Despite the creation of bureaucratic organizations and numerous National Academy of Medicine documents, it is worth reconsidering the entire pay-for-quality scheme in primary care. Reconceptualizing around known dynamics of complex systems is probably a good place to start. First, at best, one can achieve 2 out of 3 of the ideal characteristics of high quality, low cost, and timely information. At present, we would venture that most primary care clinicians would rate quality metrics as achieving between 0 and 1 out of 3. Second, a much greater appreciation for Goodhart's Law—when a metric becomes a target, it ceases to be a good metric—would do a lot to improve the system. Additionally, in the unpredictable complex systems in which we work, much greater focus should be placed on high-quality evaluation of metrics before and following implementation (more cluster randomized controlled trials). If and when pay-for-quality metrics are found to have small influences on care, become obsolete, or detract from care; they should be promptly de-implemented. It is also important to highlight that the alternative to decreasing the importance of pay-for-performance should not be an abandonment of quality reporting, but the removal (or re-working) of incentives. We'd recommend refocusing incentives to those that are impactful, time limited, low cost, and physician controlled. Otherwise, our fear is that the pay-for-performance models will continue to add administrative work to primary care clinicians that will further overburden the system with administrative care and unrecognized costs that further degrade primary care's value to the medical care system.

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Key words: clinician experience; dynamics of complex systems; performance-based reimbursement; primary care; quality metrics

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CORRECTIONS

Ann Fam Med 2025;23:92. https://doi.org/10.1370/afm.250065

Barry MJ, Wolff TA, Pbert L, et al. Putting evidence into practice: an update on the US Preventive Services Task Force methods for developing recommendations for preventive services. *Ann Fam Med*. 2023;21(2):165. doi:10.1370/afm.2946 contains an error in Figure 2. In the figure, step 3 looks at the relationship between screening and intermediate outcomes, and step 4 looks at the relationship between treatment and early detection. Thus, the boxes "intermediate outcomes" and "early detection" should be reversed. The error occurred during layout for publication and *Annals of Family Medicine* regrets the error. The figure is now correct in the online version of the article.

Ann Fam Med 2025;23:92. https://doi.org/10.1370/afm.250067

In **Menchaca JT. For AI in primary care, start with the problem. *Ann Fam Med*. 2025;23(1):5-6. doi:10.1370/afm.240504**, references 6 and 7 were listed incorrectly and should be as follows:

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The publisher regrets the errors. The online version of the article is now correct.