OPENING THE FRONT DOOR: UNSEEN PROVIDERS TRANSFORMING PRIMARY CARE

Omer Awan 00:17

Hello and welcome to Opening the Front Door: Unseen Providers Transforming Primary Care. I'm Dr. Omer Awan. I'm a professor, physician, and senior public contributor for Forbes. I'll be your moderator. I would love to just have everyone quickly introduce themselves.

Samm Anderegg 00:30

Hi, everyone. Samm Anderegg, I'm a pharmacist and founder and CEO at a company called DocStation.

Shreya Kangovi 00:36

Good morning, everyone. I'm Shreya Kangovi. I'm a primary care doc and a sociobehavioral scientist by training. I'm the founder and CEO of a public benefit corporation called IMPaCT.

Howard Reid 00:46

Morning, everyone. I'm Howard Reid. I lead the global health equity organization at Johnson & Johnson.

Kyu Rhee 00:51

Hi, I'm Kyu Rhee, I'm also primary care doc, med peds doc, and I'm the CEO of the National Association of Community Health Centers.

Omer Awan 00:58

I'd like to just start by explaining what are unseen providers? And there may be a lot of ambiguity about that. You know, what—what do they contribute? Are there—is AI considered an unseen provider? Are nurses, practitioners, pharmacists? And why are they critical to primary care? Would love to start with you, Samm, on that.

Samm Anderegg 01:16

My lens is specifically on pharmacy and pharmacists. So I think the session title is interesting. I think pharmacists are probably some of the most seen providers in terms of access. Ninety percent of Americans live within five miles of a pharmacy. Oftentimes, patients see their pharmacists more than they see their PCP specialists. And so I think pharmacies and community health workers, faith based organizations—we're all embedded in the community, but we're unseen in terms of policy, reimbursement models, and infrastructure. That's how I look at it.

Omer Awan 01:55

Dr. Kyu, how about a physician perspective of that question?

Kyu Rhee 01:58

Yeah. Look, I reflect on—just a couple miles from here, I served as a community health center doc in Upper Cardozo, the largest health system, or health center in DC, and I would say we were seen by our patients and our community, but perhaps some of the challenges are, we're unseen by the broader health system. And over the last 60 years, health centers have grown from serving those first two patients in rural Mississippi to—and also East Boston—to now being the largest primary care system in the nation, serving 52 million people, one in seven folks and one in three in rural America. The team that I had, which was so essential, included pharmacists, nurse practitioners, physician assistants, community health workers, nutritionists, dentists, and enrollment specialists. As we think about Medicaid eligibility, there are so many members of the team that play an important role and I'm grateful for the high trust we've had in communities across the country and appreciate opportunities like this to be seen at a place like Milken.

Omer Awan 03:06

What about sort of non-traditional unseen providers—maybe ways that we don't think of them, like AI or technology? Would love to get your perspective, Howard, on that—like, especially with the work that you're doing at J and J.

Howard Reid 03:18

Yeah, I think AI and technology play a critical role in helping providers, enabling providers to deliver quality care. I think one of the bigger challenges with some of the cadres that we've talked about, and them being unseen, is the fact that they're not spending enough time with patients. If you look at the data, frontline health-care providers—whether it's community health workers, et cetera—they're spending about 60 percent of their time doing administrative or non-patient activities. They're not spending enough time doing what they love—what they entered the profession to do, which is to serve patients. So for me, the question is, how can we better use technology to give them more time to do what they do best, which is, see and serve, their patients. One of the ways that we're doing this is we're investing in early-stage companies or startups that are rethinking the workflow for patients and providers, giving providers more time. One example is CareMessage. CareMessage is a startup that's essentially automating patient engagement. So the engagement between a patient and a clinic—and they're integrating electronic health records, giving providers more time, allowing providers to better treat their patients. It's a way that we're using technology to enable better patient care.

Omer Awan 04:37

And Dr. Kangovi, I want to get you in here as well. Does that resonate with you? Is that—is—you know the—with the AI space—are you guys using that as well in your—in your field?

Shreya Kangovi 04:46

Yeah, I want to go back first to unseen providers. I think about the term unseen as both reflective of visibility and power, and I am here representing a workforce that has very little of either. Community health workers are trustworthy people. They come from within the communities they serve, and they earn that title by virtue of shared life experience, which is often hard—hardship. CHWs are not on this panel, and they're probably not in this room, and they have very little power in the American health-care system. I see one—nice for—nice for you to be here—yet they are, I think, some of the most critical frontline workers in American health care. Where I'm from—India—we've had to do more with less for a really long time, and we would never dream of having expensive clinicians play both offense and defense. Our front lines were community health workers. They were people who were from the communities, the villages, and they met people where they were and addressed the real life issues that shape health for so many Americans. So that is my perspective on unseen providers. And I would encourage us to see these individuals and share power with them. I do think technology has a tremendous enabling role. The company that I lead has, you know, developed software solutions for community health workers that are grounded in evidence-based models, including an AI scribe that decreases their documentation burden.

Omer Awan 06:14

It seems like such an abstract concept—this whole—this whole idea of, you know, un—care, you know—unseen providers. You know when it's working well, like in an ideal situation, what does that team-based, equitable model look like for you guys? Dr. Kyu?

Kyu Rhee 06:30

I mean, I—when I think about the model that I experienced firsthand, but also see now nationally, it's the fact that we are affordable, comprehensive and effective. And as I look at each of those categories, affordability— we serve one in seven people and 52 million people across this country in the highest risk communities across the nation, at the cost of only $57 billion—one percent of health-care spend to serve 14 percent of the population. That includes one in three in rural America. Comprehensive—as you think about the team—you need that diversity of that team—all those disciplines, including community health workers. The average community health center has two community health workers in it. I agree it should be many more. I believe every primary care team should have at least one community health worker on the team. But the fact that we have oral health, behavioral health, pharmacy services—we're a one stop shop visit—vision services, and we also represent the communities we serve, is a key part of how we deliver comprehensive primary care that reduces downstream costs of hospitalizations and ER visits. We've delivered a two to one ROI. The Congressional Budget Office has stated that we have a two to one ROI in terms of the investment in the community health centers versus the reduction in overall health-care costs. We've also demonstrated an impact in terms of economic impact—two to one—in terms of the jobs we create and the economic impact in the communities that we serve. The last piece I'll say is we're effective. The fact is, our clinical measures are better than other comparable primary care settings, whether it's blood pressure control, diabetes control—because of that team-based approach. But I'll tell you, the secret sauce that I believe community health centers have is the fact that we have patient-led boards. In our statute, it requires us to have 51 percent patient-led boards that represents the communities we serve, and we are all nonprofits, independent, serving in those communities, and we cannot be acquired.

Omer Awan 08:30

Howard, do you have any insights on that?

Howard Reid 08:33

I think Dr. Rhee said it really well. I don't have—I don't have much to add there. I think it really comes down to outcomes. It really comes down to, at the end of the day, how we're serving patients to live better lives. Community health workers and frontline health workers play a critical role in that—in a number of ways, to your point—really emphasizing and reinforcing and getting people into the primary care system, allowing primary providers to do their job, working in the position in the health-care system where they're best suited. But at the end of the day, it really comes down to measuring patient outcomes.

Omer Awan 09:08

I think everyone in health care knows that there is a massive health-care worker shortage. I mean, no matter whether you're working in hospital, clinics, primary care facilities, EDs, everywhere around the United States, there is a massive health-care shortage. And you know, this is an opportunity. You know, these unseen providers are an opportunity to sort of bridge that gap and to address this issue head on. How do unseen providers fill this gap? Samm?

Samm Anderegg 09:35

I think it's about leveraging these unseen providers that already exist in communities around America—and make sure that everyone's practicing at the top of their license, so to speak, and incentives are aligned. So kind of going back to when does this work in an ideal state? I think about the community that I grew up in, Charles City, Iowa. It's about 7,000 people, rural. Our health-care ecosystem consisted of a rural access hospital. We had one primary care clinic staffed by two docs and an NP, and we had a pharmacy attached to that clinic. You could walk from the waiting room right into the pharmacy and pick up your medications. That worked, and it was local, it was relational. How do we make that sustainable long term, and how do we bring in even more unseen care providers into the mix as well?

Omer Awan 10:32

Dr. Kangovi?

Shreya Kangovi 10:33

Yeah, I think about this as just working backwards from the problem that we're trying to solve and then right-sizing the workforce. So the problem we're trying to solve is deliver better health at lower cost. Then the questions are, what are the inputs to those outcomes? We know—we used to think that health was a function of biomedical inputs like genetics and medical care, but I think there's been a lot of research done over the past several decades that pretty conclusively point to the fact that it's social, behavioral, and economic factors that eclipse the role of those biomedical factors. So then you have to ask yourself, Okay, what are the jobs to be done in order to actually lever to better health outcomes, and who are the types of workers who are best suited to that type of work. I'm a primary care doc. I am a clinician. I am unapologetic about clinical expertise when a biomedical question comes up, but the reality is that most of the work of improving health is relational. It's addressing social, behavioral, and economic factors. So then when you think about the relative shortages of the workers for the work to be done, there's 50 to 100,000 community health workers in the entire country. Like that is insane. And so, you know, we talk about workforce shortages of the workforces that are seen, because we're the ones that are in the room, and it's self-serving. You know, a doc is going to be like, there's such a primary care—you know? And I believe that—you know, we need more primary care docs—but there's no CHWs in the room saying, "we're not even up to bat."

Omer Awan 12:11

You know—I also think—you know, reimbursement is a key issue here, especially with—you know, unseen providers. And you know, what I've seen in health care, covering it for, you know, over a decade is—is that oftentimes reimbursement lags innovation. And this was talked about at the plenary session with Dr. Oz and Dr. Makary as well, that, you know, we have this lag. You know, he was talking about a lag of—you know—10 or 12 years before—you know—drugs are approved. And he finds that ridiculous. And I think that's absolutely ridiculous. And the same is true here with reimbursement and innovation. We have these unseen providers, but these payment models don't incentivize them to do the job that they want to do. So, how do we incentivize these payment models and how do we put them at the forefront so we're supporting these unseen providers? Dr. Kyu?

Kyu Rhee 12:59

So I mean, one thing I'll highlight is the idea of payment very much connects to advocacy—grassroots, grass tops advocac—and the health center movement, since 1965, has built a movement based on a combination of grassroots and grass tops advocacy. Grassroots is the fact that we are in these communities that members of Congress, members of local—policy makers know their local health center and understand those relationships and know the value that they provide and the citizens that are in that community. So I would suggest that as you think about payment, you have to think about your advocacy strategy in terms of grassroots. You also have to think about in terms of grass tops. As you look at the broader health system and how complicated it is in the US, and the fact that it's $5 trillion, there are a lot of stakeholders with a lot of value that they're trying to deliver to the health system. So how you engage Capitol Hill, state capitals, pharma, payers, employers, is a very key part of the strategy, as you think about those decision makers in the broader health system. And so, I mean, I just want to highlight that as we've thought—and—about the role we've had for 60 years and the role that NACHC has had for 55 years, we've emphasized we're nonpartisan, and we get bipartisan support. And so as you think about the broader health system and how complicated it is, it's going to be important. And I love—the beauty of seeing a patient board member speak to a member of Congress about why their health center matters, the value that it's provided for them and their family—there's there's nothing more valuable than that type of storytelling and that type of impact for advocacy.

Omer Awan 14:47

Dr. Kangovi, I feel like you have some insights on this as well.

Shreya Kangovi 14:50

I have something to say about all of your questions. Yeah. I mean, I think, from the lens—I agree with everything that was said. I think, you know, community health workers—it's about, are we paying for

outcomes that we want. There's randomized control trials that demonstrate that community health workers can improve chronic disease control, mental health, quality of care, reduce total hospital days. And there's a return on investment from these randomized control trial data of $2.47 for every dollar that an American taxpayer invests in the workforce. I will just briefly tell you that—so my husband is an interventional cardiologist. Love him. He is super good at his job. He can put a stent into patients' teeny little coronary arteries when they've had a heart attack, or, you know, into their leg arteries when they've—you know—had a blockage, often caused by smoking. It is not unusual for him to do a procedure that reimburses the hospital, you know, several thousand dollars an hour. What if we had reversed time a little bit and prevented that individual from smoking? Well, CHWs do that, and we know that they do that, but the really exciting reimbursement rate that Medicare just created for CHWs—which is the first ever CHW reimbursement rate—we're very proud of that— but it only pays, like, about 80 bucks an hour. It's not enough to not only pay the CHW but also pay for the infrastructure that is required to support them. So no one's even billing that code, frankly, if they just increased it by $21 you'd see community health workers, I think, really start to skyrocket. So, you know, we are on the reimbursement map now, but we're short.

Omer Awan 16:34

Yeah, I think, you know. Dr. Kyu, you touched on this as well. You know, just the power of advocacy, talking to Congress, folks telling stories. I think that's a very powerful thing, because people relate to emotions. But I want to ask you, Samm, and I want to dig into this a little bit deeper, because I think this is a it's a critical topic, this topic of reimbursement. How do we convince, you know, these policymakers, insurance companies, to make this reimbursement possible? Because, you know, we see time and time again is—you know—we talk about this, but then reimbursements don't occur. So what can we do, or what can you do, or your group do—at DocStation specifically, to—to convince real change to occur?

Samm Anderegg 17:13

Yeah, I think not—beyond what we're doing at DocStation—and by the way, DocStation is "Epic" for retail pharmacies, so it's the infrastructure piece. On the reimbursement side, I think the headlines get the policy that our profession is advocating for on a federal level. So we have the ECAPS act that's been introduced—I believe in the both House and the Senate—equitable community access to pharmacy services. So that would essentially make pharmacist providers at the federal level—while not listed in the Social Security Act as providers today. Now, while we've been advocating for that legislation for several years now, probably close to a decade, the states have kind of taken matters into their own hands, and so nine years ago, when we started the company, about seven states had some sort of law or regulations in place to elevate pharmacists as midlevel providers. So mandating inclusion to payer provider networks, mandating reimbursement at times, all while pharmacists' scope of practice continues to increase as well. So I believe the incentives are there, the reimbursement models are there. Now it becomes the infrastructure. How do we stand these pharmacies up as clinics? How do we train pharmacy technicians as community health workers to start delivering this care? And I think that just takes rolling up your sleeves and getting the work done. So while we're advocating on a federal level and on a state level, I think the mechanisms are there. We just need the funding and the incentives. One other thing that I'll add is, it's all about aligning

incentives, right? And so I think about the payer's perspective. They want to increase access to care, to prevent hospitalizations, prevent ED visits, even urgent care visits, but on a kind of managed care level and Medicare Advantage—I think about the health equity index that I've just kicked off this year. So there is incentive for payers to get to and engage these members who may fall through the cracks. And so I think that's a big piece of it as well.

Omer Awan 19:15

Yeah, I want to shift gears a little bit and talk about something we kind of briefly touched on earlier. And that is, of course, you know the use of technology, the use of AI, the use of electronic medical records, and how that's transforming care. And want to start with you Howard, because I think, you know this is particularly relevant in your space at Johnson & Johnson. You know, how—you know, there's been an explosion of AI, and everyone—a lot of people, are wondering about—well, how will AI infiltrate medicine? How does it augment care? For example, are there risks associated with it? Are there ethical issues that, you know, can compound us being successful overall, you know, kind of—in the future—and moving the needle forward in health care. But how do you see, you know, the role of AI and you know electronic medical records in sort of bridging the gap in communication and addressing some of the needs in health care going forward, in the future?

Howard Reid 20:03

And maybe what I'll do is I'll bridge one of your previous questions around health workforce shortages with health tech and the question you're asking now. So if you look at the health provider shortage areas across the country, two out of every three are in a rural setting. And if you look at the rural settings and start to look at primary providers, many of them are reducing the hours that they're working. Many of them are leaving their profession for burnout. And I think the obvious answer to solving some of those workforce challenges is yes, let's empower community health workers, but also let's empower them with the technology they need to do their jobs well. I think the challenge is we need to be really thoughtful to make sure that technology reaches the people that are unseen and underserved. If we're not targeted, if we're not intentional, it's really easy to see that technology being used in the most well-resourced settings. In addition to that, I think it's really important that the people that are using the technology in those settings are a part of creating the technology, are a part of implementing that technology, are a part of making sure that technology is fit for purpose in their setting. Sitting here in DC—a technology to simplify a workflow using AI and integrating with EHR may be completely inappropriate and ineffective in West Texas, so we need to make sure the people that are using those technologies are front and center in it. I'll give you one example. So in our impact investing arm, there's a company called Hamilton Health Bots. Essentially, they set up these pre-fabricated microclinics where they have in-person care as well as telehealth. And what's really interesting is they started with a technology-first principle. So instead of implementing AI, layering on technology onto an existing process, they're starting with AI and tech from the start, and reimagining the patient experience, reimagining the provider experience. That's a great example of how we can use technology to better empower providers, to better serve their patients, and just to pull through the importance of making sure the people that are doing the work are a part of creating the solution. The founder, who's incredible—his name is Toby Hamilton—he's from that

community. He's from West Texas. So he has deep insights, deep understanding for what the community needs, how to implement those services, and how to best use AI and EHR to deliver better quality care.

Omer Awan 22:40

Dr. Kangovi, have you—how have you guys used AI or—you know, Epic—or whatever it is, you know?

Shreya Kangovi 22:48

Yeah, sure.

Omer Awan 22:48

In your practice.

Shreya Kangovi 22:49

Well, IMPaCT Care is an enablement company. We build the infrastructure, the secret sauces, for what we call magic with consistency at scale. You know, that meaningful encounter between a CHW and the client they're serving, and actually, with support from Johnson & Johnson, we've built—as part of those secret sauces—a software platform that is not Epic, and it's very decidedly different from the EMR, because it has been designed by and for community health workers. There is a community—a frontline community health worker who is practicing in every single daily product refinement session that we lead, and they are the ones that tell us about their use cases, their workflow, their problems that they're trying to solve, and then that informs the design of the product. So just to give an example, and a story we—one of the CHWs that we work with is a wonderful person named Bree Burke, who's from West Tennessee, and we were designing, you know, the sort of tool that was going to try to keep community health workers organized, because they're delivering a lot of care across a panel of patients. And she just held up a yellow legal pad, and she's like, I write, like, I write my notes down in this, you know, because I'm often on porches or on buses and, you know, I might be in communities that aren't really safe, and I, you know, just like to kind of keep it moving and just jot my notes. And so that was the inspiration for the to-do list feature that we created. It's very kind of—it's designed for people who tend to be low-tech, and so that is a great example of that end user-driven technology, because I think that's going to be critical in order for technology and AI to deliver on their potential. Same thing with our AI scribe. You know, we were out in streets and communities, kind of, listening to these conversations, tuning the scribe to the types of conversations, the accents, the background noise, you know, the laundromat washing machine that is really part of community health workers' daily workflow.

Omer Awan 24:51

You know, I think equally important, or if not more important, to technology, is the people, obviously, right? And this concept of interdisciplinary collaboration, because that's kind of what brings and bridges all the pieces of the puzzle together. And you, all four of you guys, work for incredible organizations. And I would love to just, you know, pick your brain as to, you know—maybe you guys have a case example you guys can share about how interdisciplinary collaboration has been effective, or what model you use to allow that to be successful. And maybe we can just start with Dr. Kyu and go down to Samm, okay.

Kyu Rhee 25:25

I mean, I want to link to like a phrase, that the need for collaboration around tech is going to be essential as we look at the primary care workforce crisis and the opportunities we have. I believe community health workers should be reimbursed. I believe pharmacists should be APPs. I think there's opportunities in the workforce area to promote more of that, that team-based care. That's essential. I want to highlight that I—there's a phrase I use, which is, health professionals will not be replaced by AI, but health professionals who don't use AI will be replaced by those who do. And so as we think about the opportunities of technology, we're going to have to think about partnering with those providers—like community health centers, like primary care, like community health workers, like pharmacists—that have trust, that have high trust in these communities, because ultimately, the use of technology to enable that team—which is so essential because that team is burned out—that team is overwhelmed. That team is challenged with worsening disparities and growing aging population and caregiver responsibilities. We're going to have to think about how technology can support that team. At its core, you know the beauty of what we do, in terms of interprofessional or interdisciplinary or transdisciplinary care—it's all about trust. It's all about that collaboration amongst the team, but especially with the patient at the center, and that is ultimately the core of what it gets delivered. So the beauty of you know, a pharmacist, a dentist, a behavioral health specialist, a psychologist, and a primary care clinician and a nurse practitioner and a community health worker all being on the same team, communicating with each other on behalf of that patient and that family—I mean, I've seen so many great examples where we do mental health screenings in the dental chair. You know? This idea of integration and collaboration is so core. We empower caregivers and family members to do a lot of the teamwork, team based care on behalf of, you know, the children or the families we serve. So I love the fact that health centers are leveraging that. But as I shared with Dr. Oz in a conversation about this Rural Health Transformation Fund, health centers are high-trust, but they need high tech and we're hopeful that the Rural Health Transformation Fund will accelerate high tech. For example, we estimate less than 5 percent of all exam rooms in community health centers have ambient AI. I want that tool so I'm not a data entry clerk as part of my partner on that team, so I can spend more time with that patient and build that relationship and build the relationship with the broader team.

Howard Reid 28:03

Yeah, that's—that's really well said. I don't have much to add—maybe—maybe just a statistic on health disparities between well-resourced areas and underserved areas. Over the past 20 years, that disparity has tripled, and the care team is incredibly important. I think leveraging technology, leveraging AI, has

incredible opportunity and potential to take what's a fragmented system and make it talk to each other, make it make sense, make it more seamless for providers to do their job and serve patients. But I think the investment that we're thinking about needs to be more than just in the tech. The investment needs to be with the health-care provider. The investment needs to be in upskilling and training the entire care team so that they're at the center of delivering care, and the tech is just enabling their ability to deliver that care. I was in a meeting earlier this week, and it was a board meeting, and there was a rigorous discussion around the AI bubble, and everybody was debating, should we continue to invest? Where do we invest? How we invest? The one thing that's really clear—the case that's proven—is the return on investment when you invest in a health-care worker, especially a frontline health-care worker. There's no question around the return on investment and investing in the care team, especially on the front line, so I couldn't agree more with Dr. Rhee. I think it's about leveraging tech and AI as an enabler, but maybe even more important, investing in the care team.

Shreya Kangovi 29:34

Yeah, you asked for a story about interdisciplinary care. I'll tell a story—with consent—about a client, a woman named Serene, from a rural community in southeastern part of the country. She was outreached by a community health worker—really on the street. The community health worker did what we call the meet-the-person interview, got to know who she was, and it—you know, turned out that she was someone who was coming into the hospital frequently—hadn't engaged with primary care. But the community health worker quickly also got to realize that that was not top of mind for her. That, in fact, what was top of mind is that Serene was currently unhoused and had just gotten clean, which is a huge deal. She had recently just gotten clean and she had gotten a job. So the community health worker—and also further, kind of listened—and Serene had two young children who were in the system—who were in foster care—and that was the only priority that Serene had, now that she was, you know, clean and kind of awake and alive to this—was to get her babies back. And so, very quickly, you know, the community health worker became her friend, confidant advocate, and looped in members of a care team that really didn't exist for Serene. First of all—including the community. You know, she helped her to get into addiction recovery services, to support—support that sobriety. She helped her get parenting classes, drug screens. She reached out and helped her find housing. Reached out to a community center—that community group that she happened to be a part of, they furnished the apartment—and ultimately, they were able to get custody back. Once those needs were met, she was also able to connect her to primary care and behavioral health. So, you know, seeing the patient as the tip of the spear and then the person who can build the most trusting relationship with that patient and then bring in, you know, other care team members as needed is, I think, an interesting model of interdisciplinary care.

Omer Awan 31:45

Samm, do you have a story?

Samm Anderegg 31:47

Yeah, I think about Dr. Angelina Tucker. She's a pharmacist based in the Dallas-Fort Worth area, which is definitely not rural, but is in close proximity to underserved areas. She had access to a public health database, and noticed that there was one specific zip code where health-care costs per resident were extraordinarily high, compared to the surrounding areas. She also noticed that patients that lived in that zip code weren't coming to her pharmacy to pick up prescriptions and that got her curious, so she did some research, and noticed that there wasn't great access to primary care in that zip code, and there was one pillar or beacon in the community, which was the church. So she reached out to the pastor, came in, met the residents and started hosting diabetes education courses. Now, what prompted her to do that? Because there was some sort of incentive. If she could do that—do good by the patients, improve outcomes, refer them to primary care so they can establish care, leading to maybe an endocrinologist if they need that referral, behavioral health, access to Medicaid benefits—she can then go back to her pharmacy and leverage DocStation, the technology platform to bill for those services to the medical benefit and get reimbursed. And so that's the kind of positive cyclical change that we want to incentivize and drive, especially with this Rural Health Transformation Fund that's going to distribute funds to all 50 states, it sounds like. We need to make those models sustainable so that they can last beyond the grant funding.

Omer Awan 33:32

Your response, Samm got me thinking, you know—just when you're talking about, you know how they didn't have access in your zip code—and this may be—Howard you can answer this question—how do we ensure that we're not just providing access—because access is a big issue, especially in rural areas and we know in low-income communities that we serve—but also equity. I think there's a difference between access and there's a difference between equity. How do we ensure that this care not only provides access but also increase equity as we look at these, you know, primary care models?

Howard Reid 34:00

Yeah, I think we need to design these solutions with equity in mind from the start. You know—we're—with the Health Foundation, we're supporting Techquity, the health coalition, where we're advising and engaging leaders in health tech as they develop these incredible solutions, to think about equity, to make sure whatever they're designing is going to work for all—not just a subset of society or specific communities, but work for all. So I think a big part of making sure our solutions are equitable is that the design phase from the start—and I think it goes back to one of the points that I think were made, was made a bit earlier—we need to make sure the people that are closest to the problems are at the table where the solutions are being developed. Too oftentimes, these solutions are being developed and created at tables and in silos where the people that actually get their hands on them are not involved. And the guarantee when that happens is that the solution won't be equitable. It'll be positioned with a lens, but the lens won't work for everyone. So incredibly important that from the very beginning, we have the right people involved in creating the solutions.

Omer Awan 35:16

And I guess—I want everyone to put their forward-thinking hats on for a second. And, you know, imagine, you know, maybe five to 10 years down the road. You know—what do you think is gonna be the most challenge—or—what will transform primary care the most in the next five or 10 years? Dr. Kyu, what are you—what are your thoughts?

Kyu Rhee 35:35

I mean, we were just talking about technology before. So I think the Rural Health Transformation Fund gives us an opportunity, potentially, to accelerate some tech innovations that have not been—happened previously. And I think adding AI to the primary care team, so that we're working at top of license, which often is—and adding pharmacists, community health workers—adding AI agents to the call center, to ambient AI—there's so many opportunities to value-based care, revenue cycle management, prior authorization—there are going to be many opportunities, I think, to accelerate. Because the tech exists. It's—it's, how—how are the tech developers, as Howard was saying, working appropriate with the health-care providers that are high-trust so that that tech is then delivered in those settings, because you can't deliver tech without that trust. And so I think that'll be a big opportunity for us. You know, I'm grateful just to talk about health centers. When I started seeing patients 20—25 years ago, two miles from here, we were serving one in 21 across the country. Now we serve one in seven. And I don't think there's a better model than community health centers. And we—we're listed in Making America Healthy Again—we're listed there. We're listed with, also, Food Is Medicine. I've articulated and spent time with Secretary Kennedy and Dr. Oz, and highlighted the fact that we will support initiatives like community kitchens, community gardens—this ability to add a nutritionist, also to the health-care team—and lifestyle medicine, so we can not only just treat chronic disease, but also prevent it from happening and prevent the progression of those chronic diseases that often lead to blindness, heart attacks, strokes, amputations—diabetes and hypertension being a couple—so I think we're gonna have a big role, I believe, in a bipartisan way to make America healthy.

Omer Awan 37:44

Samm, what's your perspective on it? Because I think, you know, your background in pharmacy and being a pharmacist and now at DocStation—I think that's critical to, you know, understanding what this is going to look like five or 10 years from now.

Samm Anderegg 37:55

Yeah, I think I'll maybe just kind of summarize some of the responses that the panel's already stated. I think the big things are policy that enables sustainable reimbursement for community health workers, pharmacists, FQHCs. Two is the infrastructure and the technology that enables it, and AI is going to play a huge part in that. I really enjoyed the comments about how it's, you know, streamlining the administrative processes that exist in health care today for current organizations. And when I think about pharmacies, you know, they're not stood up or have the infrastructure as a clinic, right? They don't have front office staff, they don't have, you know, nurses, they don't have billers or coders or back-end revenue cycle

managers. So how can we leverage technology to enable that much more efficiently? And then the third thing is, really, just get out of their way. Let them take care of the patients, because they know them. They know what they need, and ultimately, I believe that will lead to better outcomes and lower costs.

Shreya Kangovi 39:00

Can I jump in on that?

Omer Awan 39:01

Yeah, please.

Shreya Kangovi 39:02

You know, Omer it's a great question you asked, like, what is going—what are the things that are going to change primary care? I think the thing that will change primary care over the next five years is existential pressure. Right now, you know, fee-for-service primary care can't make ends meet, and value-based care—excuse me for saying this—is still a bit of a racket in some, you know, way of thinking about it—and in some cases it's a great opportunity—but in some cases, it's a shell game. And—and it's hard for primary care to kind of get in on that. And so when you think about the future of primary care, there—it's—it's a big question. You know, I was on the National Academies of Medicine panel on—committee on primary care several years ago—and there's worry that this notion will go away. I think that—and we've seen, you know, some of the biggest companies, not only in American health care, but in the United States, go to bat, you know, and fail, at primary care—Walmart, Amazon—they just backed away from it. And I think what needs to happen is that we need to think more radically, and hopefully that can happen with that existential pressure. You cannot reinvent primary care simply by just putting a shingle up in a grocery store parking lot, but then doing the exact same thing—biomedical medicine—within the walls. Like, that doesn't work. The economics don't work. The outcomes are, you know, not so great. And so what needs to happen is a move from primary care to primary health, which is an age old—you know, this is old wine in new bottles, right? So, this is from the Alma-Ata Conference of 1976—primary health—which is really heavily about breaking down those walls and having Miss Jones be able to go to a grocery store, a laundromat, and at that point of her life—not entering into a health-care system—be able to access the types of services that help her address the root cause of illness, and then as-needed clinical care to address conditions that she already has.

Howard Reid 41:09

Omer, can I add to that? I agree. I think it's existential pressure that will ultimately change and force us to reimagine primary care, but technology alone won't do it. If we simply keep layering in things—layering in technology—without starting first with that as a principle and how we want to reimagine it, we're going to

see incremental improvements versus radical change across the entire system. So I know this point has come up a couple times in the panel, but in working with many organizations, seeing a lot of early stage companies and startups, most of what I see are people layering in a thing versus reimagining what health care can look like from the start. So for me, one of the big opportunities that we can—we can explore to reimagine primary—primary health care is to use technology as a first principle versus another thing that we're layering into an existing workflow or process.

Kyu Rhee 42:09

I'm gonna reference this in the next five years, a triple double concept. So I don't know—in sports, in basketball, there's a triple double. But if you look at the measures that matter, right now we spend 4.7 cents on the dollar on primary care, and if you look at countries that have spent more, they deliver better health outcomes, lower costs and broader equity. So there's an opportunity for us, in my mind, to highlight that number and double it. It should be 10 cents. I personally think it should be a quarter, but let's start there for five years, because ultimately that will deliver that whole-person comprehensive affordable care in communities across this nation and address the gap that 100 million people in our country lack access to primary care. The second part of the triple double is—community health centers have a big role. I believe that should be doubled in terms of number of people we serve. The third piece is the pipeline of the whole team we're just talking about. So many people are choosing—I had the pressure, as an immigrant, with my parents, who invested so much in me to become a specialist. They're like, why aren't you being a neurosurgeon? I want to do underserved primary care and get paid a lot less. Why? So, like, we have to build that pipeline and build our own and invest more. Right now, if you look at physicians going out of residency, only 20 percent—one in five—go into primary care. We gotta to get that to 40 percent and we gotta think about the whole team as well. So that's the triple double: double the primary care spend, the double number of people served at health centers and double the number of people going into primary care in the workforce.

Omer Awan 43:44

I just want to remind everyone that you guys can also submit questions. I don't have to be the only one asking questions. So if you submit a question online, I can ask the panel this question as well. So please feel free to ask questions. But one question I do want to ask is, I've heard a lot about policy. You know, I think every one of you has mentioned the word policy at least once in this, in this last 45 minutes or so. And I'm just curious to hear from all of you actually on—you know, if you had to pick one policy change—or if there was one thing that you could—one specific thing you could advocate for to, you know, Secretary Kennedy or Dr. Oz, or, you know, anyone in Congress—what would that be with respect to, you know, unseen providers in primary care? Maybe we'll start this way with Samm and go to Dr. Kyu.

Samm Anderegg 44:25

If I had to pick one, it'd be that ECAPS legislation. Making pharmacists providers at a federal level, so that we can bill Medicare Part B directly for services. We're seeing that play out in the states again. When we

started the company, there's about seven states. Now, I think we're over 40 states that have passed laws to enable that sort of reimbursement mechanism. And there are other ways to do this as well. There are state plan amendments that state Medicaid programs can enable to reimburse pharmacies for services. But I think it goes back to that pillar one of the policy that enables reimbursement.

Omer Awan 45:02

Awesome. Dr. Kangovi?

Shreya Kangovi 45:03

Yeah, I think, same. Referring to the comment that I made earlier—increasing that community health integration code that is the reimbursement mechanism for community health workers by $21.

Omer Awan 45:16

Howard?

Howard Reid 45:16

Yeah, for me, I think policies that care for the carers are really important. I'll give a shout out to Dr. Lorna Breen—Health Care Provider Protection Act, back in 2022—the first of its kind legislation that deployed over $100 million and worked with over 44 organizations to provide evidence-based essential mental health services to health-care providers. Mental health is a crisis—specifically with health-care providers—and legislation, funding investment, and making sure they have the mental health services they need, I think, is critically important. Unfortunately, end of last year, the legislation expired, and it's up for reauthorization. So I think that would be the one policy that I would really advocate for.

Kyu Rhee 46:08

I mentioned the triple double, but I'll add, and I brought this up to members of Congress and also members of the administration. If you look at the primary care spend related to community health centers—$57 billion this year—1 percent of all spend—serving one in seven and one in three in rural America, and the fact that we are witnessing the solutions to primary care that the private sector has looked at are—you know—we just talked about wall—Walmart, Walgreens—you know, CVS is still in there. But I want to highlight that the likelihood that primary care solutions, especially for the communities that are underserved, one in three people in our country are below 200 percent of the poverty level. One in two are below 300 percent. There's no better solution than community health centers. And so I've stated this very simply; if we had 5 percent of spend—250 billion in today's dollars—we could serve half of the US

population with comprehensive primary care that includes community health workers, pharmacists, the whole team with technology as well. We could deliver that value and that ROI that the Congressional Budget Office has identified for this country. So that would be the big policy pitch.

Omer Awan 47:22

I think that's a critical point Dr. Kyu, that you just mentioned. I mean, if you—the numbers are staggering. I mean, just how many people are in dire need of health, and how many people are below the poverty line. I think a lot of people don't understand that—how—just—just the scope of the problem. So I think, you know—really appreciate you bringing that to the forefront. We're getting close to the end of the hour, so I just want to make sure that we ask another question to each of you as well. You know, I always like to end with, if you had one takeaway that you wanted—you know, there's a lot of people here in the audience, and you know—everyone's going to walk away. And usually, when you go to these sessions, you know, you walk out and you forget everything that you just heard. Right? So I want to make sure that we don't do that here today. So if there's one takeaway that you want everyone here to kind of remember as they walk out of the door and enjoy the rest of the conference, what would that be? And maybe we'll start with Dr. Kyu and come back to Samm here.

Kyu Rhee 48:11

Gratitude is important always. Thank you for listening and having—being a part of this conversation and looking at unseen and making us seen. We endeavor at NACHC to assure that all community health centers are employers, providers and partners of choice. There's 1,512 of us. We're average 12 sites each. So over 17,000 sites. One in four of our sites are in school-based health centers in elementary, middle and high schools. So we start early. We also have a couple thousand sites, nearly, that are mobile vans as well. We want to be a partner of choice with you, whoever you are—locally, at a state level, at a system level—and I'm grateful for the fact that we've got a great partner here—Johnson & Johnson and Howard—and the work we've done on workforce over the past five years that I've looked—detailed the work we're doing and the work we could be doing—the work we should be doing around community health workers more—appreciate that and the work you're doing with pharmacists. So please think about us as a partner of choice.

Howard Reid 49:10

I'll start with gratitude as well. Thankful for the panel here. Really enjoyed the discussion. Omer, thank you for facilitating. You know my walk away point would be, as investments in technology continue to grow, let's not forget about the people that ultimately are delivering health care. Investments in health-care workers are critical. Technology will enable health-care workers, front line health workers, community health workers, to deliver better care, spend more time with patients, ultimately drive better outcomes. So let's keep the people—the person—at the center of care delivery, I would say, number one. And then I think number two, I think it's incredibly important to think about equity from the start. If we develop these tools, if we develop these technologies, without equity-first principles, I think the guarantee is health

disparities will only widen—between well resourced areas and underserved areas. So thinking about design principles and equity from the very start with this technology is incredibly important.

Shreya Kangovi 50:17

Yeah, first of all, thank you for having me, and thank you to you all for your attention. I often get asked the question, you know—there's so much evidence behind community health workers. Everybody is nodding and excited about, you know, the notion of community health workers. There's now infrastructure. So why aren't we seeing more community health workers? I think that there are a lot of explanations, but there is one answer, and that is that we do not want to share power. The American health-care system is one of the most entrenched power structures in the world, and it is mostly made up of people like us—primarily clinicians with letters behind our name. And we are going to continue to remake health care in our image. We're going to advocate for our own reimbursement rates. We're going to just try to keep hiring more people who look like us, and then we're going to get the same results. So I think the takeaway—and I hope I'm not putting you on the spot, but there's a wonderful community health worker in the audience. I'd love to invite you to stand up and just allow people to see you, because this panel is about unseen providers. [Applause] Let's see these people who reflect the communities that we're trying to serve. We need to start seeing the people that live in the communities that we are trying to serve, because otherwise we are enriching ourselves off of these communities. [Applause]

Omer Awan 51:45

Thank you. Thank you. Dr. Kangovi. Before you begin, just thank you for that, and thank you for standing up, because I think in the spirit of this—this, this whole talk, that—this is what this is all about. So thank you. Samm?

Samm Anderegg 51:55

Yeah. I couldn't agree more. Five years ago, I used to say there are 60,000 brick and mortar pharmacies all across this country. Now that number is down to 56,000. We're on street corners and main streets all across America. Nine out of 10 of us live within five miles of a pharmacy. We want to collaborate. We want to work together. We want to partner where our missions align, to increase access to care in these underserved areas, increase enrollment in clinical trials, diversity in clinical trials. We're ready to go to work, so please reach out to us and engage.

Omer Awan 52:40

Excellent, and I know I'm not a panelist, but I do want to provide one thing that—that—a takeaway, and that is that, you know, there is a dire need in this country. You know, we have, you know, more than 40, 50 million Americans that live in rural areas. There are so many that are in low income areas that have to

travel hours just to get care. And this primary care workers, health-care community—this is a feasible solution to a decades-long problem in American health care that can really have a ripple effect and really lead to very positive health outcomes. Thank you so much, everyone, for joining us today. Really appreciate you guys. Thank you for the panel.