Primary Care's Critical Role in Advancing Health Equity

Mathematica Webinar

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Transcript

[[Chris Talbot] Hello and welcome to today's Primary Care's Critical Role in Advancing Health Equity. My name is Chris Talbot, and I'll be your technical host for today's event. Before we get started, I wanted to cover a few logistics items for you. First off, for audio for today's event, it's available via your computer speakers or by your phone. If you are having difficulty listening via computer speakers, you can switch to the telephone by using the menu at the bottom of your screen and selecting "Switch Audio." Use the "Call Me" app feature, where you can enter your phone number, and the platform will call you directly.

We will be having questions for the audience today, coming in through our Q&A feature, which you'll find in the lower right-hand corner of your screen. You'll see three dots in the lower right-hand corner, then you can select Q&A. When you are sending a question, please select "All Panelists" in the "Ask" field. If you are having technical difficulties with the platform, you can reach out to me directly by using the chat feature, which is also available in the lower right-hand corner of your console. Please select the "Host" as recipient, and I will work to resolve any technical issues you might come across.

Closed captioning for today is available using the CC icon in the lower left-hand corner of your webinar module. The slides and panel bios for today's event are available for download and the link for those materials will be available shortly in the chat. At this point, I'm going to turn things over to Diane Rittenhouse, who is going to head off our discussion today. Diane, the floor is yours.

[Diane Rittenhouse] Hi. I'm Diane Rittenhouse, a family physician and senior fellow at Mathematica, and I'm pleased to welcome you to this webinar today, where we're going to discuss primary care's critical role in advancing health equity.

We're going to start with some introductions, and then I'm going to talk about a new report that's going to be available today on primary care and health equity. We'll review some background definitions of primary care and health equity just to do a little bit of level setting for the group, and then we're going to talk about the evidence that links primary care to advancing health equity and talk about some example opportunities to strengthen primary care and advance health equity. Then we're going to move, in the next thirty minutes, to panel discussion, where we'll have a conversation among our panelists, and then the last thirty minutes will be a question-and-answer session. Our panel discussion will be informed by questions that were sent in advance by registrants, and our question-and-answer period will accept live questions that you post during the webinar. Next slide.

So, I want to start by introducing my esteemed colleagues. I'm very honored to have such a great panel today. First, we have Sinsi Hernández-Cancio, who is the Vice President for Health Justice at the National Partnership for Women and Families. We have Mai Pham, who is President of the Institute for Exceptional Care. We have Kathryn Phillips, who is the Associate Director for Improving Access at the California Health Care Foundation. And with us today, we have the senior advisor to the Assistant Secretary for Health in the U. S. Department of Health and Human Services, Judith Steinberg. Next slide, please.

So, I'm going to start the discussion with an introduction to this report, which will be available later today. It's called "Primary Care's Essential Role in Advancing Health Equity for California," so it's a California-specific report. But we find that many of the things that we learned in putting this report together are relevant to a national audience. So, our webinar today definitely has gone out to a national audience, and we appreciate everyone's participation from across the country.

My co-authors are Ann O'Malley and Deliya Wesley from Mathematica, Rishi Manchanda, who is the CEO at Health Begins, and Alexandra Ament and Jan Genevro, who are both independent consultants who worked closely with us on this report.

We had two goals with the report. One was to summarize research, really put in one place all of the research that links primary care to health equity. And then the other goal was to identify specific opportunities for both strengthening primary care and centering health equity within primary care, and that, again, was specific to California, but we'll talk about the relevance for the nation. And were funded by the California Health Care Foundation to produce this report, and it will be available later today on their website. Next slide, please.

On the left-hand side, you can see our advisors. We had a national and really international group of advisors that participated throughout the process of producing this report, and then we had, in the right two columns, a number of reactors who reviewed an early version of the report and really gave us substantive feedback and helped shape what the final report looked like.

So, we would be remiss in talking about primary care and health equity if we didn't provide some definitions of both. So let's talk, first, about high-quality primary care. When we talk about high-quality primary care, what are we talking about? Let's talk, first, about who delivers primary care. So, primary care is delivered by physicians who are trained in generalist specialties, so specialties that think about the entire person, such as family medicine, general pediatrics, general internal medicine, and geriatrics. It's also delivered by nurse practitioners who are trained in family, gerontological, and pediatric care.

So, this is very different than going through training focused on a single-body system or a single-disease process. We think generally about the patient in the context of their family, and in the context of their community. And depending on where you seek primary care, you will run into a variety of members of the primary care team, which can include nurses, physician assistants, medical assistants, community health workers, behavioral health counselors, social workers, pharmacists, et cetera, that are all key to helping deliver care for the whole person. Next slide.

So, the definition that we used for the study is really based on Barbara Starfield’s Seminal work. We already talked about taking the whole person orientation. Some other elements that are unique to primary care that make it different from specialty care, primary care is the first point of contact for a person experiencing new symptoms or concerns. So, you don't have to have a diagnosis to show up at a primary care clinicians office. You can show up with an ache or a concern or a worry or something that's non-specific, maybe dizziness. It doesn't need to be tied to a particular organ system, and your primary care provider will help sort through that.

Primary care is comprehensive in a way that specialty care is not. It includes preventive services, like flu shots and colon cancer screening and mammograms. It includes acute care for the things that people often go to the doctor for, or to their care provider for, migraine headaches or sprained ankles, and then ongoing management of chronic disease such as diabetes or heart failure and co-morbid physical and behavioral health conditions like depression, anxiety, et cetera. Primary care coordinators care for patients across the health-care system, which, again, separates it from, from specialty care. And the core of primary care is a strong continuous trusting partnership with a patient over the Lifespan. Next slide.

Just a reminder that high-quality primary care happens in a variety of settings. For example, here in my home state of California, we have a lot of large medical groups. Kaiser Permanente alone cares for almost a quarter of the people in California. But, at the same time, a third of all physicians in California are in solo practice. And California has nearly a thousand of FQHC sites. So, we can see primary care delivered in a multitude of settings. But, ideally, it is located in neighborhoods where people live. It provides, therefore, a more holistic view of the patient's experience by fostering the primary care team’s awareness of the local social, physical, and structural determinants of health. Next slide.

I also, in addition to defining primary care, want to provide a definition of health equity, and we go into this in more detail in the report, but I want to use, for today, the World Health Organization’s definition, which is the absence of unfair, avoidable, or remedial differences among groups of people, whether those groups are defined socially, economically, demographically, geographically, or by other dimensions of

inequality, so, for example, sex, gender, ethnicity, disability, or sexual orientation. So that's the definition we'll be using today. Go to the next slide, please.

And this is the reason why we're here today, is that the unique qualities of high-quality primary care, so continuity, comprehensiveness, et cetera, that we discussed, make it the most fair, accessible, and cost-efficient way for people, regardless of race, ethnicity, or income, to enter the healthcare system and obtain the health-care services that meet their needs. And the whole reason why we're releasing this report and why we're hosting this national webinar is because without universal access to high quality primary care, we will really struggle to improve health and to assure equity. So, primary care isn't the only answer to getting us toward health equity, but without it, we're not going to make the kind of progress that we would like to see. Next slide.

So, as you remember, we had two goals with our report. One was to present the evidence, and the other was to present some opportunities for change. So, let's talk first about the evidence. I'm going to give you the punchline first, which is that a large body of literature, over decades, supports primary care's unique role in promoting equitable care and health outcomes, as well as the potential to do more. This is an evolving literature, and it's despite the fact that the federal government doesn't really fund much research on primary care, or on the generalist approach to health care. Nonetheless, strong evidence exists to support the connection between health equity and a variety of the unique qualities of primary care, including access, continuity, coordination, and comprehensiveness, which we're going to go through together now. Next slide.

So, let's talk, first, about access. Researchers have measured primary care across its many domains in a number of different countries at the system level using more global ecological measures of quality, and strength of infrastructure, such as how much is invested in primary care, et cetera. And they have found that access to stronger primary care systems is associated with improved life expectancy, which is a concern here in the U. S. in the last few years, and lower rates of premature mortality. And this is true also in similar studies in the U. S. that did similar types of comparisons across regions. Next slide.

All of the citations for this evidence section of my presentation today are clear in the report that will be released later today on the California Healthcare Foundation website. There are other ways to measure access to primary care. One is to say, what's the density of primary care physicians in a particular area or region. And we have seen multiple studies that link primary care physician density to better outcomes, so lower vulnerable morbidity and mortality, longer life expectancy, and stronger associations in black than white populations. We've seen reduced racial disparities and referral patterns, and an increase in necessary hospital admissions for black Americans compared to white Americans. So, these are published studies, and this is an evolving literature. But we find strong evidence that links access to primary care and health equity.

Another way of looking at it is access to higher quality primary care is associated with better rates of receipt of evidence-based screening and interventions, earlier diagnosis and treatment of important conditions, and better ongoing management of multi-morbidity, which just means multiple conditions, including physical and behavioral health. And that is something that the elderly and groups who are economically marginalized experience at the highest rates. Williams, et al., found that black patients were able to access primary care received preventative services at rates that were equal to or greater than white patients. Next slide.

We also found many published research studies that linked continuity of care with health equity, so this idea of a relationship over time. It's associated with lower mortality rates, with improvements in health and lower spending for ambulatory care sensitive hospitalizations for children, and with fewer disparities between black, Hispanic, and white populations in a variety of areas, including adherence to recommended preventive services, including COVID-19 vaccines and adherence to medications. Next slide, please.

And then we talked about how primary care coordinates care across the health-care system. And we know that that reduces the extreme burden of interacting with a fragmented and disorganized health-care

system for patients with multiple chronic conditions and disabling conditions. We found that coordination in our summary of the research is related to increased patient satisfaction and following evidence-based recommendations for treatment and self-care, and that more coordinated primary care is associated with reduced racial and ethnic disparities in things like preventable emergency department visits and improved blood pressure control. Next slide.

We also looked at comprehensiveness of primary care. And this, again, is really talking about primary care clinicians working in an inner professional primary care team and how they meet the large majority of a patient's physical and mental health-care needs -- prevention, wellness, acute care, chronic and comorbid care, and that comprehensive aspect of primary care has been linked in the literature to better health outcomes at lower costs, to improved health, to improve self-management of chronic conditions, improved adherence to physician advice, better self-reported health outcomes, reduced disparities and disease severity, and, specifically, behavioral health integration into primary care may help reduce mental health disparities for Latinos, by helping address access barriers, including stigma, mistrust, location, and transportation. So, lots there on the comprehensive aspect of primary care and its link to health equity. Next slide.

The counterfactual is also true, and there's a robust literature that shows, in the absence of high-quality primary care, people experience inequitable access to care and more fragmented, more costly, and duplicative service use, partly from poor coordination of care across providers and settings. We learned that patients’ perceptions of poor care coordination were associated with higher odds of self-reported medical errors, medication errors, and laboratory errors, and that as the availability of primary care physicians declined due to inadequate support and reimbursement, patients experienced a decline in patients-centeredness. Next slide.

So, all of this literature, which, again, is an evolving literature, all of these published literature over decades, despite us a small investment from the federal government in terms of research on the generalist approach to care, that really supports the connection between primary care and health equity. Yet, lest you should think this will be as simple and easy conversation today, in the United States, we have our work cut out for us. So, there has been systemic underinvestment in primary care, resulting in a depleted primary care workforce struggling to deliver high-quality primary care in a weakened primary care infrastructure in the United States.

Last week, our partners at the Physicians Foundation, the Robert Graham Center, the [inaudible] Memorial Fund released the first national primary care scorecard, looking at how our policies in the United States support primary care. And that primary care scorecard -- there's a link in the chat for you -- did not paint a rosy picture. So, the trends are going in the wrong direction in the United States, in terms of investment in primary care. And, for example, these numbers depend on your source, but, for example, we site in the report that despite primary care accounting for 35 percent of U. S. health-care visits, primary care accounts for only five percent of healthcare expenditures in the United States. So, we just don't put a lot of our financial resources into primary care, which is such an important foundation of the health-care system.

Over time, we've watched primary care services shift from local communities to become more centralized and consolidated under increasingly powerful hospital systems. We've seen Medicare fee for service reimbursement rates come under the control of hospitals and specialists, and we see Medicaid reimbursement rates be only a much lower proportion of Medicare, despite Medicaid population being more complex in terms of both their physical and social health-care needs. And fewer medical students are pursuing primary care then specialist careers. Primary care physicians, earn 30 percent less than other physicians, and that makes it difficult for primary care physicians to build and sustain practices when average medical school debt $250,000. So, choosing to go into a generalist or primary care specialty and making substantially less money makes it difficult to pay off that high debt that people are incurring now in the United States. So, lots of issues that are going to make this conversation difficult today. Next slide.

So, we talked about the evidence, which was the first part of this report that will be published and available on the California Healthcare Foundation website later today. I'm going to mention that several times. The other part of the report was, really, what can we do to strengthen primary care and advance health equity? And we really think of this as two sides of a single coin. We know that we need the policies in place to adequately resource primary care, both in terms of money, in terms of workforce, in terms of technical assistance as they're working to transform their practices and adopt electronic health records and connect with community-based organizations, et cetera. We need the policies in place that really incentivize and help and support that and give adequate resources.

And then there's work to do within the House of Primary Care as well, so primary care can work to even better center health equity in a very explicit and intentional way. What we do know from our literature review and our work on this is that doing the same thing and expecting different results is not going to work. So, some of the things that we found are not working is a one-size-fits-all approach to care interventions and quality improvement efforts that focuses on improving the aggregate and doesn't desegregate and think about those areas of primary care that need specific investments. Also, insufficiently engaging patients and community voices in primary care policymaking, or things like focusing exclusively implicit bias trainings for primary care providers but avoiding looking at the social and structural drivers of health and equity.

So, those are some of the things that don't work, and we need to be thinking about, as Karen Savage-Sangwan, the executive director of the California Pan-Ethnic Health Network, says, “Only through radical reimagining of our healthcare system and the explicit pursuit of anti-racist policy and systems changes can we achieve health equity.” So, centering primary care, we’re going to require something new, a radical reimagining. Next slide.

In our report, we talk about a paradigm shift, and part of that is in following with the National Academies of Sciences and Engineering and Medicine recent report on implementing high-quality primary care in the United States, they state that we need to really recognize high-quality primary care is a common good. In doing so, they provide a really robust definition of what a common good is. They talk about primary care as distinct from most other health-care services because of its population impact on outcomes and equity.

Another component of the paradigm shift that we feel is needed is to embrace the diversity of primary care practice settings. We can't just assume that federally qualified health centers are going to be a separate system for the poor or the marginalized in our country. We need to think about choice for people, for all people. We need to look at different practice settings and think about how we can improve and invest with the appropriate resources across the variety of practice settings according to need.

We need to also think about proactively applying principles of equity and justice to all decisions, so things like nothing about us without us, things like targeted universalism, where we're, again, really targeting resources, where things are most needed. And then we need to build accountability for action, and in our report, we actually call for a new forum in California akin to the Virginia Governor's task force on primary care, that would really think about provide leadership and accountability over time for this kind of work. Next slide.

In the meantime, we recognize that there are specific opportunities to make improvements; that we should not feel like action cannot happen immediately, and we focused on multiple actors, so we wanted to focus our work on thinking about, what can healthcare organizations do? What can primary care practices do if they're adequately resourced, but what can purchaser do? What can payers do, policymakers, regulators, educators, thought leaders, researchers, patient advocacy organizations? There really is a role for each of us in this discussion to strengthen primary care and advance health equity. And then there's multiple arenas in which we can make change, and you can see those listed here on the right-hand side. Next slide.

Some examples of specific opportunities that we provide in the report are listed here. This is just sort of the summary take on these examples. There's much more detail in the report, and, in fact, we provide policy context for each of the recommendations so that you can see the progress that's been made in

California on each of these, and what needs to happen next, what are some concrete next steps that could happen to, to further advance these recommendations, so these are examples. This is not an exhaustive list of everything that could be done. But these are some specific actions that could be taken. And, here, you can see we could better involve people with lived experience in discrimination and primary care policymaking and governance bodies. We could expand and scale pipeline programs to recruit, prepare, and mentor students from historically and systemically excluded communities. We could strengthen access to and quality of language assistance services. We can provide options for primary care continuity after hours and on weekends. These are things that would help with health equity. Next slide.

Other examples are listed here: Increasing the overall proportion of health-care spending directed toward primary care and developing models of payment that center health equity. We could promote equitable access to telehealth. We could implement and encourage participation in equity-focused alternative payment models, as I mentioned, increasing Medicaid payments to physician levels so that more people are able to care for the Medicaid population. Next slide.

So, now we're going to enter into our panel discussion. Having talked a little bit about the report provided some baseline definitions of what we're talking about. I want to move into -- where are my panelists? There they are -- talking a little bit in conversation with these experts who think about primary care policy and health equity on a daily basis. There we are. So let's start with Kathryn Phillips. You have prioritized this work as part of your Primary Care Matters Initiative at the California Health Care Foundation. You funded this report, and you were a key contributor to the report as well, a real partner in getting this report together. So, tell me, why is it so important to act on this topic of primary care and health equity now? What's the urgency?

[Kathryn Phillips] Sure. Well, first, thank you, Diane. And I'd like to offer my thanks to all of the authors, advisers, and reactors that supported this product. This report took a village. So, urgency is really a perfect word for this question. I have a six-year-old and was trying over the weekend, totally unsuccessfully, to get him interested in a dictionary, an old-fashioned paper one. So, I took a moment myself to look up the word "urgency." And Webster defines that as the importance of requiring swift action and earnest and persistent quality or insistence. And I really see that we have in front of us a once-in-a-generation opportunity here to address to critically important issues that have long been ignored or taken for granted.

They both require and, I think, deserve swift action, that first definition. Inequities have plagued the U.S. since we began measuring health status well over a hundred years ago, and many we know are the results of structural racism. Even when we control for income and education for example, black mothers and their babies in California are twice as likely to die in the year after birth as white women and their babies. That's a damning statistic in 2023. Thankfully, we've seen a new level of commitment to action, prompted by Americas racial awakening in response to the killing of George Floyd, and recognition of the disparate impact of COVID-19 on communities of color. California's Medicaid program, which we call Medi-Cal, for example, made eliminating health disparities the number one guiding principle and its ten-year quality agenda. That's new, and that's big.

As Diane mentioned, we saw, last week, the health of the U. S. Primary Care Scorecard, which was published by the Robert Graham Center and the [inaudible] Memorial Fund, and it provided, really, a sobering picture of, I think, what many of us working in primary care have seen and felt for years, this systematic underinvestment, shrinking workforce, problematic gaps and access to care, and virtually no funding for federal research on primary care.

Diane noted as well that [inaudible] issued a call to action in 2021, and provided, really, a clear blueprint for how to strengthen primary care. Seventeen states now have committed to tracking, reporting, and, ultimately, increasing their investments in primary care, which we know is a critical first step to addressing those issues, and I'm proud that California is among them. So, we have momentum on these topics, and I think, thanks to [NASM] and many of the organizations on this call. We also have strategies and approaches to guide us, and so that combination of both momentum and leadership and real clear

guidance about what we ought to do to make things better gives me hope that action is both possible, and that action is going to be meaningful.

So, I'll just end with a note on that second definition of urgency, which was insistence, and I think this speaks directly to the report that we put in front of you today, which is that we have a moral imperative to insist that we strengthen primary care in ways that center equity and reduce longstanding disparities and access and experience of care, and in health outcomes. We aren't just trying to build back the primary care ship. We're trying to build a better ship for everyone. So, I think now is the moment, and it's up to us to seize it.

[Diane Rittenhouse] Wonderful. Thank you. I'm going to ask, Judy, can you tell us how your work to prioritize primary care in the federal government links to these efforts to improve health equity? And can provide us with some concrete examples of how you see this urgency playing out, and how these two aspects link together.

[Judith Steinberg] Sure. Thank you so much and thank you for inviting me to participate on this very important panel. And congratulations on the soon-to-be-released report. So, the Department of Health and Human Services, or HHS, fully recognizes that strong primary care is essential for achieving the administration and HHS’s goals, and they are to improve health-care access, improve health outcomes, and improve health equity. And this recognition is really based on the data that, Diane, you just so very well went through.

We also recognize that strong primary care is essential to addressing our HHS priority areas. There's many areas. We have to choose some, and they include the COVID-19 pandemic and addressing long COVID, as well as our preparedness for the next public health emergency. Also, improving access to behavioral health, sexual and reproductive health, and environmental health care; addressing the overdose epidemic and the child and adolescent mental health crises, and improving maternal health and reducing disparities in maternal health outcomes, and improving health equity, as was mentioned.

We're in a time where improving health equity is a major focus of this administration, and that is demonstrated in our HHS strategic plans and initiatives, and there's several of them. I won't go through them in great detail, but I wanted to mention that strengthening primary care is aligned with these HHS strategic plans and efforts. In fact, we must strengthen primary care, the foundation of our health system, in order to achieve the goals of these other plans and initiatives. So, as a result, and with prompting from the release of that 2021 NASEM primary care report, HHS launched the initiative to strengthen primary health care, and that was in September of 2021.

This initiative aims to provide a federal foundation for strong primary health care so that we can improve access to health care. improve the health of individuals, families, caregivers, and communities, and to improve health equity. We were charged with the first task, and that is to develop an initial HHS action plan to strengthen primary care. The office that I sit, in the Office of the Assistant Secretary for Health, is coordinating this initiative and the development of the action plan by working with fourteen HHS agencies, many of which you know well -- CMS, HRSA, CDC, SAMHSA, HIS, and others.

So, in addition to working with federal partners, the initiative and the action plan development has also been informed by input from many non-federal stakeholders and partners through over 130 listening sessions, and information that was received through the release of a request for information. The NASEM Primary Care Report also was instrumental in informing the development of the HHS action plan.

Now the federal government is a facilitator, but I do want to underscore one of the things that Diane just mentioned about the need for collective -- essentially the need for collective action to achieve her aims, action that's taken by many other actors, such as state, local, and tribal governments, payers and providers, health systems, employers, academia, communities. We all need to be working towards shared aim to really achieve strong primary care that will afford us an improvement to health equity.

Now, as far as the HHS action plan, we were very intentional about our approach to this plan. We wanted you to take action now under the current funding and legislative landscape to set us on a path to strengthen the foundation of our health system. Improving health equity underpins all of the goals, objectives, and actions of the plan. Now, whenever you have a plan, you always need to consider what is it that we're aiming for? What is the vision? And our vision is very similar to the definition of strong primary care, equitable access to whole person primary care that supports health, wellbeing, and resilience. Care is longitudinal and comprehensive and founded on sustained trusting, relationships just as you've heard in the definition. Care is community-oriented and responsive to the needs and goals of people and community, so that means people are involved in the governance of primary care. And clinical services, like behavioral health, oral health, clinical pharmacy, for example, are integrated with primary care, and care is coordinated. And, as you heard, this requires a multidisciplinary team. And then going a step further, primary care, public health, and community-based health and human services organizations, in our vision, would partner to improve health promotion and disease prevention and work together to address structural, social, and environmental factors that impact health.

So, in developing this plan, we were guided by the NASEM Primary Care Report, which recommended actions to invest more and more effectively in primary care, strengthen the workforce through the multidisciplinary team and team member roles, improve digital health tools, and advance primary care research and its translation into practice. So, as you heard, the action plan is targeted for public release as soon as some time in Spring of 2023.

And just to close, how might this action plan actually advance health equity? Well, certainly, we've heard a lot about the relationship between primary care and health equity, so improving access to whole person primary care for all people, supporting the trusted ongoing relationship between patients, primary care, clinicians and teams, and then increasing cross-sector partnerships to coordinate preventive health promotion services and to address social and environmental factors that are impacting health. And I really feel that the integration of clinical services and partnering with other sectors, bringing the whole system together, so to reduce fragmentation, and to make it easy and accessible for people to access care is critical to what primary care can do for people to improve health and advance health equity. And lastly, the plan would take action to advance digital health and primary care research using a health equity lens. So let me stop there, and you can go on to the next speaker. Thank you.

[Diane Rittenhouse] Thank you so much. It's wonderful. It's gratifying to know that in the wake of the National Academies of Science, Engineering, and Medicine Report on implementing high quality primary care from last year that, that we are seeing federal leadership on primary care. So, I know this notion that someone wakes up in the federal government every day and thinks about primary care across all of the different agencies that you described. So thank you for your leadership in that.

So, we'd like to say it's not all about the money, but sometimes it's all about the money. So I'm going to turn to Mai who is written extensively about this, and thought a lot about it. One wonders if we could fix primary care without fixing the underlying payment mechanisms. So, can we strengthen primary care and center health equity without fixing the primary care payment mechanisms? How do we pay differently to get more equitable outcomes.

[Mai Pham] Thanks, Diane. So, I mean, obviously, you're asking a rhetorical question, and I don't think any of us expect to really get the primary care that we want without doing the payment work, which is not to say that the other dimensions of change that Kathryn and Judy have already spoken about, and that you pointed to. So [inaudible] in the report aren't really critical, but they will never reach their full potential if, as I view it, payment stays in the way. Payment right now is in the way of getting those transformations to scale. So, that's the answer to the rhetorical question. You know, the hell of it is, well, you know, coming from you CSF there's a famous quote about the worst way to pay physicians is capitation salary or a fee for service, and so I think that we have to go in this with a certain humility that there's just going to be -- it's a matter of tuning the dials and the combination of those mechanisms, depending on the settings that the clinicians, because it's not just physicians, the clinician and the teams are working in.

What we do know is that all of the needs and expectations that we're placing on the modern future primary care requires a ton of flexibility; right? It is the opposite of cookie-cutter medicine. In many ways, I think we will remain challenged unless we take head on the conflicting underlying deep narratives here. There is a current status quo culture in healthcare that values certain things, certain concepts, for good reasons. We value standardization. We, value efficiency. We value expertise. These are not evil concepts. They came to be accepted as core tenets of modern U. S. health care for a reason. However, when we talk about addressing equity and, frankly, to my mind, the accompanying crisis here is plateau and life expectancy in America, right, and declining life expectancy for those in the prime years of their life. Are we actually origination? When we talk about addressing that, that requires a new deep narrative and a new set of core values that we have not migrated health care towards. So, instead of standardization, it's about tailoring to a person's needs and their social context. Instead of efficiency or the standard understanding of efficiency, it's the recognition that if you pay attention to what I would call the genius of lived experience, you will actually get to the right answer for that patient sooner, and you will, over time, become more expert in how to take care of that person. So there's efficiency, and then there's efficiency. Which version of the efficiency would you like to value as part of healthcare’s narrative.

And then the third example is expertise. It's that same thing. There is the traditional understanding of expertise, and then there's the expertise that comes from collaboration and shared experience and empathy, things that sound soft, but actually can be operationalised within a clinical practice quite concretely.

I haven't talked about payment yet, but that's, I think, a necessary set up, where then to take a step back and you say, okay, you know, when I was given an assignment to go design a payment structure, I always have to start with my payment principles. What am I trying to achieve with this payment? If I don't know what I'm trying to achieve with this payment, I'm going to end up not where I want to be.

So, if I want to achieve a system that projects these deep narratives and concretizes them, operationalizes them in care that is truly tailored, that takes advantage of the genius of lived experience and that is truly efficient in the long term; okay, those are very clear directional signals. I need a payment structure that is extreme in its flexibility, with some safeguards around the types of services that aren't often provided enough, right? So I want to give you lots of flexibility in a per-patient/per-month type of cash flow, while also prompting you maybe with a vestige of fee for service around services like behavioral health integration or vaccinations or home visits, things that I want to push you a little bit to do more of.

And then I want to make sure that I pay you at an amount that allows you to make the investments necessary in the team, and in the relationships and collaborations you're going to need with your community partners, and the wraparound agency. Well, let's put it this way, the agencies that should be wrapping around the clinical practice, right, the public health agencies and housing agencies and such. They're not wrapped there yet, but let's set the table for them to do that. You can't connect with them if you don't have staff to help manage those relationships and figure out the data flows and, you know, the agreements, the business agreements. When I send a referral, I expect this to happen. And when you send me a response, you expect this to happen. These are very concrete things that smart committed clinical leaders can figure out how to do. They can learn how to do them. And they've done versions, shadows of them already in their current lives.

But payment is in the way. It's like asking someone to do fine metal work through oven mitts. You got to get those oven mitts off, and, frankly, acknowledge that there's been gross underinvestment, and we need not a glide path, but a rapid escalator up to where it needs to be, because the signals that gets sent when they are part of pilot programs or such, those are not the kinds of payment signals that change how clinicians in training make their career choices. Those clinicians in training need to see permanent promises that they will be there when they are ready to begin seeing patients in the real world.

And then I think, you know, in this day and age, we really can't talk about payment without talking about accountability. You don't just get a check because that's about -- that's actually reimbursement. That's not what I would call paying for outcomes, and we want to pay for outcomes. Well, which outcomes are we

paying for? We can be really ambitious and think about the most holistic high-level outcomes, like mortality. It's very difficult to hold individual clinicians or practices for those types of outcomes, but there are outcomes that we no matter if we ask the patients what it is they care about, right?

So, this is another option of healthcare's worship, current worship of standardization, is that the vast majority of our quality metrics and our quality rubrics are driven by clinical practice guidelines, which, in turn, are based on, often, cohort or randomized controlled trials that are pristine at their best; right? The grade for the evidence is higher the more pristine the randomized trial, which means that the more pristine the trial, the higher the grade of evidence, the more reductionist it is. It's not just drug A versus drug B. It’s drug A versus drug B for this stage of that condition in these patients of this age, and then gender and blah, blah, blah, blah.

A person, on the other hand, is a collection of problems and issues. And one of the irreplaceable values of primary care is that there is another person integrating all those problems and issues in the solutions that they try to come up with. It is the opposite of reductionist. In fact, if you looked up -- if you ask Kathryn's child to look in the dictionary, and you were actually willing and you looked at reductionist, there would be synthesis and integration, right? So, we need quality metrics and an accountability framework that is not based off of reductionist clinical practice guidelines, but, rather, what matters to patients.

Well, how do we do that? How do we get to some way to compare providers or hold them accountable? It's actually not that hard. I mean, not that it's not that hard, but there's already proof of concept; right? There are already metrics that are goal oriented. It's not hard to conceive of a metric where you say, score zero, you didn't even ask the patient what their goals were. Score one, you asked and you documented it. Score two, you have defined the milestones to get from where the patient is to where they want to go. Score four, where are you on that milestone track? Score Five, yay, you met your goal; right?

And this is how we could stand a chance of a primary care clinician saving a life, not because they were doing the checkbox and prescribing the aspirin after TMI, but because they did that and they listened and heard that grandfather. All he really wanted was to be able to attend his granddaughters wedding, and they helped make that happen, whether that was by getting a social worker to help him with making the plane travel arrangements or having given him a cell phone number he could call in case he started having chest pains, whatever it was, they got him to the wedding, and so he didn't become depressed and stop taking his meds. And that's how you save the life.

And in the meantime, what you've also achieved, if you are one of those many practices, private practices that are serving disadvantaged communities, is that you have, just by nature of the process of your engagement with this person, taken into account the extra barriers and challenges they have in self-care and in getting to goals. That is respect. That is what begins to rebuild trust in the community, and a lot of the payments. That I want to connect the dots for you, that there is a lot that comes through when you begin with a payment principle that is based on a deep narrative and a set of values, and then you project that in the payment structure.

In some ways, it's very basic economics. If you built it, that is what they will come to, if you build something else based on muddied values or muddied payment principles -- right now, we don't have a payment system. We have, like 564 payment systems, based on all manner of articulated confused payment principles. That is what we need to fix. So, with that, I'm happy to also tell you what I think legislative fixes should be, but we can stop there and, hopefully, that gives folks something to react to.

[Diane Rittenhouse] Excellent. Well, no, small charge from Mai this morning. I think what we'll do is maybe give Sinsi a chance to talk about how reforming -- sort of building on what Mai has introduced for us here as some of the core payment principles that need to shift. How do we make sure that initiatives or solutions to reform primary payment and transform the system sort of all at once incorporate those priorities of the communities that have the most need; that we were talking about earlier sort of targeted universalism and a need for a paradigm shift, a need to invest where the need is greatest. And Mai has outline for us some of those principles and some of the ways that we have not been prioritizing communities and community voice. How can we, how can we do better? Oh, you're on mute.

[Sinsi Hernández-Cancio] Of course, this will not be timed if somebody didn't end up getting off mute in time. So, first, I want to thank you all for the invitation to be part of this really critical conversation. I also wanted to kind of state from the outset that I'm showing up here, not just as a so-called health equity expert working in federal policy, but also as the daughter of a primary care physician, and of [inaudible], who worked with the materials in rural Massachusetts, as the person with multiple chronic conditions, and the mother of another person with multiple chronic conditions. And so all of these things, all these factors, the vantage points are experiences that I bring into this conversation.

I want to thank Mai for taking on this enormous question of how do we build payment systems that can actually achieve the results that we want. And part of it is articulating what are the results that we want, because the payment system currently was not designed --, to the extent there is a system was not designed to provide to promote the maximum health possible for any part of the population, and certainly not for populations that, for structural reasons, have not had the same resources available to them to promote health and, on the contrary, have actually been subject to a lot of piling on of health risk. And we at the Partnership, we look at this from a very intersectional way, right?

There is income and resources on the individual family level. There is the experience of living in this country and being subject to racism. There is the experience of being a woman. There are all these different factors that the health-care system, and that our systems in general, have not considered, or as part of the point of what they do. I think it's important that we understand very specifically that right now, to the degree, again, that we have a healthcare system, it’s really been part of an effort to maximize profits, maximize results for people who, for a variety of reasons, have more of the attention of decisionmakers. And it's a business enterprise that really does take advantage of, of a lot of wealth and resource extraction from a number of communities that structurally have not had the opportunity to be considered in any of this work.

I think that when it come --, I think one of the biggest examples of this is the important recommendation, that was at NASEM and in this report, of thinking about health care needs to be seen, and especially primary care, as a common good, and that is the biggest disconnect with how health care is designed and resourced right now. Not as a common good. And I mean that from a systems perspective, which really does boil down to funding and resources, not from the perspective of the individual motivation that people who work in the health-care system and what they're trying to accomplish and wants to accomplish for their fellow human beings. But that at the end of the day, it is all about the money and the resources, because there's only so much that can be accomplished in the micro level, you know, without really addressing a lot of the macro issues with healthcare when it comes to equity.

And so, for example, what that looks like has to be not only about finding ways to center the individual person or family in what is it that they want to need, like what Mai was saying about what are their goals and what are their barriers, and let's not assume that everybody has access to all the same things. But also, at a more macro level of ensuring that those voices and those priorities are part of not just consult, send out a survey, do one advisory committee, but actually have a truly collaborative role in developing the programs and policies that are needed, including what people are get paid for.

The other thing that's really important from an equity perspective, and looking at payment reform and delivery form, is that we have to understand that, as I said earlier, this is not an equal playing field, not for the patients, not for the communities, and certainly not for the providers, individually speaking, and not for provider systems either, right? The idea that we can just incentivize, you know, switch, let's completely get rid of completely get rid of fee for service and just have everybody be in an alternative payment model without addressing the underlying inequities, resource inequities that have been generational is ludicrous, right? The barrier to entry for somebody like my father who was a single solo practitioner, who couldn't even get the credit to be able to set up his office with electronic medical records, you know, had no way of billing for the three staff people that he had just helping his patients navigate the system and do their appointments and follow up and all that. There was no pot of money for him to be able to pay for that.

The idea that we can just like, okay, well now we're going to capitate you in these ways will solve the problem is ridiculous. But that is how most policy right now is looking at how payment has to change. It's not just about being flexible, having flexibility, which is important, but oftentimes that conversation about flexibility is about flexibility with the same amount of money is going to solve the problem or, you know, taking that amount of money and paying -- effectively you're paying in a capitation is going to solve the problem, when there's such deep fundamental resource inequities that need to be remedied. So that is why I'm on the board of the Primary Care Collaborative.

And part of the work that we were doing in adopting the national recommendations was, yes, we need to get a glide path, and everybody talks about the glide path between fee for service, alternative payment models, from paying for volume, to paying for quality, but that's just one aspect, one dimension of what's needed in terms of the rebalancing of resources not just towards primary care, which needs to happen, but towards the communities and the providers in communities that have been systematically under-resourced for so long and are bearing the brunt of poor health -- not just poor health outcomes, but incredible disproportionate healthcare risk, health risk, because in this country, you know, Zip code is more determinative of your health and your genetic code or, really, the health care that you get. And in such a segregated country as we are, Zip code, at the end of the day, really corresponds in most places with race.

And so it's not an easy task, but we need to make sure that there is a consistent and permanent source of funding to help safety net providers, small solo providers, rural providers, those that just are struggling, again, not just with a complex population, but with lack of resources to get the resources that they need to be able to level up, and then succeed in the kind of payment reforms and kind of payment models that are being trotted out of CMMI and CMS these days.

[Diane Rittenhouse] Thank you. So, lots to think about, about the complexities and the issues underlying. It's not simple to say, “Oh, let's just pay differently.” But we need to recognize the underlying inequities and the structural inequities and the generational systems, or non-systems that play a large role and set the path so far, and so switching paths or coming up with a new direction is not easy.

Let's talk about, just from each of your vantage points -- you know, we came up, in the report, with some concrete next steps, and we were specific to California. But a lot of these would be applicable across the country. And we thought a lot about, okay, here's something that someone could do or here's something that we could all embrace. Kind of what's the progress that we've already been in California and what's the next steps? And I'm just curious, to move a little bit from this broader discussion to concrete next steps, if each of you could just give me, from your vantage point, what you think a concrete next step would be that could really help advance primary care and health equity. Who wants to go first? Nobody.

[Sinsi Hernández-Cancio] I'll dive in. But I need clarification.

[Diane Rittenhouse] All right.

[Sinsi Hernández-Cancio] So, the question is, are these concrete next steps that are actually doable right now? Or are there concrete next steps that we know are going to be really challenging to promote to, to achieve.

[Diane Rittenhouse] You know, if you're comfortable, I'd love one of each, because I think that it's important for us to take concrete next steps that we can take and not sort of say, oh, well it's going to be too hard, or, oh, the stars aren't aligned, or, oh, there's nothing we can do, or we have already done so much. I mean, that was what we were sort of fighting against in writing the report, was the voices that say either it can't be done or it's already been done. Because there are a concrete steps that can be done now and things that can happen. But I'd also love to hear a more challenging longer-term kind of step, if you have something like that, that you feel like, well, we're not really ready for this today, but we'd like to keep it in mind for the long term, so either way.

[Sinsi Hernández-Cancio] That's really helpful, and so I'm going to do my best. I think, fundamentally, there's a lot of great work that's being done on a smaller scale, and at the end of the day, it is a payment system that is in the way. So, concrete next steps that could be done kind of on a more micro- level could be having provider systems get more involved in state advocacy around getting better payment or options for payment from their Medicaid program, right? Doing things that will support what a well-functioning medical home for people of color in rural communities would look like. Is it getting more resources for community health workers? Is it getting more resources? Is it working at the state level to have, an all-payer claims database so that we can see where there are gaps, for example.

So I think that that would really depend on where each state is. But I think that, often, health-care system providers kind of forget that, in addition to being providers of care, they're three other roles are really key. One of them is as an employer, one of them is as a community partner, and another one is as an advocate. And so being able to work, whether it's even in their county level or state level or whatever level, even higher up at the federal level to really advocate for, we need to be able to pay for things differently, even if it's something as simple as paying for doula, if you're an OB, right? I know that's not necessarily primary care, but like these are just examples of like, micro very targeted changes, a community health worker, money for primary care and behavior health integration, and then and engaging the community in deciding what that should be, right? That's critical, right?

You don't need a lot of money to decide that you're going to create advisory councils and support folks in being able to have a kind of an ongoing permanent way to get input from communities on what they feel is most needed.

[Mai Pham] I can follow on, Diane. So, first of all, completely agree with Sinsi, that, often, it is important to think about place when you want to take action. Again, that may be the shortest path there. First of all California is the size of the country, and it's got lots of little sub-communities in it that are going to have their own priorities and opinions.

But I would say another thing to keep in mind is that the faster you want to move, the more upfront support primary care providers will need, and that should be okay, because the kind of support you provide in the beginning doesn't need to be necessarily forever, right? It's about matching the support to the momentum you want to generate. And what I mean by that is, for example, in California, there's already a coalition of health plans, led by Blue Shield, that is implementing hybrid primary care capitation with higher prices. That's great.

I don't know the extent to which they have gotten their ERISA clients to come along. And so I think there is a role perhaps for the state, one, for the insurance commissioner to think about directing health plans who are not doing that already; and, second, for legislative action to really steer ERISA purchasers in a similar direction, because they hold the majority of commercial dollars, and for good or bad, usually bad, commercial dollars account for a heavier weight in terms of practices decision-making, business decision-making, then Medicare and Medicaid alone. So, some of us were working on the Medicare angle. But, within the boundaries of the state, I think there's potential here for action from the insurance commissioner, from the legislature.

And then in terms of matching the level of support to how fast you want practices to evolve, it may not be the most efficient thing to ask individual practices to create their own infrastructure. That's not a law of nature. If they want to do that, that's great, but could there, in a particular place, be a pilot where the state gathers the payers and/or the state just invests in a common shared resource that helps them connect community-based supports that helps them connect to a shared pool of community health workers. Creating pods like that, both keeps the priorities, it keeps the local priorities more centered in whatever programs practices developed with their communities, and also allows you to experiment at a lower risk fashion. You're not betting the bank on a statewide program. You're going to try it in a few places. You'll learn things. You're going to run your own little innovation center.

And you have Medicaid leadership right now that is hypercreative and hyper-adventuresome, so take advantage of that. I think those are some, I would think not easy, but kind of low-hanging-fruit ways to

signal that this is really going to happen; that this is for real. And the signaling is so important at the beginning of these movements. You know, I can't tell you -- when I was present for the stand-up with the CMS Innovation Center and value-based payment as we know it today, as much energy went into who was on what podium saying what, and what interviews to press or in front of Congress, as in building the technical models, because momentum and perception and buy-in are just so critical.

[Kathryn Phillips] Both Sinsi and Mai have talked eloquently about the importance of payment models and payment mechanisms. I think the elephant in the room is payment rates. I mentioned there are seventeen states now looking to track, report, and, ultimately, increase primary care investment. There's a handful that's doing the same for behavioral health. And we expect those efforts to increase resources in primary care across the board. I think when we want to laser in on equity, it really demands we look at Medicaid programs, which, by definition, serve low-income persons. In our state, more than two thirds of people on Medi-Cal, our state Medicaid program, are people of color, so there's both a class-based equity issue there, and a race-based -- an ethnicity-based equity issue there.

The Kaiser Family Foundation tracked Medicaid and Medicare parity, and in 2019 -- I think that's the last data they have for the whole country -- only five states had Medicaid rates that met Medicare rates, and only three states, interestingly, Alaska, Delaware, and Montana, had Medicaid rates that exceeded Medicare rates, really recognizing that most Medicaid-covered patients have high acuity, high complexity, lots of social needs, take more time, attention, need more services, and need more support than commercially insured or Medicare populations. So I think that's one really clearly area to start, both for state action and for federal advice in terms of the Medicaid program.

California was one of three states, I believe, that recently had an 1115 waiver approved by CMS, that came with a condition to increase state Medicaid provider payments, specifically for primary care. But the goal there was getting to 80 percent of Medicare, not 100, not 110 percent, which is much closer to where you would be, if you were thinking, first and foremost, about equity. So just want to make the point, the model, the mechanism is critical, the way we pay, but, also, what we pay when we think about services support, getting more providers into networks that serve Medicaid members and so forth.

[Judith Steinberg] And I'll just add, I too agree that it does begin with payment. And the fact that 17states are focused -- have recognized the importance of primary care and plan are measuring spend and planning to increase the investment in primary care is important. And touching on what Mai said, it's an important signal; right? So, as that gets spread around about the importance of primary care, then other actors, see the importance of it as well, and, again, that collective action can move forward. So it does begin, but only begins, with measurement and payment, and then everything needs to follow from that.

You mentioned at the outset, Diane, that also might want to think about longer-term type of concrete actions. And I think we do need a paradigm shift in terms of the way we approach that this first order of primary health-care services to really bring together the different aspects of what WHO calls primary health care, right, so a multi-sectoral approach to that first order of health and wellbeing services. So that means not only strengthening primary care, but also, as Sinsi mentioned, the infrastructure, right, in communities, for public health, for community- based support services, it all has to be supported and come together, and that's going to be a paradigm shift for our nation.

[Diane Rittenhouse] Wonderful.

[Mai Pham] I want to just make a practical point, which is that the investments that I think are necessary in community service infrastructure, in public health infrastructure in leveling up, right, the basic resources that are available to primary care providers serving, historically, marginalized populations, all of those will be substantial. But growing primary care payment, the reimbursement for primary care services themselves, you can grow that substantially and you would barely blink when you look at the total costs of care. Because going from five percent to seven percent is nothing compared to the annual inflation in total health-care spending. We are well under that inflation rate.

So, just to make the distinction, it is a harder social policy conversation to say we want a trillion dollars in national investment in homes for fee-based services, just to meet the unmet needs, never mind for growth, right? Whatever that number is, I believe it's somewhere close to that, is another thing, like, we shouldn't be waiting on that conversation in order to start building out primary care, because the stronger primary care is the less you might have to invest in some of those other areas.

[Diane Rittenhouse] So true. Thank you so much. I want to talk for a minute about -- I want to address some questions that are coming in in the chat, and that came in in advance. One question that has come up and that we did address in our report was, how can public health support and encourage health equity in the primary care setting? So how can the integration of public health and primary care work to better our ability to advance health equity, any of us.

[Mai Pham] So, I'm not a public health expert, but my sense is that there are resource and expertise in both domains, in clinical world and in public health world that are locked. And what we kind of want is to free them up, right? So, local public health agencies, they do community health assessments on a pretty regular basis. They have a pretty granular sense, you know, at census tract level and below, I mean, what the shortfalls are. But that is not shared right now with the clinical world, and so I think not just the data, but also public health posture, their analytic posture, their population-based posture toward thinking about problems which take into account place and environment and things like that.

Practices, you know, when your clinicians, when you get a patient, you get tend to just see the patient, and you tend to not see their place. You feel like you have to go and learn that over again with each patient, when, in fact there's an agency down the street that has all that information already. If they could share that mapping knowledge and data with you, you would have that context before the patient walks in the door. And it just lifts the burden a little bit for you to do the investigation to figure out how best to help them. So that's just one example, I think. But others may know more about other expertise hidden in those public health departments.

[Judith Steinberg] I would add to that. Public health is focused on disease prevention and health promotion. It helps support community-based resources to support people and communities in prevention of disease and health promotion. And that's what primary care does. So it makes such perfect sense for these entities to come together and work in a coordinated fashion. We're talking about the same patients, the same people. So, how do we coordinate, share data, and ensure that those services are provided across not only primary care but also in the communities and through public Health? And then secondly, also there is support in the communities through public health and health and human services organizations for addressing social determinants of health. Primary care can't do it all, but it can begin with screening, and then work with community partners to help get the resources and refer patients, and get them the needed services that they have.

So, there's a lot of work that can be done in a coordinated fashion. It does require relationship building. It requires data sharing and interoperability, and that's what, in part, what I'm getting at, in terms of paradigm shift, in terms of how we fashion and support that first order of health and wellness for our people.

[Diane Rittenhouse] It we value this, we got to pay for it, right? I'm going to turn Sinsi.

[Sinsi Hernández-Cancio] Yeah. So I think that what you just said is really important, because I worry some time that, too often, the conversation is like, well, we have the public health folks doing this and primary care doing this and community agency, community-based organizations doing, this and they're all profoundly underfunded enterprises, right? And being able to coordinate, being able to share data, all of those things, it's not as easy as flipping a switch when it comes to especially relationship building, it is time intensive if you want to do it well, in communities where there have been so many challenges with trust, because there have been so many entities that have continuously acted in untrustworthy ways with these communities.

I don't want to rain on people's parade, but I also want us to be very, very clear eyed about that even those kinds of things will require investment and support. And I want to look to big hospital systems and areas of a lot of economic activity and a lot of resources to see how they help support this work, and not keep the burden on those that are already underfunded and strapped, right? Yeah, we want to screen for social drivers and make sure that there are warm handoffs made to entities and communities that know what they're doing and have the trust to be able to address them. But they're not getting paid for that. So that's really important for us to not lose sight of.

[Mai Pham] Yes, we have not opened the floodgates to conversation about where to take money from, or where to redirect money from. I think that's extra webinar.

[Judith Steinberg] And a difficult conversation.

[Diane Rittenhouse] Fair enough. But one that's important to remember. So, we have just three minutes left. I wanted to end on a high note, because sometimes this stuff feels a little heavy. And I just was wondering, what are you most excited about in this area? What have you seen happen or is on the verge of happening or you feel sort of some promise, some hope? We will just go around, whoever wants to start first.

[Judith Steinberg] Well, I'll start. Well, I'm very excited, energized, and hopeful about the fact that primary care is being focused on, and it was for many different reasons, and the data is behind it for why we do need to focus on strengthening primary care. So I'm very encouraged by that, at the state level, at the federal level, and the important signals that these efforts will be making, so very encouraged on that.

[Diane Rittenhouse] And that's coming from the top of the Health and Human Services Department in the United States. So you should feel that something is a little different, that things are. I think, a lot of times, these conversations, people say, well, we've been talking about primary care for a long time and what's different now, and I think there is something different now in terms of investment and momentum and energy.

[Sinsi Hernández-Cancio] I'm very excited about the fact that a meeting like this can actually -- and a report, like what’s going to be released is actually talking about, you know what, health care, and especially primary care, should be common good, because that needs to be front center in our discussions. And I'm also really excited that in these meetings, we're also talking about this direct connection between health equity as something that we should be working towards, and primary care.

[Kathryn Phillips] I'd agree with both of those and build on it just by saying it's not just a lot of talk, it's a lot of talk from a lot of different types of people, which we haven't had in the past, and I think it gives us a leg up this time around, both from the perspective of strengthening primary care and being very intentional about doing that for greater health equity.

In California, we have the Office of Health Care Affordability, which is taking on the primary care investment work. We have a set of health plans that are taking voluntary action around payment reform and investments. We have historic investments in our primary care workforce at all levels from State government, and, really, again, a new level of attention from industry, from our trade and membership associations, from all sides. So there's a diversity of perspective represented, but there's also a bigger team to support this work, and I find that very helpful.

[Mai Pham] I have two points. It took me a little while to come up with them. But one is that I am optimistic that CMS has now moved beyond a decision on whether to pay more and better for primary care, but is in active discussions on the how, and so that's very encouraging. And the other encouraging sign is that I actually think healthcare, broadly, is really tired of the current measurement industrial complex, and there is a lot of appetite in some of the organizations that have led the development of those reductionist outcome metrics -- they're not even outcome metrics, most of them -- for so many years, are, themselves, now turning to understand the importance of asking the person what their goals are, and reorienting us to a world with one clinician. One very tired senior clinician said to me at the end of one of these think

meetings, “I just want to be rewarded for solving my patients’ problems.” And so I do feel like there is a sea change out there, and enough of these movements directionally are aligning, I think, just adds to the momentum, and so that makes me optimistic.

[Diane Rittenhouse] Fantastic. Well, we are actually over time, and that's on me. Thank you very much for everyone sticking with us. The report is going to be available later today on the California Healthcare Foundation's website. I encourage you to go to the California Health Care Foundation and look at their Primary Care Matters Initiative. Lots of resources available there. I also want to say that there is a webinar available from last week, which was the first US Primary Care Scorecard. That's on the Milbank Memorial Fund website, and that you should watch for the Health and Human Services Action Plan coming up this spring. So, lots of exciting things happening. Our primary care collaborative is hosting a webinar on March 21st, on a very similar topic, so lots of exciting things happening in this area. Thanks for hanging in with us, and thank you to our panel members for all of your expertise and your commitment to this work.

[Judith Steinberg] Thank you.

[Kathryn Phillips] Thank you.

[Judith Steinberg] Thank you.