COMMENTARY

Advancing Primary Care Through Alternative Payment Models: Lessons from the United States & Canada

Andrew Bazemore, MD, MPH, Robert L. Phillips, Jr., MD, MSPH, Richard Glazier, MD, MPH, and Joshua Tepper, MD, MPH

The United States and Canada share high costs, poor health system performance, and challenges to the transformation of primary care, in part due to the limitations of their fee-for-service payment models. Rapidly advancing alternative payment models (APMs) in both countries promise better support for the essential tasks of primary care. These include interdisciplinary teams, care coordination, self-management support, and ongoing communication. This article reviews learnings from a 2017 binational symposium of 150 experts in policy and research that included a discussion of ongoing APM experiments in the United States and Canada. Discussions ranged from APM challenges and successes to their real and potential impact on primary care. The gathering yielded many lessons for policy makers, payors, researchers, and providers. Experts lauded recent APM experimentation on both sides of the border, while cautioning against the risk of "pilotitis," or developing, implementing, and evaluating new payment models without plan or ability scale them into broader practice. Discussants highlighted the power of "learning at scale," highlighting large-scale primary care payment innovations launched by the US Center for Medicare and Medicaid Innovation since 2011, and called for a similar national center to drive innovation across provincial health systems in Canada. There was general consensus that altering payment models alone, absent incentives for innovation and continuous learning as well as increased proportional spending on primary care overall, would not correct health system deficiencies. Participants lamented the absence of more robust evaluation of APM successes and shortcomings, as well as more rapid release of results to accelerate further innovation. They also highlighted the importance of APMs that include flexible and upfront payments for primary care innovations, and which reward measuring and achieving global rather than intermediate outcomes, to achieve utilization goals and patient and provider satisfaction. (J Am Board Fam Med 2018;31:322–327.)

Near neighbors and sibling nations in history and trade, the United States and Canada also share a history of poor health system performance, resulting in part from the limitations of fee-for-service (FFS) payment.[1-6] Favoring volume over quality of care, such systems are also thought to limit primary care effectiveness, and have given rise to calls in both nations to move toward alternative payment models (APMs).[7-10] In March 2017, approximately 130 Canadian and US leaders from policy and academia assembled in Washington DC to discuss lessons in improving primary care effectiveness that might be disseminated across borders (See Appendix for Attendee list). The invitation-only gathering included provincial and state health ministers and leadership, academic and thought leaders, as well as leadership from many federal and provincial agencies that finance health care and evaluation in

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Corresponding author: Andrew Bazemore, 1133 Connecticut Ave NW, Washington DC 20036 (E-mail: policy@aafp.org).

both countries. Dyadic panel presentations featuring experts from both countries were followed by rich audience discussion, with taping and careful notetaking used post hoc by conference planners to thematically organize and distill seminal lessons for broader dissemination. The authors of this commentary specifically reviewed all notes from sessions on APMs, which revealed binational agreement on the importance of advancing APMs capable of improving primary care effectiveness. This article summarizes expert opinions on the current state of APMs in the United States and Canada, as well as key lessons and implications for policy makers, payors, researchers, and delivers with interest in supporting primary care to advance health in both nations.

Advancing Primary Care through APMs in Canada

Canadian provinces have primary responsibility for health care while the federal government plays a smaller role in funding and setting some national standards. In this regard, they have much more autonomy than do states in their neighbor to the south. This independence means that there are significant differences in how they operate, but improvement of primary care is a shared concern and the decentralized model has also allowed important innovations to develop. Alternatives to FFS payments rose from under 10% to nearly 30% of total clinical payments to physicians between the years 2000 and 2015, leading to innovations in team-based delivery.[11] Family Health Teams, for example, are largely funded through capitated advanced per patient payment for all services provided, and cover one quarter of the provincial population in Ontario.[3,4] Early returns on this innovative payment transition found shifts in proportional provincial spending on primary care, improved physician and team satisfaction, and improved processes of care, all without evidence of adverse impact on individual patient selection.[5,6]

In Ontario, payment reform has also been a key driver of empanelment, as capitation requires a defined group of patients for whom the practice is responsible. Having a defined population facilitates proactive approaches to preventive health care and chronic disease management including notifying patients of needed care, audit and feedback, and performance reporting.[11,12] Capitation allows providers to make greater use of virtual contacts through phone, e-mail, and videoconferencing. It also reduces the competition and disincentive to fully use other health care team members. Finally, capitation reduces the opportunity cost for participating in nondirect clinical care activities such as quality improvement activities, case conferences for complex patients and teaching. More than three quarters of Ontario primary care physicians practice in a model that features patient empanelment and blended capitation, albeit with only small capitation payments in some models.[7]

At the system level, Ontario's transformation remains incomplete as FFS continues to be a dominant payment model, interprofessional teams are unevenly distributed, and approximately one sixth of the population is left out of primary care reforms entirely.[11] As yet, Ontario's APMs have not been associated with improved timeliness of care, better equity, or cost savings. Other provinces have also implemented payment and organizational reforms. British Columbia has provided substantial chronic disease management payments for multi-morbid patients, while Alberta and Quebec have undertaken structural and team-based changes in the form of Primary Care Networks and Family Medicine Groups, respectively. These reforms have largely taken place without fundamental changes to physician FFS reimbursement and they have been associated with mixed findings with regard to better quality care and little evidence of health system cost savings.[13] While Canadian APM and team reforms have been key to attracting providers, growing the size and diversity of the primary care workforce, and averting a health human resource crisis in primary care, their measurable health system impacts have been limited.

Advancing Primary Care through APMs in the United States

Recognition of the limitations of pure FFS in the United States is hardly new. Reforms in the 1980 seconds created the Diagnosis Related Grouping system to simplify and streamline hospital payments and the 1990s and early 2000s saw attempts to refine physician payments via the Resource Based Relative Value System and Sustainable Growth Rate.[3] These programs failed to generate "sustainable growth" while radically growing the specialty to primary care income gap.[14] More recently, the passage of the Affordable Care Act in 2010 ushered in unprecedented

experimentation with APMs among private, federal, and state payors.[15,16] APM Implementation pilot programs impacting primary care have been developed within existing programs, both traditional FFS and managed care, in an attempt to move from volume-based to value-based care delivery.[17,18]

There is evidence that high-functioning APMs already in existence, or as part of recent demonstrations, put more resources into primary care.[8,9] However, movement toward APMs at the health system level does not always change the FFS payment model for primary care practices. Some large hospital systems that own practices may receive capitated payments for the care of a population while continuing to reward their providers and practices principally for services rendered (FFS) more than for value received. As such, the mixed early returns in evaluations of the US Accountable Care Organization (ACO) experiment, which offering global payments and potential "shared savings" to taking care of groups of Medicare beneficiaries.[19] Symposium experts suggested that ACO savings were significantly greater among ACOs that were independent, primary care-driven, and risk-bearing, perhaps due to their greater leverage over cost control and diminished FFS incentives. Panelists and reactors noted that powerful variation in this and other US payment experiments over recent years belies a continued lack of understanding of the value of primary care to population health in value-based payment models. They also noted the failure of APMs as a cost-bending panacea absent additional levers. For example, it was noted that primary care physicians anchoring the ACO and other shared savings and capitated payment innovations frequent lack levers to influence their patients' health costs beyond their clinic walls absent additional incentives shaping hospital and specialist behaviors. Attendees also noted that new APM investments in primary care are not always sufficient to enable robust primary care, particularly when they do not offer upfront financial support for practice transformation but burden practices with inflated expectations and measurement requirements.

Experts and discussants alike celebrated recent US efforts in the United States to "learn at scale" about advancing primary care through APM experimentation. At the state level, Rhode Island was noted to have phased in a near doubling of payor spending on primary care between 2007 and 2012.[20] The State Commissioner of Health estimates that a 43% increase in primary care spending ($18 million more annually) was associated with a 14% reduction in total spending ($115 million reduction annually)—a more than 6-fold return on investment.[21] Illinois did not mandate a primary care increase, but between 2006 and 2010, Medicaid increased primary care funding by more than 30%. Over that period, the state saw total spending for the Medicaid population fall by nearly the same percentage, also a multi-fold reduction in total spending.[22] Oregon, compelled by Rhode Island's results, recently legislated a similar increase in primary care spending by all payors.[23] There is an ongoing need to evaluate US APMs with an understanding about how they support primary care.

In addition lauded were large-scaled payment & delivery experiments enabled under the Affordable Care Act creation of the Center for Medicare and Medicaid Innovation (CMMI). Their efforts helped the of the outgoing administration achieve a goal by late 2016 of having 30% of traditional Medicare payments now flow through APMs, versus essentially none in 2010.[15] Early returns for these grand primary care experiments have been mixed, with some states in the Multi-Payer Advance Primary Care Practice Demonstration showing positive savings and others none.[24] Similarly, the multistate, multipayor Comprehensive Primary Care Initiative revealed progress in transforming primary care delivery and generating positive provider/payor feedback, while failing to demonstrate significant savings in expenditures or quality by the end of second and third year reporting.[25] This outcome was felt to be promising enough to support a Comprehensive Primary Care Plus (CPC+), which offers primary care practices in 18 states or regions a risk-adjusted, monthly Care Management Fee and a Performance-Based Incentive Payment, in addition to traditional FFS. CPC+ also supports practice transformation with the goal of enhancing key comprehensive primary care functions: 1) access and continuity, 2) care management, 3) comprehensiveness and coordination, 4) patient and caregiver engagement, and 5) planned care and population health.[26]

Lessons from the Binational Symposium for Policy Makers, Payors, Researchers, and Practitioners

A number of essential themes and conclusions emerged from the Symposium, which we have

Table 1. Conference Lessons on Alternative Payment Model (APMs)

Lessons for policymakers	APMs are falsely promoted as a panacea for health system problems. They should instead be seen as kindling for ongoing primary care innovation within a continuous learning health system.
	Regardless of the APM chosen, overall spending on primary care must increase to achieve health system aims.
Lessons for payors	The small-scale and unsustainable design of many APM pilot programs creates payor "pilotitis." Both countries must foster "learning at scale," as demonstrated in the US CPCI.
	Canada needs an innovation center like the US' CMMI to foster and evaluate scaled payment experiments across a provincial delivery models.
Lessons for researchers	We need more robust evaluation released more rapidly, with stronger comparison groups, and increased transparency of results.
	We need evaluations of how APMs promote or inhibit health equity. For example, how can we adjust for variation in SDoH without excusing poor quality?
Lessons for providers	APMs that promote flexibility and pursuit of end outcomes over process measures increase both patient satisfaction & primary care provider wellness.
	Practices cannot bear all transformation risk, and require prospective, preferably population-based payment, i.e. capitated or blended payment.

CMMI, Center for Medicare and Medicaid Innovations; CPCI, Comprehensive Primary Care Initiative SDoH, Social Determinants of Health.

parsed according to stakeholder audience in Table 1. Discussants offered clear enthusiasm for APM experimentation in the United States and Canada, and its promise for advancing primary care, but cautioned **policy makers** that shifting toward APMs alone would fail to capture the positive primary care effect on creating healthy populations, satisfied patients and lower costs (the US "Triple Aim"). Many suggested that increasing overall spending on primary care was far more important than any of the payment experiments underway.

Payors were reminded that both the United States and Canada have learned from but also suffered an epidemic of small payment demonstration projects that were designed neither for sustainability nor scaling up at a health system level. This condition was pejoratively labeled "pilotitis" by 1 panelist, who noted this to be a particularly concerning problem in Canada. Admiration for the seminal efforts of the US CMMI in driving payment innovations was widely shared among expert discussants from both nations, who called for continuing to "learn at scale" and to grow investment in APMs. One bold proposal that resonated widely among attendees called for Canada to create its own CMMI as a remedy to its epidemic "pilotitis." Attendees noted that a Canadian Innovation Center could draw on lessons learned from its successful US counterpart, while having data and structural advantages of the single-payor provincial health system to allow successful interventions to scale up even faster than in the United States.

Researchers were challenged by attendees to craft more robust methods of evaluation for the growing array of large APM innovations. There were repeated calls to improve methods for crafting better comparison groups that could overcome the challenge of detecting outcome changes, given the "pollution" and "spillover" effects from intervention to control practices inherent in large-scale payment experiments such as the US Comprehensive Primary Care Initiative. Attendees also noted the critical need to better understand how APMs can best serve health equity across US and Canadian populations. Calls were repeated throughout the symposium for evaluations of best practices in adjustment of payments to accommodate social determinants of health without excusing poor quality for vulnerable populations.

Discussants repeatedly highlighted the potential importance APMs to reducing provider burnout and returning "joy in practice" to primary care, a finding of considerable importance to **providers and delivery systems**. Attendees on both sides of the border connected best practices in APM global payments and increased flexibility in care delivery to reductions in administrative burden, enhanced team function, and less provider burnout. They also noted the absence of these connections in peer-reviewed literature, and called for richer evaluations of APM impact on these outcomes. Others noted the need for population health or risk-based payment models to accommodate primary care practices' perpetually thin financial margins and the

restrictions these place on meaningful and radical transformation. One presenter noted that, absent at least some degree of upfront payment, ongoing transformation becomes impossible, and evolving practices remain in jeopardy of closing as the result of one bad risk-bearing contract or contract year.

Conclusions

Both Canada and the United States continue to struggle to build high-performing primary care systems despite evidence suggesting their importance, the collective investment of billions in health system innovation and improvement, and a particular Canadian focus specifically on primary care reform.[28] These efforts have included shifts away from pure FFS, which can create perverse incentives and serves as a barrier to adoption of best practices. However, it remains the predominant payment model in both the United States and Canada.

Experts at a binational discussion of APMs reminded us that further moves away from FFS will require addressing several barriers including physician concern over loss of autonomy and control in a FFS model and concerns over the limits in capitation or other funding models to recognize patient complexity or heterogeneity. They also highlighted the need, regardless of APM chosen, to increase total spending on primary care and to incentivize primary care innovation explicitly. Given repeated calls for larger payor experiments, it will be important to follow innovations at the state and provincial level, which might be scalable across other states and provinces. For example, Ontario has made major new investments in Primary Care,[21] and in the United States, Rhode Island created a requirement that its insurers demonstrate that primary care received at least 10.5% of total expenditures, doubling what was spent previously. In Canada, these might be best facilitated by a Canadian innovation center modeled after CMMI. Such a center might help its US counterpart to advance desperately needed large pilot program evaluation methods, including how best to understand program impact and against what comparison or counterfactual groups. They might also track where resistance to change may occur when shifts in payment models creates winners and losers, and our understanding of ideal "pacing" of implementation and reform, and even how we might redress the rate of actual and perceived loss of market share, income, and autonomy. Finally, richer research into how varying APM pilot programs impact provider burnout and wellness, and enhance patient satisfaction are critically needed.

Although critical, symposium discussions reminded us that payment reform through APMs remains just one dimension of comprehensive primary care reform. Work remains to envision the future of primary care. Despite promotion of the Primary Care Medical Home and its variations, the model still needs to be embedded in broader system reform, and better integrated with hospitals, home, and community services. Or perhaps, as proposed in this conference, it is time to reverse a quintessential US tendency to view hospitals as the place where health systems make the bulk of their revenue, often taking if not negotiating losses in primary care, whose function is largely to feed patients to hospital-based services. There is also increasing recognition in both countries that health care has been a drain on social services and it may be time to invest health care resources in other parts of society outside of health that strongly influence health outcomes such as education, job programs, and housing stability. Ultimately, to improve health care and health outcomes in a sustainable way, it will be necessary to make primary care the center of the health care system, invest in it adequately, and organize and pay for it deliberately to align incentives, support teams, foster innovation, and provide "joy" in practice.

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APPENDIX: Cross-National Symposium Attendees

First Name	Last Name	Job Title	Institutional Affiliation:	Country	State or Province
Richard	Allman	Chief Consultanta, Geriatrics and Extended Care	Department of Veterans Affairs	United States	District of Columbia
Sharon	Arnold	Acting Director, AHRQ	AHRQ	United States	Maryland
Kris	Aubrey-Bassler	Director, Primary Healthcare Research Unit	Memorial University	Canada	Newfoundland and Labrador
Bruce	Bagley	Senior Advisor to AMA	AMA	United States	Illinois
Elizabeth	Bayliss	Director	Kaiser Permanente Institute for Health Research	United States	Colorado
Andrew	Bazemore	Director	Robert Graham Center for Policy Studies, AAFP	United States	District of Columbia
Marie-Dominique	Beaulieu	Professor, Family Medicine Department, Univ. Montréal, Scientific Director of the Quebec SPOR SUPPORT Unit	Université de Montréal	Canada	Quebec
Robert	Berenson	Institute Fellow	the Urban Institute	United States	
Onil	Bhattacharyya	Frigon-Blau Chair in Family Medicine Research	Women's College Hospital	Canada	Ontario
Arlene	Bierman	Director, Center for Evidence and Practice Improvement	AHRQ	United States	Maryland
Andy	Bindman	Professor	University of California San Francisco	United States	California
Richard	Birtwhistle	Director Centre for Studies in Primary Care	Department of Family Medicine Queen's University	Canada	Ontario
Caroline	Blaum	Diane and Arthur Belfer Professor of Geriatrics; Director, Division of Geriatric Medicine and Palliative Care	NYU School of Medicine	United States	New York
Luc	Boileau	President and Chief Executive Officer	Institute for Clinical Excellence in Health and Social Services (Québec-Canada)	Canada	Quebec
Fred	Burge	Professor, Family Medicine	Dalhousie University	Canada	Nova Scotia
June	Carroll	Clinician Scientist	University of Toronto	Canada	Ontario
Michelle	Carroll	RN Nursing Supervisor	All Nations Healing Hospital, Fort Qu'Appelle, Sk.	Canada	Saskatchewan
Christine	Chang	Associate Director, AHRQ EPC Program	Agency for Healthcare Research and Quality	United States	Maryland
Susan	Chatwood	Executive and Scientific Director	Institute for Circumpolar Health Research	Canada	Northwest Territories
Candice	Chen	Director, Division of Medicine & Dentistry	HRSA	United States	Maryland

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First Name	Last Name	Job Title	Institutional Affiliation:	Country	State or Province
Marshall	Chin	Professor of Healthcare Ethics in the Department of Medicine	University of Chicago	United States	Illinois
Patrick	Conway	Acting Administrator, Centers for Medicare and Medicaid Services	Centers for Medicare and Medicaid Services	United States	Maryland
Dayna	Cooper	Director, Home and Community Care	Department of Veteran Affairs	United States	District of Columbia
Debbie	DeLancey	Deputy Minister	Health and social services	Canada	Northwest Territories
Jen	DeVoe	Professor and Chair	Oregon Health & Science University	United States	Oregon
Patrick	Dicerni	Assistant Deputy Minister	Ministry of Health and Long-Term Care	Canada	Ontario
Perry	Dickinson	Professor	University of Colorado, Department of Family Medicine	United States	Colorado
Kristen	Dillon	Director, Gorge Coordinated Care Organization	PacificSource Health Plans	United States	Oregon
Brent	Diverty	Vice-President, Programs	CIHI	Canada	Ontario
Erica	Dobson	Associate, Major Initiatives	Canadian Institutes of Health Research	Canada	Ontario
Shelley	Doucet	Professor and Research Chair in Interprofessional Patient-Centred Care	UNB Saint John	Canada	
Elizabeth	Drake	Advisor, Knowledge Translation	Canadian Institutes of Health Research	Canada	Ontario
Karen	Earnshaw	Vice Presiden–Integrated Health Service	None	Canada	Saskatchewan
Susan	Edgman-Levitan	Executive Director	Massachusetts General Hospital Stoeckle Center for Primary Care Innovation	United States	Massachusetts
Carolyn (Lynn)	Edwards	Senior Director	Provincial Primary Health Care	Canada	Nova Scotia
Bernard	Ewigman	Chairman	University of Chicago	United States	
Sarah	Fielden	Senior manager, evaluation	Doctors of BC	Canada	British Columbia
Jonathan	Foley	Member and Co-Founder, Westcott Partners, LLC	Westcott Partners, LLC	United States	Maryland
Diane	Forbes	Director, Strategic Operations CIHR-ICRH	Canadian Institutes of Health Research	Canada	Alberta
Martin	Fortin	Professor / Family Physician	Université de Sherbrooke	Canada	Quebec
Barbara	Foster	A/Manager–Crossing Cutting Division, Health Canada	government	Canada	Ontario
José	Francois	Head, Department of Family Medicine	University of Manitoba	Canada	Manitoba
Ted	Ganiats	Senior Staff Fellow	AHRQ	United States	Maryland

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First Name	Last Name	Job Title	Institutional Affiliation:	Country	State or Province
Frank	Gavin	Board Member	Ontario SPOR Support Unit	Canada	Ontario
Lauren	Gerlach	Senior Manager	AcademyHealth	United States	District of Columbia
Rick	Glazier	Senior Scientist	Institute for Clinical Evaluative Sciences	Canada	Ontario
Michael	Gluck	Senior Director	Academyhealth	United States	District of Columbia
Stephanie	Gold	Scholar	Eugene S. Farley, Jr. Health Policy Center	United States	Colorado
Michael	Green	Associate Professor	Queen's University	Canada	Ontario
Antoine	Groulx	Deputy General Director, Health Services And University Affairs	Ministry of health and social services	Canada	Quebec
Eva	Grunfeld	Vice Chair (Research) and Physician Scientist	University of Toronto	Canada	Ontario
Jeannie	Haggerty	Professor	McGill University	Canada	Quebec
Sara	Harbord	Project Lead	Canadian Institutes of Health Research	Canada	Ontario
Anne	Hayes	Director, Research, Analysis and Evaluation Branch	Ministry of Health and Long-term Care	Canada	Ontario
Brenda	Hefford	Executive Director, Community Practice Quality and Integration	Doctors of BC	Canada	
William	Hogg	Family Physician	Department of Family Medicine, University of Ottawa	Canada	Ontario
Rhonda	Hogg	Executive Director, Finance	Manitoba Health, Seniors and Active Living	Canada	Manitoba
Lauren	Hughes	Deputy Secretary for Health Innovation	Pennsylvania Department of Health	United States	Pennsylvania
Zeena	Johar	Research Fellow	Duke Margolis Center for Health Policy	United States	District of Columbia
Sharon	Johnston	Family Physician	University of Ottawa	Canada	Ontario
Janusz	Kaczorowski	Professor and Research Director	Université de Montréal and CRCHUM	Canada	Quebec
Alan	Katz	Professor Community Health Sciences and Family Medicine	Manitoba centre for Health policy	Canada	Manitoba
David	Keahey	Chief Policy and Research Officer	Physician Assistant Education Association	United States	Virginia
Ali	Khan	Regional Medical Officer, Northern California/Bay Area	CareMore	United States	California

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First Name	Last Name	Job Title	Institutional Affiliation:	Country	State or Province
Meredith	Kratzmann	Senior Project Officer	CIHR–Institute of Health Services and Policy Research	Canada	Ontario
Anton	Kuzel	Chair, VCU Department of Family Medicine and Population Health	Virginia Commonwealth University	United States	Virginia
Maryjoan	Ladden	Senior Program Officer	RWJF	United States	New Jersey
France	Légaré	Professor	Université Laval	Canada	Quebec
Francine	Lemire	CEO and Executive Director	The College of Family Physicians of Canada	Canada	Ontario
Evelyn	Lewis&Clark	Chief Medical Officer Warrior Centric Health, LLC	AAFP	United States	Georgia
Winston	Liaw	Medical Director	Graham Center	United States	Virginia
Clare	Liddy	Associate Professor, Family Medicine	Bruyere Research Institute, University Ottawa	Canada	Ontario
Anne	Lyddiatt	Consumer/Patient	CIHR SPOR	Canada	Ontario
Gregory	Marchildon	Professor	University of Toronto	Canada	
Nancy	Mason MacLellan	Manager, Major Initiatives	Canadian Institutes of Health Research	Canada	Ontario
Michael	McGinnis	Leonard D. Schaeffer Executive Officer	National Academy of Medicine	United States	District of Columbia
Bob	McNellis	Senior Advisor for Primary Care	AHRQ	United States	Maryland
Patricia (Patty)	Menard	Chief	Department of Family Practice	Canada	Nova Scotia
David	Meyers	Chief Medical Officer	AHRQ	United States	Maryland
Therese	Miller	Deputy Director, Center for Evidence and Practice Improvement	AHRQ	United States	Maryland
Justin	Mills	Medical Officer	AHRQ	United States	District of Columbia
William	Montelpare	Professor, Margaret & Wallace McCain Chair in Human Development and Health	University of PEI	Canada	Prince Edward Island
Nazeem	Muhajarine	Professor	U of Saskatchewan	Canada	Saskatchewan
Tim	Murphy	VP Platforms and SPOR	Health	Canada	Alberta
Heather	Mustoe	Associate	Canadian Institutes of Health Research	Canada	Ontario
Jessica	Nadigel	Assistant Director	CIHR-Institute of Health Services and Policy Research	Canada	Quebec
Cordell	Neudorf	Chief Medical Health Officer	Saskatoon Health Region	Canada	Saskatchewan
Tom	Noseworthy	Professor	Cumming School of Medicine, University of Calgary	Canada	Alberta

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APPENDIX: Continued

First Name	Last Name	Job Title	Institutional Affiliation:	Country	State or Province
Maeve	O'Beirne	Director Patient's Medical Home	Department of Family Medicine, University of Calgary	Canada	Alberta
Jose	Pereira	Director, Research	The College of Family Physicians of Canada	Canada	Ontario
Nav	Persaud	Assistant Professor & Staff Physician	University of Toronto & St Michael's Hospital	Canada	Ontario
Hoangmai	Pham	Senior Fellow	Duke Robert Margolis Center for Health Policy	United States	District of Columbia
Jenny	Ploeg	Professor, School of Nursing	McMaster University	Canada	Ontario
Maria	Portela	Branch Chief Medical Training and Geriatrics	HHS	United States	District of Columbia
David	Price	Professor and Chair, Department of Family Medicine	McMaster University	Canada	
Kalpana	Ramiah	Director of Research	America's Essential Hospitals	United States	District of Columbia
Vivian	Ramsden	Professor and Director, Research Division	Department of Family Medicine, University of Saskatchewan	Canada	Saskatchewan
Robert	Reid	Chief Scientist, Institute for Better Health and Senior Vice President, Science, Trillium Health Partners	Trillium Health Partners–Institute for Better Health	Canada	
Richard	Ricciardi	Director, Division of Practice Improvement - AHRQ	AHRQ	United States	Maryland
Eugene	Rich	Director, Center on Health Care Effectiveness	Mathematica Policy Research	United States	Maryland
Nancy	Roberts	Executive Director–Primary Health Care	New Brunswick Department of Health	Canada	New Brunswick
Brian	Rowe	Scientific Director, ICRH; Professor, University of Alberta	University of Alberta	Canada	Alberta
Denis	Roy	VP, Science and Clinical Governance, INESSS, QC	INESSS (Institut National D'excellence en Santé et Services Sociaux)	Canada	Quebec
Lisa	Rubenstein	Professor of Medicine and Public Health, VA Greater Los Angeles and UCLA	US Department of Veterans Affairs	United States	California
Robert	Saunders	Research Director	Duke-Margolis Center for Health Policy	United States	District of Columbia
Michael	Schull	President and CEO	Institute for Clinical Evaluative Sciences	Canada	Ontario

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APPENDIX: Continued

First Name	Last Name	Job Title	Institutional Affiliation:	Country	State or Province
Annette	Schultz	Associate Professor, Research Lead Manitoba PICHI Network	College of Nursing, Rady Faculty of Health Sciences, University of Manitoba	Canada	Manitoba
Laura	Sessums	Director, Division of Advanced Primary Care	Center for Medicare and Medicaid Innovation	United States	District of Columbia
Alyssa	Shell	Resident Physician	American Board of Family Medicine	United States	North Carolina
Scott	Shipman	Director of Primary Care and Workforce Analysis	Association of American Medical Colleges	United States	District of Columbia
Judith	Steinberg	Chief Medical Officer, Bureau of Primary Health Care	Health Resources and Services Administration	United States	Maryland
Moira	Stewart	Distinguished University Professor	Department of Family Medicine, Western University	Canada	Ontario
Robyn	Tamblyn	Scientific Director	CIHR-Institute of Health Services and Policy Research	Canada	Ontario
Joshua	Tepper	President & CEO	Health Quality Ontario	Canada	Ontario
Marcia	Thomson	Assistant Deputy Minister	Manitoba Health	Canada	Manitoba
Andrea	Thoumi	Managing Associate	Duke University–Margolis Center for Health Policy	United States	District of Columbia
Barbara	Tobias	Vice Chair	UC Dept Family and Community Medicine	United States	Ohio
Michael	Tuggy	Vice Chair, FMAH Health	FMA Health	United States	Washington
Jeffrey	Turnbull	Chief Clinical Quality/Chief of Staff	Health Quality Ontario/The Ottawa Hospital	Canada	Ontario
Doug	Tynan	Director of Integrated Health Care	American Psychological Association	United States	Delaware
Uche S.	Uchendu	Chief Officer, US Dept. of Veterans Affairs, Office of Health Equity	United States Department of Veterans Affairs	United States	District of Columbia
Ross	Upshur	Professor	University of Toronto	Canada	Ontario
Stephen	Vail	Director, Policy	Canadian Medical Association	Canada	Ontario
Kate	Vickery	Clinician-Investigator	Hennepin County Medical Center	United States	Minnesota
Eric	Weil	Chief Medical Officer, Primary Care, Partners Healthcare	Center for Population Health, Partners Healthcare	United States	Massachusetts
David	White	President	The College of Family Physicians of Canada	Canada	Ontario

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First Name	Last Name	Job Title	Institutional Affiliation:	Country	State or Province
Shanita	Williams	Deputy Director	Health Resources and Services Administration	United States	Maryland
Walter	Wodchis	Associate Professor	University of Toronto	Canada	Ontario
Sabrina	Wong	Professor	University of British Columbia	Canada	British Columbia
Kue	Young	Dean and Professor	School of Public Health, University of Alberta	Canada	Alberta
Judy	Zerzan	Chief Medical Officer	Colorado Dept. of Health Care Policy and Financing	United States	Colorado

AAFP, American Academy of Family Physicians; AHRQ, Agency for Health Research & Quality; AMA, American Medical Association; BC, British Columbia; CEO, Chief Executive Officer; CRCHUM, Centre de recherche du Centre hospitalier de l'Université de Montréal; CIHR-ICHR, Canadian Institutes of Health - Institute of Circulatory and Respiratory Health; EPC, ; FMAH, Family Medicine for America's Health; FMA, Family Medicine for America's; HHS, Health and Human Services; HRSA, Health Resources and Services Administration; ICRH, Institute of Circulatory and Respiratory Health; INESSS, Institut national d'excellence en santé et en services sociaux; NYU, New York University; PEI, Prince Edward Island; PICHI, Primary and Integrated Health Care Innovations; QC, Queens College; RN, Registered Nurse; SPOR, Strategy for Patient-Oriented Research; UC, University of Cincinnati; UCLA, University of California, Los Angeles; UNB, University of New Brunswick; VCU, Virginia Commonwealth University; VP, Vice President.