on use of shared decision making including how to ensure appropriate reimbursement.

Washington State Health Care Authority

- Encourage the patient decision aid developer community to develop patient decision aids for the ten priority areas publicly available at no cost.

Examples from Shared Decision Making Report

Options for tracking shared decision making are below including those aligning with value-based reimbursement models from the Bree Collaborative and Federal programs:

- **Shared Decision Making Process**

Steward: Massachusetts General Hospital

NQF #2962

This measure assesses the extent to which health care providers actually involve patients in a decision-making process when there is more than one reasonable option. This proposal is to focus on patients who have undergone any one of seven common, important surgical procedures: total replacement of the knee or hip, lower back surgery for spinal stenosis of herniated disc, radical prostatectomy for prostate cancer, mastectomy for early stage breast cancer or percutaneous coronary intervention (PCI) for stable angina. Patients answer four questions (scored 0 to 4) about their interactions with providers about the decision to have the procedure, and the measure of the extent to which a provider or provider group is practicing shared decision making for a particular procedure is the average score from their responding patients who had the procedure.

- **Informed, Patient-Centered Hip and Knee Replacement Surgery**

NQF #2958

Steward: Massachusetts General Hospital

The measure is derived from patient responses to the Hip or Knee Decision Quality Instruments. Participants who have a passing knowledge score (60% or higher) and a clear preference for surgery are considered to have met the criteria for an informed, patient-centered decision. The target population is adult patients who had a primary hip or knee replacement surgery for treatment of hip or knee osteoarthritis.

Appendix C: Guideline and Systematic Review Search Results

Year	Title	Summary or Findings
<p>AHRQ: Research Findings and Reports</p>	<p>2019 Achieving Health Equity in Preventive Services</p>	<p>No eligible studies evaluated effects of provider-specific barriers; 18 studies of population barriers provided low or insufficient evidence regarding insurance coverage, access, age, rural location, low income, language, low health literacy, country of origin, and attitudes. In 12 studies of clinician interventions, screening was higher for colorectal cancer with patient navigation, risk assessment and counseling, educational materials, and decision aids; breast and cervical cancer with reminders involving lay health workers; and cervical cancer with outreach and health education. Clinician-delivered interventions were effective for smoking cessation and weight loss. In 11 studies of health information technologies, automated reminders and electronic decision aids increased colorectal cancer screening, and web- or telephone-based self-monitoring improved weight loss, but other technologies were not effective. In 88 studies of health system interventions, evidence was strongest for patient navigation to increase screening for colorectal (risk ratio [RR] 1.64; 95% confidence interval [CI] 1.42 to 1.92; 22 trials), breast (RR 1.50; 95% CI 1.22 to 1.91; 10 trials), and cervical cancer (RR 1.11; 95% CI 1.05 to 1.19). Screening was also higher for colorectal cancer with telephone calls, prompts, other outreach methods, screening checklists, provider training, and community engagement; breast cancer with lay health workers, patient education, screening checklists, and community engagement; cervical cancer with telephone calls, prompts, and community engagement; and lung cancer with patient navigation. Trials of smoking cessation and obesity education and counseling had mixed results. In populations adversely affected by disparities, evidence is strongest for patient navigation to increase colorectal, breast, and cervical cancer screening; telephone calls and prompts to increase colorectal cancer screening; and reminders including lay health workers encouraging breast cancer screening. Evidence is low or insufficient to determine effects of barriers or effectiveness of other interventions because of lack of studies and methodological limitations of existing studies.</p>
	<p>2016 Improving Cultural Competence to Reduce Health Disparities</p>	<p>None of the included studies measured the effect of cultural competence interventions on health care disparities. Most of the training interventions measured changes in professional attitudes toward the population of interest but did not measure the downstream effect of changing provider beliefs on the care delivered to patients. Interventions that altered existing protocols, empowered patients to interact with the formal health care system, or prompted provider behavior at the point of care were more likely to measure patient-centered outcomes. The medium or high risk of bias of the included studies, the heterogeneity of populations, and the lack of measurement consensus prohibited pooling estimates or commenting about efficacy in a meaningful or responsible way. The term "cultural competence" is not well defined for the LGBT and disability populations, and is often conflated with patient-centered or individualized care. There are many gaps in the literature; many large subpopulations are not represented.</p>

2012	Narrow band imaging versus conventional white light colonoscopy for the detection of colorectal polyps	We could not find convincing evidence that NBI is significantly better than high definition WLC for the detection of patients with colorectal polyps, or colorectal adenomas. We found evidence that NBI might be better than standard definition WLC and equal to high definition WLC for detection the patients with colorectal polyps, or colorectal adenomas.
2016	Interventions to encourage uptake of cancer screening for people with severe mental illness	A comprehensive search showed that currently there is no RCT evidence for any method of encouraging cancer screening uptake in people with SMI. No specific approach can therefore be recommended. High-quality, large-scale RCTs are needed urgently to help address the disparity between people with SMI and others in cancer screening uptake.
2019	Follow-up strategies for patients treated for non-metastatic colorectal cancer	The results of our review suggest that there is no overall survival benefit for intensifying the follow-up of patients after curative surgery for colorectal cancer. Although more participants were treated with salvage surgery with curative intent in the intensive follow-up groups, this was not associated with improved survival. Harms related to intensive follow-up and salvage therapy were not well reported.
2013	Personalised risk communication for informed decision making about	There is strong evidence from three trials that personalised risk estimates incorporated within communication interventions for screening programmes enhance informed choices. However the evidence for increasing the uptake of such screening tests with similar interventions is weak, and it is not clear if this increase is associated with informed choices. Studies included a diverse range of screening programmes. Therefore, data from this review do not allow us to draw conclusions about the best interventions to deliver personalised risk communication for enhancing informed decisions. The results are dominated by findings

	taking screening tests	from the topic area of mammography and colorectal cancer. Caution is therefore required in generalising from these results, and particularly for clinical topics other than mammography and colorectal cancer screening.
	2017 Decision aids for people facing health treatment or screening decisions	Compared to usual care across a wide variety of decision contexts, people exposed to decision aids feel more knowledgeable, better informed, and clearer about their values, and they probably have a more active role in decision making and more accurate risk perceptions. There is growing evidence that decision aids may improve values-congruent choices. There are no adverse effects on health outcomes or satisfaction. New for this updated is evidence indicating improved knowledge and accurate risk perceptions when decision aids are used either within or in preparation for the consultation. Further research is needed on the effects on adherence with the chosen option, cost-effectiveness, and use with lower literacy populations.
<i>Veterans Administration Evidence-based Synthesis Program</i>	2019 What is the Optimal Panel Size in Primary Care? A Systematic Review	In 2009, the Veterans Health Administration Handbook 1101.02 established a baseline panel size of 1,200 patients for a full-time physician in a Patient Aligned Care Team (PACT). This number could be adjusted up or down based on availability of support staff, the number of examination rooms, and patient complexity. After adjustment for these factors, panels ranged from 1,000 to 1,400. Veterans Health Administration (VHA) Directive 1406 reaffirmed both the baseline panel numbers and adjustment parameters.
<i>Health Technology Assessment Program</i>	None	
<i>Centers for Disease Control and Prevention</i>	N/a	
<i>Institute for Clinical and Economic Review</i>	2008 Computed tomography (CT) colonography	Given the possible benefits of introducing a widely available minimally-invasive option for colorectal cancer screening, there is considerable interest in CTC.

References

- ¹ Blewett LA, Johnson PJ, Lee B, Scal PB. When a usual source of care and usual provider matter: adult prevention and screening services. *J Gen Intern Med*. 2008;23(9):1354–1360. doi:10.1007/s11606-008-0659-0 When a Usual Source of Care and Usual Provider Matter: Adult Prevention and Screening Services
- ² Starfield B, Shi L, Macinko J. Contribution of primary care to health systems and health. *Milbank Q*. 2005;83(3):457-502.
- ³ Primary Care Collaborative. Investing in Primary Care: A State-Level Analysis. <https://www.pcpcc.org/resource/evidence2019>
- ⁴ Shi L. Primary care, specialty care, and life chances. *Int J Health Serv*. 1994; 24(3):431-58.
- ⁵ Vogel RL, Ackermann RJ. Is primary care physician supply correlated with health outcomes? *Int J Health Serv*. 1998; 28(1):183-96.
- ⁶ Levine DM, Landon BE, Linder JA. Quality and Experience of Outpatient Care in the United States for Adults With or Without Primary Care [published correction appears in *JAMA Intern Med*. 2019 May 1;179(5):733] [published correction appears in *JAMA Intern Med*. 2019 Jun 1;179(6):854]. *JAMA Intern Med*. 2019;179(3):363-372. doi:10.1001/jamainternmed.2018.6716
- ⁷ Schwartz MD. Health care reform and the primary care workforce bottleneck. *J Gen Intern Med*. 2012;27(4):469-472. doi:10.1007/s11606-011-1921-4
- ⁸ Washington State Office of Financial Management. Primary Care Expenditures Report Summary of current primary care expenditures and investment in Washington. December 2019.
- ⁹ Institute of Medicine (IOM) A Manpower Policy for Primary Health Care. Washington, D.C.: National Academy of Sciences; 1978. IOM Publication 78-02.
- ¹⁰ Starfield 1992
- ¹¹ Etz RS, Zyzanski SJ, Gonzalez MM, Reves SR, O'Neal JP, Stange KC. A New Comprehensive Measure of High-Value Aspects of Primary Care. *Ann Fam Med*. 2019;17(3):221-230.
- ¹² Institute of Medicine (US) Committee on the Future of Primary Care; Donaldson MS, Yordy KD, Lohr KN, et al., editors. Primary Care: America's Health in a New Era. Washington (DC): National Academies Press (US); 1996. 2, Defining Primary Care. Available from: <https://www.ncbi.nlm.nih.gov/books/NBK232631/>
- ¹³ Friedberg MW, Hussey PS, Schneider EC. Primary care: a critical review of the evidence on quality and costs of health care. *Health Aff (Millwood)*. 2010;29(5):766-772.
- ¹⁴ Bailit MH, Friedberd MW, Houy ML. Standardizing the Measurement of Commercial Health Plan Primary Care Spending. *Milbank Memorial Fund*. July 2017.
- ¹⁵ Mehrotra A, Adams JL, Thomas JW, McGlynn EA. The effect of different attribution rules on individual physician cost profiles. *Ann Intern Med*. 2010;152(10):649-654