

Marcus Plescia:

Hello, everybody. I'm Marcus Plescia, the chair of the board of the National Forum for Heart Disease and Stroke Prevention. And I'm glad to welcome you to the National Forum for Heart Disease and Stroke Prevention's first virtual convening of 2023. We will focus today on a recent study by the Partnership to Fight Chronic Disease, which found that advancing health equity could save the United States trillions of dollars over ten years. The National Forum's 20th annual meeting last October centered on the theme of broadening support for policies and resources that will enable people throughout society to attain cardiovascular health.

Today's convening is the first in a yearlong series on that theme. We, in public health, often talk about people where they are. We recognize this as necessary if we're to help people who are underserved, who are vulnerable, who are marginalized – who are in marginalized locations or populations, to help those people reach their potential. Meeting people where they are, applies to winning public, and, yes, political support for policies, programs, and environmental and systems changes that improve health equity.

For millions of Americans, meeting them where they are means helping them understand that interventions that improve health equity will not take something away from them, but in fact will benefit them. Today's speakers are going to share economic facts, and explain how they affect people throughout society. They're going to help us discuss these issues with people who do not see themselves as being affected by health equity. The facts and analyses we're going to hear today will help us meet the understandings of Americans where they are, and build support for policies and other changes that improve health equity.

Before I begin, I have a couple of introductions and background for you for use of the Zoom platform. First, today's convening is being recorded, and it'll be available for you or others to watch at your convenience. You'll get an e-mail from the National Forum with a link. To control the visibility and size of closed captions, click the closed caption button. You may ask questions at any time during the briefing, and we encourage you to do so. And you can ask questions by clicking the Q&A button. If you want to make comments, please use the chat feature.

All of the handouts, background materials, and speakers' bio sketches can be downloaded by clicking resources. Now, to lead today's panel, I'm pleased to introduce Candice DeMatteis, Vice President of Policy, and Advocacy for the Partnership to Fight

Chronic Disease. Candice is also an adjunct professor of Public Health Sciences at the University of North Carolina, Charlotte. Thank you. And, Candice, it's all yours.

Candice DeMatteis: Thank you so much. And thank you to the National Forum for hosting this important discussion, and giving us the opportunity to share this breakthrough research that we worked on with global data, and are thrilled to share with you today. The partnership to fight chronic disease is an organization that's been around for 15 years. We focus, as the name implies, on chronic disease. We have more than 100 different organizations that work with us, stakeholders representing a broad swath of the healthcare system, all focused, again, on the prevention, management, and lessening the burden, overall, of chronic disease.

Thank you also for joining us today. We know that you participated in a pre-event survey and wanted to share some of the results of that before we got started with our speakers. These questions should look familiar to you. But some of them, obviously, you don't know the responses. And we're going to address a lot of these questions today. One of them was the most common obstacle for Health Equity reforms. And that involved high consumer costs. Pretty close behind where systemic bias and insufficient political support, and will for health equity, are all important considerations as we all work to improve health equity across the United States for all people.

The next question involved the public and perception, which is so important, as you know. And it was interesting to see that many people perceive that one of the barriers is the perception, or should I say misperception, that health equity benefits certain populations at the expense of others. A resounding percent of you agreed with the perception that people in your state believe this. We feel like the data and the discussions today will help to equip us with pushback on that misperception.

Another question was about the most beneficial outcomes of health equity, and overall, improved health outcomes was a clear winner here. And, again, the research that we're going to talk about today reinforces that and quantifies that opportunity. And, obviously, with improved health outcomes, improved quality of life as well. One other opportunity, we planned for this to be an interactive webinar there.

Please present, as you think of questions, go ahead, and hit that Q&A button at the bottom of your screen. We will be monitoring that. There will be an opportunity for a live Q&A at the end. But, also, you know, I know if we're watching these webinars, sometimes we come up with a great question. We think we're going to remember it, and then we don't. So as you think of those, please go ahead, and put them in the Q&A function at the bottom so we can get to them all.

It is my pleasure to introduce our first two speakers today. First up is Cynthia Siego. She is a senior consultant in the custom healthcare practice at Global Data. Her work focuses on quantitative research on current challenges in healthcare, such as quantifying and projecting the burden of chronic diseases and assessing the health economic implications of proposed healthcare reforms or technology. Cynthia worked with us very closely on the study we're going to talk about today.

After Cynthia, Ken Thorpe will present. He is the chairman of the Partnership to Fight Chronic Disease, and also is Robert W. Woodruff Professor and Chair at the Department of Health Policy and Management in the Rollins School of Public Health at Emory University. Ken is a noted scholar and health economist and is a sought-after expert at the local, state, national, and international levels. And in his spare time, helps guide us at the partnership to fight chronic disease. Welcome. Please help me, join me in welcoming Cynthia and Ken. Cynthia, I'll turn it over to you.

Cynthia Siego:

Thanks so much, Candice. I'm really thrilled to be here. And my name is Cynthia Siego. I am a senior consultant at Global Data. Racial and ethnic disparities in health outcomes are one of the most pervasive, and obstinate forms of health inequities in the US. Many studies have pointed out that racial and ethnic minority groups experienced higher rates of illnesses, such as type two diabetes, hypertension, and asthma. And not only that, but they're also more likely to die from these diseases than the non-Hispanic White populations.

So in this project, we collaborated with the partnership to fight chronic diseases to explore two main questions. First: what are the implications of improving health equity in the US? Or, in other words, what are the potential health and economic benefits of Americans achieving national health targets? And two: what are the impacts of racial health disparities in disease controls, especially among key minority groups? We included all insured adults who suffer from at least one of the nine types of chronic

conditions in our model. And within this broad set of population, we looked at the implications of both the direct medical spending and indirect economic burden. Next slide.

The way we studied this is that we use our Disease Prevention Microsimulation Model, or DPMM, which is a mark of the base model that simulates how clinical improvements such as changes in blood pressure, BMI, cholesterol level, and how this could affect the onset of chronic diseases, complications, and related medical expenditures. In this project, we use DPMM primarily to start metabolic diseases. And over the years, DPMM has enabled us to understand some of the key challenges in our healthcare, such as the economic burden of drug nonadherence, or the potential value of chronic disease management programs. And dozens of these projects have culminated into academic journal publications as well.

So for other conditions included in this project, but not covered under DPMM, we use a customized Excel-based model that combined our disease projection data, published literature, as well as other publicly available data. And to answer the two main questions that we posed before, we compared the baseline scenario, that is assuming the current levels of disease care stay constant over the next ten-year period against two different hypothetical scenarios.

The first hypothetical scenario is the health targets scenario. That is assuming that disease control among all insured adult Americans is improved to the national targets, or we could understand it as improved health equity. And, second, is the reduced health disparity, where we simulate the outcomes have non-Hispanic Black and Hispanic patients been able to achieve the same level of disease control as their comparable non-Hispanic White patients. Next slide.

What we found is that comparing the baseline scenario against the first health target scenario, achieving recommended health targets could save almost three trillion dollars in medical costs alone over the ten years period. And on a per patient basis, we expected an average of \$18,000.00 in medical cost savings, with most of the savings coming from reduced needs for ambulatory visits, hospitalizations, and drugs to manage the complications of the diseases. We also found that non-Hispanic Black and Hispanic patients are expected to accrue greater medical savings than the non-Hispanic white patients. Next slide.

This is a snapshot of the state's medical and productivity savings from achieving the health target scenario. California, unsurprisingly, given its population size, is expected to accrue the greatest saving. But I think a better comparison would be looking at the per-patient basis. And I picked these four states as an example. This analysis shows that there are not only racial and ethnic differences in the expected savings but also state differences. For example, the average medical and productivity savings from improved health equity is higher in New York than what is projected in taxes for Florida. And this really reflects the baseline differences in the average level of disease control among patients living in different states. Next slide.

Now, turning to the second scenario, the reduced health disparity scenario, where we measure the savings, had communities of color been able to achieve the same level of disease control as their comparable non-Hispanic White patients. While on average, the level of disease control among non-Hispanic Whites is still way lower than the national health standard. Yet, we found that health disparities among non-Hispanic Black and Hispanic patients still cost over 600 hundred billion dollars. Most of the savings are accounted for under the medical costs with a smaller portion coming from work absenteeism costs.

And to summarize, here are our key takeaways. First, achieving recommended health targets could save trillions in medical and productivity costs. Everyone would benefit, but especially the communities of color. And, two, not all states are equal. Some states are closer to these health targets. Some are further. So it is important to understand specific contexts. And, lastly, racial, and ethnic disparities are still an issue. Non-Hispanic Black and Hispanic patients are more likely to have lower levels of disease control than their comparable non-Hispanic White populations. Reducing disparities in disease control is another way we could improve lives and save money. Thank you.

Ken Thorpe:

Thanks, Cynthia, for that presentation. I'm going to follow up on that. In terms of looking, again, at some of the overall numbers. As you just heard, we looked at this in terms of reductions in medical spending, as well as improvements in workplace productivity. So over a decade, we could potentially save just under four trillion dollars. I think that the bottom line is if we could find ways to achieve those goals, everybody wins. Private insurance premiums would be lower, they grow at a slower rate. So I think our policy imperative is to find paths in different ways to achieve these targets. So next.

So you just heard the breakdown, the 3.8 million. One of the challenges that we face, and one of the reasons why we have such disparities, is that millions of Americans live in areas that have a shortfall of primary care physicians. And we'll talk about some potential solutions for that in a minute. So that's a real challenge. Our baseline underlying health status differences are enormous. So among non-Hispanic Black adults, the prevalence of type two diabetes is 40 percent higher than the prevalence for non-Hispanic White adults. So we're starting from a very different baseline here that we need to find interventions to get blood sugar levels down, blood pressure levels under control, and cholesterol levels under control as well. So next.

This is just giving you sort of the numbers by type of condition. You can see right at the top of the chart is type two diabetes. Type two diabetes, the prevalence increases really match what's been going on with rising rates of obesity. So, certainly, some of the interventions here are our lifestyle, diet, exercise, and nutrition. So I think one of the policy challenges that we have is finding ways to better, and more effectively, engage different populations in different types of lifestyle programs.

Obviously, Medicare has done this by introducing the Diabetes Prevention Program, a weight loss program that has been proven to be effective, generating about a five to seven percent reduction in weight, and nearly a 60 percent reduction in the incidence of type two diabetes. I think one of the options is to figure out how can we get more seniors in that program, as well as people under 65 engaged in programs like that, that have been proven to be effective and generate weight loss, and get this diabetes, and blood pressure, and cholesterol levels down. So next.

So in addition to the two things I've talked about, one is to find ways to increase access to primary care services. Two is to get better traction into programs like the Diabetes Prevention Program. One way to do that on the primary care side is to continue to promote and use telehealth. That has proven to be a very effective intervention that exploded during COVID. Roughly a quarter of all visits are still telehealth. A lot of those visits are for behavioral health issues. But that's one way of mitigating some of the inequities in access, is if we could increase and promote the use of telehealth to populations that are in underserved areas that don't have lots of primary care physicians around, where it's difficult to get to them, and so on.

The other thing that you can see from the conditions we've looked at, most of them are managed through medication; diabetes, hypertension, and lipids. So effective medication management, in addition to changes in lifestyle, are two very effective ways of really having us meet these goals. To make people adherent to medications, the easiest way to do it is don't charge money. Cost sharing for people that are chronically ill and sick really doesn't make a whole lot of sense if you think about it, because the goal here is not to worry about moral hazard as we did 40 years ago, the goal here is to get patients to actually fill and refill their prescriptions.

And so if we expanded on what happened in the Inflation Reduction Act, which kept the out-of-pocket cost of insulin at \$35.00 a month, and expand that to a broader set of key chronic conditions, and really even promote no cost sharing, that would be one effective way of not only achieving these goals, but as you can see, overall, we'd save money. We'd reduce the level and growth and healthcare.

That should be applied in high deductible plans as well, that we should be able to carve out clinically-effective medications and clinically-effective treatments, so-called value-based insurance design, and not have those types of treatments and medications subject to high deductibles, which in some states, like California can \$5,000.00, \$10,000.00, \$15,000.00. And it really discourages people from using medical services and filling and refilling medications. So next.

So, the health professionals' shortfall is enormous. Eighty-four million live in an area that has a shortfall largely of primary care physicians. I think we can build on telehealth success. There's been incredible innovation in the telehealth space over the last three years. We're able to not only conduct really effective, remote patient visits but with some incredible technology, able to really monitor patients to make sure that they don't deteriorate. And we can intervene before deterioration happens.

So we have devices right now that monitor 13 vitals in one device, and you can track a patient. And using sort of risk stratification approaches, stratify a population that based on their risk of deterioration. So I think there's some really innovative things that we could be doing, that would save the need for health professionals, but really expand coverage to populations that really need the access. So next.

Yeah, so medication adherence is low. And it's really low if you look at the numbers on patients that have multiple chronic conditions. It's a real problem in Medicaid populations, privately-insured populations, and so on. But you do see big differences and adherence across different races and ethnic groups to manage these conditions. As we've noted, most of these conditions are really effectively managed by taking your medications on a timely and routine basis, as well as lifestyle changes.

So these numbers are low. And it sort of says to us that we have got to find ways to increase adherence. And as I've been talking about, the easiest way is to rethink the design of health insurance benefits, with respect to cost sharing, for medications that are clinically effective in managing these conditions. Next.

And so the good news, is we have tools out there. We can meet these objectives. But we need to make some changes. Making changes in benefit design for co-pays, rethinking high deductible plans, and the role that they play, and really continue to engage telehealth and promote it, particularly for individuals in underserved areas, are all ways and all strategies that we could use. In addition to the primary prevention opportunities we have, and encouraging, whether it's through the workplace, whether it's through schools, or other institutions that we can rely on to promote enrollment in evidence-based lifestyle programs that we know work. And then we know that they reduce the number of new cases of these chronic conditions.

Candice DeMatteis: Great. Thank you both so much. A lot of data, a lot of fantastic information. And we're getting lots of questions. So look forward to posing those to you all. And encourage the audience to continue posting those questions. Before we get to them, however, we are going to invite Dr. Warren Jones to react to what he heard and share his experiences. As many of you know, Dr. Jones is an expert in many different fields and experiences. I'll share just a few.

He is a past National Forum chair. Retired captain US Navy Medical Corps. He is a professor emeritus at the University of Mississippi Medical Center. He's founder of the Mississippi Institute for Improvement of Geographic Minority Health and Health Disparities. Also, former executive director of Mississippi Division of Medicaid, and also served as a past president of the American Academy of Family Physicians. So, Dr. Jones, thank you so much for joining us, and look forward to your comments.

Dr. Warren Jones: Well, Candice, thank you so much for a warm introduction. I guess, our attendees must say, “He’s done all those different things, he just can’t keep a job.” Well, that’s probably true. But today is a very serious problem. And in the 45 minutes, they’ve given me to talk with you, well, really not that long, I’d like to just address a few of the things that we’ve talked about, and some other things. One of the key things that we’ve learned from the two prior presentations was the cost, the cost of healthcare. This isn’t a new problem, and this isn’t something that people just started looking at.

Back in 2009, LaVice, and his group, looked at the cost of health inequities, to our healthcare system. And what they found was back in 2009, the cost of the health system of disparities and inequities was about 1.24 trillion dollars. What that means is that if we had eliminated the barriers with access to care, if we made sure that individuals had access to the services they needed, back in 2009, we would have saved 1.24 trillion dollars. As you’ve seen today, just from the strategies that our experts have laid out, we have the capacity to save almost four trillion dollars over a ten-year period. So the opportunities to improve are there.

When we look at some of the challenges that are faced by the individuals that we’re talking about here, one of the key things that came out was the primary care shortage areas, which is a part of the health professional shortage area studies that HRSA does on an annual basis, Health Resources and Services Administration. What we found is that when you have these health professional shortage areas, you have not only a shortage of primary care, but you also have a shortage of referral specialists to give this highly-specialized care to individuals who need, and, oftentimes, there’s a loss of hospital coverage.

I don’t know how many of you followed the saga of the closing rural health facilities across the country. That adds to the kinds of problems that’s going on. So the data that we’re seeing is really the result of a confluence of issues and challenges. We looked easily and early at diabetes. The March of Diabetes across our nation is one that has occurred, and been chronicled regularly from the data from HRSA and other entities.

We know that many people think that type two diabetes is a lifestyle issue, but it’s not a lifestyle issue alone. Because type two diabetes often is found in conjunction with other issues, other health challenges. So providing a way that patients can get the

right care that they need at the right time, and get the support they need can make a big, big difference.

You heard Dr. Thorpe talk about telehealth, and the opportunities that can be gained in that manner. When you stop to think that as I ran my state Medicaid program, I had several counties that had no one in the counties that were able to deliver babies. Imagine a woman is pregnant in one county has to travel all the way to the other side of another county, just to get routine healthcare. That's the kind of challenge that the workforce presents.

Telehealth allowed us to leverage the kind of information and data exchange that we can monitor patients for routine kinds of issues, and have them turn to the facilities in a timely manner, and when I had challenges that needed to be met, and made a significant difference in outcomes. And I'm glad to see that so far, there has been a decision by the government to continue to include telehealth as a part of the current response to the pandemic.

One of the challenges that was also discussed was the challenge of medication adherence. One of the biggest issues associated with medication adherence is not just a copay, but the fact that payers don't necessarily want to pay for combination products. Now, I learned way back when the Earth was cooling, that if you take a pill four times a day, you're far less likely to take it regularly on time and appropriately than if you had a pill that you took once or twice a day. So there are some combination products that are out there that can help patients with multiple conditions; hypertension, and diabetes, as well as others, to be able to take fewer pills, which would increase the adherence.

Another thing that would help to increase the adherence is the ability to participate in team care, where you go to the clinician's office, and you're met by an educator, or someone that can help you to figure out how to make sure that you meet your nutrition needs in the most appropriate way. And in some locations, how you can get the resources you need to help your family. In addition to the team care, the likelihood of getting increased community, family, and patient-based participation in the care will make a big, big difference in outcomes, as well as adherence.

All of these things play a big role in the data that we're presented today. The key thing, though, is a lot of people are looking at the price of something, but not the value or impact. When we talk about the impact on families, and in the children, and the workplace, it's more than just the dollars. It's the quality of life.

It's the ability to participate in your community. It's the ability to be a fully active individual that we're looking to have improved. Eliminating some of the barriers that are identified with the social determinants of health, implementing some of the plans and opportunities that were pointed out through the presentation of our two predecessors, can help to make a big, big difference, and where we are today, and where we seek to go.

A few years ago, there was an organization that was called "The Association of Black Cardiologists". And they had a tagline, which said: "Children should live long enough to meet their grandparents." That's one of the goals we've got to focus on today. How do we leverage the information we have to have community-focused approaches to these problems, that add not only years to your life, but life to your years. This is how we help our nation and our communities achieve their best. I thank you for the opportunity to have shared some thoughts. I look forward to responding to your questions with my learned colleagues. And I want to thank you for being here today. Thank you.

Candice DeMatteis: Thank you so much, Dr. Jones. And we do have some audience questions. And I understand that we may be doing a poll question, as well, for the audience.

Male: And we can go ahead and start that poll now.

Candice DeMatteis: Okay.

Male: So in this poll, how can we better motivate action to improve health equity? And let's give this about 20 seconds to respond.

[Brief pause]

All right. We'll keep the poll open about ten more seconds.

Candice DeMatteis: And for those of you who have already done, if you do have a question, please feel free to put it in the Q&A.

Male: All right. Closing out the poll. And here are the answers.

Candice DeMatteis: So a pretty even split, it looks like. Raising awareness about savings, and improving health equity. Greater transparency on areas of opportunity, root causes, and elevating opportunities for systemic change. All laudable goals. Why don't we turn now to some of the audience questions, and welcome responses from you,

Marcus, as well as Dr. Jones, and Dr. Thorpe, and Cynthia, one was dealing with considering uninsured populations.

The study looked at insured populations, diagnosed individuals. But one of the questions was how would that look different, particularly in magnitude, if it included or we compared it to uninsured populations and the opportunities for addressing equity there? Dr. Jones, I see you nodding. Would you like to take that one?

Dr. Warren Jones: That is an excellent question. The data if we will look at individuals, that don't have access to care, that don't have adequate coverage. That the data, if we don't find a way to get them the coverage they need, the data will increase dramatically, the cost will increase dramatically. One of the things that I found when I ran my Medicaid program in Mississippi was that we had to come up with a way to make sure that we can get more people enrolled, and make sure they got the right kind of care they needed.

And we introduced the Mississippi Medicaid Medical Home, which meant that they had a regular, and usually, and customary source of care, and a team that knew them and can provide that care. The problem is that if we don't have coverage for individuals, they don't have access to either of those. And what they relied on is the emergency room for care, and on episodic care. And that's when the cost of care goes up, the quality of outcomes goes down.

Candice DeMatteis: Cynthia, has global data looked at that comparison or looked at other studies with uninsured populations?

Cynthia Siego: Yeah. I don't think we have looked at the uninsured population, specifically. And, in specific, like with regards to the study is like how we look, tease apart the racial and ethnic differences, or state differences. So I think this is definitely something that we should explore further in the future.

Candice DeMatteis: Great. On a future study. I love that.

Cynthia Siego: Right. Another question is it gets to metrics, which is, Ken, as you know, and Marcus, as you know, is so important in policy discussion. So what metrics might the industry adopt to measure and track progress and improve health equity? What key considerations should they be looking at?

Marcus Plescia: I have some thoughts about that particular question. This may not be, you know, you may be looking for some specific metrics. But

I'd like to take a step back and say that I think one of the things that will be most helpful as far as being able to really handle, and manage, and improve health equities, health inequities, particularly when we're looking at racial and ethnic health inequities, is if we could get better data on patient race and ethnicity. I mean, I don't see how we can say that we're taking this problem seriously, when we don't really seem to be willing to go to the trouble to measure it and really track it.

And I do, I mean, I understand. I'm sensitive to the fact that, you know, one healthcare system does this, you know, and none of the others do, it's not a level playing field. I mean, you find you have health inequities with your patients, and it makes you look bad. You know, we all know that all healthcare systems would see this problem.

So, somehow, we have to get everybody to really be consistent about reporting this data so that we can look. And I think, if hospital, if healthcare systems have that data, they look at their own patients and see how they're doing. And, you know, it's not that it's purposeful, I think, but if you don't know where the problems are, I don't see how you're going to fix them. So that's a more global answer to your question. But, you know, frankly, if we don't deal with that, I don't see how we're going to make much progress, otherwise.

Candice DeMatteis: And there's a real issue, as well, with aggregating data across populations, where we don't get some population information. I know, Cynthia, that was a limiting factor among Native Americans, for example, and really trying to dig in there.

Cynthia Siego: Right, right, definitely.

Candice DeMatteis: Another question we got is dealing with a question with regard to prevention. Given limited resources to invest in prevention, have we reached a point where broad population-based interventions to prevent chronic disease just don't provide the same bang for the buck because of lingering and growing health inequities? So do we need to shift the focus from these broad-based approaches to more targeted efforts that address specific causes of inequities, or do we just need to do a better job making sure that both approaches work together. Any guidance there?

Ken Thorpe: Well, I talked a little bit a little bit about the Diabetes Prevention Program. So that's a program that PFCD, we worked with our colleagues very hard over a long period of time, really, to get

Medicare to cover it. So it's actually one of the, I think, good products of the Affordable Care Act was giving CMS the ability to add benefits that the actuary has shown will reduce Medicare spending and improve outcomes. So we have proven interventions. I think we need to find ways to make it easier to access. And one of the most obvious ways is providing that platform on a telehealth platform, and not necessarily an in-person platform in order to increase traction, increase participation in it.

I don't know that we've done a really great job. I mean, it got covered. We ran into COVID, and attention went elsewhere. So we didn't really do a great job of promoting it. But I think that we need to find ways within the Medicare program, and with our employer friends to say, well, look, it doesn't have to be this program, but there are programs like this that are really effective lifestyle programs. And they're inexpensive. They're really not expensive programs to put in place. So the promotion of what works is sort of the first thing that I do, and make it easier to access.

Candice DeMatteis: Other comments on that?

Dr. Warren Jones: If I may add, over the years, I've heard discussions about – how we can increase the prevention programs, and one of the pushbacks I've heard from employer-based payment plans is that prevention doesn't pay off right away. Okay? And, folks, many are hesitant to pay for something that may not show up for five, to ten, to 15 years. And it has to be a recognition that when we all participate in prevention, just as the adage says: "A rising tide lifts all ships, and lifts all boats."

And if we had – one of the things the Affordable Care Act has done is a lot of the prevention is now mandated, or covered, are encouraged. And if we can find a way to broaden that. One of the challenges is we still have a large segment of the population that is uninsured or underinsured. So how do we get them to participate in the coverage so that they can get the prevention services as well. But I don't think we should throw the broad-based prevention programs out the window. They have shown benefit. They have a valued outcome, and they have a valued place in our healthcare armamentarium.

Candice DeMatteis: One question that has recurred a couple times is, again, it's another issue with regard to disparities and access is telehealth has been an important tool for many people at risk during COVID, and then otherwise. But broadband access is another area, another barrier to

that. How do those – how do we address that? And, in particular, I know, Dr. Jones, you work a lot in rural health too. And some people see telehealth as an answer to rural health shortages. But, again, that broadband access, you know, ready access is a big issue. How do we address those?

Dr. Warren Jones:

The broadband challenge is a big challenge, and glad to see that one of the things the administration has done is to try to address that in the plan to help to improve the infrastructure within our country. But in addition to the broadband access, we also have a digital divide, where people in certain areas of the country, even if they have access, are not as facile or as capable of utilizing that, or have the level of sophistication.

So we've got a two-pronged approach that we have to take. One is to provide the connectivity with the capabilities to meet rural, or isolated, or frontier locations. And the other is to provide the degree of exposure, education, and training that would eliminate the digital divide, so that people can use, take advantage of that. I think that both of those would help to make a difference. My belief is that if you get to know someone through a telehealth, it doesn't mean you have to have a camera. You can make it a telephone that visit, and you can do some other things that can help to make –.

You can do with, with your cell phones, you can do remote blood pressure monitoring, that can also play a role in helping to control hypertension. So there are lots of things that can be done that can make a difference among the chronic conditions that our colleagues studied earlier today, and I think it would lead to us having a healthier community.

Ken Thorpe:

Yeah, I think we've moved pretty aggressively on the broadband component. So as part of the infrastructure bill that recently passed, there's 65 billion dollars in there to build up a broadband infrastructure, and then provides subsidies to low-income populations to make it affordable. So, now, it's there, we just have to find a way to really effectively and quickly implement it in order to make sure that those types of Internet capacities are available countrywide.

Candice DeMatteis:

There's another, we've talked a lot about some lifestyle factors that also contributed to chronic diseases. And we had a question about explaining how growing inequities relate to the prevalence of chronic disease for all racial groups, and linking that back to the USDA dietary guidelines, and how they became the law of food production and consumption. How has that factored into these, the

growth in chronic disease, and then also the health inequities we see with that? Marcus, do you mind if I ask you to take that one?

Marcus Plescia: Yeah, you went out for me a little bit there. Can you repeat the last part of the question?

Candice DeMatteis: Sure. It was relating to the growing prevalence of chronic disease, and for all racial groups since the USDA dietary guidelines became, you know, what we guide production and consumption by.

Marcus Plescia: I guess what I would say is that, I think that, you know, there are broad issues that affect all of our society. But I think what we see with inequities is, you know, that these, sometimes these policies have even more substantial impact on communities that are underserved. I don't, you know, I'm not sure that I'm looking at the question, I'm not sure that I'm familiar enough with what about the USDA dietary guidelines, the person who asked the question was concerned about.

Candice DeMatteis: And maybe we can get her to chime back in, and adding that. But I know that there have been debates about, you know, the provenance of dairy, for example, and you know, other choices that maybe there were lower, lower fat content, lower salt content, and the like. But we know that those dietary choices, and, candidly, access to healthier foods and things, can have a profound impact on people's long-term health.

Ken Thorpe: Yeah, it looks like Warren might have some insight on this. I see his hand is up.

Dr. Warren Jones: Yeah, I was going to simply add to that, that food deserts present a big problem, even though the guidelines are there, for individuals to be able to get access to healthy foods within the guidelines at a price that they can afford. And then the training and education on how to create a diet closer to what they're customarily accustomed to, that falls within the recommended caloric balance and fat balance. It's not a single-issue problem. It's a multivesicular problem, and that's why I talk about the community engagement, and sharing information, and team approaches. Those are the kinds of things that can help. I think the guidelines are not the problem, as much as the implementation of the kinds of solutions we need to have healthier people.

Ken Thorpe: Yeah, a little bit more. I'm kind of intrigued with this, but maybe if Dr. Osborne could sort of give us a sense where she's going with this. I'd love to try to address it.

Candice DeMatteis: Okay. While we give her that opportunity, we got a question about poverty, and how that is a core cause of, a root cause of healthcare and health inequity. Without – I know, Cynthia, as a part of this study, and a part of the model, you also looked at some of those health, economic gains, the potential opportunities there. And, Ken, I know you've done work as well about the impact of chronic disease onset and economic opportunity. I'd love to turn it over to both of you to kind of talk about that, about how that interaction with health and economic opportunity, and how poverty plays a role in health status. Cynthia, do you mind starting?

Cynthia Siego: Yeah, sounds good. Maybe just following up to that, just starting, thinking about the 1.1 trillion that we measure from the savings from work absenteeism, potentially. So the way I would like to think about this, maybe, that, given that if we're to improve this health equity, people are going to be healthier, and they're more likely to be more productive, and potentially increase their labor participation. And, therefore, potentially even boost up our economic growth as well. I think that's just like the general ideas of it.

But, potentially, this kind of like, reduction, and work absenteeism could also work in kind of like family-by-family basis. Because as people are getting more productive, maybe like the parents, they potentially could have more money to save, or to potentially pay for the child's tuitions, and stuff like that, but to actually help stop that cycle of poverty, and education, and food security, and stuff. Yeah.

Candice DeMatteis: And, Ken, what about your work on the impact on family income? I know a lot of times people relate lower income status with low health status. But I think your work also showed that that's a two-way street, lower health status can actually impact economic opportunity.

Ken Thorpe: Oh, no question. Just as we've seen what the productivity numbers, if we actually had a healthier workplace population, productivity/income would rise. So they would both go up. So if you have a population that is spending lots of time either in the emergency room, hospital clinics, dealing with underlying depression, you're not going to be at work. And for a lot of people that aren't on a salary basis, not being at work means particularly

in lower-income populations, you don't get paid. So it is a two-way street. So that's why it's always important when we think about chronic disease to think about not only the health aspect, but also the economic aspect that it has on families, because they are both substantial impacts.

Candice DeMatteis: Great, thank you. And we did hear back from Dr. Osborn. This will have to be our last question. I need to turn it over, back over to John Clymer. But thank you all so much for this great interaction, the great questions. She was clarifying that in the USDA guidelines, they counter basic physiology, in that they recommend high carb nutrition, which we know can, you know, boost people's glycemic index. And, perhaps, she said is, I can't even pronounce the word...insulinogenic?

Dr. Warren Jones: Yes, you did a great job.

Candice DeMatteis: Sorry about that. But any response to that about how we view food, and how are our guidelines about nutrition maybe contributing to the problem?

Marcus Plescia: I think Dr. Osborn makes a really good point. I mean, I don't know that I'm personally sort of in tune enough with the latest USDA guidelines to, you know, kind of speak to the specific issues she raises. But, you know, it's a good one. And I do think these are, these are important. You know, these federal policies that get that can make a huge difference in sort of health or for people who live in our society. And this is just one example of that. So I'm sorry, I'm not familiar with this specific thing. But, you know, USDA is a huge lever for us to work with to try to improve health.

Candice DeMatteis: That's a great point. Thank you all. Thank you to our panelists. And, again, and thank you to the National Forum for hosting us, John Clymer, I'll turn it over to you for parting remarks.

John Clymer: Well, Candice, thank you very much for facilitating this convening. You did a great job of leading an enlightening discussion. There were a lot of questions, great questions that also contributed to the discussion. And I know more, far more than we were able to cover. So we'll attempt to get more of them answered, and we will add them to the website for today's briefing. Now, you should see a briefing evaluation on screen momentarily. And when you do, I hope that you will take a moment to fill it out right now before you leave. Because your feedback is important, and we will put it to use.

The National Forum is grateful to our speakers today: Ken Thorpe, Cynthia Siego, Warren Jones, and Marcus Plescia. It was staggering, I thought, to learn how much disparities and inequities in chronic health conditions are costing Americans. Not just some amorphous, the US, or the health system, but individual businesses, and people, and families throughout the country, people of all races and economic status. So I urge you to frame health equity as something that benefits everyone because it does. And discuss policies, programs, and environmental, and systems changes that will improve health equity without using the words “health equity”. Those two words, when used together, may put off people who otherwise would lean into a discussion about how we can save trillions of dollars.

As Dr. Plescia said at the outset, today’s convening was recorded. In the next few days, you’ll receive an email from the National Forum with a link to the recording. Please share it with colleagues and fellow health equity advocates who could not attend today’s session will also add answers to some of the so far unanswered questions on that site as well. If you haven’t filled out the survey yet, please do so right now. It will take just a moment. And now let’s work together to achieve health equity, and optimize cardiovascular health and wellbeing throughout the lifespan.

[End of audio]