

Primary Care Practice Facilitation Curriculum

Module 3: The Primary Care Landscape



Agency for Healthcare Research and Quality

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Primary Care Practice Facilitation Curriculum

Module 3. The Primary Care Landscape

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Agency for Healthcare Research and Quality
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Prepared by:

Mathematica Policy Research
Princeton, NJ

Primary Authors

Tricia Collins Higgins, Ph.D., Mathematica Policy Research
Elizabeth Babalola, M.P.H., Mathematica Policy Research
Jesse Crosson, Ph.D., Mathematica Policy Research

Series Editors

Jesse Crosson, Ph.D., Mathematica Policy Research
Robert J. McNellis, M.P.H., P.A., Agency for Health Research and Quality
Janice L. Genevro, Ph.D., Agency for Healthcare Research and Quality

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Module 3. The Primary Care Landscape

Instructor's Guide

Practice facilitator (PF) competencies addressed in this module:

- Foundational knowledge of primary care environments

Time

- Pre-session preparation for learners: 60 minutes
- Session: 75 minutes

Objectives

After completing this module, learners will be able to:

1. Define primary care and describe the key components of primary care.
2. Describe at a high level how the Affordable Care Act affects primary care practices.
3. Describe key emerging primary care delivery models.
4. Describe public and private payers and the different payment models they use.
5. Locate resources to learn about new developments in primary care.

Exercises and Activities to Complete Before, During, and After the Session

Pre-session preparation. Ask the learners to review the following information (60 minutes).

1. The content of the module.
2. Starfield B, Shi L, Macinko J. Contribution of primary care to health systems and health. *Milbank Q.* 2005;83(3):457-502.

During the session. Presentation (15 minutes)

1. Present key concepts from the module.

Discussion. Ask questions and explore answers with learners (60 minutes).

1. Why is primary care a central component of the U.S. health care system?
2. What potential implications does the primary care professional shortage have for practices?
3. How have recent public policies affected primary care practices?
4. How can practice facilitators help practices understand the implications of new public policies?
5. Who are the major public and private payers for primary care services? How do they differ?
6. What are the key payment models for primary care (including both traditional and evolving models)? How do they affect care delivery?
7. What is a Primary Care Medical Home (PCMH)? What is an Accountable Care Organization (ACO)? What is primary care's role within these models?

After the session.

1. Ask learners to review additional resources provided at end of the module.

Module 3

Primary care is a fundamental part of the health care system and plays an essential role in the health of the population. According to the Agency for Healthcare Research and Quality (AHRQ), primary care is “foundational to achieving high-quality, accessible, efficient health care for all Americans.” In this module, we provide an overview of the primary care landscape, especially as it relates to practice facilitation. We also discuss how current policies and the payment environment affect primary care practices.

What Is Primary Care?

The function of primary care is to provide basic services essential to supporting and maintaining patients’ health. Effective primary care is built on a continuous, trusting relationship between patients and their physician and care team. Primary care is frequently the first point of entry for patients in the health care system. Primary care clinicians can include family medicine physicians, general internists, pediatricians, nurse practitioners, and physician assistants, all of whom work alongside other team members. In certain cases, specialists such as gynecologists, geriatricians, cardiologists, and oncologists may also fill the role of a primary care provider. Primary care providers frequently help patients access secondary and tertiary levels of care delivered by subspecialists, coordinate the care patients receive from physical and behavioral health care providers, and connect patients to community services or resources that can support their health (Starfield, et al 2005).

Primary care is the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community.

-Institute of Medicine (1996)

Many definitions of primary care have been proposed, focusing on different attributes such as the care setting and the types of clinicians involved. One comprehensive definition, developed by the Institute of Medicine, characterizes primary care as having a number of key aspects (IOM, 1996). First, primary care is integrated and accessible. This means that the care provided in this context is not only comprehensive and coordinated but also ideally available to a large segment of the population. Second, primary care addresses a wide range of health problems, including acute and chronic illnesses and prevention services as well as other physical and behavioral health issues. Finally, primary care relies on clinicians developing a partnership with patients and their caregivers to work together to manage patient health, with the clinician responsible for the patient’s ongoing care. All these characteristics make primary care the foundation of an effective health care system. Practice facilitators are well-positioned to assist primary care practices in improving delivery of services in each of these areas.

Current Issues in Primary Care

In the past few decades, the U.S. health care system has seen increased demand for primary care services coupled with a shortage of primary care health professionals. Primary care physicians generally receive lower pay than specialist physicians; this has contributed to fewer physicians choosing to enter primary care than specialized fields. The United States will face a projected shortage of approximately 52,000 primary care physicians by 2025 (Pettersen, et al. 2012). At the same time, increases in health care coverage resulting from the Patient Protection and Affordable Care Act (also known as the Affordable Care Act or ACA) and an expanding and aging population will increase demand for primary care services. As a result, most primary care professionals face substantial time and cost pressures, potentially reducing their work satisfaction.

Primary care practices are also dealing with more patients with complex care needs, such as behavioral health issues and chronic illnesses. An estimated 117 million people, about half of all adults in the United States, have a chronic disease and many have more than one chronic illness (Ward, et al. 2014). Meeting the needs of these patients is a major challenge for primary care professionals. It requires a proactive model of care delivery that differs from the more reactive approach typically used in the past to manage patients with chronic conditions.

Given these challenges, payers, primary care professionals, policymakers, and others are recognizing the need for new models of care delivery that are more proactive and patient-centered and focus on managing care for all patients in the practice, not just those who make appointments. Some health plans and insurers are promoting models of high-performing primary care that encourage health care professionals to deliver more services, such as care management and care coordination, patient self-management support, integration with behavioral health care, and expanded access to care (including evening and weekend office visits and 24/7 availability of patient health records) by providing additional payments for these services. One of the most prominent new models is the patient-centered medical home (PCMH), which is built on the chronic care model of care ([see Module 25](#)). AHRQ defines the PCMH ([see http://www.pcmh.ahrq.gov/page/defining-pcmh](http://www.pcmh.ahrq.gov/page/defining-pcmh)), as encompassing five primary care functions.

- *Comprehensive care*, with the PCMH meeting the large majority of each patient's physical and mental health care needs
- *Patient-centered care*, which is relationship-based with an orientation toward the whole person
- *Coordinated care*, which includes coordination across all elements of the entire medical neighborhood
- *Accessible services*, which provide enhanced hours for office visits (such as evening or weekend hours), short wait times for urgent care appointments, and telephone or electronic access to providers around the clock
- *Quality and safety*, with the PCMH demonstrating an ongoing commitment to quality and quality improvement

These functions or attributes are intended to meet three aims: to improve the overall quality of care by making it more patient-centered, accessible, and safe; to improve the health of patients and, by extension, the health of the population; and to reduce the overall costs of care by improving coordination to reduce unnecessary services.

As described below, a number of initiatives and approaches that build on the PCMH are emerging that are intended to revitalize and strengthen primary care in the United States.

The new health policy landscape and approaches to primary care payment. It is important for practice facilitators to understand the policy context in which primary care practices function and their relationships with payers and insurers. You will need to stay on top of how both public programs (such as Medicare and State Medicaid programs) and private insurers are shaping the policy and payment context for primary care. For example, State-level decisions in the Medicaid programs can significantly affect this context and practice facilitators need to understand their State-level Medicaid system to fully support a primary care practice. These contextual factors shape a practice's approach to delivering care and its ability to implement transformational activities. Typically, primary care practices work on a low profit margin and rely on patient visit volume to meet payroll and other obligations. Therefore, practices can benefit tremendously from practice facilitator support as they work to increase capacity to meet patient needs in a challenging environment.

Health policy is constantly evolving, and it is helpful to stay attuned to new developments in primary care by visiting Web sites periodically and keeping up to date on the latest State and Federal legislation. Some helpful resources include:

- AHRQ's PCMH Resource Center: <http://www.pcmh.ahrq.gov/>
- Patient-Centered Primary Care Collaborative (PCPCC): <http://www.pcpcc.org/>
- Health Affairs primary care blog: <https://www.healthaffairs.org/topic/91>
- The Commonwealth Fund: <http://www.commonwealthfund.org>
- Robert Wood Johnson Foundation: <http://www.rwjf.org>
- Kaiser Family Foundation: <http://kff.org/>

Affordable Care Act. Signed into law in 2010, the ACA is among the most significant pieces of health care legislation in U.S. history and the culmination of many previous efforts at comprehensive national health care reform. There are a number of provisions in the ACA that are relevant to primary care. Perhaps the most important is the expansion of health insurance availability to many who previously did not have coverage. As previously uninsured or underinsured Americans gain health insurance coverage, more people will seek access to primary care services. Moreover, the ACA aims to decrease financial barriers to health coverage by eliminating co-payments for preventive health services and regulating insurance rate increases. In addition, the ACA allocates substantial funds to support primary care infrastructure in the United States, including provisions aimed at significantly increasing the number of primary care providers and expanding the primary care workforce. Table 3.1 summarizes the key provisions of the ACA relevant to primary care.

Table 3.1. ACA components related to primary care

Area	Description of ACA Provision	Possible Implications for Primary Care
Expanded and more affordable health insurance coverage.	Expansion of health insurance coverage to an additional 34 million people. Most plans required to cover preventive services free of charge.	Increased demand for primary care services.
Enhanced payment for primary care services.	Increases Medicaid payments for primary care services provided by primary care physicians for 2013 and 2014 to match Medicare reimbursement levels; provides value-based bonus payments in Medicare from 2011 through 2015.	Improved operating margins for primary care practices.
Improved support for primary care training.	Increases the number of residency and training positions for primary care. Implements community-based teaching health centers.	Increased numbers of primary care clinicians joining the workforce.
Support for Medicaid health homes.	Creates optional benefit for States to establish health homes to coordinate care for Medicaid recipients with chronic conditions.	Support for care management and care coordination.
Improved funding for medical students in primary care.	Expands availability of low-interest student loans and scholarships for medical students entering primary care. Improves State loan repayments programs.	Increased number of medical students choosing primary care.
Established the Center for Medicare and Medicaid Innovation.	Conducts demonstration and pilot projects aimed at improving the health care delivery system.	Development and testing of innovative care delivery and payment models in primary care.
Established the Patient-Centered Outcomes Research Institute.	Supports evidence-based comparative clinical effectiveness research.	New research to assist primary care providers and patients in making informed health care decisions.
Authorized the primary care extension program (not yet funded as of July 2015).	Assists primary care physicians with implementing PCMHs; develops primary care learning communities.	If funded, could contribute significantly to primary care transformation and dissemination of new evidence to practices.

Adapted from American Academy of Family Physicians. Primary Care in the Affordable Care Act.

<https://www.aafp.org/dam/AAFP/documents/advocacy/coverage/aca/ES-PrimaryCareACA-061311.pdf> .

Although the ACA includes provisions to build the primary care workforce, expanded health insurance coverage is also expected to increase the number of patients accessing primary care services. This means that practice facilitators must be prepared to support practices in meeting increased demand, potentially without significantly increased resources.

Below, we describe the key models of primary care delivery that have been emerging since the ACA. These models have the potential to significantly improve the way primary care is delivered by incentivizing high-value care and promoting integrated care and care coordination. For additional context, we begin by discussing the key payers, or health insurance providers, and health plans in the United States.

Public and private payers. The health insurance market can be categorized into public payers and private payers.

Public payers include, but are not limited to:

- **Medicare**, the federal health insurance program for people who are age 65 or older, certain non-elderly people with disabilities, and people with end-stage renal disease (permanent kidney failure requiring dialysis or a transplant, sometimes called ESRD).
- **Medicaid**, a Federal-State program that covers low-income children and some non-elderly low-income parents, low-income pregnant women, some individuals with disabilities, and some low-income seniors (in conjunction with Medicare).
- **The Children’s Health Insurance Program (CHIP)**, which provides health coverage to children in families who cannot afford private coverage, but who have incomes too high to qualify for Medicaid.
- **Tricare**, the Department of Defense program that provides health care coverage for military families and retirees.
- **Federally Qualified Health Centers (FQHCs)**, which are community-based health centers that provide health services to underserved populations. Although not technically a payer, FQHCs provide services to all individuals regardless of their insurance status. The ACA substantially increased federal funding to FQHCs.
- **The Indian Health Service and Veterans Health Administration** are responsible for providing health care to American Indians and Alaska Natives and to U.S. military veterans, respectively. While they are not payers, they are integrated health care delivery systems that deliver care to their target populations.

Private payers include insurance carriers that provide commercial plans (which are either sponsored by groups such as employers or associations or purchased by individuals), administrative services only (ASO) plans (in which an employer purchases only administrative services from the insurer and assumes all risk). In addition, some publicly funded health plans are administered by private health insurers such as Medicare Advantage, Medicaid Managed Care, and some plans for State employees and retirees.

How payers pay for care. Both public and private payers use a range of models to pay health care providers for services delivered. (Providers here can refer to individual health care professionals, practices, hospitals, systems, or other institutions.) A few of the most common payment mechanisms include:

- **Fee-for-service (FFS).** The provider is paid a pre-determined fee for each office visit, procedure, or service (such as a diagnostic test or imaging) that the patient receives.
- **Capitation payments.** The provider is paid a specific amount for each enrolled patient during the month or year (such as \$20 per member per month). The amount the provider receives is the same whether or not the patient seeks care.
- **Care management (or care coordination) fee.** In addition to the contracted FFS amounts, the provider is paid a per member per month fee for the other “non-code-related” services that enhance the value of care, such as self-management support, proactive outreach to address gaps in care, collaborating with specialists on care for a patient, or the costs of maintaining a registry and electronic health record.
- **Bundled payments.** The provider receives a single lump sum payment for each episode of illness or episode of care. For instance, providers may be paid a specific amount for all the care a patient receives in the course of treatment of a heart attack or knee fracture. Bundled payments can be viewed as a condition- or illness-specific capitation payment.

In some cases, payers use a combination of approaches, such as offering capitation payments for certain types of services but paying FFS for others. For example, they may make capitation payments for most of the care provided, but “carve out” certain types of specialty or behavioral health care and pay FFS for them. Similarly, payers may use FFS payments for most care while experimenting with bundled payments for a small number of selected conditions. Payers may also pay FFS for most or all services, but offer bonus payments for high-quality care (as measured through patient experience, claims-based quality measures, or other metrics). In addition, practices typically have patients covered by different payers, creating a complex web of incentives and compensation approaches that may affect how practices are able to make change and improve care for all their patients.

Managed care plans versus indemnity (FFS) plans. Private payers may organize themselves in several different ways to pay for patient care. Managed care organizations (MCOs) are health plans that contract with provider networks for the care of their enrolled members. There are three major types of managed care plans:

- Health maintenance organizations (HMOs)
- Preferred provider organizations (PPOs)
- Point-of-service plans (POS)

Historically, HMOs have most closely managed the care received by their patients (for example, sometimes requiring referrals or prior authorization for services and only paying for prescription drugs included on their formulary), whereas PPO and POS plans have allowed patients more flexibility (including seeing providers outside the network) and do not manage care as closely.

As managed care has evolved, however, the distinctions between these managed care plan types have become less clear. For example, HMOs of the past tended to pay primary care physicians a set amount for each member assigned to them each month regardless of the services each patient received. This meant that practices had to cover costs above any per-member-per-month payments. Today, PPO and POS plans may also bundle services into a single payment and then pay bonuses that reflect “shared savings” achieved by effective primary care management of a patient (that is, the primary care practice or clinician may receive a portion of any savings in health care costs, relative to some benchmark) over the course of a contract year.

In contrast to managed care plans, indemnity plans, which are sometimes called FFS plans, typically do not actively manage the delivery of care or contract with provider networks. Instead, they allow patients to choose whatever providers they like. The amount that the indemnity plan reimburses the provider may be less than billed charges, and the patient may have to pay the difference. Therefore, indemnity plans can expose patients to greater financial risk than managed care plans. Patients in POS plans may also face this greater financial risk since they may have to pay extra when they go out of network.

New care delivery models that promote primary care. In both the public and private spheres, care delivery models have emerged that emphasize the importance of primary care in delivering more efficient, high quality, patient-centered services. As discussed above, the patient-centered medical home is one of the most prominent approaches to improving primary care. In some PCMH initiatives, primary care practices may be tasked with achieving PCMH recognition or accreditation ([see Module 25](#)), whereas other PCMH initiatives may require practices to make specific changes in care delivery but not necessarily achieve a particular recognition or accreditation. These PCMH pilots, demonstrations, and initiatives take various approaches to payment reform. Although some pay nothing, most provide a per member per month payment in addition to traditional payments, and some provide an opportunity to share any resulting savings or provide bonuses for improved quality and patient experience. Payments are sometimes adjusted based on the risk level of the patient and the level of additional services provided or PCMH capabilities demonstrated by the practice.

Accountable care organizations (ACOs) are another model for improving care delivery. ACOs, which combine care delivery and payment reform, are networks of providers that deliver coordinated care to a defined group of patients and are financially accountable for the health of those patients. A key feature of this care delivery model is that providers and health systems, as opposed to insurance companies, become responsible for coordinating and managing care. The broad scope of ACOs potentially allows them to invest in primary care, patient self-management and care coordination, and reap the savings of decreased hospital admissions and readmissions and decreased emergency department use. (Edwards, et al. 2014). ACOs and PCMHs are not exclusionary models. Many ACOs use PCMHs to delivery primary care.

Demonstration programs are one way that the federal government experiments with new ways of organizing and paying for primary care. The Centers for Medicare & Medicaid Services (CMS) is conducting a number of demonstration programs related to primary care redesign. Two

prominent programs are the **Comprehensive Primary Care Initiative (CPCI) and the Multi-Payer Advanced Primary Care Practice (MAPCP) Demonstration**. As part of CPCI, participating practices receive bonus payments for providing improved care coordination, access, and care management for their patients and have an opportunity to share in Medicare cost savings. Each CPCI practice site provides services in the following areas: (1) risk-stratified care management, (2) access and continuity, (3) planned care for chronic conditions and preventive care, (4) patient and caregiver engagement, and (5) coordination of care. More than 2,300 providers are participating in the demonstration, serving approximately 2.6 million patients.

The MAPCP demonstration is a multipayer initiative sponsored by Medicare, Medicaid, and private health plans and implemented in eight States across the country. Its purpose is to evaluate the impact of the PCMH and changes in provider payments on improving quality of care and reducing costs. Participating practices receive a monthly care management fee to cover costs associated with services such as care coordination, patient education, and improved access.

Primary care payment reform. Payment reform goes hand in hand with these new care delivery models and is also of great interest to both public and private payers. For instance, several CMS demonstration programs focus on testing the development of innovative new payment models. Examples include the CPCI and MAPCP demonstrations discussed above, the Federally Qualified Health Center Advanced Primary Care Practice Demonstration and the Bundled Payment for Care Improvement Initiative. More information about these programs can be found on the [CMS Medicare Demonstration Projects](#) and the [Center for Medicare and Medicaid Innovation](#) Web sites.

In 2015, Medicare will begin to pay physicians for provision of chronic care management services. Eligible providers will receive a separate monthly payment of \$41.92 for each Medicare beneficiary with multiple significant chronic conditions. To qualify for this payment, physicians must provide 24/7 access to the chronic care management services, create a comprehensive care plan in collaboration with patients, enhance opportunities for patient-provider communication, and manage patients' transitions between care settings. Patients must agree to receive this service and will have to pay a copayment or deductible.

In addition, the Medicare value-based modifier (VBM) program rewards physicians based on provision of high-quality, low-cost care. The goal of the VBM, which is a provision of the ACA, is to encourage high-value health care by increasing or decreasing Medicare payments to providers based on their performance scores. This program is being rolled out to a limited set of providers in 2015 but is slated for widespread implementation in 2017.

In April 2015 the sustainable growth rate (SGR) formula was repealed. SGR was originally designed to counter increases in health care spending driven by fee-for-service with cuts in Medicare fees to all providers for all services. The new legislation replaces the SGR with an approach that encourages improving quality of care and supporting alternative payment models like ACOs and PCMHs. A central feature of the new model is a merit-based incentive payment

system (MIPS) that replaces three previous incentive programs. MIPS will be implemented in 2019.

Conclusion

Primary care is a central component in achieving improved health outcomes, controlling health care costs, and optimizing value in the health care system (Friedberg, et al, 2010). It is important for practice facilitators to understand the broader context, as well as State, regional, policy, and payment contexts in which their practices exist in order to help them meet the challenges of efficient and effective primary care delivery.

Resources

Primary care definitions and general information

- <https://www.aafp.org/about/policies/all/primary-care.html>
- <http://books.nap.edu/openbook.php?isbn=0309053994&page=27>
- <http://www.jhsph.edu/research/centers-and-institutes/johns-hopkins-primary-care-policy-center/definitions.html>
- <https://primarycare.hms.harvard.edu/news>

AHRQ Web sites

- <https://www.ahrq.gov/ncepcr/index.html>
- <http://www.pcmh.ahrq.gov>

Centers for Medicare & Medicaid Services

- <http://innovation.cms.gov/initiatives/comprehensive-primary-care-initiative/>
- <https://www.cms.gov/Medicare/Demonstration-Projects/DemoProjectsEvalRpts/>
- <http://innovation.cms.gov/>

Health Resources and Services Administration (HRSA)

- <http://bphc.hrsa.gov/>

Primary care associations and organizations

Listing of State primary care associations:

- <https://bphc.hrsa.gov/qualityimprovement/strategicpartnerships/ncapca/associations.html>

Listing of State primary care offices (typically housed in State departments of health):

- <https://bhw.hrsa.gov/shortage-designation/hpsa/primary-care-offices>

Behavioral health care in primary care

- <http://www.nimh.nih.gov/about/organization/dsir/services-research-and-epidemiology-branch/primary-care-research-program.shtml>
- <http://www.pcpcc.org/resource/behavioral-health-integration-pcmh>

Information on ACOs, primary care initiatives, and payment reform

- <https://www.aafp.org/family-physician/practice-and-career/delivery-payment-models/acos.html>
- <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ACO/index.html?redirect=/ACO>
- <http://www.kaiserhealthnews.org/stories/2011/january/13/aco-accountable-care-organization-faq.aspx>
- <http://www.chqpr.org/downloads/BuildingBlocksofSuccessfulPaymentReform.pdf>

Other resources and emerging trends in primary care

Coordinating care across the medical neighborhood:

- <http://pcmh.ahrq.gov/sites/default/files/attachments/Coordinating%20Care%20in%20the%20Medical%20Neighborhood.pdf>

Primary care extension:

- <http://healthextensiontoolkit.org/toolkit-modules/primary-care/>

Patient-Centered Primary Care Collaborative:

- <http://www.pcpcc.org/>

Robert Graham Center Community Oriented Primary Care Curriculum:

- <http://www.graham-center.org/online/graham/home/tools-resources/copc.html>

References

Edwards ST, Abrams MK, Baron RJ, et al. Structuring payment to medical homes after the affordable care act. *J Gen Intern Med.* 2014 Oct;29(10):1410-3.

Friedberg MW, Hussey PS, Schneider EC. Primary care: A critical review of the evidence on the quality and costs of health care. *Health Aff.* 2010; 29(5): 766-72.

Institute of Medicine Committee on the Future of Primary Care. *Primary Care: America's Health in a New Era.* Washington, DC: National Academy Press; 1996. <https://pubmed.ncbi.nlm.nih.gov/25121221/>.

Petterson SM, Liaw WR, Phillips RL Jr, et al. Projecting U.S. primary care physician workforce needs: 2010-2025. *Ann Fam Med.* 2012 Nov-Dec; 10(6):503-9.

Starfield B, Shi L, Macinko J. Contribution of primary care to health systems and health. *Milbank Q.* 2005;83(3):457-502.

Ward BW, Schiller JS, Goodman RA. Multiple chronic conditions among US adults: a 2012 update. *Prev Chronic Dis.* 2014;11:130389. DOI: https://www.cdc.gov/pcd/issues/2014/13_0389.htm.