One Year In: Lessons Learned in Order to Build a Better Health Care System Going Forward

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00:01 - EMILY BARSON
Hi, everyone, good afternoon. Good morning and welcome to this webinar brought to you by United States of Care and AARP. One year in Lesson learned in order to build a better healthcare system going forward. My name is Emily Barson, and I'm the executive director of United States of care. Thanks for joining us today. I'll be your host for today's event. And before I introduce our panelists, I'd love to share a bit about United States of care and what brought us here. United States of care is a nonpartisan nonprofit organization, we work to ensure that everyone has access to quality, affordable health care, regardless of health status, social need or income. The healthcare system isn't working for millions of people in the United States. And our research shows that people want a better health care system in the wake of the pandemic. And in fact that there may be an opening for reforms that weren't possible before. We do our work in a unique way. We go around the country listening to people's needs and experiences to center health care reform efforts around those needs. And we're tackling the challenges on two tracks. First, we're working in states to expand access to quality, affordable health care right now, because people can't wait for a perfect solution from Washington. And we're also working to create the conditions for longer term change. We know we need a new national conversation and new innovative solutions to build momentum for federal change that people can rely on that won't be overturned or endangered at every election. Last year, as the scale and scope of the covid-19 pandemic became clear, we shifted our efforts to support the response, connecting leaders to resources, partnering for impact with groups like COVID exit strategy and stay home save lives, crafting multiple rounds of policy recommendations for both state and federal level policymakers, which focused on meeting people's needs during the crisis, and creating timely resources to support policymakers and on the ground providers and others in their efforts. More recently, we've been leading an effort to build vaccine confidence among unsure populations to help chart a path back to normalcy. 2020 was the deadliest year on record for the United States since 1918, when we battled a flu pandemic, and we're fighting World War One. In fact, that's increased last year by 15% 2021 will likely bring additional challenges affecting the health of our nation. As we all know, last week marked one year since COVID-19. Shut down the country. We thought it fitting to take this opportunity to bring together experts to reflect on the lessons learned over this year, and how those lessons can help us in our work to build a better more equitable healthcare system going forward. Now, I'd like to introduce our expert panelists. First, thank you all for taking the time out of your schedules to join us today. First, Dr. Jean Accius, is Senior Vice President of global thought leadership at AARP, our co host for today's event. In that role, he leads a team and positioning AARP as a global thought leader by identifying emerging trends around the world, cultivating and elevating new ideas, forging global strategic alliances that become the foundation for collaboration and sparking bold solutions to change systems and improve the lives of the global population as it ages. Dr. Patrice Harris, a psychiatrist from Atlanta, has diverse experience as a

private practicing physician, public health administrator, patient advocate and medical society lobbyist. She has served in various leadership roles at the American Medical Association, including as the 170/4, President of the AMA in 2019 and 2020, and is presently the immediate past president. Currently, Dr. Harris continues in private practice and consults with both public and private organizations on health service delivery and emerging trends in practice and health policy. She is an adjunct professor in the Emory Department of Psychiatry and Behavioral Sciences. Dr. Caitlin Rivers is a senior scholar at the Johns Hopkins Center for Health Security, and an assistant professor in the Department of Environmental Health and Engineering at the Johns Hopkins Bloomberg School of Public Health. Her research focuses on improving public health preparedness and response, particularly by improving capabilities for outbreak science and infectious disease modeling to support public health decision making. Prior to JHU in 2017, Dr. Rivers worked as an epidemiologist for the United States Army as a department of defense smart scholar, and she also serves on the United States of care founders Council. Dr. Bob Walker is a professor and chair of the Department of Medicine at the University of California San Francisco. The department leads the nation in NIH grants and is generally ranked as one of the best in the US. He's the author of 300 articles and six books. He coined the term hospitalist in 1996, and is often considered the father of the hospitalist field, the fastest growing medical specialty in US history. He is past president of the Society of hospital medicine, and past chair of the American Board of Internal Medicine. He is currently serving as the interim host of the COVID-19 podcasts in the bubble, which is downloaded about 1 million times each month. For our attendees today, throughout today's event, please submit your questions for the panel using the q&a function, which you'll find in the lower part of your screen. And we'll turn to those questions toward the end of our program. And I'll remind you of that as well. Let's jump in with our first question. This will be for all of you. But I'll start with Dr. Rivers. Really what are the top two or three health care or public health lessons that you and your organization learned over the past year?

06:00 - CAITLIN RIVERS

There are a lot and I'm sure we will spend a lot of time reflecting but two, I think that have really been elevated. I can't claim that they're new. But one is that preparedness is not optional. I think everyone leading into the pandemic, with the exception of preparedness experts were thinking that probably we would get by without devoting a lot of resources to preparedness and that if we know keep getting a lucky streak, then it's not something that we need to concern ourselves with. But we have seen this year just how devastating it can be when things go wrong. And the goal of outbreak preparedness is always to stop a small event from becoming a larger event from becoming a pandemic. And that needs to be our focus going forward making sure that we have the tools and the resources and the plans in place to stop things before they spin out of control. And I think that's going to be a big focus of policymaking in the coming next few years. And the second lesson that I would highlight, again, probably not new, but of renewed importance is that you cannot get wrong your communications with the public. It is not just a one way conversation where you are telling them what you want them to know or what you think they need to know. It's really an ongoing dialogue, especially when you're when we're in the middle of an event that has lasted this long. It's something that we need to continue to iterate on and make sure that we have refined our approaches for not only communicating in a way that people can understand but that we are able to receive their own concerns and their own perspective so that we can address them. And I think that this priority remains top of mind right now as we continue the

vaccination campaign, reaching people who have questions, concerns is, I think a top priority for the next few months if not longer.

07:45 - EMILY BARSON
Great, thank you other other panelists? Dr. Wachter, do you want to jump in?

07:50 - BOB WACHTER
Sure. Thanks for having me, and completely agree with Caitlin, I'll go in a different direction. And say, a couple of lessons are that our healthcare system which often seems calcified, and incapable of change proved itself to be surprisingly nimble. Under the existential threat of COVID and with the support of some regulatory and payment changes, telemedicine being the most vibrant example where in most places, including my own, we went from 1% televisits to 70% televisits in a month. And as I looked at my own organization sort of pivot to just deal with all the challenges of the pandemic, it was amazingly quick for a battleship to turn around. So we're capable of change, which I think is comforting. And I'd say the broader lesson, telemedicine being a piece of this, is the importance of digital transformation. You know, I got my vaccine a couple months ago, and I was handed a little card that I guess I should invest in some tech and laminate it. But you can imagine a world and early on in the pandemic. The government said we want to know how many cases there are in every hospital, please, you know, record them on a spreadsheet and fax them into us here in Washington DC. And it's just an incredibly antiquated system. And so you had Google and Apple build a wonderful contact tracing app, but it Went mostly nowhere, partly because people didn't trust sharing their data. But partly because when they connected with public health agencies, which they needed to connect with, in order to close the loop to do contact tracing, the digital systems, the technology systems and public health agencies were a lot of soup cans and strings. And so that, you know, we need digital infrastructures to support a modern healthcare delivery system. And I think we made some progress on that during the pandemic, but also showed some of the some of the gaps that need to be filled.

09:55 - PATRICE HARRIS
And Emily, I'll jump in. Thank you. Dr. Wachter, I have my card as well. So I will join you in purchasing the stock for the laminating machines. But I think there's a thread there regarding technology that certainly we could have a broader conversation about that and thinking about the acceleration of digital health. By the way, it's not my top three, but I wanted to follow up on that. I think that's critical. And as we think through technology and innovation going forward, I think we should make sure that we establish some foundational principles, one of which is centering equity. And so speaking of centering equity, I think, a lesson I believe reinforced. Many knew that already, but we really need to have a broader approach to how we even think about health care, and not that traditional stakeholders are so critical to a path forward, I think this is the first lesson is that we are going to have to have a systems approach a broad systems approach, and public health and mental health are going to have to be integrated, along with all of the other systems, and we're going to have to center equity. The next lesson learned is that trust and data and science matters. And I think there's also a thread through the technology because we have to collect the data. But certainly we need to be able to collect it in a way that we can disseminate it quickly. And again, embrace technology. And again, getting back to equity, we have to make sure that data is collected regarding race and ethnicity and zip code. But again, trust matters. Which brings me to my last lesson, following up on something Dr. River said, and it was about

communication, we have to make sure there is clear and consistent communication. But I think and this is something that I think if I Well, there are many things that we might do differently if we had to do all over again. But I think we need to communicate with horizon messaging. I think we sort of said, okay, for two weeks, and you know, and then for one week and that actually led to some frustration. And so perhaps we should think through, including that time horizon. You know, being a psychiatrist and understanding human behavior, I think folks will do better if they know, you know, what's the longer term plan, I don't think we were able to do that. Now, sometimes you can't do that if you don't have the data. But I think going forward, we need to make sure we are thinking about time horizons and our clear and consistent messaging and communication.

12:33 0 JEAN ACCIUS

And I'll chime in, and I totally agree with everything that Dr. Harris indicated as, as well as what the rest of the panelists, I think we have an opportunity. And what I mean by that is the fact that there's so many lessons learned from the last year that we are really at a juncture. On one hand, we can actually think about solving some of these issues by putting patches around them. Or we can really be bold and courageous and do what Dr. Harris just recommended. Take a systems approach to addressing many of the issues that we've seen. From our vantage point at AARP. Clearly, this pandemic has had a disproportionate impact, particularly on older adults. If you think about it, roughly about 95% of all COVID related deaths have been by someone over the age of 50. When you look at the nursing home and long term care settings across the country, around 40% of all deaths have been from the nursing homes. We just released our AARP nursing home dashboard last week, and the numbers still significantly high, while the rate of infections are declining. The overall total is still roughly extremely high at about 170,000 deaths as relates to nursing home residents. And also as relates to direct care workers who are on the front lines are essential. I think some of the lessons that we've learned over the last year really bodes well with what everyone on the panel has talked about. And I'll call it the three C's one is connectivity. The second is coordination. And the third is communication. What COVID-19 has clearly demonstrated is the fact that we are all interconnected. And I think that really speaks well to the notion and idea and the need to address these issues from an equitable state of mind. What I do impacts you, what you do clearly impacts me and if we're going to recover from this pandemic, We're really going to have to take that interconnected vt approach in a very meaningful and intentional way. The other is coordination, clearly coordination across the sector's and at all levels of government. We've done some survey work at AARP, particularly around the vaccine rollout. And over 60% of Americans are very confused, and frankly, frustrated with regards to finding out where they can actually get their vaccines, and how should they actually go about doing that. So we do have an opportunity to think about the coordination nature of this work in a very meaningful and intentional way. And then finally, communication, clear and transparent communication. An idea of trust is critically important at AARP. One of the things that we've been working on is both being that wise friend, and also that first offender, whether it's our aarp.org Coronavirus webpage that provides timely up to date information, because of the confusion that is taking place across the country with regards to the rollout and the vaccinations. We've created state by state pages. So you can actually go on our website and actually find out exactly when are you eligible? Where can you go? What are the numbers you can reach? What are the different links you can reach? It's been very nerve racking to hear from members across the country in terms of exactly how they can get access to this information in a meaningful way. And then we've also been hosting town hall meetings, bringing leading experts, including Dr. Harris, who had a

tremendous opportunity to serve on one of our panels to talk to the members directly, because they're looking for a clear, accurate and transparent information. So I think that the connectivity piece is critically important. Really think about the coordination across sectors and industries and at all levels of government to ensure that we're all in the line. And then finally, around communication.

15:57 - EMILY BARSON
Right, thank you. Thank you all for those I think, unsurprisingly, a lot of overlap, but also a lot of great, great insights and lessons that we'll get a bit more into on one of those, which we did touch on. And I'll have Dr. Harris kick us off, but I'm sure others may have thoughts. As you referenced, you know, there's rightly been a lot of attention about the racial inequities, which the pandemic has shone a light upon, and they're not new to many, especially folks who have worked in health care and public health, but it has certainly become more illuminated. So far, most of the public policy response has been centered around collecting data. And that's an important first step in order to make informed policy determinations. And we'd love to, you know, get your thoughts. Do we know enough right now? Or, you know, sort of where do you see some of the direction of policies and recommendations that would start to address some of those systemic inequities that are right now baked into the health system?

17:03 - PATRICE HARRIS
Well, clearly, the data, you know, are incomplete. And so we will have to make a commitment to collecting that data, we will have to make a commitment to technology so that we can collect the data. I'm sure everyone on the panel can agree that it's a bit frustrating that we are often acting on data that's two to three years old. And so we really have to update that infrastructure so that we can have accurate data that's more up to date. And then that data, of course, hopefully informs our policy. You know, on the physician side, on the medical side, we do recommend treatment alternatives based on data. We don't always do that, regarding policy, I always say we should make sure that our policy recommendations are grounded in some data and that we actually continue to monitor. Those are the consequences of those policy recommendations. People have heard me say inspect what you expect. So we are on that journey to collect that data. And then we have to make sure that we are looking upstream. You know, we have to look at issues around structural racism, institutional racism, all of the structural determinants of health that then impact the social determinants of health that then impact the individual. And sometimes that means having difficult conversations, it means doing that individually. It means doing that from an institution standpoint, I know we are trying to model that at the American Medical Association. Again, we are all on our journey. But I think we have to make sure that we are looking at systems change. As I said earlier, we have to be committed to meeting people where they are I belong to a group here in Atlanta steering committee, the Atlanta regional collaborative on health improvement, and we talk a lot about inverting inverting the burden You know, right now, for the most part, the burden is on the individual to figure out how to navigate our system, right. And as a physician, I can tell you that when I'm the patient, it's a struggle for me to navigate. It's complex. It's complicated. And so, you know, folks who don't have as much experience and knowledge, as I have find it really difficult to navigate our systems. So we need to build systems that meet people where they are, again, centering them, but again, thinking about the upstream determinants, and then whether or not there are good paying jobs, if we as we have looked at the inequities around COVID, again, again, COVID, exposed what was already in existence, it was our essential workers who didn't have the privilege of working from home, who made low wages, who lived in multi generational families who use public

transportation, and then as we think about who lost jobs was certainly those folks as well. So we have to make sure that we are committed number one to gathering the data and then looking upstream at the systems that cause inequities. Before we are going to be able to solve the problem.

20:38 - EMILY BARSON
Other panelists want to want to weigh in?

20:42 - CAITLIN RIVERS
On the public health side, I would say there are a lot of subfields of public health that make identifying and supporting people in solving structural inequities really key to their practice, I would say that has historically not been central and pandemic preparedness. And so I think in our my subfield, our next move will be to take lessons from the other subfields of public health, that make this really core to the way that they think and the way that they interact with communities and try to take lessons from them to make sure that our pandemic preparedness plans have this as an important element going forward. So I think that will be on our agenda.

21:17 - JEAN ACCIUS
And I will chime in with a couple of points. One is that the inequities that we've seen over the last year, as many mentioned, we're not actually created by COVID. These have been long standing structural issues. And COVID has just been a great revealer. And really put it out on the table to really show not just the inequities, but also to challenge us in terms of exactly what are we going to do about them. And going back to my earlier point about interconnectivity, addressing these inequities is in everyone's best interest. And what I mean by that is at the Kellogg Foundation, and autonom did a report several years ago, which was pre-COVID. But I think that it really is telling that if you were to advance equity, what we would see is that there would be a significant gain by close to $8 trillion dollars to our overall economic GDP. So think about it, the opportunity to create an environment where people can live their fullest, best lives, and contribute to society actually benefits everyone overall by nearly $8 trillion. If you were to actually look at this in terms of consumer spending, that would be an annual roughly about $800 billion a year and additional spending in this country. And then when you look at tax revenues, for all of those who are watching today, you will see an additional $450 billion worth of tax revenue at the federal level, and over $100 billion in state and local tax revenue at the state level. So there's an economic imperative, in addition to the moral and social imperative for addressing these inequities, that really, these inequity stifles our collective economic well being as a nation, and that we have an opportunity to solve those in a very meaningful and intentional way. I think that there are some things that we're starting to see, I know that many states in particular, created equity councils or created equity task forces in the goal is to not just come up with a plan, but also come up with a solution to really start to address those. So the first question is, to what extent is the leadership within a particular state making equity a top priority, because it impacts both the public sector, it impacts public health, it impacts the healthcare system, it also impacts private industry. So this is something that actually impacts all of us. The other aspect of that is not it's one thing to create a blueprint and a plan. And it's something totally different to execute on it. Some of these issues are not necessarily new. And I think that if you were to look even within your particular state, there might be some solutions, some models that might be scalable. So what can we actually scale up in order to address these inequities in a very meaningful way? And I think that point about data collection is so key, because I don't think we fully understand or

have an appreciation for the devastation, because we don't necessarily have full, accurate access. To the data. But in order for us to move forward, we're going to need to have a complete picture.

24:24 - PATRICE HARRIS
Could I add one more I think about the path forward on equity, because I think, heretofore the model has been, and I have participated in that model as well. So, you know, looking in the mirror here, but I think our model has been, well, let's have, you know, achieve, you know, diversity officer or a task force or a council, those are critical, right? Those are necessary, but what is, I think, not negotiable is the fact that the leader and leadership has to own accountability, right, because heretofore, we have sort of given the responsibility to solve the problem to the folks that are most impacted when there's a gender equity issue that some some folks and, and let's have perhaps women, their, you know, committee and their allies, and I'm being a bit hyperbolic here, but to solve the problem. And then we sort of look at that group of that person that office, that task force, to then come back with the plan, and then often own the accountability for execution. And my recommendation is I've talked over the last year when leaders CEOs have asked me what to do, I say, you have to own this, right. And so you have to say that I'm holding myself accountable, I'm responsible, I'm committing the resources. And every one of my direct reports, has some metric, some tangible metric regarding this issue, it will be different. There's no one size fits all, it certainly will be tailored based on the needs of the organization. But leadership has to own this only accountability, commit to real resources, and not sort of leave it up to the you know, Chief health equity officer or the task of the AMA, we talk about embedding health equity into the DNA of our organization, again, on our journey, no organization is perfect. But it is about the evolution of that. But certainly leadership has to be ultimately accountable.

26:30 - BOB WATCHER
Yeah, I guess I'd add, it's a fascinating time in American history in that, as everyone said, COVID has exposed things that were well known. I mean, when you look at the inequities of COVID, both cases and outcomes, they're no more striking than what you see for heart disease, or hypertension, or cancer outcomes or treatment of many different diseases, there are inequities. And COVID, shown a bright light on it. And it happened to occur at the same time that there was a reckoning with racial justice in the United States. So it's sort of if we can't get it done now, when are we going to get it done? It certainly raised it higher in the agenda. I think I agree with Patrice, I think it's really an important time to have metrics that allow for some level of accountability. And there, you know, the issue of diversity versus equity versus inclusion, they're all interrelated, and yet, they're somewhat different. So, you know, changing the leadership structure is important, but not the same thing as creating equity in terms of health outcomes. You know, working in a large healthcare delivery system, we're looking very hard at what we can do. And yet, I think there's a deep recognition that much of the problem relates to issues that are well beyond the purview of the healthcare system, as we come to understand the importance of social and socio economic determinants. One might argue that some money should leave the healthcare system to improve housing, or to improve income equity or, or decrease disparities. And of course, that will be a battle, because every industry sort of thinks it needs all the resources that it has. And we all have lobbyists and figure out how to know how to fight that. So to the extent that it stays within an industry, an industry, it's a little bit easier, if it's something than the healthcare world, we can do differently. It's one thing. But if we determine that what really has to happen is we invest more in the schools or more in housing or more in income redistribution. That's

particularly tricky for us, because where's the piggy bank, a lot of it is in the healthcare system. So you end up gearing up for a fairly big battle, which makes me a little worried about hearing a lot of talk about this. It will be fascinating to see what actually happens when the really hard questions of moving money from one sector to another one profession to another, headed as they invariably will.

28:51 - EMILY BARSON
Thank you. Thank you all. Switching gears slightly, and we'll start with that with Jean on this and you referenced, certainly the deaths among older populations as well as focused in the nursing home populations. And I think really the crisis that we've seen in nursing homes is giving rise to a conversation about models of care where You know, home is the new healthcare delivery setting, and, you know, exploring different models with diverse consumers. And I'd love to hear from you, especially, you know, from your perspective at AARP, what models you're seeing that might have a chance to change the landscape of care and how care is given, especially to older adults.

29:39 - JEAN ACCIUS
And I appreciate that question, Emily, we've been doing surveys since the 1980s, particularly to people over the age of 50, to get a sense as to, particularly as they age, what are some of their preferences and some of the things that they value. And I think no one would be surprised by this, that the vast majority of people would prefer to receive care in their homes and communities for as long as possible. And what we've seen, particularly in nursing home context, is really devastating and tragic, whether it's the lack of opportunity to connect with family outside of the nursing home, we're very grateful to the Centers for Medicare and Medicaid Services that came up with some updated guidance that would allow families to reunite with their loved ones in nursing homes, in a very safe manner. But if you could just imagine how devastating it has been for these residents, in that having that connected to family. So as we move forward, clearly, the opportunity to think about how care delivered in this country is very critically important. How can we ensure that the care that's being delivered is as person and Family Centered? In the context of this conversation, I think there's a tremendous opportunity to think about how we can ensure that people can age with options across the continuum of care? And how can we ensure that care is more integrated to reduce some of the complexity in the system? We know that there's over 53 million family caregivers in this country. And many of these family caregivers are doing very complicated medical nursing tasks, like giving injections, giving wound care, to feedings, and receiving liberty, no training on how to do so. I have a personal colleague who was a caregiver for her mom while her mom was alive. And she said she had to give injections. And she never knew whether or not when she gave injection, if she was actually helping her mom, or hurting her mom, because she never got taught how to do this. So we at AARP created the Home Alone Alliance, which provides tools to consumers and families on how to do some of these complicated medical nursing tasks. The other aspect of this too, is the fact that through the stimulus package that was signed by the president and last week, that there's more resources that can be allocated to the community that would allow people to receive home care and services and support in a very meaningful way. We also need to kind of think about how do we address some of the conditions for some of our direct care workers who are on the frontlines? Why is essential 40% of the deaths in nursing homes were both residents and staff. And in many cases, those staff didn't have the opportunity or the choice as to whether or not they could work from home. So how do we ensure that there's working conditions that there's adequate protective gear,

that there's transparency and reporting, that the conditions are changing in a way that really meets the needs of older adults and also meets the needs of families?

32:30 - EMILY BARSON
Right, thank you,

32:29 - BOB WATCHER
I might add sort of on the technology theme, we will have new opportunities to rethink the locus of care over the next 10 years. And we've got to be really thoughtful about how to do it, obviously, the payment system is going to be a player there. But so is kind of the overarching system of care. So if you think about that, if you think about it, a lot of care has been institutional, whether it was someone having to be in a skilled nursing facility, or something having to be in a hospital, in part because the payment models supported them being in those places versus alternative places. And in part because the technologies lived in those places, the technologies needed to monitor people or to to treat them. And I think we're entering a world where we're going to have many more options, the technology, the monitoring technologies are getting incredibly good and slick and things that we used to require hospitalization to do cannot be monitored while someone is at home. But the key there is going to be has the payment system transformed to support those models. They're probably ultimately cheaper. And yet, it's sort of cheaper to whom and and as the system is the system sort of nimble enough to kind of be in the leading edge of these models. And the technology it's one thing to say all right, we have a sensor that can sense your heart rate, your blood pressure, your glucose. We can do IV home monitoring, or home infusions, we can give you oxygen, but I can tell you if you're the doctor in the emergency room and a patient comes in and to it Get the patient to the hospital, all you have to do is make a single phone call, whereas to send the patient home to have their hospitalization occur at home with very clear literature, and much of which from Caitlin's organization from Johns Hopkins, that shows that will cost half as much be more satisfying to the patient and the family and have outcomes that are equally good. But to make that happen, I've got to make 10 phone calls to the oxygen company, the IV company, the monitoring company, or if it's not clear, all right, who are all those digital signals going to go to? And if the answer is the primary care doctor, that's not going to work. So creating sort of turnkey options, so that it's just as easy for the patient to be monitored at home cared for at home with family, that's going to be really an important part of our agenda for the next five years, figuring out how to make it essentially as easy for the patient to get care in a setting that I think in most cases, as Jean says they prefer if we can sort it out, thinking about payment models, organizational models, technology models, I think will change the locus of care for many patients, not all obviously, some will need to be in institutions. But a lot of people are institutions now because that's what the payment supports. And that's what our organizational structure supports as the is the easiest way to go. It shouldn't be.

35:28 - JEAN ACCIUS
And can I build on Bob's point? Real quickly, Emily, that's okay. Listen, let's let's look at Medicaid as a payment model. Particularly in the long term care setting, perspective, context, within the Medicaid world if you need care, personal care, Assistant, eating bathing, dressing, you have functional impairments. The width and the Medicaid program works right now is the fact that you're entitled to nursing home care. But homecare is optional depending on the state. It's an optional service, meaning the fact that the state does not necessarily need to offer it even though many states actually do. But

even within the context of offering it, there's a cap on the slots. So you may actually be on a waiting list. We did a report many years ago that found that for every one person in a nursing home, you could actually care for two to three people in the community. So if you take into account the fact that consumer preference is to receive this care to the extent that it's reasonably possible in the home in the community, and if you take into account the potential cost savings for doing so, it would seem as the approach that we need to take. And I think that the stimulus package that was signed into law helps to move us more and more in that direction. But to Bob's point, the way that the payment model actually works is the fact that one option is entitled The others option. So we still have an opportunity to really kind of think about how do we align that care with the preferences and the potential cost savings that comes as a result.

36:57 - PATRICE HARRIS
And Emily, I'll make one more pointed out, you know, Bob made a great point about the administrative and regulatory burdens. And that always seems to be an afterthought. So after we talk about maybe different payments, you know, delivery systems and all the other things and try to streamline that although we don't for the most part, as Bob says, then we typically add on another measure, right, another administrative burden. And I joke sometimes they said we should really insist upon the Marie Kondo, you know, principle about you know, for every new metric, or measure that you add, you have to take one away probably, I'd like to save for every new one, you add, you take 10 away, but we also have to think about that, because I think what, again, working in siloed systems and year after year and new legislation and new regulations, we just sort of add on. And we never look from a systems point of view. And we also need to make sure that we are measuring patient outcomes. You know, oftentimes this just sort of checkbox measures right. And so I think as we think about the new way of delivering care, that's an important part of the conversation as well.

38:10 - EMILY BARSON
Thank you, I'm Patrice we're going to go back to you and talk about the mental health repercussions of the pandemic on both adults and children. And get your thoughts on, you know, the potential long term effects of the pandemic on mental health and you know, what will be needed by mental health professionals in order to most effectively do their work and supporting the the country in the population and getting back to normal, so to speak, and knowing that these are going to be reverberating for years.

38:47 - PATRICE HARRIS
So another sort of fault line that has been exposed by COVID is the lack of a well funded, well resourced, integrated mental health infrastructure. And we are seeing, of course, not unsurprisingly, that the pandemic is having an effect on the mental health of our country. Certainly folks are more isolated. There's increased loneliness. You know, we talked about connections and we have lost connections. And, you know, as Jean mentioned, the session I did with AARP, I have to say was probably the most profound opportunity, I had to experience the loneliness and sometimes the despair, some of those seniors experienced. And certainly that has been across the age spectrum. We've seen survey after survey talk about the increase in symptoms of anxiety and depression and stress. And also, even some surveys I've talked about to increase incidence of actual disorders, actual anxiety disorders and major depressive disorder. So, again, we are seeing this and we are seeing this in the

medical community. You know, who particularly those on the frontlines, you know, who are especially early on in this pandemic, we didn't have the answers that we had now. And just speaking for physicians, I think Bob can say we like to have answers, right, we like to help folks and that was very despairing for a lot of colleagues on the frontline who didn't have answers, and so many folks were dying. So this all certainly impacted us in so many ways, and then many folks have actually lost loved ones. But I also don't want to minimize the grief and the loss for those birthdays and anniversaries and the inability, particularly for our children, to experience some of those rituals that they have been looking forward to. So here we have a problem. Now I try not to be sort of a doomsdayer, and say that, you know, we are going to have a crisis that's unmanageable. But here, I love Caitlin, and I think our preparedness colleagues can help us think through this now as our opportunity to prepare right? To write we are in the acute phases right now, and folks are sort of just figuring this out. But after we get to the post-acute phase of the pandemic, we are going to have these issues. And so we should be thinking right now about our systems and what's available. I was on CNN the other morning and I talked about families often have a plan of what to do when the smoke alarm goes off, you know, or there's a fire everybody you know, meets at a place in the front yard, folks need to be thinking about, you know, plans for our mental healthiness and, and wellness. And so I think this is a great opportunity for us again to highlight that. And fortunately though, our payment systems are not always in alignment with our needs. You know, and this is getting better. But it used to be that if you saw your primary care physician on one day, you couldn't see the psychiatrist on the same day. And, you know, we had such a ridiculous payment, disincentives to get that care, we have to address issues around stigma, that's still a huge issue. Parity is still a huge issue. I chair the AMA opioid Task Force. And we worked on some pilot projects in states where the State Health Commissioner sort of looked at their commercial payers, and they were not always in compliance with state or federal parity laws. And so we have a lot of work to do here, in addition to thinking through a systems approach that I like the the framework that the well being trust us put out in that we think about promotion and prevention, and that those are sort of the vital community conditions that are actually incentives for health in general, not just mental health, but we have to think about mental health from a preventive preventive standpoint. And then of course, coverage is key. We know that so many more folks are able to receive services for substance use disorders and for mental disorders, because of Medicaid expansion. And so we have to make sure we are thinking and talking about coverage, and Medicaid expansion. And then there's the issue around engagement around the workplace and all of the other systems that we've already talked about. We've talked about the data, we have to make sure that folks are getting evidence base and science base care. It was when we looked around the country at care for opioid use disorder. First of all, only two in 10 folks who wanted you know, medication assisted treatment, which is evidence base for an opiate use disorder were able to get that and we even had some systems that did not provide that saying that this was another medication and that we you know, you were still addicted and so that's not what the science says so we have to make sure we are focused on evidence Based treatment there. And then again, looking at outcomes, inspect what we expect, making sure there are data systems where we can see the outcomes. And all the while again, centering equity. And one more issue I'll just raise, again, that has been highlighted with COVID is trauma. I am a child and adolescent psychiatrist. You know, we saw the landmark study with Kaiser regarding adverse childhood experiences. And so there's been some conversation about that not enough. And now we're saying now the trauma of COVID-19, the trauma of racial injustice. And so we're really going to have to make sure we are centering trauma in our mental health response beyond COVID. But we have to think about that now, it

will be too late, you know, it is too late. It's almost too late now, to think about that. If we wait until next month, or next year.

45:12 - EMILY BARSON
Thank you. And I know I'm sure others have insights, I know we have a number of audience questions coming in and want to make sure that we get to as much material as we can. So we'll keep moving one item. You know, as I shared at the beginning, we are getting into work around vaccine research and confidence and communication. We had recommended $200 million for a public health education campaign. And in fact, the American rescue plan included a billion dollars to educate the public on the vaccine and get that outreach to boost confidence. I wonder if you know, this is a huge topic, and we will be doing more focused conversations around this. But a lot of you your opening remarks discuss the challenges around communication is one of the lessons and I wonder if in a rapid fire sense, if there's, you know, lessons, we've learned about the communicating with the public that can help both inform this, this current urgent need, and as well as, you know, sort of how we how we think about talking about public health issues in the future.

46:29 - CAITLIN RIVERS
Maybe start by saying that oftentimes, in public health, our goals can be fuzzy or a little underwhelming, because we know how hard it is to do big things. So it might be something like reduce some outcome by 10% over the next 20 years. But that's not what we have here, we have an opportunity to set a really crisp vision for where we want to be in a way that I think people will recognize and be inspired by, we want to get our kids back in school full time in the next six months. We want to be able to get together with our family for Christmas next year. And I think really basing our public health messaging around those shared goals. And that crisp vision is a really unique opportunity that we have here. And I think pointing out to people how they can participate in making that goal a reality by going for testing. If you're not feeling well, by getting vaccinated. There's a lot we can do here, I think around making it worth people's while and under helping them to understand where we are going.

47:18 - BOB WATCHER
The vaccine strikes me as a sort of wholly different opportunity, and that we need to take advantage of. We blew it last year with mixed messaging on mass mixed messaging on testing, Miss messaging on the nature of the threat itself, and, and we just can't afford to get that wrong. We have this really miracle of these vaccines, how good they are, how safe they are, think what we've become what we've started to learn, probably old news in the public health community, but relatively new for some of the rest of us is, you know, listen first before talking at people because people will immediately push back if they feel like they're being lectured to try to understand their concerns and some concerns about the vaccine are perfectly legitimate. Figure out who the key opinion leaders and influencers are. For some, it's going to be Dr. Fauci for some, it's going to be their own physicians. For some it's going to be someone in the clergy. For some it would be someone in their respected leader in their community. For some, it will be some kid on a skateboard on tik tok. And we have to sort that out. I was impressed when I spoke to Andy Slavitt, a couple weeks ago about this, that they are ready for that. And I think, you know, the messaging has been pretty poor, on COVID all the way around. But I think they get that, you know, we need Hollywood, we need sports stars, we need, you know, a very diverse group of people doing the messaging. And they're intentionally holding back on some of that for now, because they thought it was

premature to put out a huge campaign before the vaccine was available, and to the community as broadly as it needs to be. But I think you can expect a very large, robust and diverse campaign to start rolling out in April or May. I think the numbers that we're seeing in terms of people's willingness to take the vaccine are comfort. They go up with every survey. There's no longer a fair, a large gulf between what you see among Caucasian populations and communities of color in terms of willingness to take the vaccine, the one Gulf that has emerged is by political party, which is sad, but probably fixable if leaders on the right, endorse the vaccine, and that Trump did yesterday, which is helpful, we need more of that. So, you know, absolutely crucial. And it can't just be, you know, this will save your life, although you would think that would be a pretty strong message, but in also what it will allow you to do, that you couldn't do otherwise couldn't do safely and how much less anxiety you'll have once you're vaccinated. I think those are really important messages to get out.

50:10 - EMILY BARSON
Thank you. To kick it to one of our participant questions. Someone raised that they've personally observed during the past year, the disparities in rural America largely an unconnected aging populace, with decreasing resources, both extended family and societal, many areas lacking access to health care providers and systems. And so I, you know, the broad question, but you know, addressing some of the concerns, or the disparities faced specific to rural America, maybe. Dr. Accius? I don't know if you want to kick us off there.

50:44 - JEAN ACCIUS
No, I appreciate that question. And we've also seen a significant spike over time, particularly in rural America, as relates to the covid 19. virus and some of the infection rates. And I think, again, these are opportunities to think about how we really not just slow the spread, but really also do what we need to do as a country to really solve this in a very meaningful way. We had a conversation today about the locus of care. And I think that what Bob indicated earlier is a critically important part of the strategy for moving forward in terms exactly not just getting the information, but also making sure that people have access to telehealth and the different types of modes of care. The other aspect too, is also addressing the issues that were on broadband and internet access. And being able to do that, I think is going to be part of the opportunity moving forward both in terms of the investments that are needed to be made and in terms of our infrastructure, as well as in terms of the coordination that needs to happen across the country.

51:49 - BOB WATCHER
Something that just came out today that show that as we looked at where telemedicine was happening, it was more in urban areas where people are starting out more connected, but the promise of telemedicine and non geographically dependent care, helping it won't completely solve the issues of access in rural communities. It can't deliver you to a baby by telemedicine yet, you can't have surgery by telemedicine yet. But it should if we get our act together, it should solve some of the problems of access not only access to basic and primary care, but maybe even more challenging access to specialized care. It's one thing to have a primary care doctor in a rural community? Maybe, but can you have a specialist whether it's a psychiatrist or a cardiologist harder. And so telemedicine opens up the opportunity to provide more access to basic care and more access to specialized care. But as Jean says, we have to get the infrastructure and the payment model. Right.

52:58 - EMILY BARSON
And I think we've probably one more question before we need to wrap up. Tracy had referenced, you know, certainly the the need for coverage and specifically talked about Medicaid expansion, one of our attendees, you know, asked about how to convince governments to like Georgia, where you are to expand Medicaid as well as looking at programs like the 12 months of Medicaid coverage for postpartum individuals to help all public health instead of looking only at politics and would love your thoughts on that.

53:32 - PATRICE HARRIS
I wish I had the answer to that question. As you know, I've spent a good deal of my career, you know, in advocacy and on the policy side working with state legislators, particularly here in Georgia and at the federal level, but I think you know, so first of all, we start with the needs of the community, right, and we start there. I really loved the data also that Jean talked about, he talked about the dollars and we have to make that case. We always have to make, you know, the business case, if you will. But I think narratives are important and I think having patients share their stories or having our legislators and policymakers see the difference. It makes when someone is able to get care for their previously untreated or undertreated substance use disorder or bipolar disorder or, you know, major depressive disorder. And I think even as we look at, you know, we have to get out of our silos as we look at funding. And I realized that's easier said, than done. But I know one of the major institutions, one of the major, everyone with no health care institution saw that after I believe it was cardiothoracic surgery, patients who had treated depression stayed in the hospital longer, right, and they actually returned to the hospital, you know, earlier than the 30 days. So I think it's gathering that data which we need, but also telling the stories and how it matters. And I always say, you know, I say that a lot here in Georgia, but across the country, businesses want to come to your state, when potential employees are healthy, and well educated. And so that makes a case for, in my opinion, it makes a case or helps make the case for making sure that everyone has access to affordable, meaningful coverage.

55:26 - EMILY BARSON
And certainly, we've seen the incentives built into the American rescue plant, which tried to address what you said, the business case and making the bottom line add up for states as well, to see those benefits. And we've seen that when voters have the opportunity to weigh in on this directly. And some of the states where that's been brought up to the ballot has also been, you know, reflective across demographics. And I think, certainly, as you said, some of the narratives and really reflecting people's needs and unmet needs are powerful. We've also had someone from the audience saying, Patrice, please come help with Medicaid expansion in Texas too. So I think your services are in demand. And we're coming up to the top of the hour and want to keep everyone running on time. But I really just want to close with another huge thank you, to everyone for tuning in today, and especially to our expert panel, Jean Accius, Patrice Harris, Caitlin Rivers, and Bob Watcher for sharing your time and expertise with us. Our next virtual event for United States of care is going to be one week from today on March 24. And we'll talk about bringing together another set of experts to talk about action steps to address patient's barriers to accessing virtual care with a focus on older adults. So really apropos to much of the discussion that was raised today and digging a little deeper on that lookout for future discussions that do get more into that vaccine, confidence and messaging that we've also gotten into today. And just

really encourage all of you to go to our website, UnitedStatesofcare.org to access the information referenced as well as a deep body of resources available to support efforts for policymakers and beyond. If you aren't already on our list, please sign up so you can get notices about future events. And hopefully you'll consider joining us at a future event virtually for now. And hopefully, one day not too far away in person again, we know that entering the next phase of the pandemic and a successful recovery will require all of us and so we look forward to working with all of you, policymakers, advocates, concern people, as we strive in the midst of a public health crisis to to work to build a health care system that can withstand the next one. Be safe, take care and thank you