



To: Initiative to Strengthen Primary Health Care Team (ISPHC), Immediate Office of the Assistant Secretary of Health, US Department of Health and Human Services (DHHS)
From: The Eugene S. Farley, Jr. Health Policy Center, University of Colorado Anschutz Medical Campus
Date: August 1, 2022
Re: Primary Health Care RFI

Thank you for the opportunity to respond to the [Primary Health Care RFI](#) on behalf of the [Eugene S. Farley, Jr. Health Policy Center](#) (Farley Center) and inform the work of the ISPHC. The Farley Center is a non-partisan health policy center on the Anschutz Medical Campus of the University of Colorado in Aurora, CO. Our mission is to “develop and translate evidence to advance policies and integrate systems that improve health, equity, and well-being.” We specialize in system transformation to integrate care; finance and payment policy; workforce development; community-based prevention and well-being; and social policy to address disparities. As a center, we conduct policy research; translate evidence to inform the policymaking process; educate and mentor learners interested in policy careers; convene stakeholders and decision-makers to improve health and health care together; and provide technical assistance for implementing policy.

Before responding to each of the four questions in the RFI, we’d like to emphasize the following:

- We support the recommendations contained within the 2021 NAM report, “[Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care](#),” and encourage the ISPHC to use this report as a guide in the reforms you choose to pursue. This report is recent, well-researched, and developed in a highly collaborative way with many stakeholders.
- Clarity around the [definition of primary care](#) as a public good is essential. We recommend using the definition referenced in the above report. The ISPHC has an incredible opportunity to consistently use this definition across federal agencies and offices to promote a more complete understanding of primary care and its value and potential.
- High-quality primary care will be made even more effective and holistic through integration with mental/emotional/[behavioral \(MEB\) health services](#), [public health](#), and [human services](#).
- To best support primary care – especially as we weather year three of the COVID-19 pandemic – its foundation needs to be rebuilt with haste, including substantial increases in investment in primary care payment, data, and technology infrastructure, as well as workforce.
- We find the ISPHC incredibly promising in its integrating role. Given where the initiative is situated within DHHS, it has the visibility and authority to invite other federal agency partners within and outside of DHHS to the table to coordinate goals; metrics; funding streams; workforce plans; payment, delivery system, and technology innovations; and strategies to address the integration of clinical care with social determinants of health at the community, regional, and national levels. These coordinating and collaborating functions are foundational to forward progress. For example, the soon-to-be issued [Federal Plan for Equitable Long-Term Recovery and Resilience](#) provides a framework and strategic set of recommendations for long-term action to improve individual and community resilience on a whole-of-government scale; this can serve as a model for the ISPHC.



Describe successful models or innovations that help achieve the goal state for primary health care:

A substantial and growing [body of evidence](#) supports **the integration of primary care and MEB health services**. We recommend robust financial, data, and technical assistance support for person-centered integration independent of a particular model, i.e., there is no “one size fits all” approach depending on the type, size, or location of a primary care practice, its local partners, and/or the populations it serves. Critical to the success of integration efforts is the availability of [practice transformation](#) coaching and collaborative, peer-to-peer learning environments. We are pleased to share with you a June 2022 report produced by the Farley Center and the Practice Innovation Program at the University of Colorado that we believe will be useful in your work: [The Building Blocks of Behavioral Health \(BH\) Integration](#). This report introduces a framework for BH integration designed to align care delivery expectations across payers, providers, and patients and to enable payment reform in support of this integration. The framework includes a minimum standard of care delivery expectations, as well as flexible options to reflect the variety of ways practices approach integrated care.

Medical-legal partnerships (MLPs) are an [established model](#) of integrated services that intervene against the social determinants of health and magnify the impact primary care physicians can have on patients and communities. With [proven value](#) in more than 450 health systems across 49 states, MLPs introduce poverty lawyers into the health care team alongside social workers, care managers, patient navigators, and clinical pharmacists to tangibly reduce health inequities. Evidence shows that MLPs improve patient health, reduce stress, improve medication adherence, and [reduce hospitalizations](#).

Despite the ample evidence of the ability of MLPs to improve health and well-being, this intervention is challenged by current business models that do not support these services. MLPs are often left with unsustainable funding models including grants, philanthropy, or short-term global payments by health systems. Policies to [enable reimbursement for MLPs through public payers](#) could provide an essential stabilizing force to this highly effective health intervention.

Any successful primary care model or innovation must be informed by [lifespan science](#), i.e., **children and youth must be called out explicitly** and appropriately recognized in all the spaces and places in which they receive primary care: pediatrics, family medicine, child care centers, school-based health centers, etc. Any alternative payment model (APM) involving children needs to be uniquely designed to meet their needs. [Ensuring children have a healthy start in life](#), especially children from low-income or disadvantaged populations, is a necessity to address equity. Providing holistic, family-centered care that integrates all the components of well-being is essential, especially for populations that have been historically marginalized. Primary care cannot do all of that on its own, and it cannot be done without primary care.

Name barriers to implementing successful models or innovations:

- A primary barrier impeding the implementation – and *sustainability* – of primary care models and innovations is insufficient financial investment and payments that are predominantly structured in a [fee-for-service](#) mechanism, rather than on a prospective basis that rewards well-



being and allows primary care practices the flexibility to tailor the care they provide based on local population health needs. Furthermore, multi-payer alignment across public and private payers is sorely needed.

- We rarely pay for the very real costs of collaboration and integration between primary care and [behavioral health](#), public health, and human services. Developing integrated plans with families requires time, multiple parties, and technical skill. This also must be addressed in future models to ensure sustainability.
- Many primary care practices are interested in participating in new APMs; however, their ability to do so is limited when demonstration models last for a short time, and payment is not consistent across time and different payers. Smaller, independent, and more rural practices [need infrastructure support to participate](#) and may also need altered requirements to facilitate their participation.
- Access – or lack thereof – to [technical assistance and practice transformation coaching](#), including learning collaboratives, practice facilitation, and information technology support, is a major reason primary care practices are unable to participate in new models.
- There is an over-emphasis on clinical quality metrics, rather than on [measures that matter](#) that better capture the value of primary care to providers and patients alike. We emphasize process, not outcomes.
- There is no agreed-upon data model for primary care. Lack of high-quality, interoperable clinical, social needs, population health, and health behavior data has been a frustrating challenge for practice improvement and collaboration across sectors. Furthermore, inconsistent definitions of and [approaches to data collection](#) for race/ethnicity, gender identity, and other social factors slows down primary care in its ability to address health equity.
- [Insufficient diversity within the primary care workforce](#) leads to a cultural and linguistic mismatch with the populations they serve. Suggestions for improvement include: expanding pipeline initiatives; increasing scholarships and loan repayment programs; and developing retention incentives.
- Years of operating in a volume-driven, fee-for-service environment has created a practice culture and workflows where it is often easier to screen and refer to specialty care than it is to engage in shared decision-making and goal-oriented care with patients and their families in the pursuit of true person-centered care. Overcoming these cultural and workflow barriers will require both practice transformation support and educational resources for the effective implementation of models that support shared-decision making and goal setting.

Identify successful strategies to engage communities:

- When engaging community members in new models or innovations, invite them to be true partners at the [decision-making level](#) (appoint them to governing boards or similar entities). Ensure they are appropriately compensated for their time and for sharing their local expertise and lived experiences.
- Employ community health and peer support workers who live in the community a primary care practice serves and who appreciate the local culture and customs. Many [successful models](#) abound demonstrating enhanced collaboration, trust, and health outcomes.



- Deploy the [boot camp translation](#) method to enable communities to translate evidence into local settings aligned with local culture and assets, thus bridging the gap between research and practice.

Propose actions HHS can take:

- Increase [investment in primary care](#) to a minimum of 10% of total health care expenditures, and preferably to at least 12%.
- Accelerate implementation of revised payment policies for primary care emphasizing risk-adjusted, [prospective](#), population-based (i.e., PMPMs) payments with augmentation for desired policy objectives for all practices, not just those involved in demonstration projects.
- Provide enhanced support through non-fee-for-service means for integrating primary care with MEB health, public health, and human services, including paying for necessary collaboration costs and infrastructure.
- Fund the [Primary Care Extension Program](#), as authorized by the Affordable Care Act: close the gap between what we know and what we do at the frontlines of primary care through practice transformation support.
- Enhance [alignment of both payment](#) and measures among Medicare and Medicaid and commercial payers.
- Develop common, integrated systems in each state to gather the multiplicity of health care, public health, and human services data sources rather than requiring each program or project to do so alone. Encourage public, private, and academic collaboration in evaluating outcomes.
- Use the new person-centered primary care measure ([PCPCM](#)) approved by NQF and CMS to capture patients' voices as the cornerstone of measuring high-quality primary care.
- Contract for the development of additional non-disease focused measures that matter to both primary care clinicians and their patients, e.g., measures of equity, mental health, well-being, and/or thriving.
- Correct the lack of an intellectual engine for primary care by establishing a [national primary care institute within NIH](#) charged initially with establishing a primary care data model to organize data and reporting systems, inventing and deploying measures of primary care, discovering how health is won and lost where people live, learn, work, and play, and learning how to make primary care patient-centered and goal-oriented versus only disease-centered and commodity-oriented.
- Fill the void of no national health workforce policy by implementing recommendations from the 2014 IOM GME reform report, e.g., establishing a [National Health Care Workforce Commission](#) akin to MedPac.
- Incentivize GME programs to provide training in fully integrated primary care practices that include collaborative coordination of care with MEB services, public health, human services, MLP programs, care coordinators, community health workers, clinical pharmacists, etc.

Thank you very much for the opportunity to contribute to the ISPHC planning process! We applaud your efforts to build this critical primary care infrastructure in the US. For any questions about this RFI response, please contact Dr. Lauren Hughes, State Policy Director of the Farley Center, at lauren.hughes@cuanschutz.edu or (206) 724-7033.