Marianne O'Hare: Welcome to Conversations on Health Care. This week we welcome Dr. Cameron Webb, Senior Policy Advisor for Equity on the White House COVID Response Team on the Biden administration's quest to address health disparities and inequities.

Dr. Cameron Webb: People who have access who have privilege, they're going to get access to the resources. I think it's about tailoring and designing interventions to folks who have those barriers, those challenges with access.

Marianne O'Hare: Now, here are your hosts Mark Masselli and Margaret Flinter on Conversations on Health Care.

Mark Masselli: Our guest is a dynamic physician and public health leader whose service in the White House extended from the Obama to the Trump administration. Now after a run for political office, he's a key part of the Biden administration's effort to ensure equity in fighting this pandemic.

Margaret Flinter: Dr. Cameron Webb is the Senior Policy Advisor for COVID Equity on the White House COVID-19 Response Team. Dr. Webb is helping to shape the national discourse and the management of the pandemic.

Mark Masselli: Well, Dr. Webb welcome to Conversations on Health Care and thank you and congratulations, you've been serving patients all during the pandemic. And we really honor our frontline providers. I wonder if you could help us define how you and the administration see equity as different from equality.

Dr. Cameron Webb: Well, first, thanks so much for having me today. And I think, you know, the question that you're hitting on was actually my first question when I was deciding when and if to join the administration, I asked, what do you mean by COVID-19 Equity. And it's really important to make that distinction because in this pandemic we've seen that there's no one size fits all solution, there's no single intervention that's going to serve all communities the same way. So by equity, how we've defined in our team is, is simply that it's our goal of ensuring that all communities at all times have the resources that they need to not just survive, but thrive through this pandemic. And I think it piggybacks off of the existing definitions about equity. It's just that notion that we have to make sure that we're delivering to communities, the tools, resources, and opportunities that they need to navigate the unique circumstances that are driving the direction, the impact of the pandemic on them and on their families and their communities. So I think that's what the work has looked like. And you can imagine, that becomes, you know, pretty, pretty large, it allows us to take a pretty big vantage point on the pandemic.

Margaret Flinter: Well, Dr. Webb, the recent study found that Native Americans,

Latinos, and black people were two to three times more likely than whites to die of COVID-19 when the pandemic first hit and actually I think we started seeing that information almost as soon as the pandemic took off and it never lit up. But we're in another phase of the pandemic, we still have a long ways to go, we have some treatments available. What more can all of us do to close this gap now in the COVID pandemic and hopefully, it will give us some lessons for the future as well. But what can we do to close the gap now?

Dr. Cameron Webb: Well, you know, I appreciate that you raise some of those stats early on and at the time I was both running for Congress but also I was in the midst of helping serving my community. I'm an internal medicine doctor so working on the COVID unit, working to take care of patients. The reality is we actually didn't have all those data. We knew that in, I remember it was in Milwaukee 70% of the deaths were in the black community, in Louisiana they saw similar high numbers, and the question became how widespread is this dynamic. And the first thing we had asked for was data. And months later, in January of 2021, when I joined the Biden-Harris administration, the data that we had on the vaccination effort across the country, only 52% of vaccinations administered, did we have race, ethnicity, out of every two, we would only have one of them where we knew the race and ethnicity.

Now, in the most recent weeks, we are up to about 80%, you know, and overall, we're nearly 75%. And the way that we did that was by emphasizing the data. And so I raised that because, you know, in medicine, we say all the time, you can't treat what you can't see, it's really hard to know, where the inequities lie if we're not collecting data that allow us to know that and to drive the differences. But I hit on it a second ago, vaccinations have been an absolute huge and game changing intervention in communities of color in changing that trajectory of the differential mortality. What vaccines have done is they've really reduced that rate of mortality. And it's helped to level the playing field, if you will, because while we can't change all those upstream factors that put people at increased risk for severe outcomes, what we can do is make sure that they have immunologic protection to prevent some of those worse outcomes. When you complement that, with some of the therapeutic options like monoclonal antibodies and oral antivirals, what we're able to do is really put together the pieces downstream to prevent folks from dying disproportionately. But that does not absolve us of the need to continue to work upstream to terraform communities to make it easier for communities that have historically been hard hit to navigate this and future pandemics.

Mark Masselli: Well, I really love the idea that data is driving the sort of policymaking. And this year's theme for Black History Month is Black Health and Wellness. And the theme focuses on how the American healthcare

system has often underserved the black African-American community. Why is it important for everyone to understand this?

Dr. Cameron Webb: It's important because it informs the very nature of what we mean when we say health care in certain communities, and particularly in the black community. Again, we can go back to what was called the Slave Health Deficit, the dynamic between folks who came over in the Atlantic slave trade and ultimately we're here into forced servitude. Those individuals, the idea of appearing sick became a real risk to their life. And so that was a huge challenge. You move forward, and we continue to see that W. E. B Du Bois, the Philadelphia Negro, this is the late 1800s, and there's a chapter on social determinants of health that on health inequities, you know, Martin Luther King said, of all the forms of inequality, injustice in health care is the most shocking and inhumane. In 1985, Secretary of HHS Margaret Heckler commissioned this taskforce on black and minority health that found that there were these huge differences, these gaps in health outcomes, it's the first time Federally, we recognized that and you can keep going.

This has been a legacy. We've told this story over and over again. But the fact of the matter is, we haven't changed it, we haven't changed those dramatic dynamics that lead to increased morbidity and mortality in communities of color. The way that we do it is we have to again, get far upstream of it. There are, you know, health doesn't happen in hospitals and clinics, it happens in the places where we are born, grow, live, learn, eat, play, and pray. And so if you intervene there, you're giving communities a chance to stay healthy. And then you can put the healthcare system, you can kind of align incentives in terms of quality, access, and cost to make it easier for folks to navigate there. But it takes both, it takes interventions and healthcare. And it takes the interventions in the social determinants. And then I think truth and reconciliation, that reality of the harm that's been done to black communities through the healthcare system, that's not a remote history for a lot of people.

Even in my own hospital, the University of Virginia, its one generation back that people were born in a basement in the West complex building. And so their parents remember that. There are people who say, I would rather die at home than go to that hospital because of what happened to my grandmother, so that we have to contend with. In America we talk about race, we talk about health care, it's not something that's easily done, it takes work, and we have to be equal to that task.

Margaret Flinter: Well, let's talk about an issue that looms large and that is mental health. We know even before the pandemic, our minority populations were less likely to receive mental health support. And certainly the pandemic has only aggravated and accentuated those needs. Tell us a

little bit about how this factors into the discussions and the thoughts and planning of the administration as you work to reach all Americans but to specifically address the mental health issues.

Dr. Cameron Webb: Yeah, it's impossible to divorce the health impacts, the economic impacts and the mental health impacts of this pandemic, in particularly, the burden that's placed on communities of color. And so I think that from our perspective, a lot of that work, we are able to execute through SAMHSA, which has done really tremendous work in terms of grant making for mental health services and supports for folks facing issues with substance abuse. All of these are challenges that we've seen exacerbated by the pandemic. So by making resources available for community level organizations and entities, that's really where those interventions are getting most effective.

But the other thing is just kind of what you're raising, we have to continue to name that problem. We have to continue to sound that alarm of the disproportionate harm. And nowhere is that more, you know, salient, more critical than among our youngest folks. There's a crisis of suicidality in young teens of color. There's a crisis of just the tremendous mental health impact of this pandemic because of increased orphanhood, folks who've lost caregivers. When you think about the cases and the deaths in the black community, we're talking about young people who are losing the trusted adults who were taking care of them throughout their lives. And that's going to resonate throughout their lives. We have to make sure that we're there to support and engage. So I think it's really taking a truly holistic approach to what this pandemic is doing. We've got great leadership at SAMHSA with Dr. Miriam Delphin-Rittmon and I think taking that mentality to the whole person is going to be the key.

Mark Masselli: I know you've got a lot of jobs, including you're still on the faculty at the University of Virginia and your school has recently rolled back requirements for students to get vaccinated based on an opinion from the State Attorney General. What do you do in this type of situation? Are there additional precautions that you're going to take or recommend to people find themselves in situations like that?

Dr. Cameron Webb: Well, I think you're hitting on a really critical moment that we're in. There's a lot of, I'll say eagerness to see the pandemic end. Often I hear people talk about transitioning from pandemic to endemic. I think there's a misunderstanding of what endemic means. And for a lot of people, they just see those first three letters. And they think it's kind of a mash up of end-pandemic. The truth of the matter is that's not what it means. What we're seeing is there's this rush to roll back a lot of the strategies that have gotten us to a point where we're seeing less death from COVID-19. So there are people who just assume that we got here, by accident, or by good fortune. We got here because of

vaccination effort. We got here because of layered mitigation strategies, because of masks because of testing and because of vaccinations. So because of all that, I think it's a matter of taking a step back and ensuring that the decision makers at the school level know, the decision makers at an individual level, the students themselves know that your best way to protect yourself based on the science, based on the evidence is this. And even though this pandemic has been politicized to a point, it's indistinguishable from the rest of our political rhetoric.

You need to protect yourself, your family, and your community at all costs. And you do that by following science, not by following political rhetoric, oftentimes meant to motivate a voter base and so I think that's where have to really double down. I think the university is a public institution, there are some unique dynamics to navigate, and I think that we're going to do that. But one thing I do love about the University of Virginia is that there's an emphasis on taking care of those students. And so I know that we'll continue to find ways to do just that.

Margaret Flinter: Well, I think about where we are at this moment of time. And I think we can say that we have all been treated to a two-year intense graduate course. And now we're getting very close to FDA approval of the vaccine for kids under five. Hopefully everything we've learned will help us to ensure equity in vaccination, outreach and delivery. What are your thoughts about the steps that we're taking nationally or the administration to make sure we really just knock this one out of the park in terms of reaching the very young children?

Dr. Cameron Webb: It's funny because as an internist I recognize there is a joke that we internists often think that children are a little adults. But that's not the case. And we know that here with these youngest kids under the age of five, this is a very different vaccination paradigm. So there are some great lessons to learn. But you remember the earliest days of the vaccination effort, mass vaccination sites were critical for throughput to get as many people vaccinated as soon as possible. There's no such thing as mass vaccination sites for three and four year olds. If you've ever taken that three or four year old to get a shot, you know, you don't want them out in public. And so, you know, I think what we have to do is, we have to change our focus at each step. And so one thing that's encouraging about this is that that population under five, this is the population in this country who's the most familiar with getting shots even though again, they do it kicking and screaming, and some adults do too. This is a demographic where they're used to getting shots. They know where they go to get all their other vaccinations, especially those are heading into school.

And so our job our responsibility is piggybacking off of that

established network, think about the vaccines for children's program, what that's done for equity in vaccination efforts across the board, by race and ethnicity over the last 30 years. We say we've got a model here, but some of the most salient lessons we have learned are about how to build vaccine confidence and how to not undermine that confidence with the rollout itself. We say we're following the science that means FDA leads on this, that means we don't tell parents go get your kid vaccinated if they're three, four years old, before FDA tells us that that's what they should do or before CDC tells us that's what they should do because we don't want that to appear like a rubber stamp. We want people to know, we're going to be nimble, we're going to follow what they direct us to do, but politics isn't going to drive whether or not there are shots authorized for kids under five, it's going to be science. And we're going to be ready to implement no matter what.

I think there's good news that the Pfizer Moderna vaccines have been fully approved by the FDA for adults. I think that's given a little bit more confidence. And you know, we're not going to expect 90% of parents of kids under five to get vaccinated on day one. We know it's going to take a series of conversations, Medicaid, reimbursing providers to have those conversations, that's a big deal. We didn't have that in place before the 5 to 11 rollout. So we've learned along the way how to make sure that those pieces are in place that we can leverage schools, we can leverage providers to be those trusted messengers locally. But ultimately, I think we put all those things into place and then we just continue to stay at it.

Mark Masselli: You know, I really like that you laid out a roadmap for parents that it's not just going to snap of the fingers and have your child immunized that the FDA and CDC has looked at this, they want to make sure it's safe for children and that's, that's so important in our own experience. We ran the Connecticut's only four mass vaccination sites and vaccinated half a million Connecticut residents, but we know it's a different strategy right, for these younger children. So there's a lot to think about. I was struck by one of your earlier answers you were talking about the need, people are thinking about how do I protect my family, and I really want to go into the issue of undocumented adults and children who aren't legally present in the United States. It’s just an enormous challenge for them. And it's a challenge for the entire United States Health System, right. Just tell our listeners how they fit into the administration's equity focus.

Dr. Cameron Webb: It's such an important part of it. So I'll start off by saying we rolled out the adult vaccination effort. We heard really quickly that even having mass vaccination sites wasn't going to be an effective way to reach folks, because of the chilling effect of the previous four years of undocumented individuals accessing Federal services that concern

that this could be that type of interaction that could lead to their displacement from home and from family. And so we had to send a strong signal we worked with DHS, with FEMA, we really worked with ICS, and we said there's going to be no ICS enforcement at any of these spaces, we need to make that really clear. And that's something that really helped. And after a couple of months of that effort, we saw the uptake really jump up. I think that what's critical is you can't design with them as an afterthought with undocumented individuals as an afterthought, especially with a disease like this, where every single human body in this country is a part of the equation. You have to make it as easy as possible for people to access. And you do that by designing it with folks in mind.

And so I think that's what we've learned along the way. I think I'm always reminded from a policy perspective that for so many of these individuals, they're only undocumented because of harmful policies in past years that have kept them in that state, that have made it impossible for them to have a pathway to citizenship. And that's something the President has talked a lot about, how do we change that, how do we reverse that, how do we create opportunity, so some of it is just a matter of political circumstance. And then no matter what I think our value of human life is to make sure that everybody has access to the tools and resources they need to serve people. So I think it begins with centering that community. It begins with centering all communities that have historically been marginalized or forgotten about and designing from that perspective, people who have access, who have privilege, who have power, they're going to get access to the resources, no matter what. We tailor too many interventions toward that population. I think it's about tailoring and designing interventions to folks who have historically and contemporaneously have those barriers, those challenges with access. That's where we need to focus.

Margaret Flinter: Well, along those lines, I wonder if I could ask you to comment as well, if there are any thoughts or planning around best strategies to reach our rural populations. That's a group that has suffered some adverse health impact as well. And certainly people often think of our minority populations living in urban areas, but certainly, they are in our rural areas as well. Is there anything targeted or thoughtful in terms of innovation about reaching our rural populations at this point?

Dr. Cameron Webb: You know, I'm from a rural county in Virginia, my wife's from a rural county in Virginia. She said she grew up with three stoplights and one blinking light. So I mean, we know what rural means. I think the way that I think about this, is that in rural communities, you have several overlapping dynamics. Here we know there's a dynamic of politicization of the pandemic. But we also know that rural hospitals

and rural health care settings have been decimated in the last 20 years, just in terms of the lack of access that we've seen in rural communities far outstrips that that we have in some other parts of the country. So it's a matter of making sure that we're showing up in those spaces with those tools with mobile resources, but also directly connecting with those providers. Because what we know from rural communities is that those local trusted messengers, the public health and the health care professionals, the folks who took care of you your whole life, took care of your mom and took care your daddy, those are the folks who are going to be critical to you or making a decision on what you're going to do with your health, whether it's vaccinations, or whether it's about wearing masks in public spaces, how you protect your health and well being. Yes, you're hearing a lot of messaging from various spaces, but if you're hearing from your doctor how to take care of yourself from the nurse practitioner who you trust or another public health professional makes a huge difference.

And, you know, we've also talked about how we can partner effectively in rural spaces. We are always dreaming up this great partnership with Dollar General because we know that there are great opportunities and spaces like that. It's not meeting people where they are making sure that messaging is spot on at the end of the day making sure you center rural health because so much of our country is rural. America I think is so much driven by the rural experience, we have to make sure that what we often see is this big spike in urban spaces first, and then we say oh, we're out of the woods, things are getting better. And that's when it's hitting rural communities the hardest. So we've actually developed occasions where we really focus in on rural communities earlier on, and we've seen from an equity standpoint, you look at Alabama, you look at Mississippi and some instances we have higher vaccination rates in communities of color in rural spaces than we have in the white community. There a lot of reasons for that, but I think it speaks to the effectiveness of that outreach.

Mark Masselli: Well, from a rural county in Virginia to the White House, helping advise the President---the President's about to give a State of the Union address, but what can we expect to hear from him about the portfolio you focus in on and I think the $64 million question or whatever is do you think there is going to be additional funding for health equity issues?

Dr. Cameron Webb: Well, you know, one of the things that really endeared this position to me was the idea that President Biden was saying, equity has to be at the center of our response. Vice President Harris was saying equity has to be at the center of our response. And if you look, you know, day one of the administration over a year ago, there was an executive

order on racial equity. Day two there was an executive order on ensuring equity in the pandemic response that became a consistent and ongoing theme was how do we make sure that that equity is at the center of our work as an administration. And so I think the President is going to continue to drive that home. I know every time we engage, every time we brief and talk with the President, which is regularly, his questions about equity are coming from a place of authenticity. And I think his expectation is that we deliver on that, understanding the historical dynamics, understanding the challenge that exists there, we use the full resources of the Federal government to deliver on equity, and I think that's something that, that there's really encouraging to me, as somebody who's been an advocate in this space for a long time.

I think the President's going to continue to drive that message home, I think he's going to name the successes that we've had, but he's also going to name the work that we still need to do. And when it comes to funding, you know, again, a lot of that question goes back to Congress, a lot of that question goes back to our legislators' spaces and if they're going to continue to invest in this space, because in a crisis, oftentimes people pay attention. But as we think about next phases, future states, are we going to continue to invest in equity and in the dynamics that drive equity. And the hope is that they will, I think the hope is that we learn this lesson from this pandemic, that we are all tied to mutual, you know, single garment of destiny. And that is what's critical to our nation's success.

Margaret Flinter: Dr. Webb, we want to thank you for all that you have done for all that you are doing, and for sharing your insights with us today. And thanks to our audience for joining this important talk. And remember, you can learn more about Conversations on Health Care and sign up to make sure you get notification of our shows at www.chcradio.com. Dr. Webb, thank you so much again.

Dr. Cameron Webb: Thanks for having me.

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Mark Masselli: At Conversations on Health Care we want our audience to be truly in the know when it comes to the facts about healthcare reform and policy. Lori Robertson is an award winning journalist and Managing Editor of FactCheck.org, a nonpartisan, nonprofit consumer advocate for voters that aim to reduce the level of deception in U.S. Politics. Lori, what have you got for us this week?

Lori Robertson: COVID-19 has killed more than 800,000 people in the United States according to the Centers for Disease Control and Prevention. Yet a viral video on social media suggests the disease is the same as a common cold. COVID-19 is in the same family of some cold viruses,

but its potential for severe outcome, including death is much higher than for the common cold. COVID-19 was the third leading cause of death in the United States in 2020 according to the CDC. Heart disease and cancer are in the first and second spots. An analysis of CDC data from the Kaiser Family Foundation and the Peterson Center on Health shows that the same ranking is expected for 2021. Despite those facts, a TikTok video suggesting that the disease is the same as a common cold has racked up more than 4 million views. The video merely shows that a medical encyclopedia published in 1989 lists the common cold as being caused by the Coronavirus family.

As we've explained Coronaviruses are a family of viruses, there are hundreds of Coronaviruses most of them circulating among animals. There are seven Coronaviruses known to infect humans according to the CDC, four of them cause upper respiratory tract illnesses often referred to as a cold. Three of them cause more serious illnesses, including Severe Acute Respiratory Syndrome, Middle East Respiratory Syndrome, and COVID-19. Common colds can be caused by a variety of viruses, Rhinoviruses, not Coronaviruses are actually the most common. Some cases of COVID-19 can be mild, but the potential for a severe outcome is much higher than for the common cold, especially for older people.

And that's my fact check for this week. I'm Lori Robertson, Managing Editor of FactCheck.org.

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Margaret Flinter: FactCheck.org is committed to factual accuracy from the country's major political players and is a project of the Annenberg Public Policy Center at the University of Pennsylvania. If you have a fact that you'd like checked, e-mail us at www.chcradio.com, we'll have FactCheck.org's Lori Robertson check it out for you here on Conversations on Health Care.

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Mark Masselli: Each week Conversations highlights a bright idea about how to make wellness a part of our communities and everyday lives. One in five Americans will suffer a diagnosable mental health condition in a given year and most often don't seek treatment. For those with serious mental health conditions the consequences can be devastating. Seeing a rise in mobile Apps aimed at behavioral health entering the marketplace, the University of Washington researcher Dror Ben-Zeev thought a comparative effective analysis study would be a good idea.

Dror Ben-Zeev: My team and I conducted a three-year comparative effectiveness trial having a head-to-head comparison between a mobile health intervention for people with serious mental illness called FOCUS and

more traditional clinic based group intervention called WRAP or Wellness Recovery Action Planning. So the study really gets at some of the core differences between mobile health and clinic based care--- is there something about the mobile health approach that would make it more accessible or less accessible?

Mark Masselli: More than90% of the mobile App group engaged in the online program, which was a series of text messages offering coping strategies and self monitoring of symptoms, along with weekly call-ins with a behavioral health clinician.

Dror Ben-Zeev: The second thing we wanted to see is after people complete care, what are their subjective ratings of their experience in treatment, are they satisfied with both interventions, are there differences, and probably the most important piece of the study are the clinical outcomes. So we measure to see whether involvement in both interventions for a 12-week period, would that create some sort of difference in psychiatric symptom severity, and 90% of the individuals who were randomized into the mobile health arm actually went on to meet a mobile health specialist to describe the App to them and train them how to use it and use the intervention App that's assigned to them at least once. Whereas in the clinic based arm, we saw that only 58% of the participants assigned to that clinic based intervention ever made it in for a single session.

Mark Masselli: Both groups of patients saw roughly equal results from their completed treatment, but the mobile group was more likely to engage in therapy. Ben-Zeev says this suggests that mobile therapies may provide a useful tool for clinicians having trouble getting those with serious mental health issues to engage with the clinical interventions.

Dror Ben-Zeev: The group dynamics, the fact that there's a sense of shared experience, and perhaps even normalization of some of the experience, that on its own is quite potent for people. But for others, the interaction is anxiety provoking, just making it to the clinic to engage in that interaction is logistically complex. In both intervention arms people improved both in terms of reduction in their symptoms and the distress associated with symptoms and improvements in their recovery.

Mark Masselli: A targeted mobile App aimed at facilitating access to clinical care for those experiencing serious mental illness symptoms, proving equally effective in managing the condition improving access to intervention, now that's a bright idea.

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Mark Masselli: You've been listening to Conversations on Health Care. I'm Mark

Masselli.

Margaret Flinter: And I'm Margaret Flinter.

Mark Masselli: Peace and Health

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Marianne O'Hare: Conversations on Health Care is recorded at WESU at Wesleyan University, streaming live at www.chcradio.com, iTunes, or wherever you listen to podcasts. If you have comments, please e-mail us at www.chcradio@chc1.com or find us on Facebook or Twitter. We love hearing from you. This show is brought to you by the Community Health Center.

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