

Crisis Conversations: The (Virtual?) Future of Medicine

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BRIGID SCHULTE, HOST: Welcome, everyone to another edition of *Crisis Conversations* live from the Better Life Lab. Here, we gather to share stories and try to understand as the pandemic and now the widespread racial justice protests are unfolding across the country to try to understand what's happening, but also try to learn what's being exposed that isn't working, that we can learn from and emerge from this better, more equitable and stronger. Today, we're going to be talking about the future of medicine and really looking at telemedicine.

I'm so excited that we have this amazing panel today. We've got Amanda Williams, who's an OB-GYN and the physician maternity director for Kaiser Permanente in Oakland. We've got Lucy McBride. She's a primary care physician who writes a daily newsletter on COVID and physical and mental health, which is excellent, and I read it every day. We've also got Mina Raj, she's an incoming assistant professor at the University of Illinois, Urbana-Champaign, who researches family caregiving and health and information technology.

I'd like to start with you, Amanda, and I have to be perfectly honest. When I was first talking with Lucy, and she said, "We really should do something on telemedicine and the future of work or the future of medicine," I just thought, "We look at work and care issues. We look at family issues, gender equality, equity across race and class as well. What does telemedicine have to do with any of this?" Let me turn it over to you, Amanda, and make the case. Why is this so critical for equity and work in care systems?

AMANDA WILLIAMS, PANELIST: Thanks so much for having me. This is a subject that is very near and dear to my heart, both as someone who's committed to racial justice and, in particular, within the area of medicine and shrinking health disparities, and it's my body of work. What I'm doing is, trying to redesign prenatal care for Kaiser Permanente in Northern California, where we deliver 45,000 babies a year. It's exciting.

We try to have what are the "cup half-full moments" in COVID. I'd like to think of this as one of them because we have to do more virtual care.

Prenatal care, in particular, in women's health in general, is a time when people come into the office a lot. We have to ask ourselves, "What can be done remotely? What can't be done remotely? What are the factors that are impacting women's ability to have those appointments? Do they have broadband high-speed internet at their house? Do they have smartphones? Do they have any place private to talk about their issues?" We know that we're very concerned about family violence and child abuse, in this era, also.

There could be some risk associated with telemedicine. On the flip side, there can be huge benefit. People don't have to take time off of work, they don't have to come in and commute and park. They don't have to find childcare for their children, even though trying to work, take care of your children, see your doctor at the same time is tough, but we don't know which way this is going to go. We have to be really conscious every step of the way as we're designing our care delivery in the telehealth space, what is the impact going to be on marginalized patients and across the race and ethnic divide.

BRIGID: Staying with you, Amanda, what do we know? It's still a fairly new kind of a thing. What do we know about how it impacts equity, or patient care, or work and family systems? Do we know much about it or is it still so new, we don't know a whole lot yet?

AMANDA: We don't know a whole lot yet, and in particular we don't know much about the race and ethnicity side. Inside of Kaiser Permanente, because we're a closed system, we will know a lot because we do have that demographic data about our patients, but we're still in the very early stage of interviewing patients and docs. Then in the maternal health space, we have no babies being born yet because this is all very new. We don't know about our longer-term outcomes, but the key is, as we're doing this design, because COVID is not going away tomorrow, we're going to really have to think about these systems. We have to keep that consciousness around what is this going to do in terms of disparities.

BRIGID: Thanks so much for that, Amanda, and let me turn to you, Lucy. This is something that we've had really some very interesting discussions about, and you've also had some incredibly intense experiences around telehealth and telemedicine during the pandemic, and not just around physical health, but also mental health. Can you talk a little bit more about that?

LUCY MCBRIDE, PANELIST: Sure, Brigid, and thanks again for having me. It's really a delight to be here with all of you. Yes, as you know, and I think many of your listeners know, this is a mental health crisis as much as it is a physical health crisis. Americans are suffering collectively with grief and loss and trauma to varying degrees. Because our mental health affects not only how we feel day-to-day, but it directly affects medical outcomes, there's no shortage of data to show that our emotional health and our behavioral health and, of course, layered on top of that is our social determinants of health, affects our medical outcomes in very real ways.

It's essential that primary care doctors and doctors in general understand that intersection. For many people in the pandemic, for my patients, telehealth has been a lifeline. As Dr. Williams said, it's not a panacea, not everyone has access to a smartphone or internet access, but for people who need supports physically and mentally, it has offered a new avenue. I think it's going to be here to stay. I don't think it's ever going to replace individual one-on-one, face-to-face care and, actually, as Dr. Williams and I know, the foundation of my work with patients is the relationship.

The relationship between patient and doctor is crucial. That is not going to be replaced by virtual care. However, it's going to augment existing care. For example, I have a patient who lost her husband to COVID during the pandemic. I would not have been able to have the end of life conversation I did with that family from their home pre-pandemic, because now we have these virtual platforms and insurance companies are loosening regulations to allow these visits to be paid for similar to what they would be in person.

Then, this patient of mine, who is going through natural grief and trauma losing her husband on top of the pandemic, is able to, for the first time, access a grief counselor remotely, and that is something that is not only important for her day-to-day feeling, but it's going to directly affect her medical outcomes. That is what gives me hope for our future.

BRIGID: What was that conversation like? At pre-COVID, how would that have gone? How did that change, or how is that different having to have such an intimate conversation over a technology platform?

LUCY: It is interesting. First of all, the patient, who is at the end of his life, could not have made it physically into my office, but I was able to have an hour-long conversation with him on a virtual platform and his family surrounded by his bedside and talk about

very important decision-making that pre-pandemic wouldn't have been covered by his insurance. Now, I probably would have had that conversation anyway, but doctors need to get paid for their services, and mental health providers need to get paid for their services.

Pre-coronavirus, the regulations were such that insurance wouldn't reimburse for care that wasn't face-to-face, and particularly for mental health issues you had to have a comorbidity. In other words, if you had an addiction like an alcohol addiction, your therapist would only get paid if you also had diabetes. Those things need to change and need this change here on out.

BRIGID: Mina, I want to get to you in a minute, but Amanda, if I can go back to you, let's stay with that stick reserves, systems question. That's interesting, that we've had this technology, we've all Zoom and Microsoft Teams, and we've had the ability to connect virtually for some time. Has it really been an insurance issue that this hasn't really taken off before now? What is changing as a result of the pandemic?

AMANDA: I will take a step back and say that I do work inside of Kaiser Permanente. Our reimbursement models are different than in most of the fee-for-service world, but yes, part of the story is reimbursement. Then it's also familiarity and comfort, both on the physician side and also on the patient side. As Dr. McBride and I have talked about, it's with existing patients, people who you know, people you have a relationship, the transition to virtual visits, has been very smooth, but for new patients, it's a little harder to make that connection. I think that's why video is critically important, because you get to see people's faces, you get to see their eyes, their expressions. I actually highly suspected preeclampsia, a severe complication of the end of pregnancy on a video visit, because I saw that the patient's face was very swollen-

BRIGID: Oh, wow.

AMANDA: -and it made me wonder, "What is your blood pressure? What is going on about this fluid retention?" I brought her into the hospital for assessment when I was just doing a video visit at home.

BRIGID: Wow.

AMANDA: I think the video component really makes a difference, and Medicare has recently just said that they will start now reimbursing for video visits. That's a big payer for us and for much of the country. I think that will help shift the perspective, and then

people are using it for their work. As folks are more comfortable using distance work in general, they can then apply that with their health as well.

BRIGID: Great. Let me turn over to you now, Minakshi Raj. You've been doing some really interesting research at looking at this intersection of telemedicine, virtual care and family caregivers and aging populations. Can you tell us a little bit about your research and what you're finding, particularly now in the pandemic?

MINAKSHI RAJ, PANELIST: Sure. My research is really driven by the fact that family caregivers are becoming more involved in a wider scope of activities and intensity of those responsibilities for caring, especially for older adults. They're increasingly involved in medication management, health care visits, making decisions with or on behalf of their older relatives. My questions that I ask in my research are related to how do we better involve family caregivers and integrate them into the healthcare setting so that we can alleviate what we've been calling a "caregiver burden."

I think we call it a "burden," and it's really something negative, but I find in some of my other research asking caregivers, "What does it mean to be a caregiver?" that they actually see it as an honor, they see it as love, they see it as the right thing to do. Health information technology like telemedicine, like the health record, is a great opportunity to involve family caregivers. In my research, I try to understand, how do we make that happen, what are some of the policies that we need to put in place, and what are some of the practices that physicians and other clinicians may need to adapt to in order to invite a caregiver to a health care visit? What does that look like? How would that work?

In the past few months, I have fielded a survey statewide in Michigan to family caregivers of adults 60 and over and just to learn more about some of their experiences as being a caregiver and then also their experiences with telemedicine. One story that stands out to me from a response and a message that I had back and forth with a caregiver was, she comes home from the grocery store, is a caregiver for her partner, and wipes down the floor of the garage once she enters, wipes on every item that she gets from the grocery store, brings it in, wipes down the entire house, all the floors, in order to keep her partner safe.

This is the experience of someone in the same household. I also hear experiences of caregivers from different households, that haven't been able to see their care recipient or their older relative for months, and they have no idea what's going on. For them being

able to participate in health care visits would be comforting, and it would also help them, help physicians and other practitioners to provide better care to their older relative.

BRIGID: I'm wondering, you're talking about the role of the family caregiver. We've also explored home health and how that so much of in recent decades, there's been a movement trying to move away from nursing home care to be able to have more home care, which then you do rely more on family caregivers or professional home caregivers. I'm wondering, you talk about that caregiver burden, once it moves into a virtual setting or a telemedicine setting, does that make things easier or better for both the care of someone who needs an elder person, aging person?

Does it make it easier to get that care? If you don't have to, as Amanda was saying, schlep into the office. I'm just thinking about my dad who was bedridden for so many years, he couldn't, and we'd have to transport him in an ambulance to get to the hospital? The mobility is so restricted. Can you talk a little bit about the opportunity then that being able to connect virtually, what are the benefits then for people who are trying to have care at home? How could family caregivers be involved in that?

MINAKSHI: Sure. One of the biggest barriers to telemedicine that I'm seeing among family caregiver respondents in the survey is that their older relatives in a different household don't necessarily know how to use the technology, or they're frustrated by the fact that they can't establish a relationship with their doctor in the same way that they would if they were able to go in person. I have a couple of caregivers in my survey who have driven 150 miles to get to their relative's house in order to set up the technology.

BRIGID: Wow.

MINAKSHI: It's unclear after that. They said, "I wasn't really sure if I was invited to be a part of this health care visit. I drove 150 miles and that's perfectly fine, but what next?" I think caregivers are likely to have an extended period of concern about transmitting the virus to their older relatives. I think they're likely to keep social or physical distancing from their older relatives in order to keep their relatives safe.

BRIGID: Yes.

MINAKSHI: For that reason, this period of what we call the "digital divide" might persist even longer, where older adults may not be able to access the technology, family

caregivers are trying to be involved, but aren't necessarily able to be in person to assist in that way.

BRIGID: Amanda, can you talk a little bit- I see you shaking your head, talk about this virtual experience in the prenatal space?

AMANDA: As you probably have heard in the news, there have been lots of restrictions around hospital visitor policies, and birth tends to be a time that's community, family engagement, and we've had to severely limit. In New York actually, for a while, there were no visitors at all, not even partners. That quickly went away. What we do now, even on my own hospital system, only have one person allowed to be there. People have to make that hard choice. Who do I want, my partner or my mother, my partner or my doula?

I'm not going to comment on right and wrong choices and who might actually be helpful, but that's tough, and that's not what we want. That is not ideal for birth, but being able to engage people through using different technologies, especially grandparents, oh, my gosh, grandparents want to be there and they are the most at risk. Trying to have Zoom set up in a prenatal appointment or doing FaceTime at the time of birth so that the grandparents can get there, I think it definitely helps, but it's not ideal. For in the future, though, for long-distance relatives, I think it's fantastic.

We have the ability, with our video visits, to get a third person in. We use it for interpreters, but you can also use it for my mother who lives in New Jersey and be on at the same time as the pregnant patient and partner. It is a really nice opportunity for the future in terms of engagement far-away family members, but it will be nice to be able to have folks back in the room.

BRIGID: Absolutely. I can't imagine how lonely that's got to be for so many patients who've had to go through such incredible life transitions, like you say, birth, it's so joyful, or in Lucy's case, death, which is, again, an important time for families to come together. We get in a very painful way, but it's so important to have that community. Lucy, you were talking about the importance of having some kind of medical home. Can you talk about what you mean by that?

LUCY: Sure. As you know, and it's nice to hear my fellow panelists agreeing that health care reform, which, held center stage before the pandemic, is even more of an urgent issue. Now, we're seeing that the problems, the fragility, and the fragmented nature of

our healthcare system has been laid bare. Of course, the wreckage on people's health and emotional health and the economy is huge, but we can also use this moment to re-envision what health care should look like. Telemedicine offers a wonderful, potentially, it's, again, not a panacea, but it offers this opportunity to meet people where they are. Part of the problem with primary care and OB-GYN is primary care pediatrics, primary care which I am, and pediatrics or primary care, they are the first line of defense for outpatients, or people who are not hospitalized.

People come to me first for their- everything from their heart disease, their diabetes, and their depression. We need primary care to work for patients. Patients need a medical home and a hub for problem solving, and not just gate keeping. If the home, the medical home, and there's no shortage of research on-- Numerous studies have shown that states with a higher ratio of primary care doctors tend to do better. Other countries that prioritize the integration of behavioralists, social workers, and patients working together, do better and save money.

What I hope is that primary care, in various areas of people's lives, whether it's gynecologic, pediatric, or internal medicine, will be a place where families can be a part of the decision-making, where social workers can be a part of the decision-making, where geriatric care managers could be a part of the decision-making. Then, the telemedicine offers a way to integrate all those voices to best care for the patient. This is our moment. This is the moment to think about change and to think about all the flaws and all the barriers for people who need care, from access to payment, but also just treating their whole person.

So many of my patients, by the time they're 80, have a doctor for every body part, and no one's talking. My job is really to integrate-- Right, it's like you have a foot doctor, an arm doctor, a toe fungus doctor, a cardiologist. My job is to integrate those people, communicate with the patient, communicate with the family, communicate with all of the relevant stakeholders. That's what care is. I think, before we think of anything else with the healthcare reform, we got to think about, what is care? What does it mean? It's really treating the whole person.

Again, you can never replace face-to-face interaction with a human being. That is the foundation of our work, but if you can augment care by looping in other people in that person's life, we all have families and homes and lives and social determinants that very, very importantly inform our health and our health outcomes that need to be brought in.

BRIGID: Amanda, you're saying that teams are essential. Yes, I love that idea that we've got a specialist for every body part. When we talk about the future of medicine, what do teams-- What kind of role does that play?

AMANDA: That's really the direction, I think, we need to go, and Lucy's certainly alluding to it, that we aren't islands. We need to have not just the physician, but the physician then needs the associated health educator, or social worker, or behavioral medicine specialist. It's not just a gatekeeping to referrals, it's actually the ability to work as a collaborative team to see more of the whole patient so that you don't end up, as she was saying, a doctor for every body part. I think reimagining, not just keeping our existing care and putting it into a virtual format, but actually rethinking how the care is delivered and what people need to be healthy, as opposed to what we need to fix their ailments.

Some really big mental framework shift, but this might be a moment to take advantage of where people are and shift our perspective.

BRIGID: I love that idea. Let me ask a question. Mina, we've got a question from Heather, one of the participants. She asked, "Can you address how working family caregivers need different types of support from their own employers now, and as we move through COVID? What would you ask of employers to support their employees who are caregivers?"

MINAKSHI: Sure. That's a great question. I think, in terms of caregivers were employees, I think an important thing for employers to recognize is that we rely on a lot of data that assumes that caregivers identify as being caregivers. I think Rosalyn Carter said, "We're all some sort of a caregiver." At some point, we receive care, and at some point, we care for someone else. Employers, I think, can begin to recognize that caregiving looks different, depending on who you are or where you are.

You might be advocating for your relative, or you might be helping with language, if your older relative or any adult relative receives a recommendation that they don't really understand because of a language barrier. You might be the person that's helping them follow that recommendation.

I think, first, we need a wider recognition of what caregivers are doing and that many more people may be caregivers than what we realize. The other thing is, to recognize that caregiver health is intertwined with care recipient health. Many of these family

caregivers are stressed physically, mentally, emotionally. We need to realize that their responsibilities as a caregiver ultimately have implications for their own health. In order to support employee wellness, we need to also make sure we have policies in place that help caregivers support their relatives or care recipients.

BRIGID: Absolutely. We're coming down on time, so I want to go to some closing thoughts. As I ask each of you for closing thoughts in the way forward, I want to keep a couple things in mind. Lucy, you had talked about- this is a real opportunity, and, Amanda, you as well, but this is an opportunity to really redesign, rethink not only how we think about care, but medicine and medical systems. I think we can't possibly talk about the future of work without talking about the fact that tens of millions of Americans have now lost their jobs, are furloughed, they're unemployed, they're out of work.

As such, because of our system tying health care to jobs now are out of health insurance and do not have the access to get care, to get this wonderful holistic team care, rather than a doctor for every body part. They don't even have access to something like that. How can we move forward in really redesigning health and medicine top to bottom? The other question we've got from Jahdziah St. Julien, who is our wonderful program assistant. It's like, "What role can telemedicine play in addressing racial health disparities and how can address some of the structural and social determinants and barriers that affect racial disparities in health outcomes?"

I know that's a lot for closing thought, but we try to cram a lot into these half-hour conversations. Amanda, I see you laughing, you've got all the answers, so tell us where we go from here. [laughs]

AMANDA: I could talk about that for about half a day.

[laughter]

BRIGID: I know.

AMANDA: That's little troubling, but I would say this. One, when designing any kind of program, or policy, or even a healthcare delivery vehicle, every single time ask yourself, and that's a collective you, "Am I going to worsen health disparities across racial and ethnic divide?" We know that they exist, so everything you do, keep that in mind. Next, to think about how telemedicine might be helpful, to help patients get set up. If they don't have broadband internet, let them know where there is free Wi-Fi. You

want to lend somebody an iPad for their pregnancy to get through their appointments, if they don't have it.

You want to provide blood pressure cuffs, as opposed to hoping that they'll go by the pharmacy. To think about what do we need to help facilitate. Then, lastly, I hope that we all keep working on these racial justice issues, even when they stop trending on Twitter.

We work terribly hard in this country to control diabetes, to control high blood pressure, to get early prenatal care because we know that it's associated with real health outcome. This injustice is not just a political issue or a social issue, this is a public health crisis that kills people. If our job, as caretakers and as physicians, is to save lives, we must address this and keep using that public health lens as we advocate that this is not talking politics at work, this is helping people live their best lives, which is what we're supposed to be doing.

BRIGID: Mina, what are your thoughts, and how do we move forward?

MINAKSHI: I actually had exactly the same thoughts, as Dr. Williams, not so eloquently said, but, I think, first definitely healthcare and public health will need to do a lot more outreach to figure out where patients are and how we can meet them there. I think the other side of it is also, we really need to understand what these inequities look like and where they're coming from and the upstream solutions to them. We need to think of public health and healthcare as being hand in hand and complimentary. I think that'll be helpful going forward.

BRIGID: Awesome. Lucy, since this episode was brought on by our conversation initially, I'm going to give you the last word.

LUCY: Oh, wow. That's so nice. My husband would love to hear someone else say that.

[laughter]

I agree with what my other two panelists have said. I think that, as Amanda said, this disparities along racial lines and along gender lines in the pandemic are atrocious, and this is not a new issue. I'm talking to my Black patients, and hearing about their distress over the statistics and the fact that they have a higher tendency to have the diabetes, high blood pressure and heart disease that make them even at higher risk for negative outcomes from COVID, then you add on the trauma they're experiencing, have

experienced, again, not just since this was trending on Twitter, but since the beginning of time, unfortunately.

My message is, really, and my hope for the future of medicine, is that mental health is treated co-equal with physical health that we address the very real trauma that the Black community is feeling right now, that people are feeling in general, the particularly the Black community, of course, right now. We leave that conversation about trauma acute and chronic, because it affects the very underlying conditions that put people at higher risk for COVID. We have a lot of work to do. We have a lot of peeling away the layers of the onion to get at root causes and we need to address people in a holistic way. That's my hope for the future of primary care and medicine in general. We'll see how it goes.

BRIGID: All right, we'll leave it there. There are lots more to talk about, lots more to fix, but thank you so much to Lucy McBride, Amanda Williams, Mina Raj. Thank you so much for coming and being part of this discussion today. I want to thank all of the participants. Thank you for sharing your stories and asking questions. Also want to thank the new America events team, the Better Life Lab team, David Schulman, our producer.

We're going to take a break next week, and then we'll be back with more episodes of *Crisis Conversations* where we're going to be exploring pregnancy discrimination. Much more about childcare, much more about how the next bailout should focus on women in communities of color. Thank you so much for tuning in, for being part of this conversation. Wash your hands, stay safe, and we'll see you in two weeks.