Interest Group 17: Strengthening Primary Care as a Solution for Current and Future Health Priorities

Mary Wakefield: Hello everyone and welcome to the primary care special interest group meeting of the National Academy of Medicine. And this particular session focused on strengthening primary care as a solution to current and future health care priorities. We're really delighted that you're here joining us. I'm Mary Wakefield, and I am a member of the National Academy. Along with the terrific Dr Andrew Bazemore, we're co-chairing the planning committee that is bringing to you this particular session.

Before we get into the content of today's meeting, though, I want to thank just a few people who helped us to get to this point. First, Jamal Samuel with the National Academy of Medicine, who's been terrific in providing his assistance in facilitating the session. And secondly, I also want to mention the planning committee colleagues who volunteered to serve and work with us to put today's program together. Those individuals include Drs Kara Walker, Harold Sox, Jim Perrin, Bob Phillips, and Andrew Bazemore.

With that, in terms of a few specific logistics, I need to share with you. First point is that the introductions our speakers that you're going to hear today those introductions are going to be really brief. The reason why we're doing that is because we want to spend as much time as possible on discussing content. Brief introductions are not at all a reflection of a tremendous set of players and panelists who have a long list of professional achievements. However, if you do want more information about these individuals, you can find that information in the chat room where their bios are available by clicking on the link that's provided for you there.

Next for you to know, this meeting is, as was mentioned by Dr Dzau, open to both National Academy of Medicine members as well as nonmembers from now through the panel discussion. For our public registrants or non–National Academy of Members, you're going to be viewing this meeting as a webinar, so you will not have real-time access to submit any to chat comments or participate via audio. However, the Academy does want to hear from you and our special interest groups certainly wants to hear from you, so to the extent that you've got any observations or questions, please don't hesitate to make them available to us at the email address listed on our viewing web page. After the meeting those questions will be sent to any panelists that you may have directed them to.

Then, for the members of the Academy, please do feel free to use the Zoom function or the chat function at any point in time during today's session. Also, if you wish, you may want to use the raised hand function after all the panelists have spoken and we get into a discussion; that will also be an opportunity to engage as well. Either via the chat session, or our chat function, or via hands raised, we'll try to catch those questions as we go along.

With that, let's go ahead and turn our attention to today's topic. A conversation that in a very exciting way is going to pivot right off of the National Academy of Medicine report that was released earlier this year titled, "Implementing High Quality Primary Care: Rebuilding the Foundation of Health Care." This report explores the challenges around primary care in the United States and the impact of those challenges on health and health care. The report also very quickly moves to advancing important features of an implementation plan for rebuilding primary care as a core foundation to health. To talk about the report and to provide us with an overview of some of its key messages and observations, with

us today is Dr Bob Phillips, who is an expert on the report and he's an expert for a lot of reasons, not the least of which is he was a co-chair of the National Academy of Medicine that produce the report. I also want to mention his co-chair, Dr Linda McCauley, who co-led the committee with him. She is also a National Academy member and a nurse.

Following Dr Phillips' remarks, Dr Bazemore will introduce the panelists to you. The panelists are going to weigh in on some of the key actions that are recommended in the report, all with an aim of strengthening primary care in service to the health of the nation. So, that quick word about Dr Phillips, and then straight over to him.

Dr Phillips trained in family medicine, and he is currently the founding executive director at the Center for Professionalism and Value in Health Care that's part of the American Board of Family Medicine Foundation. With that, Bob, over to you, and thanks for being here.

Bob Phillips: Thanks so much for that kind introduction, and thank you to you and Andrew for organizing today's topic.

As Dr Wakefield said, I'm going to be talking about the report and giving you some highlights. One of the things I want to emphasize, and I think that I will be emphasizing throughout the discussion today, is this issue about implementation, how we actually make sure that the recommendations reach fruition and have champions.

As Mary said, Linda McCauley, the Dean of Nursing at Emory University was co-chair with me, and many of our colleagues who helped prepare the report are on the panel today. I'm grateful for their help and also for the three National Academy of Medicine fellows, and our staff, Marc Meisnere, Sharyl Nass, Tracy Lustig, Sarah Robinson, and Samira Abbas, who were essential to making sure that the report came to fruition.

We did have 17 sponsors: that's a lot. They gave us a lot of upfront feedback about what was expected of the report. The good news is on the back end it's given us a lot of champions, many of whom continue to advocate for a lot of the recommendations in the report, and we're very grateful to them.

Our statement of task is a little unusual. We were not only challenged to talk about how to build on the 1996 IOM report about primary care, focusing on strengthening primary care, and informing primary care systems around the world, we were given this up this task of developing an implementation plan, which is very unusual for National Academy's consensus studies. We have a very strong focus in the report on how to follow through on the recommendations and who could be accountable.

As in 1996 our committee started with developing a definition. This slide is really focusing, too, on that implementation plan and considering the successes and limitations of the prior efforts to innovate in primary care. Our statement, our definition around implementation, was quite specific, and we made sure that the committee understood this as the definition of what we were trying to achieve. As I started to say, we also had a challenge of coming together around a definition for primary care, which I'll talk about in just a moment.

In terms of context, some of the key things that came out of the review the literature: The first and kind of primary one was that primary care remains the only part of the health care system that results in

longer lives and more equity, emphasizing its importance and why fixing it becomes such a high priority. We can point to other countries that have high-quality primary care and better health outcomes, as a result. Primary care is inaccessible for large portions of the US population, and we're actually seeing a regression, a loss of primary care use and utilization, and we're seeing an erosion of the workforce.

One of the explanations is that primary care is now only about 5% of total health care spend. It remains more than one-third of all visits, more than half of all outpatient visits, but receives only one-third of funding that goes into subspecialty care and one-fifth of what goes into hospital-based care. One of the things I want to emphasize is that this has actually declined over the last 15 years. As a function of the health system and as a funding target of the health system, it has declined.

It is under-resourced, and its share of total health care spending is decreasing in most states. This underinvestment really leads to health inequity. Financial pressures on practices results in clinician burnout and really suboptimal care and is part of the explanation for why we're seeing a loss of life expectancy gains compared to the last hundred years. Primary care as a function is weakening United States when it's needed most and fundamentally lacks a unified voice within Health and Human Services.

COVID-19 and the pandemic really amplified the economic mental health and social inequities that are happening in the country. If you listened to the interest group panels in the last session, this came out very clearly. It's created problems with access to care. It's created financial pressures on practices that are driving some to close and others to be absorbed into larger health systems. Primary care is where the majority of adult and children vaccines have been given for many decades; it was true before the pandemic, and yet it was not considered as part of the vaccine distribution plan until recently. There have been some meaningful policy changes like relaxation of telehealth rules, but it remains to be seen if some of those will stay in play.

So, back to the definition. We thought this was essential for the committee to make sure that they started on the same page in what we were talking about. It is slightly different than the 1996 definition. It is that high-quality primary care is the provision of whole-person, integrated, accessible, and equitable health care delivered by interprofessional teams that are accountable for addressing the majority of an individual's health and wellness needs across settings and through sustained relationships with patients, families, and communities. Two of the important changes here were the focus on interprofessional teams, because that's how we get to more robust comprehensive care delivered in primary care settings, but that we recognize we shouldn't neglect *relationship,* which is at the heart of the therapeutic benefit of primary care. That relationship isn't just with the patient, it really means refocusing on their families and their communities as well.

The second kind of high-level focus that came out of the committee is that primary care should be a common good. Everyone should have access to it that wants to have access to it. It has such high societal value, yet it's in a precarious state. Without some specific public policy and accountability mechanisms, that's unlikely to happen. We've also turned to colleagues on the committee and off the committee, trying to create some pressure for advocacy and organized leadership, particularly at the federal level.

But we didn't stop there. We certainly looked at government in terms of implementation, but we also looked at what needs to change within health systems, what needs to change in practices, and

recognizing that we need an accountability system; that means creating some champions within the federal government who have oversight of primary care broadly and creating some accountability tracking tools like public scorecards. We've worked very hard, both during the committee's work and after to align the recommendations with the priorities of the administration and the priorities coming out of the pandemic.

We really boil this down to five very specific objectives. The first is around payment; second around access; third around workforce; and the fourth around digital health—with this wrap-around fifth objective called accountability that we'll talk about more.

The first is really paying for primary care teams to care for people, not doctors, to deliver services. I'll explain that in a moment. The second really deals with our objective of making primary care a common good by ensuring that high-quality primary care is available to every individual and family in every community. The third is around making sure that we train primary care teams where people live in work and not just in academic health centers. The fourth is around making sure that our digital platforms really work to serve patients' and families' interprofessional teams. The fifth, as I mentioned, is about implementation and accountability.

To get really specific, we talked about payers being able to evaluate and disseminate payments based on their ability to promote delivery of high-quality primary care, not to reduce overall costs. Our primary function should be making sure that people get the care they need, when they need it. Costs should be a secondary issue, and we should recognize it's a long-term function, if at all. And we should really move from fee-for-service models towards hybrid reimbursement models, with increasing turning to population-based payments so that we can make sure that the kinds of care are available to people that we need them to have.

Now, if I put a little red asterisk next to an action, it means that we may not have identified a champion for that yet. In this case it's around the Centers for Medicare & Medicaid Services increasing the overall portion of primary care spending by improving the Medicare fee schedule and restoring the Relative Update Committee to an advisory nature. So really taking the lead among payers and shifting more payment toward primary care specifically to help secure the workforce and to make sure that we can put more robust teams in place.

We should really at the state level focus on multiplayer collaborations because we know most practices work off of seven, or eight, or nine different payers, and if only one makes a change then the practice can't really make a change.

Objective 2 around access is making sure that payers ask all beneficiaries to declare usual sources of care; say who you go to when you need help, and when you need health care. This can be health centers, it can be hospitals and primary care, but making sure that each of those are assuming an ongoing relationship for the uninsured that they treat in particular.

And action 2 is really just really building out more of our critical access points in health centers, and rural health clinics, and Indian Health Service facilities in shortage areas. There's been a lot of resources pushed toward these services already.

Also under objective 2 is that CMS should revise access standards for primary care for Medicaid beneficiaries and provide resources to state Medicaid agencies for these changes, really getting to

payment parity and making sure that there aren't payment barriers for people on Medicaid to get into care. The fourth under this is that CMS should permanently support COVID-era rule revisions, many of which liberated telehealth and health practices immensely. The fifth is that primary care practices should include community members in governance, design, and delivery, much like federally qualified health centers do, so that we can really create partnerships in the communities and with community-based organizations.

Objective 3 is around training, and you'll notice that both of the recommendations here have asterisks; we don't have champions yet. The first one is that health care organizations really looking to diversify their workforce and customize teams to meet the needs of the populations they serve, and that government agencies should expand the educational pipelines and improve economic incentives for getting more people to work and train in these teams.

The second one is that CMS, the Veterans Health Administration, HRSA, and states in their funding of training through Title VII, Title VIII, and GME funding under Medicare should really support interprofessional training in community-based, primary care practice environments; this is getting back to training and working where people live and work.

Objective 4 around digital health really points in the first recommendation that the Office of National Coordinator for Health Information Technology and CMS should develop a next phase of digital health certification standards that support relationship-based, continuous, and person-centered care—the kind of care that primary care should be delivering most broadly. We should simplify the user experience, then we should ensure equitable access and use to those health information technologies, and we should be holding vendors accountable, not the providers, not the clinicians. The second one is that those two agencies should work together again to adopt a comprehensive aggregate patient data system. Because people are getting care all over, and we're not able to, in primary care, coordinate their care very well if we're not able to access those different sources of their health information. Right now, patients can't even give us permission to access those data in a regular way.

Under Objective 5 the highest priority, the number one recommendation, is that the Secretary of Health and Human Services should establish a Secretary's Council on Primary Care. This is an interagency workgroup within HHS that works to coordinate primary care policy across the agencies and make sure that there's adequate budgetary resources for that work. It should have a reporting function. The second part of this is that we recommended that it have an advisory committee so that stakeholders can help with identifying priorities and helping get the support that the Council needs to move its agenda forward.

Also under Objective 5 is the recommendation for formation of an Office of Primary Care Research at the National Institutes of Health. We identified other evidence that suggests that primary care gets less than 1% of all funding for research from federal resources. We feel that having a footprint on the NIH campus might help that, just like the Center for Emergency Care Research did 15 years ago. We also call for funding of primary care research at the Agency for Healthcare, Research, And Quality, much like RAND did the summer before. The National Center for Excellence in Primary Care Research has never been funded by Congress, even though it was established in 1996 by Congress as the place where primary care research should be funded.

And the third action under Objective 5 is calling on primary care professional societies, consumer groups, and philanthropies to assemble and regularly compile a high-quality primary care implementation scorecard. In the Appendix, one of the appendices of the report lays this out as something that could be done right now using existing data sources to help track some of the things that our recommendations are aiming to achieve.

The scorecard measures are items that are already in use; they're not new. They are few in number, so they're easily understood and can be tracked consistently. They're built on data that's regularly collected and publicly available, and they're appropriate for use at the national level and at the state level.

As a follow-on from the report for folks wanting to read more, we did publish a viewpoint in *JAMA* on the same day that the report was released. A few weeks later, with the leadership from Kevin Grumbach, a *New England Journal of Medicine* piece came out really focusing on the implementation plan from the report. Alex Krist, who is on the committee, led a recent paper in in *JAMIA* on the digital health needs. So there are a number of products coming out of this report that people might find useful for becoming champions for some of the things that we've recommended.

I also wanted to just point to a couple other resources on our website at the National Academies. There are briefs for each of the objectives, including one on implementing high-quality primary care—two-page brief, very easy to enter and easy to use to help talk about the recommendations. We've also had five workshops, one on each of the objectives. Many of the folks on our panel and on the webinar were parts of the panels for each of these. I invite you to go to the website, because the videos for each of these panels are still available. On October 25, we're not finished yet, we will actually have our last workshop hosted by the National Academies. It's a closed-door workshop between payers and health systems trying to understand if payers do shift resources to primary care, how will we know that health systems are using them with that intention and how will they be accountable.

I will stop there so that we can get to our illustrious panel.

Andrew Bazemore: Thanks so much. That was a wonderful tour de force doing a very full report. I do want to make sure I move quickly so we can turn to this remarkable panel.

We've asked to respond and really further explore dimensions of the NAM report as important pathways to implementing its recommendations on the national scale. I think you'll see in the panel why we‘ve asked each of them. We’re really grateful for their attendance on a Sunday.

I do want to ask, since I see, particularly some of our international members starting to fill the chat, that as the panel speaks, you do the same. Impart your questions; we will make sure we get to the question and answer to address those in the chat as well as those who managed to speak up and raise their hands.

I’ll start with a very quick run-through of these panelists’ backgrounds and bios. As Mary had noted, we have put together a complete bio for your perusal; you'll see we could spend the rest of the session speaking to the panelists.

First, Christopher Koller is not only a member of the committee that produced this wonderful report but the President of the Milbank Memorial Fund. He's going to transition from Bob's overview of the report

to really focus on a rationale behind some great news this week and what we might do with a federal Health and Human Services interagency committee or council on interactions. He's also going to touch on the Millbank Foundation's support and interests in the work that comes after the report.

Judith Steinberg, I'm pleased to say is serving in a truly exciting new role, a senior advisory role to the immediate Office of Assistant Secretary for Health. She can tell you a little bit more about that role, why we think it's exciting, and what it means as a part of an initiative to strengthen primary health care in our nation with an aim of improving health outcomes and advanced any equity.

Steven Lopez is the Counselor to the Secretary of Health and Human Services specifically on equity issues. He will speak to the link between equity and primary care and also give us reactions to the NAM report—the objectives, particularly those that are related to an interagency committee.

Jim Macrae is the Associate Administrator for the Bureau of Primary Health Care at HRSA. He is going to discuss the Bureau of Primary Health Care's recent efforts to support primary care, and really to help outline and connect their consistency with the National Academy's report recommendations.

Kameron Matthews is the Assistant Undersecretary for Health for Clinical Services and Chief Medical Officer for the Veterans Health Administration. She's going to touch on the VA's strong and particular interests and related actions in advancing the report's objectives. She's also, and we're grateful to her, one of those who served on the committee.

Mai Pham is the President and the CEO of the Institute for Exceptional Care and has served in many roles that give her authority to discuss primary care financing, both present and in the past. She's going to point out and reference all the relevant points from that recent *New England Journal* article that Bob mentioned but specifically talk about primary care financing and the important need for its reform and change to implement the recommendations that are in the report.

And last, certainly not least, Kevin Grumbach, who is the Chair of the Department of Family and Community Medicine and the lead in that *New England Journal* article, is going to have the opportunity to try to synthesize and add his views based on what he's heard from the panelists and as we look forward.

We've agreed in preparation for the meeting with the panelists that they will handoff one to the next in the interest of efficiency, leaving time for discussion and your questions. With that, I'm going to handoff to Chris Koller.

Chris Koller: Thank you very much, Andrew, and thanks also to all of our attendees for showing up.

It's my job to talk about particularly the implementation plan that is contained in the committee's recommendations. Before I start, I want to echo Mary's comments and salute the leadership of Bob Phillips and Linda McCauley in leading the committee. It was a privilege to serve with them. I also salute the excellent staff work by Marc Meisnere and his team.

As Bob noted, we were tasked with an implementation plan; the value of primary care had been asked and answered in comprising the group. That made our work focusing on implementation particularly important. As Bob said, we start by declaring primary care to be a public good because of its unique

contributions to both reducing disparities in health outcomes and in increasing lifespan, unique among all health services.

It's the job of the government to steward public goods, and we have local, state, and federal government in our recommendations. We really focused on the role of the Federal Government, because that's ultimately where the buck stops. In the case of health care, they're all the significant levers; the ability to steward these public goods rest at the federal level—or most of them—that's where policy decisions regarding Medicare and Medicaid research and workforce are all made. You'll see that while we reference a number of stakeholders, we focus on the role of federal government, and I think that will be our conversation today.

We recognize that there are lots of public goods and they compete with one another for attention and action by the Federal Government. We really looked as we were doing this work in developing our implementation plan to understand which public goods get attention by the Federal Government. So you'll see reference to the policy window and, practically speaking, the notion that public goods must be a priority for both the presidential administration and also for the agencies that are charged with implementing or acting on that public good.

In the case of public goods, there are significantly different parts of Federal Government that are involved. So using this language of levers, it's important that the levers be coordinated. That led to this notion of the Secretary's Council. I will read, just to underscore what Bob went through, the recommendation regarding the Secretary's Council says that the HHS Secretary should establish a Secretary's Council on Primary Care to enable, and this is a primary goal, to enable the vision of primary care captured in the committee's definition. It makes recommendations and details in terms of its members, and it outlines six duties related to payment, workforce, to coordinate the adequacy of the research to look at the technology, the evidence, and the data regarding primary care, to align public and private payers, and to come up with meaningful metrics. More generally, we think that with the significant, again I'll use that word, levers that the Federal Government possesses with regard to primary care, there is just enormous potential to implement the actions in all five of the areas that Bob covered in his opening remarks relating to payment, relating to access, relating to workforce, relating to information technology, and finally, with regard to accountability.

You'll notice that there was not a star next to the action 5.3 under accountability, and that is because I'm pleased to announce that the fund, the Milbank Memorial Fund will take up the challenge of coming up with a high-quality primary care implementation scorecard. We will be producing that scorecard. We are, I would say, weeks away from announcing both our funding partners and our implementation partners, but we envision an annual report to measure the health of primary care.

Bob outlined, frankly, the fact that we're moving in the opposite direction. Primary care is fragile and weak at just the time when it could be of help in terms of helping to address the effects of the pandemic, to prevent the pandemic, to address decreases in lifespan and increasing disparities. We improve what we measure. On behalf of the Fund, I'm pleased to take up this challenge of a high-quality primary care implementation scorecard.

The other thing I want to speak to is my experience as a state official. I was the Health Insurance Commissioner in Rhode Island. What I see now in our work as a Fund with state officials, there is leadership at the state level of our primary care, but we need partnership and leadership at the federal

level. That's why I'm really pleased that we have a number of our partners from a number of different agencies in the federal government with us who've taken time on a Sunday afternoon to talk about this common goal. I'm sort of the setup for, really, I think these important discussions that will follow about the role of federal government.

What I'm going to do is hand it off at this point to Judy Steinberg. She is the senior advisor to the Assistant Secretary of Health. She's been heavily involved with these conversations. She has borne the brunt of Bob Phillips and his relentless advocacy around this work; you should know that you are well represented. Judy, please, take it. We're very anxious to hear how you've been working with recommendations that the committee has come up with.

Judith Steinberg: Thank you very much, Chris, and thank you to the meeting organizers for inviting me to present on this panel today. It's a pleasure to be here, even if it is a Sunday.

I do have some slides. Let me just pull them up. There you go, you should see them now, yes? Good.

As you just heard the National Academy of Medicine's primary health care report calls on HHS to implement some very specific actions and also to take on this leadership role in overseeing and steering its recommended action plan. I want you all to know that HHS and the office of the Assistant Secretary for Health recognizes the importance of having a strong primary health care foundation in our health care system. We are exploring actions that we can take to strengthen primary care to ensure high-quality primary health care for all.

Our work begins with our mission, and here is the mission of the Department of Health and Human Services. I do want to emphasize that underlying this mission is an underlying principle, and that is health equity. Also on this slide you can see the agencies that the National Academy of Medicine's report calls on for specific actions in the implementation plan that was just reviewed.

Just a word on the Office of the Assistant Secretary for Health: Our new Assistant Secretary for Health is Dr Rachel Levine. She's a pediatrician and adolescent-medicine specialist, and she gets primary care. Here on the slide, you can see the vision for the Office of the Assistant Secretary for Health and the role that we play in all that we do. So, given our focus on health and our role in convening partners, both federal agency partners and external stakeholders, to organize and lead national initiatives, strengthening primary care and working in that realm is right up our alley.

That brings me to what is it that we're doing. The initiative to strengthen primary health care was launched by the Office of the Assistant Secretary for Health in September. Its aim is to explore actions that HHS could take to strengthen primary health care in our nation, ensure high quality primary care for all, and improve health outcomes, and advance health equity. And we have a specific activity; that is to develop an HHS plan to submit to the Secretary for review. It begins with delineating the HHS's role in steering, coordinating, and overseeing the implementation of the plan for strengthening primary care; and how we would do that; and also the specific actions to be taken by HHS and across HHS agencies with deliverables and timelines. The National Academy of Medicine Primary Care Report can inform the development of the HHS plan.

Here's a status update. It's just been a month; I was asked to take on the lead for this initiative in the end of August, and we started in early September. We're working on staffing a team and also looking to receive additional support for the development of the HHS plan. We are working with our HHS agency partners, HRSA and AHRQ, who were sponsors of the National Academy of Medicine's report and meeting with their leadership on a regular basis for guidance and to keep them in the loop.

We're also, as per our work plan, reaching out to federal agency partners to discuss specific actions and also reaching out and speaking with external stakeholders to hear about the actions that they are they're suggesting. We have developed an HHS Plan proposal framework, like an outline, and that's currently under review.

Importantly, I wanted to highlight for you, that there's a lot of activity that's happening in HHS and in the current administration, and we're going to do a crosswalk of the National Academy of Medicine implementation action steps with some specific activities such as the HHS strategic plan, which is under development right now. As well as some committees and councils that are developing action plans that are focused on behavioral health, social determinants of health, and health disparities. And also a plan that's coming underway around telehealth. We're doing this to be efficient and avoid duplication of effort, also to align our efforts across these different plans, and importantly to understand the actions that agencies have proposed or have already committed to that will essentially work toward strengthening primary care.

Last, we aim to complete the HHS plan proposal by spring 2022.

With that, I'll close. Thank you all very much. Here's my contact information, and I look forward to our discussion. Now I'll turn the presentation over to Mr Steven Lopez, Counselor to the Secretary of HHS. Stephen?

Steven Lopez, HHS: Thank you, Dr Steinberg. Hello everyone. I just want to extend my thanks for inviting me to join today's panel and represent the immediate Office of the Secretary of the Department of Health and Human Services.

As Judith mentioned, the mission of HHS is to enhance the health and well-being of all Americans by providing effective health and human services and by fostering sound, sustain advances in the sciences underlying medicine, public health, and social service.

Equity is an important priority for the Biden-Harris administration and is a key part of our mission at HHS. This includes addressing health disparities and promoting equity for underserved populations. The Secretary's made it very clear that this is a key priority for him as Secretary of HHS.

Underserved populations include individuals who belong to communities that have been denied consistent and systematic fair, just, an impartial treatment, such as Black, Latino, Indigenous Native Persons, Asian Americans and Pacific Islanders, and other people of color, LGBTQ+ persons, persons with disabilities, persons who live in rural areas, immigrants, and persons otherwise adversely affected by persistent poverty or inequality. Secretary Becerra aims to carry out President Biden's vision to build a healthy America, and his work will focus on ensuring that all Americans have health security and access to health care.

We understand that the root causes of health inequities are societal and structural inequities at multiple levels, including interpersonal, institutional, and systemic biases in policies and practices that favor some groups but not others. Strengthening primary care provides a path to improving health outcomes and advancing health equity. The data are clear: Better primary care is associated with more equitable distribution of health. Stronger primary care systems are generally associated with better population health outcomes, including lower mortality rates, higher infant birthweight, greater life expectancy, and higher satisfaction with the health care system. And a larger primary care workforce is associated with better health outcomes, including increased life expectancy and reduced cardiovascular, cancer, and respiratory mortality.

What actions are we taking at HHS? Well, the Biden-Harris administration recognizes the urgency and the need for action-driven efforts, and we are pleased to see that there is now a concerted focus on health equity and environmental justice across sectors—federal and state governments, professional societies, and academia, among others. At the federal level, some of the work that we're doing to advance equity include the development of the HHS strategic plan that Judith referenced in her presentation, which will place equity at the center of our strategies; designating an Agency priority goal with a focus on equity that will hold us accountable to measure progress over the next 2 years on our equity work across the department; convening the COVID-19 Health Equity Task Force and recommendations on how to address public health emergencies moving forward; and launching the Office of Climate Change and Health Equity in the Office of the Assistant Secretary for Health; and now, this initiative to strengthen primary care in our nation, well described by Dr Steinberg.

Again, primary care is the foundation of our health care system, and we look forward to the recommendations in the report and identifying opportunities for HHS to move the ball forward. To achieve our aggressive goals, we must have a strong foundation of health care and primary care.

Again, thank you for your time and for inviting me to participate in today's conversation. Now we'll pass the mic to Jim Macrae. Thank you.

Jim Macrae, HRSA: Great. Thank you so much, Steven, and thank you so much to the National Academies for the report, for convening today's session. I really do personally feel like we are at an inflection point with respect to primary care in this country, and I think your report is a key piece of it. But, as you said, I think the key part of it is whether this will actually turn into action and meaningful change.

What we've seen with the pandemic has really put a spotlight on the importance and, to be honest, some of the challenges that we have with primary health care in this country. I think it's really a moment for all of us collectively, wherever we sit, to make that kind of impact.

I, myself, have been overseeing the Community Health Center Program, for, I hate to say it, but almost 15 years at this point, and have seen just tremendous growth in the program itself but also tremendous change. Because of all of that, it really does give me hope that primary care in this country, not just for the underserved, which I think is critical and a key piece of what we do in the Health Center Program, but really across the board can make meaningful change. In our Health Center Program, we have about 1,400 community health centers across this country that operate about 13,000 service-delivery sites,

providing care to about 29 million people—that's roughly about 1 in 11 in this country. A vast majority of those are living below 200% of the poverty level, over 90%; two-thirds are racial and ethnic minorities. They serve almost a million people experiencing homelessness, as well as almost a million migrant seasonal farmworkers, as well as about 400,000 veterans. I'm really happy to see Kameron on the call today and the great partnership that we've had with the VA.

What I really see, though, is sort of three key things going forward that I wanted to share related to the report. The first is about expanding access. You see that commitment from the administration, first through the American Rescue Plan; we have invested almost $7.6 billion into the Community Health Center Program to expand their capacity to do vaccines, care and treatment, as well as testing for COVID-19. As Stephen said that was really a focus on the whole issues of health equity and making sure that those most vulnerable in our country were reached. It also included investments in primary care itself and, in particular, just recently invested in capital to actually support the infrastructure to support that kind of expansion.

In addition, the President's 2022 budget includes a commitment to double the overall investment in health centers on an ongoing basis, which is significant; that would be almost a $5 billion ongoing investment to expand the capacity. It's three prongs to address that: One is to go into communities where there isn't currently available primary care—and there are a number of communities in this country as the report pointed out that don't have adequate access to primary health care. It's also expanding that footprint of what primary care actually looks like, and I was really appreciative of the report that you talked about not just medical care, but behavioral health, oral health, and all the enabling services that are critical to make sure that people get access to care. And then, finally, one of the key other components of the whole effort to double the program is to truly address health equity and health disparities—implementing evidence-based practices but involving the communities to address those social determinants of health.

Another key part that we see from the report is investing in the primary care workforce. One of the reasons why we are co-sponsoring this project, and Andrew and Bob know this, is that we were worried about primary care providers before the pandemic. Issues of burnout and well-being and COVID-19 has just put an enormous spotlight on that, and we continue to be very concerned about it. We really see that concern and the effort to be addressing everything from training at the very beginning of primary care all the way through practice. We know that getting people exposed to primary care, we know getting people exposed to underserved communities makes it much more likely that they're going to practice and be involved in primary health care; and if we don't do it, it's going to have a negative impact. We also know we need to make primary care more attractive. We need to create opportunities for reductions in overly burdensome paperwork. We need to create opportunities for them to engage more fully in the practice and training of future providers; we've seen that as a huge recruitment tool. In fact, almost 70% of our health centers are now involved in training. And we need to expand our efforts to bring joy back into primary care, so one of the things that we're actually doing is this year we're going to be conducting a survey of all of our staff to set a baseline of where we are with our workforce and their satisfaction. But we have a lot to do in that space to really address our workforce.

Finally, the last piece of the report, which we're starting to work on with our colleagues in CMS is really looking at payment. How do we move from really the orientation of pain for visits to that more comprehensive role that primary care can play, and making sure that the reimbursement follows that?

When we've had our conversations, what we've said is, what do we want primary care to look like, and then let's figure out what a reimbursement structure that supports that would actually be; because far too often the payment drives how care is delivered as opposed to the reverse. I'm very excited to be a part of today's conversation and dialogue, very excited about the report. A big thanks to the National Academies. At this time I'd like to turn it over to Kameron Matthews to share perspectives from the VA.

Thank you.

Kameron Matthews: Thank you so much, Jim.

This is such an exciting discussion to be a part of. I have to acknowledge, of course she's already spoken up, Dr Carolyn Clancy.

I think from the VA's perspective, it is without a shadow of a doubt that we are not only aligned strategically but I would even say operationally as far as looking at the implementation of high-quality primary care throughout our health system. Our very values are aligned: our delivery model, which many of you are aware of, really promotes the concept of usual sources of care that's both accessible and equitable; as you look even beyond that with how we even purchase care outside of our system. We are indeed prioritizing the enrollment of our veterans in primary care systems and how that integrates back into VA through care-management models and the like. We promote that our primary care is both multi-disciplinary and interdisciplinary, that we bridge multiple modalities of care, even state lines, with our really federal supremacy over telehealth work, and how we are able to look at that veteran's care regardless of where they may be living, where they may be summering, but that, indeed, that technology even is helping facilitate that communication.

I think it's also worth highlighting, more than anything, this delivery model that we have—I'm assuming all of you have seen it. I know Bob has forwarded it around in multiple circles. We are very proud of the recent article that was published this month in the *Journal of General Internal Medicine* regarding the primary care through VA primary care teams having about 25% lower costs just through the sheer enrollment in primary care and our ability to control costs in other modalities even when comparing the same sort of patients through their own Medicare enrollment outside of the VA.

I think we have to acknowledge that one of the strengths of the VA system is that we have the strength of our national data that allow us to approach our interventions as equitably as possible and to really even resist the one-size-fits-all mentality. We tend to think of veterans as, or at least where we're trying to step away from this, but I think traditionally we tend to think of veterans as a single unit, but that instead we really are seeking through our data to differentiate our patient populations, to look at tailored responses that acknowledge primary care, even down to our women veterans, our homeless veterans, our geriatric TAC teams, as we even have it, really do supply different scopes of care and acknowledge the larger concepts of what is parallel to really community-based care, really differentiating the needs of the individual veterans and what they're receiving in primary care and, again, stepping away from the one-size-fits-all concept. We are equally as interested, as I am so happy to hear the conversations from our HHS colleagues, we're equally as interested in being in the federal conversation. Our partnership, our interoperability, and even our operational integration all differentiate with our partners—the public health–commissioned corps as well as DoD—really does lend

itself with our ability to continue to influence and continue to advocate for that stronger primary care infrastructure. Although we may have different approaches to our delivery with regard to DoD's mission with regard to military readiness; ours is more of a different sort. We have the ability to really emphasize that partnership and to look beyond payment incentives at really how to best coordinate that care, especially when you're looking at our veterans that are dual eligible. We could even look at that broader population of the triple eligible, those who are also enrolled in Medicare.

It even goes beyond that. Jim, I'm so glad you are acknowledging earlier the connection VA and Health Center is a significant portion veterans are enrolled in. Individual Vet centers are still receiving services in the VA. The ability for us to bridge these multiple different programs and to use this as a model, it is not just about veteran care, but why are we not also making those connections of other patient populations between multiple federal services. I think it would behoove us to look at VA as a model, and we are ready, and willing, and able to serve in that role. Our ability to be a part of this larger not just academic conversation, but operationally how we can move forward with influencing these changes across our nation. We can be at the lead of that with Dr Clancy's leadership. How can we not acknowledge the strength of our research program, of our training programs, and the emphasis that we place on training our staff in the communities where their patients are being served? Many of our staff are veterans themselves, they have the experiences of the veterans themselves; that exact parallel should be applied to the communities that we are concerned about when we're discussing inequities and when discussing poor primary care infrastructure as a whole. What we've stood up as far as the VA can be directly applicable to other communities when you're thinking about building up resources, and we are happy to be a part of that conversation.

With that, I think I'll just end. Many of you are aware of our upcoming, well, current deployment as far as the digital health concept that we are taking part in. Again, hoping to lead the nation in our modernization effort as we move to our Cerner deployment, along with DoD, I think there is plenty of room for us as well, to be a part of that conversation and how we can really hold our partners in the IT space more accountable when it comes to primary care and how their tools are actually assisting us in achieving a lot of the goals of the committee, and we stand ready to serve in that advocacy space, clearly being the largest deployment that any EHR product has ever seen. I think we'll have the ability to really stand by everyone's side here to see that we're achieving those goals as were outlined by that specific objective.

With that, thank you very much for including VA in this conversation. We are eager, and willing, and ready to continue to move forward with these objectives.

I'll hand it over to Dr Mai Pham. Thank you.

Mai Pham: Thanks very much, Kameron.

Thank you for having me here today. It's wonderful to be back in the tribe of primary care, which is not a pleasure I've always had in the past decade, but also to help move the conversation along a little bit. I know that we've spent some amount of time talking about the vision for primary care and its challenges. We also have to talk about action and what it takes to help fix the problem.

It's my job to touch a little bit on the recommendations from the NASEM report on financing and payment for primary care but more so to share with you a vision for how we can move forward on that.

As someone has said, we would like payment to follow the outcomes that we want to achieve rather than dictating outcomes we happen to dangle incentives for. However, I think that within this circle of friends, it's really important to grapple with the reality that, I honestly don't think as a matter of practicality, we can go forward and advocate for better financing and payment for primary care on the basis of saving the workforce or a kind of me-tooism that primary care is just a good and end in and of itself. We don't live in that political world right now, unfortunately, and so I would posit to you that it would be more effective for us to reframe the conversation for policymakers who have staid, deliberate goals of reducing inequities, of improving rural health, of generating whole-person in community health, and of finding value in our health care system. None of those goals are achievable without a sound primary care infrastructure.

So that we change the conversation so that it is not about giving primary care providers there due; it is about achieving the results you're trying to get to anyway, but you have to go through a solid primary care infrastructure to get there. Under that framing, the NASEM report touched on many recommendations where there's strong policy consensus around the need to invest net new funds into primary care because it is an infrastructure that has been starved for such a long time. That net new investment should take into account what modern primary care could and should look like, including, for example, the appropriate financing and payment mechanisms for telehealth and other modes of care delivery that could broaden access and help reduce disparities while at the same time moving the system to higher value.

Doing so, in all likelihood, must require moving away from fee for service. The NASEM report wisely recommended that we begin with a hybrid approach to try to find that balance between fee for service in order to ensure productivity, but also a population-based payment that gives primary care clinicians and practices the flexibility to do what they need to do for that patient in front of them as well as to invest in infrastructure that can sustain their enterprise and make them much more able to actually execute on population health.

Once again, premise on significant net new investment. There is a group of us advising some primary care advocates. We estimate a very minimum, bare floor of 25% increase, and we think that's extremely conservative and low and it probably needs to be closer to double that in terms of net new investment.

To do that, keeping in mind that this is not a redux of the 1990s primary care capitation. We are not interested in insurance risk for primary care clinicians; we're interested in performance risk because that's something they can handle. Until you have re-engineered the overall delivery system in such a way that primary care providers can actually move market levers and influence other providers, they have no business taking insurance risk. Its performance risk; it’s population-based payments hybrid with fee for service, although full performance de-capitation for anyone who wants it; with appropriate risk adjustment, which implies to us new risk adjustment tools that are specific to primary care because hospital utilization may not at all predict what is necessary in a primary care setting under current risk-adjustment rubrics; and with quality metrics that reflect the outcomes we’re after as opposed to checkboxes that are easy to measure.

Having said all that, what does the practical path look like going forward? I am stateless, I am nationless as a primary care advocate right now, although my organization advocates on behalf of people with NIDD. It is not for me to say what the political strategy should be, but I will tell you that it will have to be political, and I will tell you that many friends of primary care won't want to take up that banner unless primary care fights for itself. That said, I do believe this will require a much broader coalition, nontraditional coalitions—I don't mean just payers and professional societies—I mean other primary care professions; I mean consumer organizations that have a stake in this; I mean investors who have a stake in primary care doing well. There's a lot of money flowing, capital funds flowing into primary care right now, and they're going to want their investments to succeed. We need to think broadly about the coalition that can make the case to policymakers.

Who are those policymakers? I think that the NASEM report made a cogent argument for Medicare being that critical linchpin, the leader among payers that can really shift the whole system because the Medicare fee schedule and Medicare payment policies are so critical as the backbone for how other payers design their systems. That said, it is an entire federal government, Judy, with many levers at its disposal. It is not just Medicare; it is also FEHMP; it is also the ACA exchanges and plans there; it is also Medicare Advantage plans and TRICARE. We talk about multipayer engagement, but we have a lot of multipayer within just federal government that can be leveraged as well.

I want to acknowledge that this is hard, and this is… We are we are below 50% probability for this being a successful campaign. Nothing about recovering from a pandemic or a recession helps this effort, except that this is a sector in the delivery system that lost $15 billion last year; that's a conservative estimate. The country cannot recover from COVID without helping primary care recover as well.

I want to acknowledge that the Primary Care Collaborative is really trying to take a leadership role in this regard and cue in closely to the NASEM recommendations. Please keep your ear out, your personal and professional ears out, for how organizations you're affiliated with may become a part of this coalition. There is some really concrete analytic work that needs to be done in order to feed policymakers the nuts and bolts of how to do this. I'm happy to share more with you offline about that, but some of that work would be funded, I think we can say publicly now, by the Commonwealth Fund and another foundation that I'm probably not allowed to say yet. There is broad support from the intelligentsia. We need to make this real and feel real to policymakers who worry about their communities and their constituents and what it means economically and in terms of life outcomes. If we can make that real to them and not about saving a burned-out workforce, as deserving as I feel that is, then I think we might stand a chance.

With that, I'll turn it over to Kevin.

Kevin Grumbach: Thanks Mai. All right, you set us up for challenge here, so this is great.

It is a treat and an honor and a little bit intimidating to wrap up this panel of illustrious speakers. I do want to say it's wonderful to see so many friends and colleagues in attendance, so hello to you all.

Let me go back and start with a positive, and then I'm going to challenge us to redouble our efforts to tackle the root causes of the primary care predicament in the United States picking up, I think, on some of the themes and encouragements that Mai just put forward to us.

The first thing I would say, it is really a terrific National Academy of Sciences and Engineering and Medicine report, so I really want to thank everybody on the committee. I think it was an unusual report in several respects.

There's two things I really want to hit home from what Bob gave in his overview. The first is the committee coming right out and saying that primary care is a common good. Now that may seem self-evident to all of you here in attendance today who understand primary care and care about it, but let's face it, in the United States, context of a very market-oriented health system environment still, that was a profound, and I would say a bit edgy, statement to come out and just declare that primary care is a common good and to try to move us away from thinking about judging primary care in terms of short-term return on investment. That's really true, has been true in my experience, not just from private payers but from government payers, which is the idea: show me within 12 months your patient-centered medical home intervention will yield some short-term return on investment but lower hospitalization. It's really helped us to move out of that framework and think much more broadly of long-term benefits, to society, of primary care.

The second was really emphasizing an action-oriented implementation of strategy plan, which was really terrific. For the panelists today, I mean I hope you all feel as positive as I do to have these great people coming together from different sectors—from foundations, from health agencies in the federal government, from professional organizations—who all so clearly are committed to advancing primary care in this country.

To see Chris Koller talk about Millbank Fund this for the long-term. It's not just ending with funding the report, but they have skin in the game to try to move this scorecard for it. I believe the Samueli Foundation that also contributed to the report is also planning to have some continued investment on the implementation aspects. That is terrific to have some of the funders here say we still are going to continue to help move this work forward.

Second, I mean today to have it heard here, this is in many ways among the first public announcements of this new federal initiative to strengthen primary health care. I'm really grateful to Dr Steinberg and Steven Lopez for sharing the outline of what I think is really an effort to take the Committee's and report's recommendation for a high-level Primary Care Council in the Department of Health and Human Services and really manifest that in this new initiative. I think we're really excited to see that moving forward.

Having people like Jim Macrae and Dr Kameron Matthews talk about, man, they are so all-in in understanding community health centers in this country, rural health centers, for the VA system primary care is critical to what they're doing and that they are committed to this. Then they have some of the new evidence from the VA that Kameron cited is terrific. I think this is all positive.

I think the real question is one that Jim put to us. Jim, I believe I heard you say, the question is will the report translate into action and meaningful change? And I have to say, having been at this for a long time like many of you, I always have to think, why are things the way they are in the United States and in our nation's health system and what will it take to change the state of affairs so that the disadvantaged primary care sector can really be revitalized in service to the needs of our nation? It's always great to have our international colleagues on these meetings, because you can just sense the incredulity of Jim Meissner sitting there, and Carmen Garcia-Pena, and Carol Herbert, Martin Roland. I'm looking because I

can read their body language even on Zoom is saying, what is up with you folks in the United States? How do you spend 40% more than any of our nations on health and have a life expectancy, on average, that is 3-1/2 years less than what we have in our nations? What's up with you all? I also saw Rosemary Stevens participating; Rosemary is a great historian in health and medicine, and you have to understand history to understand where we are today. I think we do have to look at a historical perspective. Why has there been such stubborn lack of progress, frankly, in so many of the things we care about to make primary care work in this country?

So 40 years ago, Paul Starr published the book *The Social Transformation of American Medicine,* really a classic. The first sentence of that book reads, "The dream of reason did not take power into account." I'm thinking a lot these days about the persistence of structural problems that threaten the health of our people and our planet, such as the issues of climate change and equity that are the themes at this year's National Academy of Medicine meeting. I mean, despite the clear evidence about what needs to be done to rectify these problems, and it seems to me that it comes down to Starr's observation that what is reasonable to do often conflicts with the interests of those in power.

Let's face it folks; we cannot monetize primary care, a whole way of delivering care based on relationships, not on commodification of health. Primary care, as the committee declared, is a common good; it's not a profit center. I think we always have to come back—there are fundamental differences when talking about the United States compared to our compatriots and other nations that all have some universal health program with a strong role for government planning if not actual government financing and administration.

I would close by saying the challenge to our interest group and to all those committed to strengthening primary care and service to the people of our nation is to speak truth to power, go back to Paul Starr's comment, and to call out what Daniel Dawes at Morehouse refers to as the political determinants of health. I think as part of that, I would take Mai's comment to heart about maybe we just need to think a little bit about our own complicity in maintaining the status quo. Do we too often advocate in a way that seems self-serving? Do we talk about primary care spend that it seems like, how do we make doctors earn more money? Have we been so much in our sectors as physicians and nursing, and divided and conquered, and seen, ultimately, a lot of the work we've been doing comes across in the public as self-serving? How do we take up Mai's challenge to form a broader movement in partnership with the public, with patients, with consumers, with advocacy groups? My fund is working with advocacy groups around people with disabilities. How do we link arms and really have a much broader coalition that can march forward together to make primary care a policy and political priority in this country that will become sufficiently resourced and organized to achieve its promise as a common good?

I think this NASEM report is a terrific step, to see Judith and Steven here today and say yes, we will see some action at the federal level to really create some of this organizing structure, to see leaders of agencies, foundations committed to wanting to move this forward. Let's absolutely keep pushing that, but I think, then what's beyond that? What do we really have to do fundamentally to shake up the kind of dynamics in this country that seem to always hold us back from really getting primary care where it needs to be hitting a more reasoned approach to health care delivery in this nation?

With that, let me close and turn it back to Andrew, I think.

Mary Wakefield: Close enough, Dr Grumbach.

First of all, many thanks. First to you, Bob, for setting up the conversation talking about some of the details that are really important action steps that were advocated in the report. It's really such a dynamic report with a lot of expectation, much of which was just talked about across our various panelists. Special thanks to each of the panelists, too, for sharing the insights that you've shared. Kevin, as always, your synthesis and, in addition, adding in your seasoned expertise and perspectives really value-add for the conversation.

We have some important observations that have been shared in the chat, not always so much as questions, sometimes as observations listed there. I do think it's important for us to bring some lift to some of them and Ed is going to help me do that because it's been a lot of chatter there.

Before I do, and Andrew if it's okay with you as a co-chair, I'd like to go back to the panelists one more time. They have now heard each other speak on this topic with this particular agenda, for the first time hearing each other. We've got people from foundations, federal sector, private sector, etc., on the panel, and I would just like to give them a chance, very quickly, if any of them would like to react to what somebody else has said or add to their own remarks. Then immediately following that pick up on some of the observations and questions that have been raised in the chat. Before I do that, is there a burning observation, addendum, that one of you on the panel, or you too, Bob Phillips, for that matter, would care to add in before we get to some of the other comments in the chat? As an aside, I'm not going to assume that everything that's been added in the chat has been seen, especially by our outside-the-Academy participants. I'm not going to assume that they've seen that, and that's the reason why I will bring in some of those comments.

First to the panelists and to Bob, anything that you heard that you want to react to or add to the conversation thus far? It's been so rich.

Bob Phillips: Mary, this is Bob. I would just add very quickly that there's a lot in this report, and there are a number of comments that have come up in the chat that are so helpful because they've let me point to some other things in the report that we've not had a chance to talk about today.

The integration of behavioral health is a priority, lifted by the report as an example of integrating more team-based functions into primary care. There's a lot in the report about dealing with social determinants of health at the community level not just the patient level and getting back to community-oriented primary care models of care.

I would invite folks to take a little bit deeper dive into the report. It's very searchable for particular ideas, but with the notion that there might be things here that are closer to your heart that might be something you'd see a path to championing. We need a lot of the folks in this interest group to pick up pieces and to join some of the collaborations discussed today to make sure that this report doesn't fall flat. Thanks.

Mary Wakefield: Thanks, Bob. Then I'm going to go to Judy, then Jim, then Chris. Judy?

Judith Steinberg: Thank you, and thank you all. I've been taking my notes, as well as I'm sure others have as well.

I really would like to reinforce some comments that were made about the importance of working actually across government, not just in HHS. Kameron, I want to let you know that the VA is right on top of my list of agencies to reach out to, and also I think there's much to be learned through the Department of Defense, the White House has some offices that are that are applicable, for example, the Office of Science, Technology, and Policy as it relates to telehealth and connected health. We've already made some connections with them, and I want to assure you that kind of approach is what we're taking in developing this plan for HHS.

Mary Wakefield: Thanks Judy. Jim?

Jim Macrae, HRSA: I think the two pieces that really struck me, and I really appreciate the feedback from my other panelists, was: One was the focus on primary care being a common good and what does that actually mean. I think that was in the chat. How do you actually operationalize that because we have such a mentality around payment?

And then the other comment at the same time saying we have less than a 50% chance of being successful because of all of the current forces in the system, how things are set up, and how we've been talking about primary health care and what it does and almost reconciling those two realities.

The other piece, honestly, for me, Mary, is, and this is my appreciation for you, is it takes leadership within the organization and real commitment. I know when Mary was running HRSA, one of the things she continually did with us was really push us to think differently about how we do our work; you need that in a bureaucracy. But the other part of the equation is you need outside forces also pushing on the same way if you're really going to do anything different. It's really combining those two different pieces in terms of making real change. It's going to be incremental. It may be in fits and starts, but that's the other thing that I've seen overall. I think for me it's that reconciliation between common good and the payers, and how do you reconcile those two pieces in terms of how health care is organized in this country?

Mary Wakefield: Thanks for those comments, Jim. Chris, your hand is up.

Chris Koller: Thank you, Mary. I just want to underscore some comments that Mai and Kevin made, and it's a good baton pass from what Jim just said.

I think we've won the argument about primary care from a logic standpoint. Kevin, I never heard, I'm embarrassed to say, I never heard that Paul Starr quote; it's wonderful.

It is up to us to make it easier for our federal partners to do what they know to be the right thing. That means almost… Bob, I wish we could have come up with a science of coalition building, because that's really what we need for our implementation. It's looking for partners that prioritize primary care so it's easier for the federal partners to act on what they know to be true. We have a real opportunity now because the Biden-Harris administration has framed this as equity. As Mai noted, the road to health equity goes through primary care. I see Neil Calman on the call. Jim knows this; you cannot get to equity without talking about primary care. We have to get other people engaged in that discussion so that our federal partners can do this work that we're urging them to do.

Mary Wakefield: Thanks, Chris. Mai, I'm going to go straight to you.

Mai Pham: Thanks, Mary. I appreciate all the comments.

For me internally, it's very important to hang on to that framing of health care is a common good; however, I don't have such high regard, frankly, for many political leaders on either side of the aisle. I think for them it's very pragmatic decision-making, and so I approach it a little bit more in a motive parenting, if you will. I'm going to hope for some internal motivation on their part in the framing of common good, but I'm not going to rely on it. I don't mind using somewhat scary counterfactuals to help motivate them. But it's also important to make concrete what it means for primary care to be a tool to the ends that they care about. We can't just say it's important for equity; we have to spell it out for them to say, it's important to equity because populations that have many social challenges, environmental challenges, need clinicians who have the flexibility to spend more time with them in order to connect with the community-based organizations and support services without having to worry about the lack of a billing code for that activity. You have to really spell it out for them and make it visceral for them, because they have constituents.

Right now practically anyone with an elderly population in their Congressional district, which is everybody, is concerned about COVID. Elderly people, those who are vulnerable to infection, are the last people you want to bring into the office if you don't have to. You want to fund health. There is no way that the Congressional Budget Office or OMB or even CMS will allow you to offer payment parity for telehealth on a fee-for-service basis. Get over it. Here's the path. Let us offer you a path to solving that problem. It is paying primary care population-based payments at an elevated price so that they can afford to deliver the telehealth to save your constituents. I'm not a communications expert, but I am cynical enough about our political leadership that I know this group can be creative enough with your argumentation in order to get the point across in a visceral way.

Mary Wakefield: Thanks, Mai, for those comments, too.

Both the last comment, Mai the comments you were just making, as well as some of the others that have preceded you, actually speak to some of the observations that were raised in the chat. One of them, for example, being how do we distinguish this report from prior reports? How will this report be executed, operationalized fully, robustly compared perhaps to earlier or other reports that are released

by the National Academy of Medicine? You just talked about, Mai, just because you're the last person speaking, talked about what you think needs to happen and how it needs to happen differently in terms of really fully moving this agenda forward. That's just one example.

Bob Phillips, you talked about, for example, the report speaking to behavioral health; you mentioned that in passing. There was a comment in the chat asking whether or not primary care includes oral health. Very specific question, but I don't want to minimize any questions or observations. Bob, since you talked about behavioral health, would you mind just coming in on that, whether or not oral health is part of the primary care rubric as well?

Bob Phillips: No, thanks Mary. It was really helpful to have a dentist and folks who work in health centers with dental access; it was very important.

I talked about behavioral health because the evidence for it is so strong, and the evidence about the lack of payment systems to support it is equally strong. Oral health is also really important, particularly in communities where people have poor access to oral health. There are really good models, particularly as Jim mentioned, in fully qualified health centers for integrating oral health, so that people can get all of the care that they need in one place.

The report talks about the value of doing that more broadly, integrating oral health into primary care. Where it's not possible, where your practices are small and being able to invest in that kind of infrastructure is not possible, there are good models like Vermont's where there are community-based resources where multiple practices refer patients because they have relationships for mental health, for oral health, for social work. It's not one model, but the capacity to have those relationships where handing off a patient has a particular need, including oral health, is just so important.

Mary Wakefield: Thanks, Bob, for answering the specific and then also putting it in that larger context of other services needed. There was a lot of conversation that I think was catalyzed by Dr Clancy's observation that DoD has equities in this space, VA does as well, and I think Judy answered that really nicely in terms of calling out the intention to link with other federal agencies, not just operating divisions like HHS but also, more broadly. I don't know that we need to spend more time on that other than just to reinforce it, that there's clearly, and Kameron raised the issue, that many others came in behind it being incredibly important. That does get at that issues needing to be less siloed, more cross-cutting in terms of activity in this space. I don't think more needs to be said about that.

Andrew, I just want to turn to you for a second and see if there's anything from the chat. I have others, but I'm also sensitive to time; I know I'm a little bit over time.

Andrew Bazemore, is there anything you want to tee up from the chat? Then I can transition us on to the next part of our meeting. Andrew?

Andrew Bazemore: Mary, there's more than we can possibly get to in time. I think the only one I might tee up is a note that the report is specifically calling for adjustments of payments for social risk so the

primary care coalitions and teams specifically that are taking care of disadvantaged populations actually have the resources and tools they need to address not only clinical care, I'm ad libbing a little bit here, but also the social needs, specifically. I just wondered if Steven Lopez had any insights or comments on the linkage that's calling out between primary care payment reform and equity.

Steven Lopez, HHS: Thank you for the question; I'll try to be brief. Before I respond to that, I just wanted to go back to Mai's comment, just lift that up again. She said it much more eloquently than I did about you have the road to making progress. On health equity, no question it includes primary care. I just wanted to reinforce that, once again.

I think, to what Mary just said right before this, there are a number of equities here, and there are a number of stakeholders internally at HHS that need to be a part of this conversation. I don't want to speak for my CMS colleagues who are deeper into the weeds in this, but certainly I think there is a case to be made, to your point Andrew, about that point.

I think, having listened to this panel, I just have an even greater appreciation for just the multiple threads that need to be woven together in order to get this ball moving forward.

I certainly appreciate the question.

Mary Wakefield: Thanks, Steven. Let me just say thank you to all of our panelists and to Bob for your remarks and for sharing this wealth of expertise that runs through and across all of you. What an incredibly interesting conversation. I also want to thank the members of the public who have joined us for this part of the meeting, because at this point they will be disconnecting and we're going to turn our attention to the last part of our meeting, which is going to be facilitated by Dr Bazemore specifically with members of the National Academy.

For that part of our conversation, the panelists are absolutely invited and encouraged to stay with us if and as they can. As I said, for the members of the public who have joined us, thanks much for giving us your time and, hopefully, this was a helpful conversation for all of you.