Reshaping the Health Care System in a Post-Pandemic Era

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Table of Contents

Introduction

Stuart Altman opened the 30th Princeton conference, Reshaping the Health Care System in a Post-Pandemic Era, thanking the sponsors, organizers and speakers. The conference provided insight into the range of contemporary health care innovation challenges and opportunities. A Washington update demonstrated considerable success of the Biden administration particularly in putting the Affordable Care Act on solid footing. A keynote address by Dr. Atul Gawande described how a transformational reconceptualization of primary care could lead to better health at lower cost. The first day panels addressed issues of affordability, workforce shortage solutions, Medicare innovation, health care delivery system models for change and how system transformation could help create a sustainable high value system.

Dinner at Brandeis University continued the discussion of system transformation through an interactive discussion with Professor Steve Shortell on a Blueprint for Improving America's Health Care System. The second day's examination of Medicaid post pandemic transition was followed by panels on innovations in health equity essential to achieve health and wellness, and an exploration of mega trends include artificial intelligence.

Both policymakers and researchers in attendance were offered a wide selection of critical and pressing issues in today's health care system by leading experts in the field. Attendees benefited from both an acknowledgement of the barriers to progress and guidance on strategies to eliminate inefficiencies and to increase equity along the care continuum.

Opening Night: Washington Update

The opening night provided an update from Washington on the accomplishments of the Biden administration and a potential agenda for the remainder of this term. Chris Jennings, President of Jennings Policy Strategies (JPS), introduced the keynote speaker Christen Linke Young, JD, Deputy Assistant to the President for Health and Veterans on the Domestic Policy Council. Linke Young assisted the President in developing and implementing his health and Veteran policy.

Young highlighted four major accomplishments. First was the implementation of the drug price negotiations in the Medicare program. The Administration is starting with 10 drugs which were eligible only after they should have gone to generics. Young noted that strong public support (80 percent) for this provision. She also cited the CBO estimate that the prescription drug provision would save Medicare $100 billion over the next decade.

Second, she discussed a series of legislative and executive efforts to bolster the Affordable Care Act and make coverage more available and affordable. Young said that progress was made in reducing the number of states that did not expand Medicaid down to 10. She suggested that those states that have not expanded were foregoing "gobs of money" by not providing coverage to the most vulnerable in their state. Young then turned to the increased subsidies made available in the American Rescue Plan to those low-income individuals that purchase health insurance thru the "market place." These additional subsidies have made coverage more affordable for most low-income individuals and help generate a significant increase in market place enrollment. The administration also reversed actions of the Trump administration and reinstated marketing, outreach and enrollment efforts. Finally, the administration is

working with states to improve the Medicaid and ACA enrollment process to catch people losing coverage because of the end of pandemic related safeguards.

Third, progress was made on a range of public health issues such as the ban on menthol in cigarettes and cigars. One third of cancer deaths are link to smoking and this ban is estimated to save over 600,000 lives. A number of additional measures were enacted to reduce hunger and to improve nutrition and improve physical activity. Fourth was a discussion of the wide range of initiatives to address the mental health crisis. This includes coverage and payment reform as well as the institution of the 988 hotline, which has already saved lives.

In her conclusion, Young indicated that while no major reforms are likely during an election year, bipartisan work continues, increasing transparency of how pharmacy benefit managers operate, addressing shortages in generic and other drugs, drug supply pricing reform and more comprehensive health insurance coverage for foster youth. These may be incremental but important changes.

Conference Keynote: Reducing Inequities in Lifespan: Global Lessons

The morning session began with a Keynote address by Atul Gawande, MD, Assistant Administrator for Global Health, United States Agency for International Development (USAID).

Dr. Gawande presented both anecdotal and peer-reviewed data to urge a shift towards primary health care as the catalyst to improving healthcare quality and reducing spending. Throughout his ongoing work at USAID, overseeing 2,500 workers and an aid budget of about $10 billion, he has found that despite massive efforts throughout the Covid-19 pandemic, and some notable areas of improvement in global life expectancy, inefficiencies and inequities in the U.S. and global healthcare systems have become starkly apparent. For example, lower vaccination rates, setbacks in efforts to decrease the prevalence of tuberculosis, malaria, and HIV, and persistence of preventable deaths, particularly among those between the ages of 5 and 50 in low- and middle-income countries, imply that there are shortcomings specifically in primary health care through both funding and availability.

Despite this, the scaffolding for robust primary care enhancements exists. A randomized control trial implemented in Ghana demonstrated that improved primary care access can have a transformative impact on improved health and health care system efficiency[1]. Primary care nurses were uptrained and community health workers were deployed to deliver education and needs assessments among communities, prioritizing an increase in service access and other preventative care (e.g., contraceptive use). Within 3 years there was a 50% reduction in child mortality, and by 7 years the reduction rose to 70%. This model has successfully been applied in other countries indicating scalability and that investment in primary care brings results. Dr. Gawande argued for a shift from vertically facing interventions focused on specific diseases or conditions to primary health care as a basis for

[1] Alhassan, R. K., Nketiah-Amponsah, E., Spieker, N., Arhinful, D. K., Ogink, A., van Ostenberg, P., & Rinke de Wit, T. F. (2015). Effect of community engagement interventions on patient safety and risk reduction efforts in primary health facilities: evidence from Ghana. *PLoS One*, *10*(11), e0142389.

comprehensive care, both preventative and curative. He outlined key strategies for garnering support in these efforts.

For policymakers, successful engagement and implementation strategies can be aided by:

- Establishing clear and measurable targets
- Moving away from abstract language (e.g., "we need to invest in primary health care")
- Determine specific targets for investments like the primary health workforce
- Highlight the essential nature and push for integration of community health workers as a critical component to primary care's success
- Assess current health care scaffolding for strengths and weaknesses, addressing concerns that arise (i.e., successful cross-integration of electronic health record systems to streamline continuity of care)

Acknowledging the scale of this paradigmatic shift in health care strategy, Dr. Gawande sees a mix of private and public systems as a key mechanism to innovation. Local, state- and city-level examples of primary health initiatives that are successful provide real-world evidence of preventative care outcomes. A balance of impact and feasibility and aligning goals and values at all levels—health systems, federal, state, and local—are critical to the success of primary health care becoming a desirable option for both policymaker efforts and patients' needs.

Session 1: Affordability of Healthcare Services

Mark E. Miller, PhD, Executive Vice President of Health Care, Arnold Ventures
Ben Ippolito, PhD, Senior Fellow, American Enterprise Institute

The first panel of the Conference addressed issues of health care affordability as a major barrier to both access and equity. Current pricing models are the key drivers to increased costs and inefficiencies in the system. Rising costs specifically in the private sector result from administrative cost growth, increases in mergers and acquisitions, surprise billing, and varying increased utilization of several expensive services. Medicare and Medicaid costs are impacted similarly, in addition to provider payment schedules, high prevalence of low- to no-value care, and managed care upcoding. The increasingly ubiquity of hospital consolidation, vertical integration between physicians and hospitals, and growth of private equity's presence in healthcare all drive cost without improving care.

This and greater patient out-of-pocket costs, leads to higher levels of medical debt, risk-adverse behaviors (e.g., avoiding prescription refills due to cost), and general care avoidance due to an inability to pay. Those mechanisms designed to alleviate some of this burden, like Medicare Advantage and Medicare Shared Savings Programs, often fail to decrease costs and improve affordability in the long-term. For example, although Medicare Advantage plans have reduced utilization in some cases, they have generated significant overpayments leading to higher government costs. Despite these barriers, there is strong interest among those in the healthcare sector and among policymakers to alleviate consumer burden. While Bipartisan support remains rare at the federal level there are example legislation of positive activity like the No Surprises Act which has helped many consumers. Reiterating Dr. Gawande's strategy to provide concrete policies and solutions, it is critical to build into the legislative process an implementation strategy that helps ensure that good policy leads to real action.

Session 2: Workforce Innovation

Karen Donelan, ScD, Stuart H. Altman Professor and Chair of US Health Policy, Schneider Institutes for Health Policy, The Heller School for Social Policy and Management, Brandeis University
Tom Cornwell, MD, National Medical Director, Village MD
David Auerbach, PhD, Director of Research: Massachusetts Health Policy Commission and Visiting Scholar, Brandeis University
Bihu Sandhir, MD, Chief Quality Officer, AltaMed

The Workforce Innovation panel introduced new data indicating a positive change in recent workforce supply. This followed significant shortages during the Covid-19 pandemic. New data from the Massachusetts Health Policy Commission showed a medical workforce that returned to pre-pandemic levels. Workers in Nursing Homes were the exception, still suffering from a 10% decrease compared to prior years. Shortages also remain serious for most types of mental health occupations. Additionally, data trends show a younger workforce, a general shift among physicians towards hospital-based care, and among registered nurses, a shift away from hospital employment.

The panel also discussed some new pathways to enhance the workforce for primary care services. Altamed, for example, has 25 primary care sites that focus on care from conception to end of life and equity for all patients. Altamed's growing success is in part due to the move towards full risk-based Medicaid and Medicare models and their steady shift away from fee for service towards capitation. The successes were driven by a team-based care model, strong preventative medicine orientation, and investments in workforce initiatives. For example, the company offers a professional development program for nurse practitioners beginning in high school. Policy shifts at the health systems-level can benefit from engaging residents to train in primary care and exposure to clinical settings that reinforce this training.

Outside the clinical setting, the home-based care workforce has increased as more patients prefer to receive care and age at home or in the community. The pandemic increased demand for this type of care but requires a workforce that is paid well and trained to deliver care at home. Specifically, nurse practitioners in home-based care play a vital role in ensuring high-value and high-quality care. The drive to shift away from hospital- and institutional-based care is underpinned by data that show significant savings and high-quality care under the right conditions. The increased prevalence of beneficiaries on Medicare Advantage, for instance, and the concurrent benefits afforded that reimburse home care will necessitate a workforce prepared to deliver care outside of clinical settings.

Among those solutions offered were a strong investment in primary care, a shift towards team-based care, engagement in curriculums that reinforce the primary care basics, and a general shift towards caring for those with co-morbidities. Moreover, it is critical to invest in and strengthen the development of the ancillary workforce (e.g., community health workers, clinical pharmacists) as part of the clinical team. This should be expanded to incorporate those needs outside of the providers office, such as social barriers that impact access to quality care.

Session 3: Medicare Updates

Michael Chernew, PhD, Leonard D. Schaeffer Professor of Health Care Policy, Department of Health Care Policy, Harvard Medical School
Stacie Dusetzina, PhD, Professor, Health Policy and Ingram Professor of Cancer Research, Vanderbilt University Medical Center
Ateev Mehrotra, MD, MPH, Professor of Health Care Policy, Harvard Medical School; Professor of Medicine and Hospitalist, Beth Israel Deaconess Medical Center
Erica Socker, PhD, Vice President, Health Care Payor Reform, Arnold Ventures

Medicare faces significant cost problems in the coming decade, as its financing system that pays for hospital care as well as rehabilitative services faces insolvency in the coming years. Also, excess payments to Medicare Advantage Plans combined with their increased popularity are driving up Medicare expenses. The speakers thus recommended that Medicare focus on providing high-quality care more efficiently and developing new types of more efficient delivery systems. A good start would be to change incentives, scrutinize administrative costs in the health care system, and reduce inefficiencies in general care areas. Recent legislation via the Inflation Reduction Act is a significant step forward through negotiated drug prices and caps on out-of-pocket maximums.

With the expansion of medical technologies, AI, and other efficiencies (e.g., surgical procedures) both the physician fee schedules and general Medicare payments need to be changed to reflect these advances. For instance, the recent uptick in patient portal messages has become a significant demand on clinicians' time but this is not built into the fee schedule. To better support these changes, research and data must be grounded and evidence based. It was also suggested that an independent entity to integrate these data to inform and set payment rates may be beneficial.

A further and more pressing example is Medicare Advantage which is on track to cover over 60% of beneficiaries in the coming decade. As growth continues in the Medicare Advantage space so do costs which are subsidized more than in the fee for service system. Medicare Advantage, while billed as an avenue for significant savings, has failed to deliver on cost decreases. It is true that beneficiaries are offered more encompassing benefits, experience fewer hospital readmissions, and have more flexibility in ancillary coverage (i.e., transportation, dental) in these plans. However, these advantages are paid for by significant upcoding in patient acuity and higher than appropriate payments due to favorable selection of members in these MA plans.

Policymakers face an opportunity in Medicare Advantage to restructure incentives to promote efficiency. They can do this by reducing overpayments, changing quality benchmarks, and reforming quality bonuses. There is also an opportunity to redesign the cost sharing models in traditional Medicare and add additional benefits for those beneficiaries that remain in traditional Medicare similar to the added benefits provided by MA plans.

Session 4: Innovations in Care Delivery Models

Rob Mechanic, MBA, Executive Director, Institute for Accountable Care
Rushika Fernandopulle, MD, Co-founder, Iora Health
Bob Rauner, MD, MPH, Chief Medical Officer, OneHealth Nebraska ACO
Emily DuHamel Brower, MBA, Senior Vice President of Clinical Integration and Physician Services, Trinity Health

Innovations in health care often suffer from a lack of scalability, proper infrastructure to build upon and sustain, and capital to ensure longevity. More needs to be done to leverage existing population-based health programs, valued-based care models, accountable care organization (ACO), and primary care-based systems to bolster efforts to make innovation long-lasting and patient-centered.

Iora Health serves is a prime example of a rapidly expanding organization that has successfully scaled team-based, patient-centered care delivery. Organizational cultural practices were reorganized to deliver whole-person care focusing on a holistic view of the patient and prioritizing the integration of social supports that engage community health workers. Iora Health has the benefit of significant capital to achieve these goals and serves as an example of a large-scale population-based primary care focused delivery model.

Smaller-scale ACOs, like OneHealth, provide evidence of a physician driven model making robust changes with fewer resources. Critical to OneHealth's success was the willingness to accept short-term losses for long-term gains while prioritizing a health clinical culture that empowers patients. Moreover, by focusing on the physician-patient dynamic they were able to provide a high touch continuity of care.

Primary care can act as a significant driver of cost reduction if properly aligned to community needs and population health. Trinity Health is working to manage costs and provide high quality care and views fee for service as merely transitional to this without readjustment. Health systems face significant pressure to remain financially viable in the short run. One persistent yet unrealized strategy is to realign this model to better serve population health by shifting more aggressively from a fee for service to an at-risk model which may increase care quality and reduce unnecessary spending.

Despite the general focus on primary care, hospital based ACOs and physician care within hospitals serve a critical role as innovation strategies. The problem of high cost remains, however. as hospital care, routine testing, and other functions are generally priced higher than in a physicians' office. The paradigm shift should be to rely on ambulatory settings as the main source of care to reduce the need for hospitalization long-term.

Session 5: System Transformation: Components of a Sustainable High-Value System

Kristine Martin Anderson, MBA, Executive Vice President and Chief Operating Officer, Booz Allen Hamilton
Jaewon Ryu, MD, JD, President and Chief Executive Officer, Geisinger
Shelly F. Greenfield, MD, MPH, CAO, McLean Hospital; Professor, Harvard Medical School
Margaret O'Kane, President, National Committee for Quality Assurance (NCQA)

System transformation requires a shift in resources upstream towards prevention and population health, the need to center primary care and measure its effectiveness, and for behavioral health to reduce stigma and integrate behavioral health into more holistic systems.

While health systems seem to focus on the highest risk and sickest patients, this, unfortunately, creates a funnel by which resources are drawn to support this population to the detriment of all covered lives. Geisinger, however, addresses acute patient needs, while also delivering care upstream. Investments in primary care via increases in community health workers, social workers, and home care services, as well as programs and services to address social determinants and other population health-oriented components, enable high-value care.

The National Committee for Quality Assurance continues to support the drive for primary care and the growing need for quality metrics to ensure not only growth but sustainability. Additionally, quality and performance can be leveraged to bolster funding and visibility, akin to the Medicare Advantage star system. There is opportunity to harness the increase in digital technology and machine learning to streamline care, care coordination, quality improvements, and to provide a means to support de-fragmentation of primary care.

Pivoting to behavioral health, both care coordination and stigma remain major barriers to integration of mental health into the "mainstream" of holistic care delivery. While some advances have been made, for example the 2008 parity law, stigma, a lack of political will, and inadequate payment systems hinder progress to advancing mental health care scalability.

Uwe Reinhardt Memorial Lecture: A Blueprint for Improving America's Healthcare System

Stephen Shortell, PhD, MPH, MBA, Professor Emeritus of Health Policy and Management and Dean Emeritus, University of California, Berkley School of Public Health
Robert A. Berenson, MD, Institute Fellow, Urban Institute

Discussion centered around the Better Care Plan, which is a comprehensive blueprint to address the persistent flaws in the American healthcare system. The presentation began with a history of access, quality and costs improvement plans and efforts, which have largely failed to rationalize the system. The U.S. healthcare system is the most expensive in the world. Payment incentives have led to a lack of transparency, poor care coordination, and inefficiency with safety and quality concerns. The Blueprint plan includes a commitment to continuously improving care, quality and outcomes while controlling costs. It would move all payers to risk-adjusted prospective payment and requires transparency across the system. National organizations would be created to collect, analyze, and report patient safety and quality-of-care outcomes data.

Design principles include technology enabled patient centered primary care, continuous quality improvement, a focus on equity, payment reform, value-based team care, transparency, and safety standards. At the heart of the system is competitive health plans and provider organizations with the right incentives to move towards a more coordinated efficient systems.

Discussions focused on political feasibility and broadening a coalition to push the plan forward. The Better Care Health Policy Group is a made up of a diverse group of stakeholders coordinating a range of outreach activities to forward this plan.

Session 6: Medicaid: Issues for the Future

Donna Frescatore, Senior Vice President of Strategic Initiatives, Maximus
Julian Polaris, JD, Partner, Manatt Health
Kate McEvoy, JD, Executive Director, National Association of Medicaid Directors (NAMD)
Hemi Tewarson, JD, MPH, Executive Director, National Academy for State Health Policy (NASHP)

With the end of temporary pandemic funding boosts, requirements, and flexibilities, Medicaid faces the immediate problem of significant disenrollment with the end of requirements for continuous enrollment. Many are being disenrolled due to administrative issues such as missing forms or documentation. There is a push for the more efficient use of digital technology and general standardizing methods and operations, however this creates burdens in states unable to adequately adapt. To address this issue in the longer term, CMS has proposed a rule to update eligibility and enrollment processes, including better leveraging existing data sources to minimize the burdens on applicants and enrollees. CMS has also proposed significant reforms for monitoring access to care, as well as more general oversight of managed care delivery systems.

Politically, the public view of Medicaid has changed over time. Initially viewed as a welfare program, Medicaid has grown to touch more American lives than in prior years. Aside from coverage of births, children, and low-income women, Medicaid serves as one of the largest funders of long-term supports and services for older and disabled Americans, and also covers a growing number of non-elderly, non-disabled adults. The Covid-19 pandemic showcased Medicaid's rapid adaptability and provided new health care touch points to many beneficiaries that have increased in popularity in a short period of time. Among the more popular new services are telehealth and to a lesser extent, services to address health-related social needs. There is a push for these components of Medicaid to be funded more robustly. The major mechanism of innovation in Medicaid, the waiver system, proves a significant barrier to this funding as applications continue to be bottlenecked. An additional and growing challenge is the adjudication of disputes between CMS and individual states on requirements and federal mandates. Aside from the existing state-by-state variability among Medicaid programs, adjudication issues prevent attempts at standardization across the country.

Medicaid is also an incubator for innovation and has historically partnered with other state and external agencies to align priorities between the program and population needs. Specifically, approaching health holistically and addressing social drivers of health equity. For example, harm reduction efforts for people with opioid use disorder are increasingly even in conservative states indicating a political will for further expansion. In doing so, however, policymakers should be careful to avoid medicalizing social issues writ large. Leveraging increasing external partnerships holds the possibility of avoiding this eventuality.

Session 7: Health Equity Innovations to Achieve Health and Wellness

Debbie Chang, MPH, President and Chief Executive Officer, Blue Shield of California Foundation
Purva Rawal, PhD, Chief Strategy Officer, Centers for Medicare and Medicaid Services (CMS)
Amanda Van Vleet, MPH, Associate Director of Innovation, North Carolina Medicaid, NC DHHS
Palav Babaria, MD, Chief Quality and Medical Officer, Deputy Director, Quality and Population Health Management; California Department of Health Care Services

The federal health financing programs support innovations that lead to improved health and wellness for millions of people and help achieve health equity. Medicare, for example, is requiring hospitals to screen patients for social drivers of health like food insecurity, housing instability, transportation problems, utility needs and interpersonal safety. Medicaid is no longer just providing medical care but is now helping connect people to the non-medical supports they need and two states, North Carolina and California, are on the forefront of innovation. Medicaid managed care organizations in these states are increasingly developing the systems and processes to contract with community-based organizations to offer an array of social supports for Medicaid members. The federal and state levers and environments are fostering innovations to address the root causes of health inequity.

At the Federal level, approaching health equity successfully requires a patient-centered approach with a focus on health system transformation. Specifically, a focus on equity-based care coordination. This includes building on pre-existing scaffolding and models which act as social safety nets, and developing new models, screenings, and improved data collection. The desire among patients is there; patients have been found to accept help navigating social system supports when offered. This often begins in primary care.

Among the primary drivers of change to support equity is the Medicaid 1115 waivers that have, across states such as California and North Carolina, provided evidence of success in providing new pairings of medical services with addressing health related social needs, such as housing, transportation and services to ensure interpersonal safety. Paired with a general shift towards managed care among the Medicaid population there is the opportunity to provide population-level care that encourages an ROI for services situated outside of the health system to achieve wellness and overall health. Progress must be measured long-term as the general shift towards preventative, comprehensive care takes time be fully implemented.

Efforts to ensure the scalability of existing infrastructure include investments in primary care and identification of high-risk patients, shifting care from the clinical setting to care in the community, working with community-based organizations to address health related social needs, and regulatory flexibility. Moreover, an increased and culturally diverse and competent workforce can support these efforts long-term. The inability to align public and private payors incentives also acts as a barrier to addressing social needs. More uniform policy to hold plans accountable to quality and equity thresholds is key. Because of this, effective implementation and sustained investments are essential to the success of a more equitable health system.

Session 8: Megatrends on the Horizon

Karen Wolk Feinstein, PhD, President and Chief Executive Officer, Jewish Healthcare Foundation (JHF)
Caroline Pearson, Executive Director, Peterson Center on Healthcare
Vivian S. Lee, MD, PhD, MBA, Executive Fellow, Harvard Business School

Panelists for the final session stressed that scaling technologies that have proven efficient outside of the health system that have the potential to increase productivity and quality of care within the health system. Among these are predictive machine learning algorithms that assess health data to identify high-risk populations. There is significant potential in these algorithms beyond risk capture. Electronic health record datasets and claims data can be used to improve actuarial models and project cost of care which can streamline capitated rates. Free-text algorithms have potential to generate notes between patient and provider, easing administrative burden. Lastly, AI technologies offer the possibility of personalization on a population level for covered lives.

Despite excitement about the rapid growth in technology throughout and after the pandemic, digital solutions have outpaced the system's ability to evaluated, assess, and engage efficiently with new innovations. This has created pressure among hospitals, for example, to adopt expensive technologies without proper vetting. The risk is that high cost technologies that are adopted too quickly can create long-term problems for health systems and negatively impact on the quality of care delivered. Evaluative efforts at the Peterson Center on Healthcare are attempting to assess the efficacy of new and expensive technologies and to provide recommendations on how and when to f adopt these technologies.

To bolster adoption of technologies that are generated from outside the health sector, specifically among patient safety efforts, innovation grants from the Jewish Healthcare Foundation are being made to provide financing for the adaption of digital technology for health care. One of the critical areas of concern is medical errors which continue to plague the health care system. Focus and technology holds the promise to address these issues, but what is often missing is the will.

Final Thoughts

The 2023 Conference represents the culmination of the on-going and critical work of the leading health policy and health researchers working today. Panelists covering a range of topics agreed that primary and preventative care are essential to progress in areas of health care efficiencies, quality improvement, and cost reduction. We have the opportunity to leverage the complexity and size of our health care system to build on pre-existing scaffolding to scale primary care and population health initiatives to improve access, equity, and affordability for even the most vulnerable populations. The vigor, excitement, and expertise brought to bear on the issues facing our health care system among this year's panelists promises change for the future. We are thankful to our speakers, funders, and audience for the engaged discussion and participation in community solution-making.

NOTE: All the speaker's comments and recommendations expressed in this material are theirs only and do not necessarily reflect the views of the organizations and institutions they work for.