

Cherry Blossoms, COVID-19, and the Opportunity for a Healthy Life

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Abstract

To date short-term funding and policy fixes for the COVID-19 pandemic have focused on saving the current health care system; policies have not maximized the population's health, prioritized the safety net, nor addressed the fundamental problems that have hindered our nation's response for our most vulnerable neighbors. We need to plan more lasting equity-specific reforms now. I explain three lessons that should inform reforms to the healthcare delivery and payment systems to reduce health disparities and maximize the public's health: 1) Proven roadmaps and processes for reducing health care disparities already exist, as do themes of successful interventions. Implement them; 2) Payment reform needs to create a business case for health care organizations to address social determinants of health and implement care interventions to reduce health disparities; 3) We as a nation need to have hard conversations about whether we truly value the opportunity for everyone to have a healthy life.

Cherry Blossoms, COVID-19, and Opportunity

Searching for peace and beauty in our COVID-19 world, my wife and I walked daily to the Japanese cherry blossoms around the placid pool of water near the Museum of Science and Industry on the South Side of Chicago. Over a 3-week period, pink cherry blossoms grew ever more radiant, becoming our highlight each day. But the cherry blossoms eventually faded and dropped to the ground. Cherry blossoms have been a metaphor for life in haiku poetry, beautiful and ephemeral, ultimately withering into death.

Japanese cherry blossoms are also a metaphor for our nation's response to the disproportionate harm COVID-19 is inflicting on low-income and racial and ethnic minority communities. To meet the immediate medical and social needs exposed by COVID-19, state and federal governments have rapidly responded with stopgap funding and incremental policy fixes. While flawed this funding has still been helpful and attracted many applicants like bees to nectar; however, this funding will gradually fade away like cherry blossoms. Now is the time to address the fundamental structural problems in the health care delivery and payment systems that perpetuate health disparities.

More of the Same or True Reform

The American public and health care organizations have been overwhelmed by the medical, social, and financial stresses of COVID-19. Two fundamental questions have implicitly hovered over the immediate health policy relief efforts: 1) Should the goal of aid be to help the patients most adversely impacted by COVID-19 or to save the current health care system? 2) Should the nation prop up the status quo or encourage a health care system better designed to address the complex medical and social needs of high-risk populations? The de facto answer has been to save the current health care system, not to maximize the population's health, not to

prioritize the safety net, and not to address the fundamental problems that have hindered our nation's response to COVID-19 for our most vulnerable neighbors.

If helping the patient was the primary goal, we would have improved access to health care and COVID-19 testing by expanding Medicaid and re-opening all the Affordable Care Act health insurance exchanges to allow the newly unemployed to enroll in a health plan. Instead, \$50 billion of the initial CARES Act Provider Relief Fund were allocated to support the current health care system by giving hospitals and providers funding “to support healthcare-related expenses or lost revenue attributable to COVID-19 and to ensure uninsured Americans can get testing and treatment for COVID-19.”¹ The funding formulas favored big hospitals rather than safety net providers, based on market shares of Medicare costs and total patient revenue.² Key regulatory changes to Medicare to improve access to care are temporary, such as increased and expanded reimbursement of telehealth by physicians, nurse practitioners, mental health professionals, and physical therapists.

Incremental, short-term, stopgap measures reflect the logistical and political realities of the urgent such as helping patients in critical need and keeping small, rural practices open. It would be a mistake, however, if policymakers, key stakeholders, and the public stop there. They should consider what health care system and payment reforms would care for vulnerable populations more effectively, both in times of extreme stress such as COVID-19 and routinely. It is short-sighted and unconscionable not to address the root drivers of inequities and the structural problems in the health and social service systems that have contributed to the disparate suffering, burden, and death in low-income and racial and ethnic minority populations.

Lessons to Reduce Health Disparities

What lessons do we already know that can inform reforms to the healthcare delivery and payment systems to reduce health disparities and maximize the public's health?

1. Proven roadmaps and processes for reducing health care disparities already exist, as do themes of successful interventions. Implement them. It is not a magical or impossible task to reduce health disparities.^{3,4} Expand health insurance coverage. Identify disparities in health care quality and outcomes data. Do a root cause analysis to understand why the disparities exist that includes speaking with the affected populations. Design and implement interventions that address the causes of the disparities. Revise and improve over time. What reduces disparities are culturally tailored approaches, team-based care that involves close monitoring of patients, multiple human touches and social connections with patients, community health workers to bridge the worlds of the health care system and community, involving patients and communities as partners, and addressing social factors that impact health outcomes. In addition, increasing the racial and ethnic diversity of the physician, nurse practitioner, and physician assistant workforce can improve health disparities by increasing access to care and quality of care for racial and ethnic minority populations.^{5,6}

2. Payment reform needs to create a business case for health care organizations to address social determinants of health and implement care interventions to reduce health disparities. Even the most well-meaning organizations have difficulty sustaining interventions to reduce disparities without a business case.⁷ In the Robert Wood Johnson Foundation Advancing Health Equity: Leading Care, Payment, and Systems Transformation program, we are working with teams consisting of a state Medicaid agency, a Medicaid managed care organization, and

frontline health care delivery organizations to enact payment reform that supports and incentivizes the care delivery changes that reduce health disparities. No one stakeholder can do it alone. Stakeholders must align their efforts. Each team is considering how to provide flexible upfront funding (e.g. – capitation, per member per month payments) for care interventions that reduce disparities such as community health workers and culturally-tailored team-based care. Each team is also considering how value-based payment programs can use performance metrics to incentivize and reward reduction of disparities (e.g. – pay for reducing disparities; measures sensitive to addressing social determinants of health such as preventable hospitalizations for ambulatory care-sensitive conditions). In the Merck Foundation Bridging the Gap: Reducing Disparities in Diabetes Care program, Marshall University has worked with Appalachian federally-qualified health centers and payers to fund community health workers with a shared savings model.⁸ Regardless of whether fee-for-service, value-based payment, or alternative payment models are used, the approaches must be intentionally designed to support and incentivize the reduction of health disparities. The problems of fee-for-service incentivizing volume rather than quality are well-known, and currently there are few or only weak incentives in most value-based payment schemes and alternative payment models to reduce disparities.⁷

3. We as a nation need to have hard conversations about whether we truly value the opportunity for everyone to have a healthy life. Care delivery and payment reforms are necessary to reduce health disparities, but will not happen unless we have a culture of equity in which we truly value giving everyone a fair chance for a healthy life. We need to have free, frank, and fearless discussions about the structural racism and systems of privilege that have caused racial and ethnic minorities and low-income communities to suffer health disparities, have worse housing,

worse education, and less economic opportunity, and commit to leveling the playing field.⁹

Diverse crowds are repeatedly protesting police brutality against African Americans, reflecting an increased willingness of our society to discuss systemic racism and advocate for change.

Specific suggestions for increasing the effectiveness of conversations around racism and inequities include leading with stories not numbers, not blaming the individuals in the discussions, teaching about systemic solutions rather than only problems, and discussing concrete ways each person can advocate for reform.^{10,11}

A Call to Action Locally and Nationally

For example, we can look in the mirror and implement anchor institution principles at our home organizations, such as hiring neighborhood residents and using community vendors to improve the local economy, and screening routinely for social needs in our patients.¹² We can insist that our clinics and hospitals improve their quality of care with an equity lens, designing their systems to specifically meet the needs of diverse patients including the most vulnerable.⁴ And we can mobilize support in our professional societies to advocate for payment reforms that intentionally support and reward health care organizations that address social determinants of health and advance health equity.⁷

The Cities of Osaka and Chicago partnered to revitalize an exquisitely beautiful, peaceful Japanese Garden of the Phoenix near the Museum of Science and Industry to symbolize friendship and respect. On our walks, my wife and I pass by a stone *tōrō* lantern near the fading blossoms. The stone structure has strength and beauty that are permanent and timeless. Our nation has the potential to unite and commit to long lasting care delivery and payment reforms to advance health equity. Similar to the Greek legend of the phoenix, good can arise out of the destruction from the COVID-19 pandemic. In Chinese and Japanese cultures, the phoenix

appears in virtuous times; it is up to us to ensure that everyone can have a fair and just opportunity to live a healthy life.

Conflict of Interest Statement

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