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Kendal Williams MD (Host): Welcome everyone to the Penn Primary Care podcast. I'm your host, Dr. Kendal Williams. So we're back with our guests, Dr. Matt Press and Dr. Kevin Fosnocht to talk about value-based primary care and what that means. In the first session, we really went over what value-based primary care means, how it changes the practice of providers, why we're trying to move to that.

I think a key concept, that Dr. Fosnocht had raised is the idea of the quadruple aim. That we're trying to achieve better outcomes for patients at lower cost, with a better patient experience and a better doctor and provider experience. So that's what we're trying to achieve as we shift to a different paradigm away from the fee for service model that has so permeated healthcare for the last, I don't know, decades.

So again, I'm on here with Dr. Matthew Press. Dr. Press is the Physician Executive of Penn Primary Care and Dr. Kevin Fosnocht. Dr. Fosnocht is a longtime Penn faculty member who is now the CMO of Tandigm Health, who is in a partnership with Penn to basically help Penn network shift to this new value-based primary care model. So, you know, before we start, I wanted to just highlight what we want to do in this particular podcast. We want to get very granular into what does a primary care practice and a primary care provider's life start to look like under a value-based model.

But before we do that, I want to stay a little bit high level just to understand the overall environment here and particularly what's happening nationally and locally at Penn. So Kevin, in the last session you had talked or made reference to vertically integrated healthcare systems. And by that I assume you meant places like Kaiser Permanente or Geisinger to some degree, local and national health systems where the providers are basically owned by the insurance company who insures most of the patients. And so because they're co-owned, if you will, they're both the same, improvements in the value of care that's delivered, goes back to both entities. Is that what you meant, Kevin?

Kevin Fosnocht, MD (Guest 1): Yeah, Kendal. And again, thanks for the opportunity to be here with you and Matt. That is what I meant. Vertical integration is a strategy that can be used to deliver healthcare in a certain way. That integration can extend not just between payers and providers, but also include, pharmacy benefit managers, facilities, and other kinds of integration where the ecosystem is a shared one, in terms of the bottom line, which then

allows for some efficiencies, but also, it allows for and is often driven by, um, being able to secure and maintain profits.

Host: And I think it's true Matt, that those types of systems where everybody is aligned, do tend to achieve better outcomes overall. Is that right?

Matthew Press, MD (Guest2): Kendal probably hard to have conclusive evidence to that effect, but I think generally speaking, that is the idea that when the payer and the provider are closely aligned in organizations like Kaiser or Geisinger, then the potential for efficiency is there. Certainly if you look at Kaiser, I think is quite well known, even pre pandemic for its use of telemedicine, and that's a good example of the kind of service that in a traditional fee for service environment, particularly before the pandemic that other provider organizations weren't able to do.

We looked at, you know, primary care was barely doing any telemedicine before the pandemic. Whereas Kaiser was, because their payment model is divorced from that CPT code driven system. What these new kind of arrangements do Kendal, is I think help primary providers who are not part of a system like Kaiser or Geisinger, act a little bit more like that. It's almost a mirror financial model that should enable those primary care providers to be able to deliver care in a way that you certainly hear about the Kaiser's and Geisinger's doing.

Guest 1: Yeah, and part of the driver of that and maybe the impression that is out there those kinds of organizations have better outcomes, is there just their ability to measure and make assessments of their performance in a way that is very difficult or at least harder to do if you are not integrated with your data systems.

We'll get to data systems probably further in our discussion and how important that is to executing high quality value-based care our primary care. So, look forward to coming back to that topic.

Host: So I highlighted that just to sort of use it as a relief, if you will, against the actual background in which most people practice and that is where they are separate from their insurance companies, that are getting paid to deliver services, by those insurance companies and so forth. But the switch to value-based care, which requires really restructural adjustments in the nature of how we do practice, requires a great deal of cooperation between insurance companies and providers so that the money is there to support the structural adjustments within that framework. We have organizations like Tandigm, right.

Kevin? So maybe if you could tell me a little bit about what the history of Tandigm, what it is, and the value it's bringing to this equation.

Guest 1: Sure. Tandigm is a population health management company. It is designed to bring solutions to primary care providers to help them succeed in value-based care contracts. We also bring value-based care contracts to providers, really on behalf of payers. And through a variety of tools and resources, including designing efforts to help them redesign practice, execute on the necessary components of population health management in a value-based care payment environment.

So we aggregate practices. We partner with payers to bring a different kind of contract to primary care providers that aligns incentives for the work that's necessary to actually take care of patients across a care continuum and ensure that there is a funding model to support that work.

Tandigm Health has started in 2014 as a joint venture between Independence Blue Cross and DaVita. Within a short period of time, IBC became the sole owner of Tandigm and really kind of as a company, then partnered with over 400 PCPs in the five county region, and structured a contract, with and through IBC, to provide an incentive model and a variety of resources to help the PCPs deliver high quality primary care in a value-based care environment.

Over the last few years, the Tandigm Health Network in the five county region has grown. Now with the addition of Penn, which we'll get to in a second, has over 700 PCPs, who are taking care of well over a million lives. And by 2024, we'll have around 180,000 patients in the five county region who are being cared for in this model. As of January 1st of this year, Tandigm, has a new co-owner. Independence Blue Cross and Penn Medicine, developed a joint venture wherein Penn has a minority ownership stake in Tandigm. And we can talk about the rationale for that and what it signals in the region and in particular the primary care in the region.

Host: So, Matt, this is not happening just here. Right. And organizations like Tandigm as great as Tandigm is, it's not the only organization doing this. So this is a process that's happening nationally, right?

Guest 2: Yeah, I think if you look nationally, you see major change afoot with the way primary care is structured and financed. So there are primary care practices that are employed by payers, by insurance companies that have that structure that looks a little bit more like that Kaiser or Geisinger that we talked about.

And then you have independent primary care practices that don't have the financial and structural means to take on risk, to take on insurance risk. Meaning how is the whole healthcare dollar spent? An independent practice, regardless of how big or small they are, really doesn't have the means to do that.

And so a company like Tandigm, and there are several others across the country, provides that platform. So as Kevin said, what Tandigm can do is bring the full risk model to a primary care practice and that's what they've done in the region and now are doing for Penn Medicine. They bring that financial model so that again, we start to look and feel a little more like a Kaiser and Geisinger.

We're more detached from that fee for service widget model dependent on every encounter to more of that population health model where we think the population of patients who have a insurance plan that Tandigm has contracted with, that Tandigm has said to that insurance plan, we are going to take full risk on this group of patients and we're going to work with the primary care providers, whether it's Penn or non Penn, to deliver a more efficient model of care and we're going to deliver better outcomes.

That's the model and it's really spread quite rapidly across the country through a number of these companies that Kevin mentioned; these kind of aggregator type companies. I think in this day and age, it's almost hard for primary care to survive not with some type of risk arrangement. I think, to, keep the lights on in a practice outside of some more niche settings like a concierge or direct primary care; that's another area where there's maybe some more financial sustainability of primary care. But when you look at primary care nationally and how do we sustain it, the risk approach is really the way to get us, as we talked about in the last episode, get primary care that little bit bigger slice of the healthcare dollar, and be able to support and sustain provider compensation, staff compensation, new clinical programs. It really is, in this day and age, the path to sustainability and growth for primary care.

Host: So if you're a traditional primary care provider in solo practice, let's start with this model. And I have some insight in this cause my brother, who's a very fine physician, very well trained, went back to the small town in Pennsylvania where we were both from, opened up a solo practice near a small hospital of, you know, 20 to 50 beds and did everything. He is med peds trained, so he was everything. He went into the hospital, he managed ventilators, he did everything in that small town. And so, for a practice like his, in order to make money, because let's say, you're almost entirely fee for service, and it certainly was when he started; you have to see as many patients as you can. You want to keep your overall office staff as streamlined as possible. Obviously somebody needs

to greet patients, somebody needs to manage appointments, and somebody needs to do some basic things, and a nurse needs to deliver immunizations and so forth. But you're trying to keep your office staff as minimal as possible.

And because you're only paid by visits, you do things like if you order labs, you have patients come in for a visit to talk about their labs, right? So everything's in that environment and that's how you can survive then. But you're really it's completely just flipping hamburgers, right?

You're just trying to get as many hamburgers out as you can, right? So, now those folks, obviously, as you pointed out, Matt don't have the money to a shift to a new model. Now the new model you guys have outlined is taking care of a population of patients, which requires, sort of a doctor to be on a manager level, right?

You're not just the person making the fries and flipping the hamburgers. You're the person that thinking about the client experience, the overall experience of the whole system and so forth. Quality, everything. You're on a manager level, right? So you need a team around you to help do everything that needs to be done to deliver the highest quality care that you can including the types of things we talked about last time, ensuring that everybody's getting proper preventive care, ensuring everybody's getting timely care, but also you're having time to focus on those higher comorbidity burden patients who just need more time. So you have an ability to structure your office in a completely different model.

Now the question is who's going to pay for that? And that's where we get to these relationships where somebody can come in and help you make that shift from the old model to this new model that you're describing; and that's where Tandigm fits into these relationships to help you make those transitions. Right. Is that kind of a summarizing it?

Guest 1: I think that's a good summary. I love where you started, with both your brother and physicians like him. This was, and we still have many, in fact, over a 100 PCPs who are in small practices in this region, who are in that setting. I love your description of all of what they had to do in order to make money in a fee-for-service environment. And boy, if you contrast that against the quadruple aim of how you get quality, an optimal cost, a good patient experience, and of course, even more important, or as importantly, the provider experience, in a setting like that; it does seem impossible and in fact probably is, especially with the current payment rates for the specific services. You know,

we said this last time about transitioning from a model that is paying doctors to deliver services and instead paying for teams to take care of people.

And that contrast, I think you really nicely outlined. I'd say one other thing because, and we can get a little bit more into the specifics of what it means to be able to cover costs to provide team-based care, but there's also a lot of process involved. In other words, there's the how to do that, not just, funding to do it.

And, those things are also where a Tandigm is bringing in expertise, is bringing years of experience that gets continuously refined to our current and new partners.

Guest 2: Yeah, I think I would add to that Kendal, that participating with a in risk contracts or with a group like Tandigm doesn't mean fee for service goes away completely. So number one, you still have patients who are not in these risk contracts that you are paid for through fee for service.

And number two, even when patients are in these contracts, this is not a single capitated payment, meaning a single per person payment that you would see in a Kaiser organization. So when we see a patient who has an insurance plan that Tandigm is contracted with to take on full risk; we still bill for the office visit with me or with you Kendal for that patient.

We still get paid by the insurance company. But what happens is at the end of the year, there's sort of a calculation done to say, okay, well how much was spent in total on that patient? And that's not just in primary care and that's not just in your own health system that's anywhere that that patient gets care, and how does that match up against some total budget?

And there's different ways that that's calculated. And so what you're trying to do is bend that cost curve so that you come under budget, but also delivering the highest quality care. But it is important though Kendal, that I think we don't completely ignore the fact that the services provided by primary care and the fees that are paid for them nationally, remain too low.

Okay. We still undervalue primary care, and while I do feel, as I said earlier, that the move to these value contracts and these risk arrangements is the path to sustainability and growth for primary care; I think we also need pay for primary care services appropriately. And Medicare did take some steps to do that a couple years ago by increasing the value, the RVU value of a evaluation and management visit, the typical office visit.

But there's some research coming out now that has shown that really has not had the impact that was hoped. There was, I think the hope was to redistribute the imbalance a little bit in terms of fee for services paid in procedural specialties versus fees paid for services in non procedural specialties, including primary care, but others like neurology or rheumatology or endocrinology. That redistribution has not really happened I think, in the way that CMS had hoped. So I don't want to lose that piece of the policy conversation and the payment conversation that both paths need to be pursued from my point of view. Primary care needs to be paid appropriately for its services and primary care practices need to participate in value-based contracts so that they have the financing as well as the expertise, as Kevin mentioned, to be able to deliver a different and better clinical model for patients.

Guest 1: Yeah, agree, Matt. I do want to come back to though the most models in including the model with Tandigm, does include the continuation of claims and putting claims back into the payer and, and that usual transaction happening that the Tandigm structure in particular, for the commercial and Medicare Advantage plans; that does involve a different kind of payment model, that sits on top of that transactional one, that provides additional funding that can and is being used to support team-based care. So, now, that is part of the contract and part of the value is bringing a different kind of funding model to the practices upfront.

Matt referenced once there's a comparison of total costs against what were expected or budgeted costs were, that if that's less, there is a sharing in those savings between Tandigm and its provider partners. That does happen after a period of time. So, our typical performance period is a year.

But, there is a different kind of funding model that is ongoing, that happens upfront as part of the model that it is used to fund the work that we're doing together.

Host: Yeah, and so the money that really funds the transition to value-based primary care really comes from the savings achieved by the improved outcomes that happen in patients, right? So if an insurer, a payer is then not having to spend as much money on expensive hospitalizations and other aspects of care, they're saving money on those patients. Then, that savings gap is what is then spread among the various players, including providers, right?

But you still have to continue to do the basic work, which is the fee for service work that really is still structural. At some point, the whole thing may be shifted over to a different model, but while you're in this two canoes, as you had framed

it, Kevin, you've got the fee for service completely that way. And then, you're trying to also transition to value-based and this money that funds that is the savings that you'll achieve by better outcomes.

Guest 1: Yeah, it's not, I think in the most global sense, the total available dollars do come from total savings. But I want to emphasize that the point in time where there is a savings calculated and then the sharing of those savings goes back to providers, is not the only method that the contracts allow for dollars to flow back to providers.

So, for example, again, even though that's the pool of money; hitting an exceeding quality benchmarks, including patient experience benchmarks; there is an opportunity to bring more dollars into the practice because of performance. Ensuring that patients are coming in and getting a comprehensive evaluation and capturing their severity of illness, in a way that can inform a lot of downstream population health management efforts, the prospective health status assessment, that is also there are dollars associated with doing that. And again, so that those are real time flow of dollars that allow for the funding of new models of care at a practice level. But also, extend that to the other services that Tandigm brings into this relationship.

And some of those are very, very tied to data and analytics. At the most basic level, one of the problems for PCPs in managing a patient across the care continuum, is they have no line of sight outside of their practice and so, you don't have any information about the care continuum.

And so there have been of course, efforts to help that with required discharge summaries and some things that the CMS has put in place around the kind of information that needs to get back to PCPs. Epic and other vendors and EMRs have also attempted to bridge gaps in a line of sight on the care continuum for physicians.

But if we think at these, the basic level that claims meaning the data that is indicated when something happened with and to a patient involving a provider, that whole data set, traditionally has not been available to providers. So, there's no line of sight there. Similarly, though the payers have claims, they don't have all of the really important data in the EMR and in the medical records in general, to have an understanding of the patient. So you have these two parties with a system built in a fee for service model that has largely been built on data sets that are really meant to be transactional, to pay for fee for service environment, not information that is actionable about patients to optimize their care.

So, what Tandigm with its partners and certainly, Penn Medicine has done a great deal with their own understanding of their data across patients and their care continuum. But bringing these together so we can get a comprehensive look at the patient, across the care continuum. And maybe even more importantly, for the purposes of value-based care, an understanding of populations and cohorts of patients, where we can really understand because now we have enough in to say there's a trend here or there's a gap here, or there is a locus of cost that is low value, in terms of low value care. That's where the combined forces of analytics can be brought to really create interventions that can execute the quadruple aim.

Guest 2: Kendal, can I add just two things that are really important to me in terms of how this change is experienced by PCPs at the frontline. Number one is that the way we have approached this and the way I think other organizations need to approach this is in a pretty payer agnostic way. You do not want to put a PCP in a position where they have X set of resources for one patient based on payer and Y set of resources for another patient based on payer. And that PCP is trying to navigate that traverse. I think that will be demoralizing for PCPs and uncomfortable you know, oftentimes not clinically appropriate.

So the way I think it needs to be approached is in a payer agnostic way, meaning, even if I see a patient that's not in one of these risk contracts, I can still avail myself and them of the resources that our practice has built to help succeed in one of these risk contracts. So I think that's important.

You can have work going on behind the scenes to identify patients, let's say on a list that comes from Tandigm of patients who are due for colorectal cancer screening. And we will combine that list with the broader list of patients who are due for colorectal cancer screening. But I think at the point of care, it's important that it be payer agnostic.

Second point is this issue of savings return to the provider at the end of the year. I think that it is, very important that PCPs not feel like they have any direct incentive to quote, unquote, cut costs. That's not how you succeed in these programs. And it's also unethical and unprofessional.

If you treat a patient, you treat the patient in front of you, as the patient in front of you, and they should receive whatever services they need. What we try to do is make the high value care pathway the easy one. So if a patient comes in with low back pain, we want to have decision support in place to identify if and when imaging is appropriate, when referral is appropriate, how do we get to the most evidence-based treatment pathway sooner. All the things, Kendal that you

know, you spent many years working on evidence-based pathways. The idea at the point of care is not to say, that's what, so I really want to be clear. Patient X, I'm not going to order this test because I'm worried about the total cost of care.

That's not how it works. But what we do want is patient X, you've got this symptom and this condition, and thanks to this program and financial infrastructure, we've built a pathway that follows the evidence and allows you to get right care, right place, right time.

Guest 1: Yeah, I think both points are really important, Matt. The concept that this is not a cost cutting exercise is essential. Again, and I think we touched on this last time, that's the point of the quadruple aim. It is meant to be care that is ensuring that all components of the quadruple aim are met.

That's value. That is, because it is one of our expressions of value is all four aims as you mentioned at the outset of this Kendal, which was a great way to ground us. To the issue of a point of care, I'll make one qualification, but it's only supports what you're saying Matt, which is, most PCPs know that in order to take care of the patient in real time, they are making decisions that they know are not high value, because they have to take care of the patient.

This is the patient that just has to go to the ER because there's no way for me to manage them in my office. This is the patient who gets held two or three days more in the hospital because sending them home would be too difficult. These decisions are being made for the benefit of the patient very often in a very, very specific and deliberate way. Or there's so much inertia in how we usually take care of patients that we don't even recognize that there are high value alternatives. And Tandigm one with its provider partners, can work to shed light on where those opportunities are as well as help build interventions. And there are many. In our community network, we have worked with specialists to develop care pathways for same day or soon office visits for specific clinical conditions, so that you can get into a specialist visit either the same day or very soon as clinically indicated rather than relying on so many of the pathways quote unquote, that we use, which is calling a colleague and begging to get them in, and so on.

So, a lot of the work that Penn Partners in Care is doing, is to facilitate high value care and ensure that transitions of care are not fraught with bad patient experience, high cost, and an outcome that might be questionable during transitions. And our own care team does the same. We bring pharmacists, social workers, behavioral health specialists, and our nurses with an in-home program

as a service to our PCPs and the patients who are in the panels so that we can make it easy to do the right thing.

And, Matt, so again I want to underscore that, agree about the importance of those two points.

Host: Because most of what we do does fall into some clinical pathway, or algorithm, and building out those pathways so they're efficient, easy to order and implement, is a critical part of all this work. So, I want to finish our discussion, really asking you both to project out 10, 20 years, maybe more than that. What does primary care look like, if you're a medical student now thinking about going into primary care? What is that person's career going to look like that's different from our career? Maybe Matt, I'll start with you. What do you think this will be?

Guest 2: Kendal, I love the metaphor that you used earlier about the primary care physician functioning a little bit more like a manager or, I've seen our colleague David Ash, coined a phrase, care traffic control. So you're in that seat in the air traffic control tower and directing those planes as some are taking off, some are descending and you're working with other airports, to continue that metaphor.

So, I think that is what the role can and should be. I think right now primary care physicians are spending a lot of time on activities that are low value from the perspective of their own time. It's not a physician level skill and training is not required.

Having said that, those activities do need to be coordinated with everything else going on with the patients. So that's why I think it's really important that team, that expanded care team be built in the practice. Now, it doesn't need to all sit physically in the practice and the way we've structured it as shared at a regional level, we've got the care management program with pharmacy and social work and nursing.

We've got our integrated mental health program, which is, I would say the most foundational aspect of value-based care is providing access to integrated mental health services in the primary care setting. But that team needs to be connected at the practice level. I think one thing it can't look like in 10 to 20 years, Kendal is an outsourced model of all these other things that happen for the patient, happen away from primary care.

Primary care is still the home for the patient and primary care, the reason, as we talked about in the last episode, that primary care has been proven to deliver higher quality care, including lower mortality and lower cost care, the reason is because of the longitudinal relationship. We primary care physicians, we know our patients, we know them over time, and there's tremendous value in that.

And so this shift, I think over the next 10 years will continue. I think that there is a growing siren around the state of primary care and our state of our primary care workforce and our discontent with the way primary care has been valued over the years. So I believe that these value contracts will grow.

My hope is that there's other support from payers and the government to continue to invest in primary care, invest in the primary care workforce, to have that multidisciplinary care team model that's connected to the practice that creates that real medical home.

And I think my only concern is how do we do that in a way that meets the demand for patient care that we have in primary care. We have an aging population, we have a population that's getting sicker, and we have medical interventions that are getting more complex.

So even with this new model, how do we meet the needs just from a numbers point of view? How do we do that? To me that that is going to require a real investment in the primary care workforce to sustain and grow the primary care workforce. That, I think over the next 10 years, Kendal to me is the biggest threat to not just primary care, but to the US healthcare system.

Guest 1: Yeah, thanks Matt. I would say that just in an attempt to a little bit summarize what you said is, because you're asking about what is our healthcare system going to look like in 10, 20 years? You know, the health of a healthcare system is as healthy as its primary care, uh, model and the calls for action, which are increasing this evolution of payment models to help evolve primary care, and the understanding that cost and its increases of healthcare is untenable unless there is a more robust and vibrant primary care model, I think is getting increasingly understood.

Matt, I also like how you said that the longitudinal care and really understanding the patient over time, ends up being so important. Couldn't agree more. One of the criticisms of whether or not we call it manager or care traffic controller or even team-based care, the risk there is that it implies that the PCP does not have a relationship with patients, a thing that I believe is still core to bringing people to the profession. And also really important for patients,

especially as they go through stages of life and are in various degrees of complexity of what they're coping with from a health standpoint. And we're likely to see more with our aging population and a greater need.

Well, we are seeing more in terms of the need for more primary care. So, want to underscore that this is a sweet spot, which is how do we make sure the PCP is really delivering high value care, in a team-based way while maintaining the really important relationship with a patient that is necessary for everything from adherence, to probably just even clinical outcomes, in general.

So I want to underscore the importance of that and certainly the models, and the journey that Tandigm and Penn are on, are meant to preserve that and support it, as we move forward. I would love, in 10 years, for this relationship that Penn and Tandigm have for the primary care practices, in the region, and the PCPs, and other specialties in the region because the hope is by 10 years we'll be a really integrating specialists into this model. are able in a payer agnostic way to care for patients in a population health management mode, meaning really understanding the care continuum, knowing how to really execute on the quadruple aim as we've talked about today.

Host: I want to end on one of the things you raised, and that is that as we get a greater scientific understanding of the diseases that plague modern humans, we'll be able to better predict even earlier those that are most at risk and intervene before these things ever become an issue. So, I'd be interested to see, for instance, how many myocardial infarctions are preventable events when you view on a lifetime level, that this is an individual presented to the ED with a STEMI at 56 years old. But could we have seen that when they were 41 and they had higher than average cholesterol and they were trending with a little bit of an A1C up and they smoked a little bit, you know, I mean, identifying folks early in a population-based model and preventing things.

You all remember the famous show, ER, that was on NBC and drew so many people to medicine because it was so exciting and you know, especially emergency department medicine. But that's really the point at which the horse is out of the barn, right? We really want to see it be boring, not exciting, boring, nothing happens. You come in to see your doctor, you get on a pill, you take it every day. Nothing happens, right? But we want to see nothing to happen. And so if we're good at this, we'll be able to predict, you know, 10, 15 years who's going to get in trouble and be really good about preventing on that level once we start viewing people from a population framework. So I think that's going to be a lot of fun to see.

Guest 1: I mean, to some extent those analyses are part of what informs the cost effectiveness of certain preventive care measures but are bringing that with an understanding of our population. And like you said, maybe it won't be a position to say how many MIs can we prevent over the next five years in our population together?

Host: Yeah, for the next 20 years if we're sticking really far ahead. So I want to thank you both. This has been a great discussion. I had my own questions about what value-based primary care meant and needing to understand what Tandigm is doing and what the new Penn Tandigm relationship is about. But, as Matt has pointed out, this is a national thing that's happening all over.

Everything that's happening at Penn is happening all over the place, these same transitions are occurring. So I think this discussion is valuable to anyone thinking about primary care in our country. And, I hope to you bring you back for another discussion at another time. Maybe we can update where we're at with things in a year or so, or bring you back for a clinical discussion where you co-hosted with me and we talk about something clinical.

Thank you both for coming.

Guest 2: Thank you Kendal.

Guest 1: Thanks Kendal. Thanks Matt.

Host: Thanks to the audience for joining Penn Primary Care podcast. See you again next time.