Weitzman Institute
2022 VIRTUAL
Symposium

Keynote Presentation #2:
Moving Upstream: Barriers and Opportunities to Optimizing and Creating a More Equitable Healthcare System

Reimagining Primary Care through a Health Justice Lens **May 4, 2022**

SPEAKER:

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LEARNING OBJECTIVES:

By the end of this session, participants will be able to:

- **Describe the importance of healthcare optimization and payment transformation in order to address barriers to access to care and health equity concerns that impact marginalized communities.**
- **Describe trust and community engagement as critical ingredients to improve whole person health and experience within the transformation of healthcare models.**
- **Identify solutions for broader workforce development and innovation in order to meet the needs of marginalized communities.**

April Joy Damian: I am very excited and pleased to introduce Dr. Kameron Matthews, who serves as the Chief Health Officer of **Cityblock Health**, the transformative value-based healthcare provider integrating medical, behavioral, and social services for Medicaid and dual eligible and low-income Medicare beneficiaries. A board-certified family physician, Dr. Matthews has focused her career on underserved and vulnerable communities, having held multiple leadership roles in correctional medicine, Federally Qualified Health Centers (FQHC), managed care, and other nonprofit organizations, as well as lead transformational efforts in Veterans Health Administration (VA), including the implementation of the Mission Act of 2018 and the EHR modernization effort. When I think about someone who truly embodies our values of excellence, innovation, equity, and inclusion, as a professional and as a human being, I cannot think of anyone better than Dr. Kameron Matthews.

Kameron Matthews: Thank you, April Joy. I am excited to be at Cityblock and I am excited to use it as an example of what I am going to continue to refer to as a transformational effort. I wholeheartedly believe that we need transformation within our healthcare system to elicit the change that we are all seeking out there. A lot of the conversation that we are having, a lot of the solutions that might be devised within individual healthcare systems, individual community health centers, are not going to be possible if we are not looking at the larger healthcare system in which we are working, the policies that are allowing us—**forcing us**—to perhaps prescribe specific interventions and solutions. Therefore, the transformation of the health system as a whole is necessary. I am using Cityblock as an example, but I will also refer to the VA. I am honored to have served our nation's veterans for the time that I did. I was honored to work alongside an amazing national set of caretakers, leaders, physicians. We truly embodied an understanding of what it is to put the patient first, put the veteran first.

The Status Quo is Not Working

Let me just start by describing what I mean by transformation. Point blank, bottom line, up front, however, you want to think about it, the status quo is not working. **What we are doing, the solutions that we continue to bring about, are not getting us to the end goal, are not changing our patient's outcomes in the way that we need to.** Our current set of solutions are keeping us in that hamster wheel, and we need to look in a different direction.

That is depicted most when we are thinking about care on a community level and, more importantly, our most vulnerable communities, ones that I've really turned most of my career to. Probably a lot of eyebrows get raised when you hear about my time in correctional medicine, but I honestly see it as probably the most impactful that I have ever been as a clinician, but also as a policymaker, having really started my leadership roles there. I think what I saw most in the correctional setting is how our traditional healthcare system is failing the most vulnerable.

I would argue that the way we approach medical care is so much more than just the healthcare system and the operations and administrative policies that are in place. I would also argue that the way we approach the actual medical interventions that we devise are also failing our patients. Yes, we can take a patient's medical history. We can understand that this young woman is under respiratory distress. We can look to counsel her and refer

her to outpatient behavioral health. But is it doing enough? Are we actually changing the status quo with just this type of plan of care? I would argue that we are clearly starting to label members of the community of who aren't really fitting into our solutions as "non-compliant", as "withdrawn", as "not really being committed to their care." I think there's absolute reason for us to be looking at this from a different direction.

If we are thinking about this person as instead a survivor of trauma, as someone who has been a part of a social system that is not sufficient, who continues to have behavioral health, mental health problems that are limiting her in access in general, as someone who's had lifelong experiences that actually caused her to actually question and not engage with the healthcare system that's supposedly here for her, you would see her in a completely different light. **You wonder why we continue to look at her as if someone who's just going against medical advice when she's actually looking to prioritize a lot of other issues that she's dealing with on a day to day basis.**

So the question is really why do we continue to place our patients in this cycle and why do we continue to promote a system in which we are not really solving the issue that is immediately in front of her? We are solving what is *our* priority within the medical model. I would actually argue that this is where the transformation is needed most. That we need to understand what it truly is to be as **person-centered** as possible. Our current healthcare solutions do not afford that.

How do we approach this at a population level and at a neighborhood level? It is first in recognition that there are limitations across the board. We traditionally rest what we know in healthcare on a medical model that sidelines the importance of social drivers of health. **The people who are seeking out our assistance are suffering from social and economic risk factors that lead to those worse health outcomes that actually increase their use of healthcare in a very expensive system.** Also, that our providers are actually left on our own. I am not pointing fingers at those of us who are participating in the medical model. We are just as much succumbing to the fact that we are left with needing to identify their unmet needs, and potentially come up with solutions when we are not in a system that either incentivizes us (e.g. pays us) or actually gives us the ability to look at the patient fully and beyond just their medical issues.

Policymakers and payers are in a place to do it, but, right now they are making the argument that they are not in a place that could actually truly incentivize a different financial approach that would incentivize us as providers to change our model. Most importantly, communities are unable to truly mobilize the resources, the limited resources, that they have at their disposal. We keep thinking digital health technology is going to be enough. It is not. **We need to look at larger barriers such as health literacy and access to broadband.** I think the pandemic, where we have come, where we continue to go, what we're about to experience this summer, is going to continue to shed light on the fact that we can impact a population that is not able to truly overcome a lot of these issues. I think we continue to perpetuate that by not stopping and actually solving the problem that is causing the issue in the first place, as opposed to just writing a prescription.

The Path to Transformation

The path to transformation is truly something that is simple. It is something we all know, but that we do not take the time to do, and we are not appropriately incentivized to actually address, and that is, trust. We know from the data **(Figure 1)** that by understanding what a person's experiences are; understanding how they are actually interacting with the care team; by understanding the structural, as well as individual factors of how they're interacting with any system, including the healthcare system, is truly where we need to start. Not necessarily just asking a simple question when they walk into an emergency room, but truly understanding where the lack of trust is coming from, **reframe it as that it's not that that person has a lack of trust in us, it is that we have not earned their trust in the first place.**

I have seen this at every stage of my career. I talked a little bit about my time in corrections. I have got another third party within my healthcare relationships, which is security, the actual correctional staff. They are a huge barrier and it is often a three-sided dynamic between the provider, the security, and the patient. The patient trusting me whether or not we have care team and actually trusting the patient since they are incentivized to do as much as possible to get to the medical staff. How are we able to actually address their concerns when that trust is clearly not there?

We saw this at the VA where we made so much progress. When you are thinking about one of our nation's veterans, we are talking about individuals who had service experiences that impact the rest of their lives, particularly when you are talking about our black and brown veterans. You are also talking about those who might have had an inequitable military experience that actually causes them to question their government and their ability to actually take part in a larger system. I saw this time and time again. Much of

Now I am going to read you a list of institutions in American society. Please tell me how much confidence you have in each one—a great deal, quite a lot, some, or very little?

Sorted by most to least confidence in 2014

	% A "great deal" and "quite a lot" of confidence
The military	74
Small business	62
The police	53
The church or organized religion	45
The medical system^	34
The U.S. Supreme Court	30
The presidency	29
The public schools	26
Banks	26
The healthcare system†	23
The criminal justice system	23
Newspapers	22
Organized labor	22
Big business	21
News on the Internet	19
Television news	18
Congress	7

June 5–8, 2014 ^Based on 510 responents; †Based on 517 respondents

Figure 1. Gallup Poll in Confidence in U.S. Institutions.
Source: Harris Interactive Polls

our focus is therefore not just about trusting us as individual providers, but trusting a healthcare system as a government and as an entity that is here to assist you. The goal is to recognize that, first and foremost, before I can diagnose anything, it is about understanding why that veteran is coming in at the door and is seeking out our services in the first place, and how I can remain engaged with them.

Now, this is something we're seeing, even more so during the pandemic. We recognized, especially conversations about testing early on, and vaccinations, of course, a larger issue that really displayed that **the priorities of the healthcare system is often not aligned with the priorities of a community, of an individual, particularly essential workers from black and brown communities across the country.** What we consider to be good medical care is not their first goal. We need to align our goals, so that we can truly make sure we're impacting not only their outcomes, but also the equity of outcomes between different communities. We need to earn their trust and not necessarily just ask why is it lacking in the first place.

Radical Transformation

I started with Cityblock on January 3rd of this year, and it has been a big transition for me coming from the VA, which is a very structured bureaucracy, but I absolutely see the parallels every day. I came from an integrated health system where we were taking care of that veteran regardless of whether they were in our walls, regardless of how frequently they visit us, and we did not have to worry about how their care was being paid for. We were responsible for their wellbeing from the time that they ended their service all the way to the time of their death. It did not matter what their interaction with our system was, we were responsible for them and we owned that. We also sought to coordinate their care, even when they were not receiving it through the VA.

I see the same thing at Cityblock. We are truly trying to integrate primary and behavioral care, as well as pay attention to the social drivers of health in a different business model, in order to truly impact those underserved in those marginalized communities. What I argue, is that in order for this to be scalable beyond just Cityblock, it requires a radical transformation of how we actually look at the system. Cityblock is not the only one that believe this.

I was happy to be affiliated, as a Fellow, with the National Academy of Medicine's Consensus Study that was released last May focusing on implementing high-quality primary care. We were truly focused on how we actually take this beyond just the academic conversation and transform the system. How can we actually implement a different level, a different approach to primary care, because good primary care is not sufficient. The way that we treat our members, one on one, is not going to be enough to truly change the larger system in which we are practicing. Therefore, that larger transformation is exactly what we need in order to ensure equity and high access for all persons, regardless of their coverage and regardless of their ability to pay. We know for a fact that this is where a great deal of the inequities lie.

Our business model in Cityblock is one that focuses on that first point of payment transformation. We are thinking about the entire amount of necessary solutions of a care team, and not just billable fee-for-service opportunities. Now, of course everybody remembers back in the '80s about capitated models and accepting risk, but this is a completely different, data-driven world in which are analyzing risk and defining our approaches, our solutions, for individual members, and are being adequately paid. We are adequately incentivized to build a care team to truly address individual members as well as population-level concerns.

Much of this is in recognition that we need to meet the members where they are. We need to provide primary care in an integrated fashion and bring down those walls that we have created even in our own profession. In healthcare, we love to think about the doctors over here and nurses over there. Primary care over here, family medicine versus internal medicine. We have to bring down those walls and we have to recognize that there is an entire care team. The patient does not care what your board certification is. The patient needs to know that you are advocating for them and that you are meeting their needs.

Patients have started to vote with their feet. The way we think about primary care separately from the rest of the healthcare system is not sufficient for them. They are voting with their feet by walking into what we consider to be less optimal situations, which are those kind of walk-in urgent care facilities that are open 24/7 and are meeting their needs and answering their questions. It may not be to the level of quality we would like, and it may not offer the same level of continuity, but again, that's our priority, not the patient's. Their priority is to get their needs met. As much as we want to step back and say we can educate the patients about how to do this, we actually recognize thinking through human-centered design terms. We need to recognize that actually we need to allow them to set their own goals. If we're not meeting it, they will continue to vote with their feet.

We need care to be personalized, we need it to be respectful, and a trust-based relationship. That is truly what our model in Cityblock is able to do. We need to fully grasp what their community is offering and what their community is lacking, and how we are going to able to supplement that. Traditional primary care right now allows us to participate in that relationship, but is transactional in nature. We need to think about payment reform and transformation and how we're able to communicate with the patients. We need to be able to meet them where they are. We need to be able to think of them beyond visit-based and transactional. We're also proud to think of this not only being data-driven, but technology-enabled and it's something, unfortunately, that we're not incentivized to do within the primary care structure. We need to continue to be innovative and work in this new startup world, in order to really think about how are we going to serve these communities that need us most, these vulnerable communities. **A single solution is not going to be enough to address the suburban family versus the young lady that I described earlier, who's really dealing with some social concerns.**

In order to do this, we are proud at Cityblock to really be able to identify and address their social needs. This is a larger piece. We are training now, we're focused now in a lot of our systems on the social needs of a patient. But when we're looking at the system as a whole,

what are we truly able to do about it? Sure, we can fundraise with partners, we can have community based organizations working with us, we can even rent out apartments and put some patients in there to address homelessness and send them to a food bank down the street. But as the system, have we even really made an impact or are we just worried about our immediate individual health systems bottom line? I think the transformation that is necessary is that we need to think of social needs and these solutions as part of our model in the first place. I'm proud to say that's what Cityblock does.

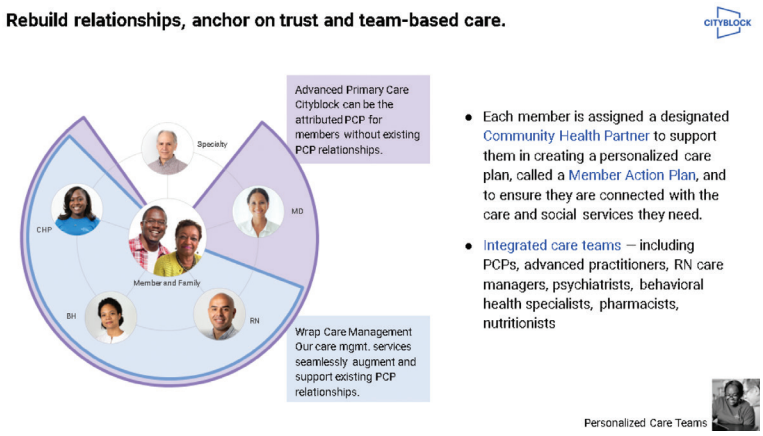

Figure 2. Personalized Care Team Model. Source: Cityblock.

So where do we differ? We truly are deploying a model where we're acknowledging that, yes, we can offer some primary care services, but it's not possible to truly build that across the board as well too. We're all in competition for the good primary care, or any primary care doctors, but definitely the good ones, are all in competition. How do we work with the primary care providers in the communities that we serve? How do we maybe establish some primary care when we see that there is an issue there? We need as complex of a solution as the communities that we serve need. Part of this is in building out our models, we do so to meet the member where they are. **We help jointly build out a member action plan with our community health partners, what we call our Community Health Workers, to truly address and give them that point of contact to get to understand them, to engage with them, and to bring through the care team in order to answer their questions to help prioritize, not force the prioritization on them, and to be as integrated as possible crossing primary care and behavioral health**, which, in my mind, should be more than integrated and be considered one and the same.

It is also not just what services you're providing, but ***when*** and ***where*** you're doing so. This was my point earlier about the fact that we're still considering ourselves a service industry. We are finally looking more at customer service, but we're still considering ourselves like a nine to five business. Yes, some of us offer evening hours and weekend hours, but are we truly meeting the patient where they are? I worked on the West Side of Chicago and I actually had some patients coming to see me from the South Side taking three buses, without paid leave, without sick leave, to be able to take that time off to come see us within our walls. Only a portion of the communities that need us most are really able to do this. In order to establish these relationships, to earn that trust, we need to be going to them. We need to understand what access truly means. It's not about access to our walls, coming to see us, but about offering home-based care delivery. We do that in the Cityblock to a significant extent, but we are not in any way, the only players in the space. Again, when we're thinking about a larger transformational solution for the healthcare system, we need to be doing this at higher volumes.

Diversity as a Solution

Let us say we've changed the system. We build out these opportunities, we incentivize our teams the right way, we're paying them differently in risk, value-based sort of setting, we're getting them to care when and where they need it, we're going to the home, and I'm not doing anything in my office anymore, is that sufficient? I would say, without understanding what that relationship of the care team to the patient is, without understanding that community engagement needs to continue through the membership of the care team, that's also a problem that we have. So the transformation of course I'm discussing is diversity within the care team as a whole, across all members of the care team.

I am really proud to promote that Cityblock, our city folks as we call ourselves, truly do provide culturally competent care. Of course, the expectation is that every single person within the healthcare system, down to the front desk staff, needs to be culturally competent, but there's a clear impact on larger outcomes when we're talking about the actual diversity of our care teams and the significance of racial concordance between both patients and providers. Not only do we need to be training these care teams to understand and engage with the communities in which they are working, but we need to assure that by bringing diversity into the care teams themselves, that we're actually addressing every individual, every family, every community.

In Cityblock, 57% of our workforce are underrepresented persons of color. We've got a board of 50% of people of color, our executive leadership team is 71% female. **This needs to be the future of medicine, this needs to be the transformation of the healthcare system for there to truly be the impact on the communities in which we hope to serve.** One of the strengths of the FQHC is that the majority of the

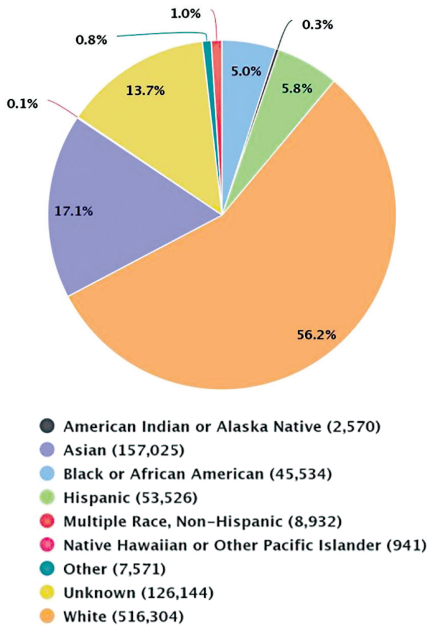

Figure 3. Percentage of Active Physicians by Race/Ethnicity, 2018. Source: Obtained from a variety of sources including DBS, ERAS, APP, MCAT, SMDEP, GQ, MSQ, PMQ, FACULTY, GME, STUDENT with priority given to the most recent self-reported source

Board of Directors needs to be the patient that is served, needs to actually be a member there. This is what we're hoping to do in Cityblock and I know a lot of health systems around the country are doing that, but I think there needs to be a larger sense of urgency, more than even just the racial justice conversations of the past couple of years. Even when you go back to the Project 3000 by 2000, we knew early in the '90s that we needed to go there, and that totally bombed out. We're still only matriculating 7.1% of students as Black and African American, while only 5% of active physicians are the same **(Figure 3)**. This continues to reflect the same exact tactics that we do elsewhere. We love to think that there's just a dearth of these students out there. We love to just continue to recruit at the same universities out there. Of course, this is way beyond physicians, but we need to be thinking of nurses and we need to be thinking of all members of behavioral health teams. We need to diversify in order to truly improve access and quality of care. **We need to be thinking about implicit bias and cultural competency of the larger care teams.** I'd also argue, not only is that not sufficient, but we need to be synergizing the conversations, the efforts, around both equity, looking at actual patient outcomes, and diversity within our care teams, because they're one of the same. We need to not necessarily be so divisive in how we're approaching those solutions in the first place.

The outcomes are there on the impacts of diversity; although, we're still trying to convince that racial concordance does actually have positive impacts, and that we're improving not only satisfaction of the patient, we're decreasing bias within care teams, because there is that level of respect between provider and patient. That we're actually increasing the care, just the outright volume of care, of those of us like myself who focus our careers on minority and vulnerable patients actually does increase as you start to diversify the workforce. Therefore, we are improving patient outcomes, we have more adherence to treatment plans, and it is based on trust and engagement.

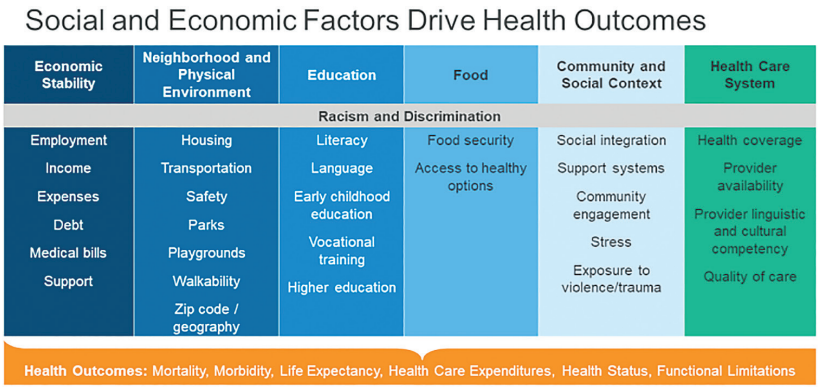

Figure 4. Social and Economic Inequities Driving Health Disparities.
Source: Kaiser Family Foundation (KFF)

We love to think about social drivers of health and how there is so many levels of community and individual based issues that lead to how they impact our health and well-being **(Figure 4)**. What I'd argue is that we need to be thinking in the same exact format around that the fact that our underrepresentation within the workforce results in the same exact social and economic inequities. They are impacting our ability to recruit our workforce. We need to not just be thinking about social determinants of health, but social determinants of education. How are we actually thinking about the future of our workforce if we aren't addressing the true pipeline that leads these community members into our industry in the first place? It is not enough to just be thinking about our patients, but our future colleagues.

The Future of the Healthcare Workforce

There is a lot of conversation that we should be changing the metaphor because the pipeline denotes that once we lose those people, whether it's in middle school, high school, or college, they're lost. It's hard to put water back in the pipeline. There's a new metaphor of the highway, and that people exit at different times with the goal to get those bridges back to help them go over, maybe a boulder in the road, and to keep them on the pathway into healthcare.

My own nonprofit organization, Tour for Diversity in Medicine, has been doing pipeline pathway programming now for 10 years. I am excited to bring these resources to students on campuses across the country. We've been to 27 states, where we are purposefully targeting those students that don't get the attention of their advisors on campus, that don't necessarily have those resources of an academic medical center down the street. So much of our efforts are focused around ourselves. We ask our patients to come to us. We ask future doctors and nurses to come to us. We purposefully get on a bus and go around the country to meet them where they are, to show them that you can't be what you can't see. We truly have been able to collect a great deal of data over the years. One of our publications outlines that there's inadequate institutional support and resources for these students. Students are told as a freshman that they should be looking at other professions because they're not good enough to enter healthcare. We also have been able to outline that there's limited personal resources, family conflict even, not just family financial resources, lack of access to information, mentoring, and advising. A lot of our campuses that we

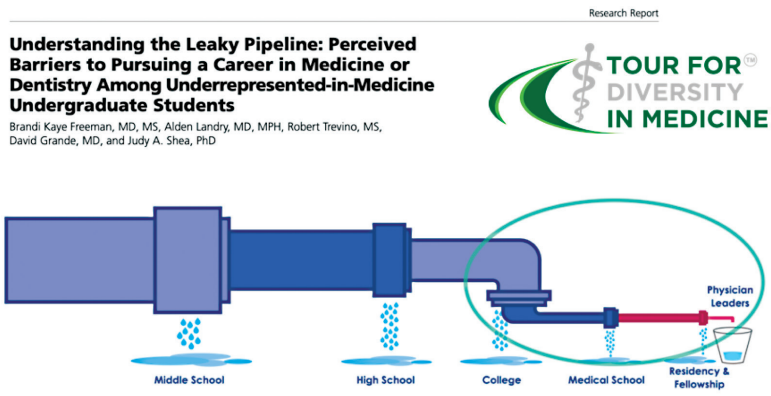

Figure 5. Medicine or Dentistry Career Pipeline. Source: Cityblock.

visited around the country don't have someone who truly understands pre-health advising and they're using their science faculty to serve as pre-health advisors, although they are completely different fields, completely different experiences and skill sets. There are also larger societal barriers, including their understanding that this is even an option for them. Hearing that students see themselves in us is one of the best pieces of feedback that we get on our program, and we will continue to travel around the country and hopefully getting **#backonthebus** this fall.

Figure 6. How to Invest in the Future Workforce. Source: Various, Tour for Diversity in Medicine; MAPPD, BNGAP; HPW; Black Men in White Coats.

This is truly another area of transformation where we need to be. **We need new and innovative tools in order to really break down these barriers of understanding why there's such decreased participation in healthcare as a whole, not just medicine.** The tour and other amazing pathway programs around the country are necessary to really ensure that the pathways into healthcare to address our patients concerns, first and foremost, are truly there.

I tend to think about the workforce as four different levels of engagement. The tour is one of the first to **engage** with them and help them know that this is an option. We introduce the field to them, we introduce ourselves, so they can see that there's someone who connects with them, someone who tweets back to them. Social media is necessary in this space, but we still invite students to come sit in our auditoriums and listen to talks. We need to be meeting them where they are, we need to be engaging where they are, which the same exact concept with our patients. **Recruitment** is the next level. Once they're engaged, once they start thinking about healthcare, how can we actually think about what field they should go into, what information they need, what podcast do they need to listen to? I've shared a couple of examples **(Figure 6)**. There's so many amazing podcasts out there. The idea is that they need to understand a little bit more about our fields in order to make that decision. Then, we need to **retain** them in medical school. We have significant issues of retention while coming through training. There's the Student National Medical Association, which I was proud to be National President of as a student, and the Latino Medical Student Association. We need to make sure that these students are successful, and that we help address their academic concerns. Those societal barriers, those concerns about mentoring and support are a real problem for our students, for our communities. We even started this Road to Residency program as a part of the tour, where we're helping students get paired with physicians around the country in their fields that look like them, that are interested, and dedicated to their futures. They also help them do mock interviews, review personal statements, and hopefully get them to that next step of residency. Then we need to be talking about **sustainment**. Every single one of us who are practicing or attending need to be thinking about how we can be assuring those just a little junior than us to follow in our path. I'm seeking out mentors as well, so that I can continue on my own path. This is a pathway, a pipeline, in which we need activity at every single step, and students need to be pushed along. Professionals need to be sustained and pushed along this pathway. Otherwise, we will not be successful in improving diversity of the workforce as a whole.

Upstream Solutions

Primary care, more than anything, is based in trust and engagement and needs to be prioritized over a quality measure or some clinical outcome. I'm not saying those aren't important, but if we don't have our patients working with us in the first place, the rest is irrelevant. As we measure quality outcomes, my first thought of a community is that I'm looking at outcomes of only the people that are coming in my doors. That is not sufficient. I need to be thinking about the larger community, the larger disparities and how we're going to address them. **By truly making sure we have a workforce that understands our needs and looks like them—that's where the level setting is going to be.** We need to be able to incentivize our workforce appropriately and we need to understand that the development of that workforce is just as important as the diversity its composition.

What I've discussed today is just some upstream solutions that are necessary to address our communities, to address their needs, to address the lack of equity and empathy that our healthcare system has for them as whole people, as opposed to just patients within our system. **Transforming for an individual alone is not sufficient.**

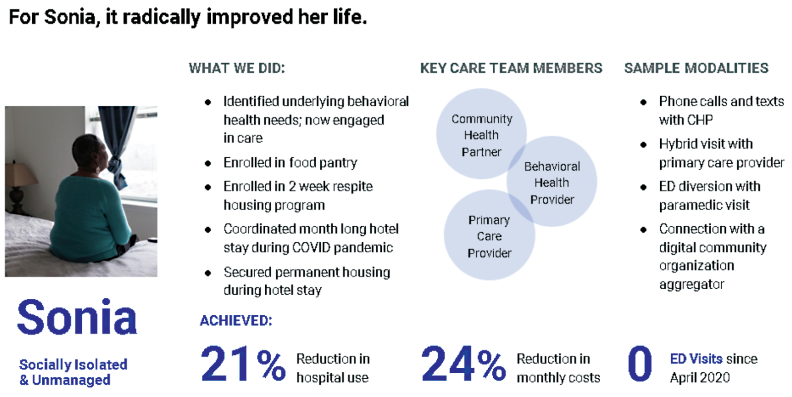

Figure 7. Impact of Cityblock Health. Source: Cityblock.

Even if we're able to improve their quality outcomes we haven't necessarily improved their wellbeing. I'll go back to our example from our patient earlier, Sonia (**Figure 7**). Her pets, her cats were such a priority within the work that we did. What I was most proud about is that we were able to really think about getting her to an allergist. Making sure that her cats were as much of a priority, as opposed to making sure she stayed out of a hospital, I mean that's so important don't get me wrong, but in understanding her entire experience, we really did also prioritize her cats. That truly resulted in a different set of outcomes in its totality with a 21% in reduction of our hospital use and 24% reduction in our monthly costs because we approached this holistically.

This is about the whole person. Hopefully, you get from this that our healthcare system doesn't afford us to really do that. We need to transform more than just how we approach this individual patient. This was great but it's not sufficient.

Question and Answer

QUESTION 1: Thanks so much, Kameron. You've made a compelling case for what redesigned primary care looks like and what its impact can be on improving outcomes, but primary care doesn't exist in isolation. ***Often, we need support from specialists so how does Cityblock engage with a specialty care community to coordinate care effectively and meet the needs of patients with complex needs?***

I couldn't agree more. As much as we are an integrated primary care system, we completely acknowledge that the care team as a whole must include the necessary specialists, the inpatient team, and the emergency team that is taking care of them on more of an acute basis. That's where the real engagement of understanding and even wrapping around our services of the primary care doctor, the specialist, the transplant group, and the dialysis center that is taking care of some of our patients. We need to think of ourselves as a whole care team as opposed to a specialty-based approach and this concept of handoffs between these different specialties are not doing our patients justice.

We need to think about how our model can actually help, particularly with the communities that we're serving and some of the primary care providers that work within. My colleagues in FQHCs, a lot of times you may not necessarily have the resources or time to think outside of your fee-for-service space. So, if you had a Cityblock who was able to supplement and offer care management, the pharmacy medication management, the behavioral health in house, or even coordinate services. We see ourselves wrapping around our specialty colleagues, our primary care practices in our network and having a holistic approach, not just to the patient, but to the care team as a whole.

QUESTION 2: ***What suggestions do you have for promoting organizational change within FQHCs that are trapped within the current broken systems?*** Leadership seems frozen in the "old ways" and money and time is limited, which has been made worse by the pandemic.

I agree, this is the frustration. We need to think about this transformation, particularly in the FQHC space to assist these practices to get out of a fee-for-service model. It's been so traditional. I've even seen putting productivity on the back of the doctors alone and not expanding and understanding the entire concept of a care team. **That it's more than just those billable hours that justify something on a financial ledger.** I think that's where organizations like the National Association of Community Health Centers and our state Primary Care Associations can start to turn that conversation, and we get leadership to truly understand that in order to truly improve outcomes that there may be different approaches in getting there. I've been a part of that conversation in many different arenas and it is a lot of individual change, but again, the transformation of the system as a whole, getting them out of this productivity-based payment structure will ultimately lead to changes as well.

QUESTION 3: ***How can a white healthcare provider be an ally when concordance from a racial ethnic perspective isn't possible in the moment? Are there any books you can recommend for white healthcare providers who want to show up as allies?***

I think it's a cop out, to be honest, to be thinking of diversity as the only solution to get there. Racial concordance is important, but it's also a cop out that we're not holding the entirety of the healthcare workforce responsible for competency and acknowledging implicit bias. Thank you for this question as an ally. **It is completely on every single one of us to not only understand cultural competence but the concept of cultural humility, where there is an understanding that separate from race, there's a need to humble, to ask yourself your own questions about your own biases, and to not project that on our patients.** It is important to truly understand that the patient's understanding of culture, whether it's about their geography or urban versus rural, race and ethnicity, sexual orientation, gender identity, is so much about their experience and their well-being. Being humble enough to ask those

questions, to jointly devise and come to solutions and how you're going to meet them, is the best approach, as opposed to again us prescribing things to them.

I apologize I can't think of any books off the top of my head, but I'll post it on my website. But, it's absolutely necessary for all members of the healthcare workforce to be a part of this conversation. Racial concordance is an important piece but it will never be the full solution. We do need all of you to be a part of the dynamic that we need to change as well.

QUESTION 4: ***What policies at the state level can help foster this transformation?***

A lot of the roles, particularly around Medicaid, are state level decisions. We need to understand who our delegates and representatives are, and we need to educate them on value-based arrangements, looking at quality and the cost of care. We need to be able to explore these arrangements and figure out how we're going to measure and oversee and produce different outcomes. We can't do so in a fee-for-service sort of experience, so at the state level is really where we need to be starting.

That's why at Cityblock, we're proud to be in five states, potentially three more this year and even more the year after. We're going to continue to work with our partners in each state to get an understanding of what their individual communities need and how their legislatures can make the difference.

QUESTION 5: ***Do you at Cityblock offer home base mental health services as well? If not, is this something that you're considering adding?***

We do. We're trying to expand what level of services, such as counseling versus medication management. We send different services to members' homes based on their need, based on our staff, and the local market. We consider who we need to partner with and if we need to build or buy.

QUESTION 6: ***As we are talking about change in academic learning environments and needing radical change in our curriculum so that we can recruit students of color who are also at risk of dropping out at higher rates, or are struggling with classroom content or learning experiences not being relevant to their own lived experiences, can you outline some basic beginning steps to make these radical changes in curriculum?***

Transformation needs to start from the top. There needs to be that commitment. There needs to be that involvement of executive leadership to own that transformation of the curriculum and to help set the expectations of what will be transformed and how quickly that transformation will occur.

I hear from students all the time about their lack of engagement. It's the same thing that we see with our patients. There's a lack of trust and engagement in the academic centers that are training them. Do they see themselves in the examples that are being set in their problem-based learning? Are we addressing these social determinants and social drivers in the curriculum separate from a single day, where you may talk about the impact or just a single sentence or chapter being read? Are we using our students' experience to learn from and to build additional education? That's the perspective that they're looking for in the curriculum and that they're often not receiving. It's about then diversifying the members of the curriculum committee. It's about setting expectations that we are looking beyond just clinical outcomes, and to understand the whole person in the first place is what the students are looking for.

Data shows an increase in applications to schools of public health and a bit of an increase at least in some demographics to schools of medicine and nursing during the pandemic. **That means these students are invested. They are not scared. They are firmly invested in helping the people around them who are in their communities.** They want to know what impact they are going to have and they need to see that in their training. How you actually do that will differ from school to school and how curriculum is adjusted. But it needs to be immediate. It needs to not be a long-term discussion. It needs to not just be a 42 year old female with diabetes and you think that's diversity. It needs to be diversity of experiences. It needs to be an understanding of hair and skin tone and just experiences period that actually impact patient experience. **They want to see themselves in what they're learning.**

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