The Power of Primary Care

Dr. Elisa Choi: [00:00:00] Welcome to the DEI shift podcast, focusing on shifting the way we think and talk about diversity, equity and inclusion in health care. My name is Elisa Choi. I'm an Internal Medicine and Infectious Disease specialist in clinical practice and also a clinical educator of medical students and resident physicians.

I'm the Governor of the Massachusetts Chapter of the American College of Physicians and a current member of the Executive Committee of the ACP Board of Governors. I'm also the Chair-Elect of the Board of Governors of ACP. And in that role, I'm also a member of the Executive Committee of the Board of Regents of ACP. I'm passionate about health equity and healthcare advocacy. I love to write. And I'm also an [00:01:00] aspiring writer.

Dr. Marianne Parshley: Hello, my name's Marianne Parshley from the other side of the country in Portland, Oregon, I'm a general internist practicing primary care medicine with a geriatric focus. And through the last three decades of changing our health system, I've seen the transformations and challenges.

I'm also an outgoing governor of the Oregon chapter of American College of Physicians and incoming Regent of the ACP. And I'm a healthcare advocacy enthusiast. I love engaging and teaching others that they have a voice in making life better for our patients, our communities, and our colleagues. And I also love making organic yogurt and granola for our breakfasts.

Dr. Elisa Choi: As your co-hosts, we're delighted to talk today about a topic that impacts all of us personally and professionally: transforming healthcare in order to address health inequities by harnessing the power of primary care. The COVID 19 pandemic has highlighted the inequities that have [00:02:00] previously existed in healthcare for a long time, and the challenges faced by primary care physicians and their teams.

Dr. Marianne Parshley: Ida B. Wells said, almost three quarters of a century ago, “the way to right wrongs is to shine the light of truth on them”. Data over the last few decades and collected in the last year showed deep divisions in healthcare outcomes, depending on your zip code, which neighborhood, which county you live in. In addition, it has become clear that primary care is essential to a thriving healthcare system.

In addition to addressing these disparities, at the same time we see significant pressures on those who practice in primary care. So this episode of the DEI Shift with two champions of primary care and healthcare system reform is to explore the intersection between these issues.

Dr. Elisa Choi: Let's introduce our guests today. It would be hard to find more expert individuals on these. Their bio's are extensive. So see our program notes on the website for all the complete [00:03:00] details. I have the honor of introducing Dr. Darilyn Moyer, who is the executive vice president and chief executive officer of the American College of Physicians.

Dr. Moyer is board certified in internal medicine and infectious diseases, is a fellow of the American College of Physicians, a fellow of the Infectious Disease Society of America and a fellow of the Royal College of Physicians. She has served on the Board of Regent, which manages the business and the affairs of ACP and is the main policy making body of the College.

She has chaired ACP's Board of Governors, and she has previously served as governor of the ACP's Pennsylvania Southeastern chapter. She currently serves on the board of directors of the Council of Medical Subspecialty Societies and serves as that organization's president. Dr. Moyer also serves as the chair of the board of directors of the Primary Care Collaborative.[00:04:00]

Dr. Moyer works part-time at Temple University's Internal Medicine Associates. One of the most admirable aspects of Dr. Moyer's incredibly impressive resume is that despite all her leadership roles, she is still committed to the care of patients as a frontline physician in her continuity clinic. She is also a self-described Jedi as in justice, equity, diversity and inclusion, and a fierce proponent of high functioning primary care and also of health. We at the DEI Shift are honored to welcome Dr. Moyer as one of our guests for this episode.

Dr. Darilyn Moyer: Well, thank you, Dr. Choi. It's really a pleasure to be here. I'm really looking forward to our discussion and in other full disclosure, I'm also a PGY 36 and recovering internal medicine residency program director.

I still do see patients where I precept internal medicine residents at [00:05:00] the temple, internal medicine associates, a clinic, which is associated with the temple university health care system. So thank you for that kind introduction.

Dr. Marianne Parshley: I'm delighted to be able to introduce Dr. Susan Bornstein, Sue Bornstein, a fellow also of the American College of Physicians,

and now chair-elect of the American College of Physicians' Board of Regents. The ACP represents internal medicine physicians, related sub-specialists and medical students and the Board of Regents is the main policymaking body of the college. Dr. Bornstein is also immediate past chair of ACPs' Diversity Equity and Inclusion committee, and has previously served as chair of ACPs' Health and Public Policy committee, and as the governor of the Texas Northern chapter. A resident of Dallas, Dr. Borenstein is the executive director of the Texas Medical Home Initiative and co-leader of the Texas Primary Care Consortium, a statewide collaborative whose mission is to advance accessible, [00:06:00] continuous and coordinated person centered care for all Texans. I hear that their annual meeting is a wonderful place to go, if you're interested in primary care and supporting medical homes.

She received her medical degree from the Texas Tech School of Medicine and completed a residency at Baylor University Medical Center. Dr. Bornstein's areas of professional interest and expertise also include health and public policy, healthcare access and reform strengthening the safety net and government relations.

Welcome Dr. Bornstein.

Dr. Sue Bornstein: Well, howdy y'all, from Texas! I'm a big fan of the DEI Shift podcast. So I really am delighted to be here with you all today and to be on the program with my dear friend, mentor and inspiration, Darilyn Moyer, and to spend more time with Dr. Choi and with you as well. Dr. Parshley. It's just delightful to be here. Thank you.

Dr. Elisa Choi: Thanks to both of you for joining us here today. [00:07:00] Just to check generally, we've gone by first names during our DEI Shift episodes. Is this okay for all of you?

Dr. Darilyn Moyer: This is Darilyn and that's fine. My name is pronounced like Marilyn with a D...so Darilyn.

Dr. Sue Bornstein: Absolutely.

Dr. Marianne Parshley: Okay. So let's go to our first segment, a recurring one that we do here on the DEI Shift with our guests, called "Be the change." It's an opportunity for our listeners to get to know you. This question is based off the famous quote, "Be the change you wish to see in the world."

So when did you realize you wanted to, or have become part of the change you wanted to see Dr. Moyer, Darilyn.

Dr. Darilyn Moyer: You know, I came from a family where not neither of my parents went to college. My mother had to quit school in high school. She was one of eight, a poor Polish family in rural Pennsylvania. My dad made it through high school and then went into world war two and luckily, he and all of his buddies came back.

No one in my family was a nurse or a doctor. In fact, no one in my immediate family [00:08:00] had actually gone to college. And so I became intrigued with my pediatrician. I was sick as a kid, and sometimes you hear this story that people who have contact with the healthcare system in their formative years are more likely to go into healthcare careers.

My pediatrician was a rare person in rural Pennsylvania in the 1960s and 1970s. sShe was a woman, Dr. Sandra Rowan. And she came to my bedside a couple of times when I was hospitalized with pneumonia. She told me she thought I should think about becoming a physician. And I sort of went in full charge, decided on a career in medicine and chose to go to medical school at Temple School of Medicine, now the Lewis Katz School of Medicine at Temple University.

I did that because Temple really had a mission to care for the community in their catchment area, which is the poorest community in the Philadelphia area. [00:09:00] And early on I saw all the inequities that my patients were suffering. You know, my diabetic patients didn't have a good grocery store within three miles of their home because of safety issues. They couldn't go outside and get exercise, et cetera. And, quite frankly, patients where I care for people have 20 years less longevity than their counterparts, just three miles away in center city Philly. So I became very passionate about patient care and I believe that advocacy starts with the patient right in front of you.

But then you can amplify it and translate it. I got very engaged with the Pennsylvania ACP in the mid 2000s and served on some of the committees, including the Health and Public Policy committee. Well, I felt again that we could amplify, magnify and synergize all the concerns that so many of us had, [00:10:00] in our daily patient care issues.

So I decided to get more involved with the ACP. Ultimately, five years ago, I took the position as EVP-CEO, and it's my true honor to work with all of the passionate members that serve on our committees and our councils to really

advance patient care, to enhance the quality and effectiveness of patient care and health care by fostering excellence and professionalism in the practice of medicine is the ACPs mission statement.

I'm very, very lucky. I get to live that every day and I get, once or twice a month, to go back and take care of patients in conjunction with the internal medicine residents at Temple in north Philly.

Dr. Elisa Choi: Thank you so much, Darilyn, for sharing the wonderful stories of how you became inspired to become a physician.

It really does exemplify how impactful physicians [00:11:00] can be to all of us. Particularly when we have a physician who has made an impression on us, even in our early stages of life. How about you Sue?

Dr. Sue Bornstein: Well, I grew up in a segregated Texas in the 1950s and sixties, and I saw firsthand the indignity and the dehumanizing effects of segregation.

Department stores had separate drinking fountains and bathrooms for blacks and whites and, in pre-integration days, and even persisting after that,the demarcations between the haves and have nots were very clear to me, even as a child. And I knew that it was wrong, but I had a wonderful role model.

That was my father, David Bornstein, who was an internist and a ACP member. I'm proud to say he practiced in Dallas in the fifties, all the way up, actually into the nineties. He had a very long and wonderful career. I watched my [00:12:00] father and the way that he treated each patient in his practice with the same dignity and the same respect, how he advocated for them to get the best possible care regardless of their financial or social situation. So, contrast the segregation, all the issues with that, with someone who saw through that and saw beyond that. So my father was definitely a role model. Another thing that happened to me is I had the wonderful opportunity of completing my third and fourth years of medical school in El Paso, Texas.

I was immersed in a wonderful population of individuals, but these individuals really lacked access to a regular source of care for many reasons: cost, language, cultural barriers, health literacy, immigration concerns, and more. So I saw in El Paso, people who presented with very late complications of illnesses that really could have been [00:13:00] addressed much earlier.

So I think I might not have known in those days that that was about access and that was about health equity, but it certainly made a strong impression on me. And I think it has really helped me end up where I am today and that is working towards health equity and towards access, person centered care.

Dr. Elisa Choi: Thank you so much, Sue, for sharing your journey. I have to say, after listening to both your stories, Darilyn and Sue, my admiration for you can only deepen that much more. I so appreciate hearing about both your respective journeys to where you got to today. So now let's move into our topic for this episode.

We know that high quality accessible primary care is a key to improved health outcomes. Poor access to primary care is associated with worse health, but recent studies, including in a recently published paper in the Annals of Internal Medicine, [00:14:00] titled "Estimated Effect on Life Expectancy of Alleviating Primary Care Shortages in the United State", which was published online in March, suggests that by increasing primary care access, more than 7,200 deaths per year could be prevented. These new data along with other recent data support the case that a substantial investment in primary care will pay off in saving lives and increasing life expectancy. Particularly critical now, as the U.S. life expectancy has declined from 78.8 years to 77.3 years in the first half of 2020, largely due to COVID-19. Focusing on getting more PCPs into the areas with the most shortages would make the biggest differences in increasing population longevity.

As the COVID-19 pandemic has revealed stark [00:15:00] inequities of care and health outcomes, how would you see the role of primary care physicians in addressing this in a meaningful way? Darilyn, would you like to take the first chance at answering this question?

Dr. Darilyn Moyer: Thank you, Elisa. I think that just to lay a little bit more of the groundwork about what we mean by the lack of investment in primary care, we need to know where we are and the Primary Care Collaborative does have an evidenced report.

Every year they use various databases, databases that are connected to Medicare and Medicaid databases, that are connected to employer based insurance. And what they find is that, sadly, the average investment at a state level into primary care is about a 5 to 7% spend, at the most. And that is unfortunately also declining.

To give this some perspective, I think you [00:16:00] need to remember that primary care visits account for about 35% of the total visits and in healthcare in the U.S. and 55%, if you just look at outpatient visits. Yet we're looking at a primary care investment in the 5% range. And it's not just about the money, right?

It's also that primary care prior to COVID was struggling with the under-investment in terms of the financial resources. You know, having people having to work till three or four o'clock in the afternoon, just to keep the lights on in their office, not knowing sort of what the next month's bills would bring, but then also having to deal with the incredible administrative burden that's been laid at the feet of many primary care practices, and so many other challenges for which we need to improve primary care in that.[00:17:00]

I think it was truly amazing to see that despite this lack of real resources, these committed physicians and their teams were able to rapidly pivot,when COVID hit. They rapidly deploy tele-health, they rapidly deploy, infection control protocols, trying to get PPE, which was a really big struggle early on.Which is why ACP partnered with Project 95 to help our practitioners, especially those in the smaller and independent practices.

We saw primary care pivot, in order to help with the testing. And most importantly, they really made a lot of connections with their patients by checking on their patients every day, you know; keeping them out of the office, so that they didn't need to come into the office, keeping them out of Urgent Cares, the EDs, the hospitals, if they weren't sick enough to be [00:18:00] hospitalized. So it was really sad to see that there were so many practices that went through incredible distress. Some of them closing, some of them significantly having to curtail the services that they were able to give. There were staffing issues. There were all kinds of additional barriers that they had to really overcome. But they continue, you know, to continue to beat the drum of primary care, because they understand that...you know that as you alluded to, areas of the country with a higher density of primary care, physicians have better longevity at lower costs and higher value to the system overall.

Primary care is foundational and it’s the backbone of the health system, yet it's under invested in every sense, and it's not well-connected into public health and communities. We need to, we need to fix that, all work together to fix it. It's not a zero sum game. When primary care [00:19:00] is stronger, everyone else in healthcare is stronger, because we can leverage then, what we were trained to do, in our chosen domains of healthcare.

And I think the final thing I want to say about the importance of primary care in COVID is that every survey that is out there has said that building vaccine confidence for our patients who aren't confident about vaccines, falls squarely in the lap of primary care practitioners, because patients trust their primary care practitioners.

Dr. Elisa Choi: Well, thank you. Darilyn you did such a marvelous job of spotlighting. Just how essential primary care has been and continues to be during this ongoing COVID-19 pandemic. Sue, do you want to add your thoughts?

Dr. Sue Bornstein: Sure, and I think really Darilyn alluded to this, but I would just sort of flesh out a little bit in terms of the financial stresses that [00:20:00] certainly were exacerbated significantly by COVID, but have been there really for as long as I've been involved in, any of us have been involved in studying primary care.

And part of that really has to go back to the prevailing payment model for primary care, and that is the fee-for-service model. Now it is true that we are in various states of moving from fee-for-service or transactional, if you will, payment for primary care to more of a value-based system, but that is a rocky road and there's a lot of uncertainty around.

And so with fee-for-service, the predominant payment model, there really is no safety net for primary care practices. However, again, ACP did advocate, and other organizations advocated for, support for primary care practices. But in some senses, the damage was already done - that they were, they were already [00:21:00] really fragile.

And so I, we really need to see movement toward either a prospective payment model or some type of value based payment system where we don't have to rely solely on seeing patients, whether it's through telemedicine or in the office, to be able to provide the care that they need. You know, we don't just care for that person in front of us that day.

We now think about our entire panel of patients and what they need on a given day. And so funding, the funding mechanism really has to change.

The other thing is Darilyn talked about, telemedicine, and the dramatic and really kind of amazing ramp-up that so many practices did to offer telemedicine quickly. And then there is in the back of people's minds, there's the concern that that payment parity will not persist, now that they've ramped up and have found

that yes, telemedicine does have certainly a lot of benefits, But will that be [00:22:00] able to continue? And the other thing that is really a threat is the proliferation of telehealth providers without continuity of care. That's something that we're seeing a lot of. So, I think there's a lot of positive, but there are a lot of warning signs.

Dr. Marianne Parshley: Thank you, Sue. Thank you, Darilyn. You know, as you referred to, in this year of multiple pandemics, COVID, racism, climate change to name a few, many of these things have become so evident. Many of the challenges and disparities have become so evident. We can no longer just talk about them. Many of us are working towards addressing them in a meaningful way.

Amongst these, as you both pointed out, have been highlighted by the challenges increasingly faced by primary care physicians and their teams. In the years coming up to the pandemic, and surveys of primary care clinicians by the Larry A. Green Center during this past year, found that 20 to 40% of the respondents from primary care practices were considering [00:23:00] sale permanent closure or consolidation, and the most effected places where the safety net practices, moreover primary care share of the.

U.S. health expenditures, you know, as you have pointed out, have decreased. So Sue, what are the lessons that we can and should learn beyond the financial stresses about the challenges increasingly facing primary care teams and underserved areas?

Dr. Sue Bornstein: Well, yeah, I think they are very significant and they have a lot to do with health equity.

They have a lot to do with social determinants of health. How can a practice address, how can a practice familiarize themselves with the social determinants of health and moreover, how can they in a systematic way? Address those social determinants that have such a profound impact on their patients' health and wellbeing,in a way that does not add to the already significant administrative burden.

And the good news is there actually is a [00:24:00] lot out there. There's a lot out there in literature about how this can be done. But I think the first step really is for us as practices, safety, net, private practice, academic, whatever it is really to look inward and say, how are we doing? How, how were we positioned as a practice, as a group of individuals to address those social determinants?

And I think it really starts with educating ourselves to what the situation is. We all practice in a community. What are your patients, communities? What are the resources? What are the barriers? I also think a very important part is confronting implicit bias. In your own practice, you know, we hear terms like noncompliant, oh, that patient, they don't take their medicine and look heard they're not compliant.

Well, has anyone really tried to find out if that person has literacy challenges or health literacy challenges. Then the other thing, and I think this really fits nicely with the ACPs' point of view on things, is the entire [00:25:00] healthcare team has to be involved in this. It is not just, it can't be, it shouldn't be a physician centric issue.

So, all team members really have unique skills that can be brought to bear on understanding, identifying and acting on social determinants. I also think our office staff need to look like our patients, right? We need to look like our patients as clinicians. And that's a whole other challenge that we're addressing.

The other thing is being an advocate. Get out there and be an advocate! Be an advocate in your community for better access and better coverage and better resources. So, I think there is a lot that really can be done. Sometimes it seems like one more thing, but I think if it is approached properly, I think the benefits will become apparent. To your practice as well as to your patients.

Dr. Marianne Parshley: Thanks Sue. So you're talking about culture change and also individual education. Self-education. I know that in the last [00:26:00] three or four months we've started asking patients, actually the medical assistants are asking the patients, in the privacy of the exam rooms, about whether they have challenges in transportation and food and shelter.

We have a clinic that's surrounded by homeless camps, so it's not unusual, but we'd never asked before. We have also formed a collaborative with community resources so that if we pick up on needs that are beyond just the medical, we can have a place to refer them to. I'm inspired by what you said, and it makes me want to take this back to my clinic and share it with the teams.

Dr. Darilyn Moyer: Marianne, let me add in a little bit to what Sue had to say. And I think, you know, a really big challenge facing primary care is...I don't know if you saw the new headlines that came out that less than 50% of physicians are now self-employed? Actually by ACPs data, about a little over [00:27:00] 20% of the physicians who internists and who are members of ACP, are self-employed. So increasingly, physicians are employed. And they are

really at the behest of their employer as to how primary care practices are actually getting funded and resourced.

So it's not just about making sure that the payers have a better primary care investment, it's also about making sure that those dollars flow to where they need to go from the healthcare systems. They are the folks that are employing so many of the practitioners who are caring on the front lines of primary care. And I do think that moving from a fee for service to a more prospective payment system, where we pay for value, we don't pay for volume, where we pay for outcomes, not for procedures and doing things [00:28:00] to patients, is really critical.

And then that risk adjustment is absolutely critical. You know, there are some, indices that say that non-medical determinants, social determinants of health and other determinants of health account for more than 50% of health outcomes, we have to figure out how to risk adjust for that in our new world of what will hopefully transform primary care and, you know, get a better investment overall.

Dr. Marianne Parshley: Thanks, Darilyn and I really appreciate that. And as somebody who's been in independent practice and as an employee, there are trade-offs between the resources that the large system can give you and the loss of direction that you can give on how those resources are spent. So we need both independent practices and we need the employer-employed systems.

Dr. Elisa Choi: I want to add my thanks also to both Sue [00:29:00] and Darilyn for some incredibly insightful comments, and we'll definitely be touching upon the social determinants of health shortly, but I actually wanted to direct my next question to health disparities. So the CDC defines health disparities as preventable differences in the burden of disease, injury, violence, or opportunities to achieve optimal health that are experienced by socially disadvantaged populations.

How do you see robust primary care addressing these health disparities and health inequities, particularly as it pertains to providing culturally competent linguistically accessible care for marginalized communities that can also help, as you both alluded to addressing the social determinants of health?

Darilyn, would you like to start off for this?

Dr. Darilyn Moyer: Sure, thank you for that question. I mean, this is a really, [00:30:00] really complex conundrum. Primary care is on the front lines of care.

They see the need. They know, and meet, patients where they are. They know what they need, but frequently can't access. You know, we're having a lot of discussions about infrastructure in our country, right now, the bridges and the roads and the things that you can see and the things that you drive on. What we really need is a much better health infrastructure in our communities.

Primary care is absolutely positioned to be leading that. They know the challenges that their patients are facing every day. Whether it's transportation issues, access to good food, being able to pay for their medication, having internet access...having literacy. I mean, in my practice, the average literacy rate is at fourth or fifth grade level.

And many of my patients don't have [00:31:00] access to broadband and they don't have the IT skills. So I think that the primary care practices are absolutely in the best position to help to work with the other folks in healthcare, the healthcare systems around them. But more importantly, the people in those communities and the community organizations and the local community public health structure, which we see has just been so tattered.

I mean, COVID-19 really demonstrated these issues around structural racism that we have, and other sorts of inequities that we see and laid them bare for us to really see given the disproportionate impact on so many marginalized and traditionally marginalized and excluded patient populations.

So I do think that primary care [00:32:00] is absolutely in the position to lead this. What do they need? They need everyone else to roll up their sleeves. To get in the game, to work with their communities, to work with their local public health, and obviously the patients, to get this done. You know, you're seeing that more and more academic health centers and other organizations, hospitals, and healthcare systems are trying to connect with the community.

A good example of this is where I work. They have a robust legion of community health workers that are people that are mavens and trusted folks in the communities that we serve. They are able to really connect and be that bridge, to be the voice many times for the patients. So that they can get the appropriate care and get it delivered in the correct setting and get it delivered in the correct amount.[00:33:00]

So you're starting to really see some of these really wonderful, robust community health worker programs emerge and various permutations of that. We need to be able to bright spot: what are the best practices here? You know:

“think globally, act locally”. We need to be able to understand and to push that out and to do it with really primary care being the leaders in this.

Dr. Elisa Choi: Thank you Darilyn, and absolutely appreciate the spotlight you showed about primary care being the leaders, addressing some of these issues, affecting our patients. Sue, I wonder if you would also weigh in on how primary care can help address health inequities and health disparities affecting our patients.

Dr. Sue Bornstein: Sure. Darilyn did a fantastic job, but I'll try to add a little bit to it. And I said this earlier, I think, but I would just reinforce the fact that, [00:34:00] we, all of us, whether we're physicians, whether we are healthcare professionals, nurse practitioners, medical assistants, whomever it is that we encounter in the healthcare system.

We all really, we're all learners. We all have to be continually learning. And in this case, learning, I think, about cultures. So learning cultural differences and an example is in, for example, behavioral health. So if I say to someone of a particular racial or ethnic group, depression, that may have a very different connotation than it does to someone else.

So I think it's incumbent on us to really understand, based on the people that we care for, what are the cultural differences and cultural experiences and cultural norms that influence their care. And I think we are at peril of making a lot of mistakes if we don't really step back and understand [00:35:00] again, back to, I think, what I said earlier, and understand the community that we live in.

I think we have to understand, and we have to deal with, some very inconvenient truths about our society, such as the persistent effects of segregation, even though segregation was officially outlawed in the 60s. We all know that the ills that have been perpetuated by segregation persist in terms of unhealthy neighborhoods, that really it's really a cascading effect.

It's food deserts, et cetera. It's unsafe housing. It's relying on public transportation. As we saw during the pandemic, who were the people that were most adversely affected? Well they were essential workers that had to, in many cases, rely on public transportation to get to their job, that they couldn't telecommute like some other professionals could. And again, living in multi-generational [00:36:00] households.

So I just, I really feel that there's a tremendous opportunity for us to educate ourselves and to advocate. And again, that's one of the reasons that I am so

proud, #IMProud to be part of the American College of Physicians, because we do advocate. We advocate strongly for these kinds of things. Sometimes maybe they seem overwhelming, but I don't think that they are. And I think that if we approach our patients, our practices with cultural humility, and not just humility, but a genuine interest in learning more about them, we will be better and they will be better.

Dr. Elisa Choi: I can't underscore enough what you said, Sue, thank you for putting an emphasis on how we as physicians want to meet our patients where they are at and particularly understand their various cultural practices and beliefs so that we can actually support them. For members of the Asian American [00:37:00] community, your example of depression really hit home because depression and mental health is highly stigmatized in our community and may be interpreted differently by some in our community than by those from other communities.

So it is important to appreciate that we really want to educate ourselves about our patients wherever they are from and whatever community they hail from.

Dr. Marianne Parshley: Thinking back to Sue's conversation with Dr. Kimberly Manning at the Internal Medicine meeting last week, and something that my palliative care colleagues have been teaching, we have to develop an attitude of curiosity and start to practice cultural humility while we're practicing our medicine.

Shifting gears, this week a landmark consensus study report was released by the National Academies of Science, Engineering, and Medicine (NASEM) on the importance of primary care and what needs to be done to support and build a foundation of team-based patient centered primary care in our country.

I've [00:38:00] downloaded the entire report. I haven't had a chance to read it, but I did read the executive summary and applauded. I believe that ACP had input into this for which we are very grateful. So Darilyn, can you share with us some of the specifics of the report.

Dr. Darilyn Moyer: Well, you know, the ACP put out a new vision for American healthcare; an executive summary, a paper on Cost and Coverage, a paper on Payment and Delivery System reform, and then a paper discussing Public Health and Inequities.

We put that paper out in January of 2020. Some have called it prescient. We saw many of the same elements in the National Academy report for which ACP

was a sponsor. There were four internal medicine specialists who actually served on that committee. You really did see a lot of what you've been [00:39:00] hearing today. And that is, that we've got the financing all wrong. We need to move primary care from a fee for service, volume based system to one that is a much more prospective payment system that appreciates that a lot of the care of the patient is not just the face-to-face care for seeing someone in the office.

It is about the coordination, the communication, the collaboration, the connections that primary care practitioners make every day to make sure that their patients can navigate the healthcare system and get the best care possible. So we really saw that, front and center, in terms of the primary care investment really moving to a different funding model.

We also saw a lot in terms of the other things that we need to do. We need to be able to have [00:40:00] streamed-lined, interconnected communication systems that are seamless so that we can all communicate very well. Boy, I really would have loved it if I could've just pressed one button and we could be able to understand every single patient in our practice and who is already vaccinated, whether it was at a mass vaccination site or a community site or a FEMA vaccination site or a retail pharmacist or, or elsewhere. But we weren't able to do that. So one of the premises around the NASEM report is to ensure that the information systems are harmonized, synergized, connected and simplified. And also so that they are much more accessible by patients and their families.

They (NASEM) also have put some really important parameters in there around, for example, at Health and Human Services (HHS) having [00:41:00] actually a position and a Secretary there, that is the primary care person and oversees it. Really giving it the gravitas that it needs and deserves, in that primary care, you know, is the engine that drives everything else in our country and should be.

I say to my friends, who say, "Well, what about us? We're sub-specialists, we're proceduralists, we're surgeons. You know if you (primary care) get more, are we going to get less?" And I say, "No! We all get more. Because if we can get primary care to do what it needs to really do for patients, then everyone gets to practice at the top level of their chosen domain in a way that benefits both them and benefits the patients. Because we really would need primary care, not just to survive, but to thrive."

So we really saw a lot in the national academy [00:42:00] report that we liked. There was actually a press release that went out of the ACP newsroom about it. I think that we really need to have the reckoning in our country. And the

reckoning is that despite spending the most amount of the gross domestic product on healthcare of any of the OECD (Organisation for Economic Co-operation and Development) countries, we have some of the worst healthcare outcomes.

And so I think it's time. It's time that we finally understand how we work together to get to a better place. Our patients are suffering. Many of our practitioners are suffering. Our systems are suffering. We've seen a lot of healthcare systems and hospitals and practices that serve patients in our rural communities and our underserved communities go out of business. Particularly, in the wake of the COVID-19 pandemic.

Dr. Marianne Parshley: Thanks. [00:43:00] Darilyn.

I was actually thinking, reading this, that it sounded an awful lot like it echoed much of those vision papers that were released in January of 2020 by the College. Sue, you were really involved in writing some of those papers, through the Health and Public Policy committee. Do you have, through that lens, any comments about the new report or how we go from here?

Dr. Sue Bornstein: Oh, I think it, as Darilyn said, I think it really is very congruent with most of the things said the ACP has really advocated for years. One thing, in particular, that I was really pleased to see, was their emphasis on team-based care. I don't see our health system moving forward in any meaningful or productive way without really embracing the concept of team-based care. And certainly ACP has been a leader in that, and we have a toolkit coming out [00:44:00] pretty soon about that.

Daisy Smith, from our staff, has been a real leader in this. And Daisy, some of her work actually has shown that effective healthcare teams can actually help reduce burnout in physicians and other healthcare members. So I just, I feel like that is really critical. You know, teams don't just happen. They have to be created, they have to be nurtured, they have to be supported, et cetera. I just see that that is really the way forward. So I was very pleased to see that report really talked a lot about that and emphasized the importance of effective health care teams.

Dr. Marianne Parshley: Yeah. I love to hear them say training primary care teams where people live and work, as well, so that we have, as you said before, staff that look like the people we serve as well.

Dr. Elisa Choi: Thanks Marianne. And thank you, Darilyn and Sue for your leadership.. We could easily talk for an entire podcast about the NASEM report and, like Marianne, I certainly look forward to [00:45:00] diving into the details of that report. I wanted to shift a little bit back to concepts from earlier in our conversation that we had touched upon and dive a little bit deeper into this notion of social determinants of health.

The CDC has defined social determinants of health as the conditions in the places where people live, learn, work, and play that affect a wide range of health and quality of life, risks and outcomes. While these factors are sometimes viewed as falling outside the traditional sphere of primary care, high quality primary care and primary care teams could have the resources to help patients beyond their medical needs. Also ACP has been a leader in addressing these issues and has actually issued a number of papers about social determinants of [00:46:00] health, as well as the impact of racism and violence on health in the last several months.

How do you think primary care physician led teams can take the lead in addressing these issues? Sue, would you like to take the first step at answering this?

Dr. Sue Bornstein: Absolutely. Again, I think the idea of the team, as you just pointed out, is really essential. As far as papers, I have to say I'm kind of proud of the fact that, back in 2015, the Health and Public Policy committee wrote what I think...I will use the word prescient again because I think it actually applies here.. a paper on social determinants of health.

And that was, you know, that was pretty early, really, I think in people's recognition of, at least on a large scale, how important these social determinants are. And we talked about the things like, [00:47:00] which, which Darilyn has talked about, which is a perennial challenge, and that's the electronic health record.

But in our paper, we call for developing best practices for EHR (electronic health record) as a tool for improving individual and population health... without adding to administrative burden. And again, you have to really say that, because I think when clinicians, the busy clinicians, hear this, in some sense they realize, yes, this is the right thing to do. But, "oh my gosh, I already have pre-authorizations and et cetera, et cetera, how am I going to do this?"

But again, it can be done. It needs some retooling. It needs some rethinking, but it certainly can be done. And we also call for adjusting quality payment models and performance measures to reflect caring for individuals who are historically marginalized or excluded, which I think Darilyn also alluded to.

And again, you know, it's interesting when we, ACP, are very involved in performance measurements. I think there's increasing [00:48:00] discussion and evidence about moving more to a shared decision-making type measurement system, it may be better for, especially for, populations that have been historically marginalized or disadvantaged, that may have different health literacy. And so, as you said, Elisa, since early 2020, the ACP really has released quite a few papers about equity, health equity. And from a number of different angles including things like care for incarcerated people or care for marginalized, other marginalized, LGBTQIA populations. How do we reduce the barriers? And they're very comprehensive.

The other thing you alluded to, the ACP stand on anti-racism and so in the September of last year, we released a [00:49:00] statement declaring our intent to become an anti-racist organization. That was, and Darilyn will probably want to speak to this as a CEO-EVP, but that was a result of a lot of inward looking. Where are we with this? ACP has for many, many years taken a strong stand about equity and reducing barriers to care and reducing discriminate, eliminating discrimination. But as far as actually becoming an anti-racist society, we had to look within and we had to acknowledge as other organizations had, we had to say, we didn't have black members until, I believe, it was 1947. And we didn't really have our first declaration, I guess, about health equity and things until the early 90s, or first to start to look at it. So I think it was very important, it's a very important part of the process of being credible and being honest, to say, "This is where we are coming from, but this is where we want to go".

So I think our statement [00:50:00] from September 28th, 2020 on being an anti-racist organization is very powerful. And I think we're all very proud of it. You mentioned Dr. Manning. I asked her, how will we know, how will we know we have become an anti-racist society. And she very wisely said, "It's a journey." But she also said something that I really liked, she said, "You'll feel it".

Dr. Darilyn Moyer: Yes, I think Sue, I completely agree with all of that. And I think team is so important. You know I think about how we have a PCMH (patient centered medical home) and start with a huddle every day. And at our huddle is our head of our community health worker group, our social worker,

our RN, our nurse practitioner, our PharmD, our medical assistants, our front desk people. That's really the way that we have to be able to work is to leverage the team, the skills, the resources [00:51:00] that the patients need; to work together and all pull in the boat in the same direction. In terms of getting us to a more just, equitable, diverse, inclusive, and actively anti-racist place, you know the College really needs to ensure that our leadership are reflective of our rank and file members, and that our rank and file members are reflective of the patients that we care for.

You know, we're getting very strong signals on race congruency in care relationships between practitioners and patients potentially leading to better outcomes where this data is starting to emerge. We're starting to get signals. What can we learn from this? How do we peek around the corners to get great people to be engaged locally, regionally, nationally, and internationally for the ACP. That's one of our big goals. And, to get the [00:52:00] folks that are representative of our members as the leaders of our chapters, and ultimately, the leaders at the national and international level. We'll all be better for it.

We'll all learn. Every data point that you look at, whether it's healthcare business or non-healthcare business, is that when you make decisions around a leadership table, the best decisions are made by diverse and inclusive groups that are reflective of your rank and file. Whether that's your patients, your employees, the market that you're covering. And I think that's really critical.

Dr. Elisa Choi: Thank you both for spotlighting ACPs anti-racism focus. I personally could not be more proud to be a part of an organization that is willing to look inward, as you alluded to Sue, and that is recognizing the importance of diverse representation in our members and our leadership to also serve our patients.[00:53:00]

Darilyn, your point about the emerging data about race congruency between physicians and patients is an even more powerful reason to be very intentional in all our efforts to be anti-racist and welcoming and to be the open tent. Marianne.

Dr. Marianne Parshley: Thanks,Elisa. And thanks to both of you. It has occurred to me several times during this conversation, so I'm going to add a question that was not on our script, and that is talking about the pathway or the pipeline. Dr. Kimberly Manning talked about the fact that the pipeline has been broken and needs to be fully reconstructed in her talks last week. But for the

pathway, we talk about the coming shortage of primary care physicians and we talk about the barriers that have been in place for underrepresented groups going into medicine from the pre-medical school education: from [00:54:00] encouragement and sponsorship and mentorship to finances to active discouragement and not having communities that looked like them throughout the pathway.

I'm wondering if you can say something, either one of you-it's for both of you, how do we strengthen the pathway? How do we remove those barriers and how do we support people from marginalized, underrepresented groups going into primary care medicine at any level, but particularly physicians in general internal medicine.

Dr. Darilyn Moyer: Well, you just asked a big question there, Marianne, and I think this is something that we all want to improve. We want to make sure that those pathways are open, robust, supportive but we're just not seeing that. And we really need to all work together as a community, not just the healthcare community.

We know that students that come from a lower [00:55:00] socioeconomic groups are going to need more socioeconomic support. How do we ensure that folks are getting a robust and well-grounded education? There's been a lot said about admission criteria for medical school and trying to get to a more holistic place for both that and for, under transition, from undergraduate to graduate medical education. We really need an all hands on deck approach here.

Every aspect of our community benefits from having a more diverse group of folks, that are reflective of the patients that are in our healthcare system, to be the folks that are leading that healthcare system. And there are, you know, there's a lot of mentorship programs that are around. I know that there is one that our new governor, from Southern California, Dr. Tammy Lin, has put together, called Med Mindset. She is working with UCSD [00:56:0] (University of California, San Diego) medical students. She has put together a program, identifying a group of, again, traditionally marginalized, underserved local high school students in the San Diego area. And they are going to have a longitudinal program.

You know, I think there's a lot of questions. When do we start? Some people are saying we need to start as early as when kids are three, five and seven years old. Be able to give them the support they need, at that time, in a comprehensive way and fashion programs longitudinally.

We need to be working with physician and practitioner groups of color, such as the NMA and NMH and other groups, to ensure that we can all sync up our resources and work together. And we really need to draw on additional resources in the community to help with the financial support, the [00:57:00] educational support, the other support that folks are going to need. Because this is a tough journey, even if someone is well-resourced. And when they have a lot of challenges, in addition to the challenge of the pathway to becoming a physician, it makes it even more difficult.

Dr. Marianne Parshley: Thanks Darilyn, Sue?

Dr. Sue Bornstein: I completely agree with everything Darilyn said. And I also just would reinforce the whole, the importance of role models, sponsors, mentors. Recently a friend of mine, who's a pediatrician in the Dallas area tweeted, and I love this, she said "what it meant to me the first time, a black physician" (she's also black), "what it meant to me the first time a black physician walked into my medical school lecture hall, a black neurosurgeon...I can't put it into words. In two years of lectures, he was the only black physician I saw." And she's young, she's in her forties, it's not like [00:58:00] this is a, you know, an older person. So I like what Darilyn says. Darilyn has a great phrase, "I can't be what I can't see". I think that just really sums it up.

So yeah, it's a very multi-factorial, multifaceted attack from many different angles and there's not just one solution. But, I think we know what needs to be done. It's a matter of having, I mean, I read that statistic... There was a report out recently that the number of black men going into medicine, which is around 5%, has actually not increased since 1940, the percentage. You know, there is something seriously wrong here. There is. And we, it's incumbent on us to do our best to fix it.

Dr. Marianne Parshley: I am so grateful for the two of you for leading that effort and for ACP to be engaging in exploring how we move forward on this. So thank you [00:59:00] very much. And also, thank you for your mentorship and sponsorship of so many people and so many women and so many who are working in this space. Elisa?

Dr. Elisa Choi: Thanks, Marianne. And thank you, Darilyn and Sue for your thoughts and comments. I could not agree more with them. We really need to build the path for diverse future physicians and ensure that our physicians, particularly in primary care, represent the patients who we take care of. Thank you, Darilyn and Sue for both of your leadership in this area and thank you to ACP.

So I want to ask more specifically about those very prescient and seminal papers ACP released back in January, 2020. Our conversations thus far have touched upon those in various peripheral ways. But my question is specifically referring to those papers, which were [01:00:00] offering a better vision for healthcare and were calling for a transformation of our healthcare system to ensure equitable and affordable access to healthcare. This question is really for both of you, Sue and Darilyn. Could you talk a bit about this vision and what aspects of it really resonate with you and what do you think will be most impactful to primary care and primary care's ability to promote robust, high value, accessible care to our patients? Sue?

Dr. Sue Bornstein: Thanks. There's so much, and again, I read those again, and I think, as Darilyn said "wow, prescient was correct". I mean, some of these things that we talked about in those papers are things that ACP has advocated for, for many, many years. And one of the ones that I would really focus on is for universal coverage, something that we have really tried hard to achieve and have certainly...Certainly the Affordable Care Act brought us [01:01:00] a lot farther than we were. And I praise the Affordable Care Act in many of the wonderful things that it has done. However, in our system where most people's health insurance is tied to their employment, I think that we always sort of knew that that was problematic...but it's pretty clear that COVID really showed us how problematic that was, when so many hundreds of thousands, if not millions, of people lost their employment and then found themselves either without health insurance or with the prospect of paying COBRA...which, they don't have a job, so how are they going to pay an expensive premium?

So I think universal healthcare coverage is really, it's key to a lot of this. And again, one of the significant barriers to addressing health inequities is a lack of insurance. And we know that lack of insurance is associated with fewer primary care visits. If you don't have insurance, you're not going to go generally. So that results in lower odds of a clinic visit when you need one. And when [01:02:00] patients do come in for an office visit, if they don't have insurance, then they have a lower odds of getting whatever service they need. So it's really critical.

I think having universal coverage is critical. Not only that, I think it's critical to improving the health of our country. And that is a major, major goal of the College that I think was really spelled out very well in those patients.

Dr. Darilyn Moyer: Yeah, and this is Darilyn. We didn't specify how you get to universal healthcare. You could do it through a public option. You could do it in a pluralistic system, or a single payer. We just said, you need to get there. And, you know, one wonders if we did have everyone insured, whether the

COVID epidemic would have been a lot different since we saw so many people who were sick, who didn't seek care, who spread it to other individuals. And so I [01:03:00] think one does wonder that.

You know, the other big ask here is to put patients first. You know, patients before paperwork, to reduce administrative burden, prior authorizations and other incredibly burdensome things that are happening, and to do that much more mindfully, to really sync up our information systems.

And you know, the College has also, for a long time, had policy around graduate medical education, that we need to ensure that we can fund graduate medical education to make sure that folks are trained in contemporary, successful, positive ambulatory models rather than just quote, "Throwing someone into a dysfunctional clinic."

You know, we know people are inspired. They... when you're a physician, you're going to be doing what you do for 40 years or more, and you really want to love what you do. And we [01:04:00] need our students, our medical students to be able to see all of the amazing things that happen in functional high value, primary care settings.

And we need to be able to fund GME appropriately for those settings rather than always being bootstrapped for GME funding to the sponsoring institution where ultimately, predominantly inpatient services benefit from those fundings. So, you know, there's a lot of work that we need to do in this area.

And now I hope people will go back and at least read the executive summary of those papers. Those papers were very dense. They talked about, you know, everything on the continuum of care, including things like getting to a new model of performance measurement in that it really accounts for what we really do. And that payment being accountable for what we really do in all that behind the scenes care [01:05:00] that happens that typically isn't valued in the current payments.

Dr. Sue Bornstein: Well, and perhaps one of the most prescient things about these papers was talking about strengthening public health infrastructure and connecting that with primary care. We unfortunately saw in big bold colors how our public health system had been really weakened..weakened is just too, too... not even strong enough a word…. had just been chipped away at for years and years and years and years. And I think Dr. Fauci and Dr. Walensky both said that during our annual meeting. And so we now see, and it's more obvious than it ever has been, how we need to have a strong, active public health

infrastructure that is connected with the rest of our healthcare system and funded appropriately.

Dr. Elisa Choi: Well, thank you Sue and Darilyn for spotlighting some of the key highlights from those really remarkable series of papers [01:06:00]

On personal reflection, I had the privilege to summarize some aspects of those papers when I was invited to give a talk about ACPs new vision for healthcare immediately, right before COVID-19 hit all of us in our state when we had to lock down. And my reflection was that the audience was so excited to hear about ACPs new vision...and then COVID 19 hit.

As you pointed out, Sue, the gaps in our public health infrastructure were really manifest during the pandemic. It would be interesting to go back and dive into the details of those papers to use as a blueprint for how to move forward, particularly with COVID-19 and its effect on unemployment. Sue, your point about universal health coverage, irrespective of one's employer status is key.

So we are nearing the end of our conversation. [01:07:00] And I will say that, personally, I could talk amongst the four of us for many more hours, and I have been thrilled to be able to listen to our two guests, to learn so much from your insights and your personal stories, and really hear about how primary care can be an agent of change for better healthcare for all of our patients.

I want to thank you, Darilyn and Sue for your time and for all of your insights and wisdom. I have really enjoyed being part of this conversation with my colleague and partner and co host, Marianne.

Dr. Marianne Parshley: And I want to thank you also for taking this time out of your very busy schedules.

Thank you for addressing primary care, healthcare, disparities, and inequities in the house of medicine. We're very grateful for your leadership. I speak, I think, both for Elisa and I saying, we look forward very much working with you and the College to move forward [01:08:00] on these things. So thank you.

Dr. Sue Bornstein: Thank you.

Dr. Darilyn Moyer: Thank you for having us. I want to just get, with more gratitude, say thank you for doing this podcast.

Thank you for both leading the way that you are at both your local levels and your regional levels and the national, international level, and we're all better for it. And we'll get there. I'm a glass half full kind of gal and I'm absolutely optimistic that we will get there.

Dr. Sue Bornstein: Me too. I'm too old to not be optimistic at this point in my life. I'm not going to change. I'm going to continue being an optimist. There you go.

Closing [01:09:00] **:** **Disclaimer:** The DEI Shift podcast and its guests provide general information and entertainment, but not medical advice. Before making any changes to your medical treatment or execution of your treatment plan, please consult with your doctor or personal medical team. Reference to any specific product or entity does not constitute an endorsement or recommendation by The DEI Shift. The views expressed by guests are their own, and their appearance on the podcast does not imply an endorsement of them or any entity they represent. Views and opinions expressed by The DEI Shift team are those of each individual and do not necessarily reflect the views or opinions of The DEI Shift team and its guests, employers, sponsors, or organizations we are affiliated with. The DEI Shift podcast is proudly sponsored by the American College of Physicians Southern California Region 3 Chapter. Our theme music is brought to you by Chris Dingman. Learn more at www.ChrisDingman.com.

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