How a Program at Pardee RAND Graduate School Is Shaping the Future of Public Policy

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NEW LEADERS

What telemedicine needs to succeed

How to strengthen the U.S. blood supply

The future of warfare: a strategic assessment
Civic Development in the Era of Truth Decay

Where are social studies teachers getting most of their instructional materials? How much time do those teachers spend searching for or developing their own materials to teach civics? What are their perceptions of social studies materials? RAND researchers unpack ways in which teachers across the U.S. reported using instructional materials in their classrooms to teach civics.

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Helping Students Understand Gun Policy Research

This tool is designed to help high school educators and students in grades 10 through 12—who are increasingly interested in joining the conversation about gun policy and mobilized to respond to gun violence—access the high-quality, evidence-based materials on RAND’s Gun Policy in America website. The researchers’ overarching goals are to help students understand existing research related to gun policy and consider the complexity of gun policy-related issues.

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Confederate Statues and Racism

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The Strategic National Stockpile and COVID-19

In June 2020, senior policy researcher Daniel M. Gerstein presented testimony before the Senate Committee on Homeland Security and Governmental Affairs.

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From a Distance
Telemedicine in the age of COVID-19
Health Care at the Beginning of Life and Child Survival

A RAND research project in Nigeria saved an estimated 260 young lives by giving pregnant women small incentives—around $14 each—to see a doctor before birth. If the program were expanded, it could prevent up to 85,000 stillbirths every year in Nigeria alone.

The country has some of the highest rates of newborn deaths in the world. Around a third of women receive no prenatal care. Working with a grant from the Eunice Kennedy Shriver National Institute of Child Health and Human Development, researchers looked at what it would take to get more women into formal health care, and what it would mean for their infants.

They recruited more than 10,000 pregnant women in five mostly rural Nigerian states for the study. They offered half of the women small cash payments to attend three prenatal checkups, deliver in a health facility, and attend one postnatal visit. The payments—5,000 Naira, or around $14—were about a third of what an average household spends on food every month.

Women who received the payments were twice as likely to use the full package of health services as those in the control group. Their children were 8 percent more likely to survive into their first few months—a number driven almost entirely by significant reductions in pre-birth mortality.

“The improvements we saw in child health occurred in the absence of any major investments or improvements in health care services,” said Edward Okeke, a senior policy researcher at RAND who led the study. “This suggests that there is value to policies that promote utilization, even under status-quo conditions.”

The study provides some of the first credible evidence that giving women small incentives to use formal health care during pregnancy can save lives. It also suggests the focus should be on providing institutional care not just at birth, but throughout pregnancy. If it were scaled up to include every pregnant woman in Nigeria, the researchers estimate it could reduce the global number of stillbirths by 3 percent.

MORE AT www.rand.org/t/EP68048
Using Air Travel Data to Track the Spread of COVID-19

As the coronavirus began its worldwide sprint to pandemic status, the numbers coming out of China seemed manageably low. On a single day in mid-January, for example, the Chinese government reported a total caseload of just over 500 infections.

Air travel data and some basic arithmetic suggest it was off by around 3,700 percent.

Researchers at RAND paired coronavirus case numbers with detailed travel information to track the spread of coronavirus infections around the world. Their model uses the rate of confirmed infections in a country to estimate how many international travelers from that country may have carried the coronavirus with them.

In the early days of the pandemic, for example, China’s official numbers suggested a daily average of around one active case for every 8.2 million residents. Far fewer than 8.2 million Chinese people flew to Japan, Thailand, South Korea, the United States, and Taiwan during that time period, so the number of cases exported from China should have been less than one. Yet every one of those countries traced new infections to Chinese travelers.

The odds of that happening if the infection rate in China were really so low is around one in 1.3 million. To even those odds, researchers calculated that China must have had around 18,700 infected people by January 22, some of them still flying. The total number it reported that day: 503.

RAND’s COVID-19 Air Traffic Visualization tool also showed that outbreaks in the Persian Gulf likely started with travelers from outside of the region—not with Iran, as had been thought. Separately, it showed that countries with low infection numbers, like South Korea, could still pose a significant risk if they had high numbers of international travelers.

As the United States and the world manage their reopenings, insights like that can help policymakers weigh the risks—and take steps to prevent another surge of infections from taking flight.

MORE AT
www.rand.org/airtraveldata

The U.S. Postal Service in the Age of COVID-19

If trust were money, the future of the U.S. Postal Service would not be in doubt. But with COVID-19 dragging down its business, and Congress reluctant to pass a bailout, the agency needs more than goodwill to get through 2020.

In a recent RAND survey, people placed the Postal Service just behind the Centers for Disease Control and Prevention when ranking American institutions by trustworthiness. The service outperformed national newspapers and television news, the Federal Emergency Management Agency, and the CIA. It also far outdid the U.S. Congress, which brought up the rear with nearly 15 percent of respondents expressing complete distrust in it.

The survey of more than 2,000 people found that trust in the Postal Service is especially high in rural areas. It echoes findings from a 2008 RAND study that found that 89 percent of people think the Postal Service is more reliable than private couriers. More than half the people in that study said they don’t want other carriers to have access to their mailbox.

But the Postal Service has been losing money and sliding deeper into debt for years. It receives no tax dollars for its operating expenses, instead relying on the sale of postage and mail services. The COVID-19 pandemic hit it hard, as businesses cut back on bulk mail and advertising.

Postal officials warned that the agency could run out of cash by the end of this year. The U.S. House of Representatives included emergency funding for the Postal Service in a relief bill, but President Trump made clear he would not sign it without rate increases and other concessions. Earlier this summer, the Treasury Department agreed to loan the Postal Service $10 billion in exchange for information about its biggest private-sector service contracts.

MORE AT
www.rand.org/t/RRA308-5

Funding for this research was provided by gifts from RAND supporters and income from operations.
What will the next decade of warfare look like for the United States? A team of RAND researchers sought to answer that question for the U.S. Air Force, examining trend lines and interviewing experts on four continents.

The United States has an uninterrupted record when it comes to making such predictions, former Secretary of Defense Robert Gates once quipped: Since Vietnam, “we have never once gotten it right.” To make their findings more reliable, the researchers took a much more holistic approach. They considered not just technological or force changes, but also how global politics, economics, and the environment will shift and evolve between now and 2030.

Raphael “Rafi” Cohen oversaw the project as the associate director of the Strategy and Doctrine Program in RAND Project AIR FORCE. He’s a specialist on defense strategy and force planning, the lead author of reports on topics ranging from Israel’s wars in Gaza to the citizen soldiers of the National Guard. He’s also a military intelligence branched lieutenant colonel in the U.S. Army Reserve who served two combat tours in Iraq.

There are a few directions this pushes us in terms of capability development. We probably need more longer-range platforms, for example, but there’s really no silver bullet.
Q  How did you start looking at the future of warfare?
A  The Air Force has a requirement to produce a new strategy every couple of years, and they do a strategic assessment as part of that. If you think about the time they need to build new forces or introduce new systems, they really need to look at least a decade out. That sort of long-term, visionary planning is really what RAND was created for, and so they gave that task to us.

Let’s start with the big picture. Who are the main U.S. adversaries in 2030?
None of our main competitors—Russia, China, North Korea, Iran, and terrorist groups—are going away, and some of them will probably strengthen. China will become a more formidable threat as its economic and military influence increases. We’re not going to have the same freedom of movement that we have with China now. By contrast, there are limits to how far Russia, Iran, and North Korea can go. They’ll be able to have significant sway within their own regions, but they’re not going to have the same global reach.

How do you see the global economic picture changing?
The United States and its allies are going to lose some of their share of global economic output. China is growing, and growing at the expense of our allies, particularly the Europeans. If you think about economics as the underlying bedrock that allows you to produce military capabilities, that trend is the opposite of what you want to see. At the same time, economic sanctions have been a really powerful tool for U.S. foreign policy, but you need to have a dominant share of the global economy to make them effective. The power of U.S. sanctions is going to decrease as the economy shifts.

How will environmental change play into this?
First, it will have an effect on where we can base. Some of our installations around the world are in places that will be threatened by climate change—they’re in low-lying areas or flood plains, for example. But second, it also will have a destabilizing effect. Some of the places that will be hardest hit by droughts or rising sea levels tend to have weaker governments. That could increase domestic instability, and more domestic instability can lead to terrorism and civil war, the kind of sub-state conflict that we’ve been dealing with for the last decade or so.

What role will domestic politics in the United States play?
We’ve seen a steady trend over the last several decades toward increasing polarization among the U.S. electorate. That creates some significant constraints. Just to get the defense bill passed requires a bipartisan consensus, and that will face increasing pressure in the years to come. We’re also seeing a second major trend, which is a growing push to retrench, to pull the U.S. back from a global posture. That will shape the United States’ proclivity to be involved in overseas conflicts, but it could give space for other, more likely nefarious, actors to fill the void.

What should the United States be doing to prepare for 2030?
There are a few directions this pushes us in terms of capability development. We probably need more longer-range platforms, for example, but there’s really no silver bullet. The bigger finding is that the United States is going to increasingly face a grand-strategic choice. It can double down on its role for the last three decades as the world’s leading superpower, in which case it needs to spend more on defense and defense capabilities than it has. It can try to retrench and go back to a somewhat less ambitious posture and accept the consequences, knowing that some of the people who fill that void are going to be hostile to American interests. Or it can continue to keep the public rhetoric and ambition but increasingly not have the capabilities to back it up. The conclusion of our study is really that you want to avoid that third option. Kicking the can down the road is not going to be prudent, and it increasingly is not going to be feasible.
The Racial Disparity in Unemployment Benefits

By Kathryn A. Edwards

Imagine that two individuals worked the same number of years and were paid the exact same salary—and yet in retirement one receives twice as much from Social Security than the other. Such a disparity would be shocking among retirees.

With unemployment benefits, that is precisely what happens.

Go a step further. Imagine two levels of benefits—one for white workers and one for Black workers. This would be even more shocking, but is, in effect, what happens.

Unemployment insurance—as 40 million Americans have started to discover during the pandemic shutdowns—is not a single public program, but a set of 53 distinct programs. Each state (plus the District of Columbia, Puerto Rico, and the Virgin Islands) has its own method for defining a worker’s past earnings, its own formula for determining how much of that income will be replaced by unemployment insurance, and its own cap on benefits.

It’s the federal government’s intention that at the end of all those calculations states replace about half of a worker’s lost wages. So a worker earning $50,000 a year, at 50 percent replacement, should get $481 per week. This is no problem in Massachusetts, the most generous state, where benefits are capped at $823. But in Mississippi, the least generous state, the cap is $235. Instead of getting 50 percent replacement, that worker would get 24 percent.

Kathryn Anne Edwards is an economist at the RAND Corporation and a professor at the Pardee RAND Graduate School.
This drastic state variation is where the difference between the Black and white benefit comes from. The Black population in the United States—and, by extension, the Black labor force—is not evenly distributed across the country. Six states have a near-zero percentage of the country’s Black workforce: Maine, South Dakota, Idaho, Vermont, Wyoming, and Montana. Another dozen states have fewer than 0.5 percent each. On the other hand, one in four Black workers lives in just three states: Texas (8.5 percent), Florida (8.1 percent), and Georgia (8.0 percent).

The problem is that, overall, the states with more Black workers have less generous unemployment benefits. So when we look at this picture on a national level, Black workers are less financially supported in unemployment than white workers simply by virtue of where they live. To be clear, all workers in these low-generosity states are ill-served, whether they are Black or white, but these states are home to a high share of Black workers.

To demonstrate this, I calculated the average maximum unemployment benefits separately for all white and Black workers in the United States weighted by where they live. (I based state weights on five-year labor force estimates from the American Community Survey, covering 2013–2018.) So in determining the Black worker average, states like Vermont got zero weight while states like Texas were more weighted.

Those calculations show that white workers have an average maximum unemployment benefit of $463 and Black workers $423, a difference of $40.

Maybe $40 does not sound like much, but over 26 weeks of benefits, it adds up to $1,040. That’s nearly the size of the stimulus checks ($1,200) sent out as part of the CARES Act. It’s also the size of about two car payments, a month’s median rent in 13 states, or annual household water bills.

It’s also important to note that these calculations represent the maximum potential benefit, not what workers actually receive. Previous research by the Urban Institute has shown that Black workers are less likely than white workers to receive unemployment at all, a difference that cannot be explained by education or prior job tenure.

That Black workers live in less generous states is not an accident of modern policymaking. The reason unemployment is administered by states at all—unlike Social Security, which is federally operated—dates back to the New Deal in the 1930s.

There were two things going on. A handful of states already had created unemployment programs and did not want a federal program. At the same time, passing the New Deal legislation required a bargain between Northern and Southern Democrats. The former wanted to expand worker support, and the latter wanted to make sure Black workers in the South did not benefit from that support. Keeping relief programs under state control helped both groups accomplish their aims.

Today’s unemployed inherited this system of state policies with racial implications that persist. Southern states today not only have the lowest benefits, they also have the lowest recipiency rates among Black workers. During this pandemic, the miserliness and racial disparity of benefits is only becoming more stark.

For decades there have been calls to reform unemployment insurance; this is one more reason. Economic racial inequality in America cannot be solved through unemployment insurance, but it certainly shouldn’t be exacerbated by it.

By Doug Irving, Staff Writer
In the early days of the COVID era, as schools closed and offices emptied, the American Red Cross warned that blood shortages would be severe. A few months later, with no relief in sight, officials there predicted a “staggering” drop in blood supplies. “We’re basically looking at a new world,” a blood center spokesperson in Texas said.

In normal times, the American blood system is a model of efficiency, shuttling millions of units of blood from donor arms to patient arms every year. Yet that very efficiency leaves it with slim margins when something goes wrong, RAND researchers found when they looked at the strength of the U.S. blood supply. One of the biggest risks they identified: a global pandemic.

“With an industry operating on razor-thin margins and complex logistics, you do run some risk of things breaking down when there are disruptions like a pandemic,” said Andrew Mulcahy, a senior policy researcher at RAND who led the study. “As a society, we need to decide whether we want a more robust blood supply than what the market would otherwise support. If we do, we need to start thinking about how we can more effectively get there.”
A system under stress

The first ripples of fear and uncertainty from the new coronavirus shut down blood drives around the country almost overnight. In one state, Washington, hit hard and hit early, officials warned of the risk for a systemwide collapse in the blood supply as hundreds of expected donors stayed home. By early this summer, as hospitals resumed elective surgeries and ramped up their need for blood, some providers reported a barely one-day supply of universal type O-negative blood.

“What we have seen since the emergence of the COVID crisis has been just extreme fluctuations in both supply and demand,” said David Green, the chief executive of Vitalant blood centers and president-elect of AABB, an industry group. “It’s been a scramble.”

A few years ago, fearing just such a scramble, the U.S. Department of Health and Human Services asked RAND to investigate the sustainability of the U.S. blood supply. The result was one of the most comprehensive reports to date on a slice of the health care system that gets little scrutiny but on which millions of lives depend.

U.S. hospitals and clinics use around 10 million units of red blood cells every year—to keep trauma victims alive, to help cancer patients get through chemo, to give people with blood disorders another day of wellness. Blood transfusions are among the most common hospital procedures performed. Every few seconds, someone in America gets a dose of someone else’s blood.

Behind the scenes, a multibillion-dollar industry makes it happen. One pint of blood collected at a high school blood drive might pass through a blood center, to a hospital storage rack, to an operating room, with suppliers, brokers, contractors, consultants, testers, and insurers involved along the way.

Their report, released in late 2016, predicted that donors would stay home, blood drives would close, and infections spreading through the ranks of essential personnel would hit blood workers as well.
Nobody has a full picture of how much blood is in the system at any given moment, or whether it’s enough to meet demand. The federal government has no way to collect that kind of data, and hospitals don’t share it with each other. Some blood centers still rely on daily phone calls with hospitals to track supply and demand.

But periodic surveys of blood centers and hospitals have made it clear that the market for blood was tightening even before COVID-19. Demand has fallen, year after year, for more than a decade as hospitals refine their surgical techniques and better manage the blood they have. Blood suppliers, competing with each other for hospital contracts, have had to lower their prices even as their collection and testing costs stay fixed, or go up. That has led to a wave of blood center closures and consolidations.

Building a better blood supply system

The system still works—and works well—most of the time. The best estimates suggest blood centers collected nearly a million more units of blood in 2017 than hospitals and health centers needed for transfusions. But there is risk, the researchers wrote, that fewer blood centers with fewer donors will be less able to handle the supply shock of a major disaster. As one trauma center representative told the researchers: the system works, “for the middle of the road.”

The researchers considered three catastrophic events that could test the limits of the blood supply. Two would have a regional impact, they concluded: a terrorist attack like 9/11, or a natural disaster like Hurricane Katrina. In both cases, donors in other parts of the country could be expected to roll up their sleeves, making up for any loss of supply in the affected area.

Just one scenario could “critically compromise” the blood supply, the researchers found, and that’s a pandemic. Their report, released in late 2016, predicted that donors would stay home, blood drives would close, and infections spreading through the ranks of essential personnel would hit blood workers as well. “Thankfully,” they wrote at the time, “there has not been recent historic evidence of large-scale, mass-casualty illnesses in the United States.”

Now that there has, their report provides some possible steps forward. The federal government should consider taking a more active role in monitoring and managing the blood supply, the researchers concluded. That could start with a nationwide database to track blood supplies in real time, and flag any possible shortages before they become urgent. The government also could establish how much blood hospitals need to keep on hand in case of emergency, and then help them cover the costs of stocking up.

There’s no evidence that COVID-19 can spread through blood. If it could, the entire health system would be in a much more dangerous place right now. But we might not be so lucky in future pandemics, and so the government should also consider investing in developing new and improved tests of donor blood.

Blood centers have pushed for changes in the labyrinthine way the U.S. health system pays for blood. Right now, insurers pay hospitals by procedure, with all costs, including blood, wrapped up in a single lump sum. That gives hospitals an incentive to cut costs—by finding ways to use less blood, for example. But there is a public interest in ensuring it doesn’t drive blood centers out of business, the researchers concluded. The government should consider targeted grants or other financial incentives—not wholesale changes to payment structures—to ensure a stable and sustainable blood supply.

“In some ways, blood is no different than a stent or a bandage,” Mulcahy said. ‘It’s something that hospitals need, and suppliers sell it to them. That’s just bread-and-butter health care economics. But then, in other ways, it’s this almost mythical, life-saving stuff. Without it, people die.”

He’s moved on from blood to look at other corners of the health care market that get little scrutiny until things go wrong. His latest research is on ambulance services, but the story is the same. Lives depend on getting it right.
From a Distance

How the COVID-19 Pandemic Is Changing the Practice of Medicine

By Doug Irving, Staff Writer
Peter Yellowlees was a young psychiatrist working in central Australia—“bang in the middle, about as isolated as you can get”—when he had his first experience with telemedicine. The equipment was balky, the video quality poor, but the woman he treated for depression from 300 miles away was so appreciative she said she wished he had taped it. He became a convert on the spot, and an evangelist for a mode of medicine that has never quite gone mainstream. For years now, RAND researchers have documented telemedicine’s potential to make health care more convenient, more accessible, and more efficient. They’ve also mapped out the significant barriers standing in the way.

Then the coronavirus hit, and some of those barriers came down. Virtual doctor visits—like virtual business meetings, birthday parties, and high school graduations—became an accepted part of the new normal. “People thought you had to see somebody in person to do a proper exam,” said Yellowlees, now the chief wellness officer at UC Davis Health in California. “Then COVID appeared, and their attitudes all changed. Suddenly, they couldn’t work any other way.”
Rising to the moment

Telemedicine today can describe a quick video chat with an urgent-care nurse, or an hourlong therapy session conducted entirely online. It can link a desert health clinic to a big-city hospital, or bring a medical specialist into a patient’s living room. The first known COVID-19 patient in America was initially treated by a doctor who conversed with him over a video monitor in his isolation room.

But to really see the role telemedicine can play, consider Houston, 2017. Hurricane Harvey had just thundered across South Texas, dumping so much rain that the National Weather Service had to update its rain maps with a new color, pale purple. Roads were flooded. Thousands were stuck in their homes. And, as RAND researchers found when they studied the aftermath, telemedicine became a valuable alternative to trying to drive to a doctor’s office.

Yet fewer than 10 percent of American adults had ever tried telemedicine before this year. In part, that was because of the tangle of red tape that providers often had to wade through to get reimbursed. Medicare and other payers would only cover telemedicine for rural patients, and not in their homes. They had to go to a clinic, where they would be connected to a doctor sitting in a distant office.

“I’ve been to a lot of research conferences, and every year, someone at the podium would say, ‘This is the year for telemedicine. It’s about to take off. We’re on the cusp of a big change,’” said Lori Uscher-Pines, a senior policy researcher and RAND’s leading expert on telemedicine. “We kept hearing that, year after year.”

“But this year,” she added, “COVID-19 has really put it on the map. Telemedicine has exploded.”

Almost from the first stay-at-home orders, Medicare and other big payers relaxed their rules to make it easier for patients to connect to care. They allowed more people—urban or rural—to consult with doctors, from home, using apps like FaceTime or Zoom. The results were apparent within weeks in health care claims data. The share of billed items related to telemedicine shot up more than 8,000 percent in April 2020 compared with April 2019.

At UC Davis Health, the psychiatrists working with Peter Yellowlees needed just three days to move all of their appointments to phone or video. Yellowlees told them to treat virtual visits like an old-fashioned house call, an opportunity to see their patients as they lived. He worked with one woman grieving the terminal illness of her beloved cat—with the cat right there on screen, on her lap.

“The patients were all very accepting; they were actually pleased that we were prepared to carry on seeing them,” he said. “It meant we could continue looking after our normal case load of patients at a difficult time.”

Uscher-Pines and other researchers heard a similar message when they interviewed nearly two dozen psychiatrists in the early days of the pandemic. More than half had never tried telemedicine before the coronavirus forced them to...
work from home. There were bumps along the way—off-screen distractions, privacy concerns, difficulties reading a patient’s nonverbal cues. But a majority said the transition went more smoothly than they expected.

That didn’t mean they wanted to work from home forever. Most expressed a strong preference to return to in-person care as soon as possible, with telemedicine a second option for patients who preferred it. Without permanent changes to the reimbursement rules, they weren’t sure they could make telemedicine a permanent part of their practice.

“We’re already seeing some evidence that providers are moving away from telemedicine now that things are opening up,” Uscher-Pines said. “A lot of them are waiting to see what happens with those temporary changes in policy. That will really drive utilization going forward.”

Those policy decisions could have an especially big impact in communities not well served by traditional health care.

**Hybrid care**

RAND researchers have been following the experience of California as a case study. Starting in 2017, the California Health Care Foundation invested hundreds of thousands of dollars in expanding telemedicine services at nine safety-net clinics around the state. The clinics serve mostly low-income, minority patients. Most of them had been losing money on telemedicine.

The funding allowed the clinics to hire full-time staff dedicated to overseeing their telemedicine programs, and to expand their remote offerings. Psychiatry was the big one, accounting for around half of all patient sessions. But the clinics also used telemedicine to connect patients to eye doctors, dentists, rheumatologists, neurologists, and transgender care specialists.

The California experience shows that telemedicine can help patients with few other options get the specialized care they need, researchers concluded. But it also underscores the need for new reimbursement policies, if the goal is to reach more people. Most of the clinics said their telemedicine programs were permanent—but the scope of the services they provide will depend on the finances. “There’s no going back,” one clinic coordinator said. “That train has left.”

Psychiatrists at UC Davis Health talk about a new standard of care—“hybrid care”—even after the pandemic is over. They anticipate spending a few days every week in the office, seeing patients face-to-face, and a few days working from home, screen to screen.

“A lot of patients just don’t really want to be going to a clinic and waiting 45 minutes,” said senior fellow Keisuke Nakagawa said. “That type of mentality used to work, but it’s going to have to change. Telemedicine allows us to meet the lifestyle demands of the incoming generation, patients and providers alike.”

But, like office workers everywhere, he had one concern: “All of a sudden, our whole day is on Zoom.”

### Telemedicine visits, by specialty

**OF 53,135 COMPLETED VISITS**

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<thead>
<tr>
<th>Specialty</th>
<th>Visits (%)</th>
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<tr>
<td>Psychiatrist or behavioral health specialist</td>
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<td>Ophthalmologist or optometrist</td>
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<td>Rheumatologist</td>
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<tr>
<td>Dermatologist, nutritionist, primary care physician, infectious disease specialist, nephrologist, gastroenterologist, pulmonologist, transgender care specialist, pain specialist, allergist or immunologist, urologist, other or unknown</td>
<td>Less than 2%</td>
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*NOTE: ALTHOUGH THIS EVALUATION OCCURRED BEFORE THE PANDEMIC DRAMATICALLY ALTERED THE REGULATION, REIMBURSEMENT, AND USE OF TELEMEDICINE SERVICES ACROSS THE HEALTH CARE SYSTEM IN SPRING 2020, THE RESULTS WILL BE INFORMATIVE FOR HEALTH CENTERS AND POLICYMAKERS Aiming TO INCREASE THE USE OF TELEMEDICINE TO IMPROVE ACCESS TO CARE IN SAFETY-NET SETTINGS.*
As a Black woman in academia, Shearon Roberts thought the rules seemed pretty clear. Don’t get too close to your research. Don’t make it personal. Don’t speak out too loudly. That all started to change in one week at the Pardee RAND Graduate School.
For years now, the school has made a unique investment in the future of public policy. Every summer, it invites a small group of scholars to campus to learn and practice policy analysis. They come mostly from the professor ranks of colleges and universities committed to serving students of color.

The goal is to bring more people from more backgrounds into the historically monochrome field of public policy—the professors, and then through them, their students. The need is critical, as months of protests against systemic racism have shown. Public policy is where change happens; to be effective, it needs to better reflect the aspirations, lives, and perspectives of the people it serves.

For Roberts, an assistant professor of mass communication at Xavier University of Louisiana, the opportunity to share notes with fellow scholars of color changed how she thought about her role in the world.

“It liberated me, to be quite honest,” she said. “You’re always worried, particularly as an academic of color, that if you’re too outspoken it will affect your ability to be tenured, to be hired somewhere, to be published. I had to throw off some of that pushback I got in my first few years, to shift my thinking about what kind of academic I’d like to be.”

Searching for scholars

Susan Marquis had just become dean of Pardee RAND in 2009 when she looked around and realized something had to change. “It was clear we needed to do more to diversify our student body,” she said. Working with Sally Sleeper, then the director of the RAND Gulf States Policy Institute, she set out on a road trip through the South, to pin up fliers and meet with students at historically Black colleges and universities.

Midway through her first sales pitch, she could tell the students had heard it all before—just another graduate school looking to improve its diversity numbers. She stopped. “What can we do for you?” she asked. The answers were the same at every school she visited: Engage the faculty. Give them the tools to be more effective as scholars and teachers. Connect them with fellow faculty leaders around the country.

Marquis had the program on paper by the time she returned from that road trip. It came to be known as the Faculty Leaders Program, and it brought its first class of fellows to campus in 2013. Since then, nearly 100 scholars have participated, drawn from 18 states and the District of Columbia, with academic backgrounds that range from water policy to feminist studies to education reform.

The school recruits applicants from historically Black colleges and universities, Hispanic-serving institutions, tribal colleges and universities, and regional universities that serve underrepresented student populations. It selects around a dozen fellows a year to spend one week at Pardee RAND in classroom courses based on the school’s doctoral program.
curriculum. Foundation funding and donor support covers their costs. Participants are required to bring at least one research idea with them to workshop and refine with fellow scholars and researchers from RAND and Pardee RAND.

Those ideas have led to projects investigating equitable discipline in schools, the quality of neighborhood food environments, and the effects of anti-immigration rhetoric. One program participant helped craft a bill to move juvenile defendants out of adult prisons in Louisiana. Another pushed for the creation of mental-health response teams in Mississippi. Shearon Roberts looked at the uncertain status of Haitian migrants in the U.S. during her week at Pardee RAND in 2018. She left the program inspired by other Faculty Leaders to put more of herself into her research—to become, in her words, a “scholar-activist.” A specialist in the recent history of Haiti, she has since helped establish a Haitian community center in her hometown of New Orleans and fought to protect Haitian migrants from deportation.

“It made me wrestle with, ‘What is the purpose of an academic?’” she said. “I’m not so guarded anymore about what I write about and how I approach research projects. I used to think I didn’t want to have too many close relationships with the community. I would study them, but try not to get too involved. The program helped me see that it was OK to do more.”

Paying it forward

A recent survey of program graduates found that 70 percent had used what they learned to advocate for change in their city, state, or university. Nearly 85 percent said they had made changes to a course to add or incorporate policy analysis. And 87 percent said they had encouraged students to pursue policy-related advanced degrees since graduating from the program.

For Marquis, one other number stands out. In the past two years, Pardee RAND has accepted two students into its Ph.D. program who came from the classrooms of former Faculty Leaders.

“We knew this was a new idea. Our Faculty Leaders have really helped us achieve our vision for what it could be,” she said. “It’s a model that we hope gets replicated. There’s plenty of room for other schools to take this on.”

Roberts has added policy analysis to her courses on mass communication and diaspora studies, and she’s seen it make a difference. One student heading to medical school now plans to focus on health policy. A student in her communication course decided to go into public diplomacy.

She keeps in contact with her fellow Faculty Leaders, part of a growing national network of program graduates who share research ideas and day-to-day support. “We share the challenges of being one of the few [professors of color] in our institutions or of being
from marginalized institutions,” she said. “Of trying to protect our livelihoods but still speak up for our own lived experiences. That’s really been the most valuable part of this program.” She’s got a book coming out soon about the experiences of Haitian journalists after the 2010 earthquake that leveled neighborhoods and killed thousands. It was inspired in large part by her own experiences as a young reporter in New Orleans in the apocalyptic aftermath of Hurricane Katrina. She plans to give all proceeds from the book back to the Haitian community.

The goal is to bring more people from more backgrounds into the historically monochrome field of public policy—the professors, and then through them, their students.
Her gift comes amid an unprecedented campaign at RAND to raise $400 million to support world-changing research on the critical issues of the 21st century. It will establish the Ellen Hancock Impact Award for Social and Economic Well-Being.

“There are very few research organizations that pursue the breadth of topics that RAND does,” Hancock said. “You have this cadre of talent with the skills and abilities to really make a difference. But they need to have some independent, unrestricted funding to increase the impact of RAND’s research and analysis.”

Hancock began her career as a junior programmer at IBM in the late 1960s, when desktops were desk-sized and memory meant magnetic tape. Over the next three decades, she worked her way up the ranks to the executive offices. She was the first woman to become a senior vice president at IBM.

From there, she moved to National Semiconductor Corp., and then to a struggling company named Apple. USA Today described her 1996 appointment as Apple’s chief technology officer as “jumping aboard what some pundits consider a sinking ship.” She oversaw the development of a new operating system for the company’s Macintosh computer.

She later became the chief executive of Exodus Communications, a web-hosting company in the early days of the dot-com boom. The company went public barely a week after she took over. Within a few years, it had become the largest host company on the internet, with clients that included Merrill Lynch, Google, General Electric, and USA Today. Hancock left the company in 2001.

She joined a RAND advisory board in 2008 and later served as its chair. The board, today known as the Social and Economic Policy Advisory Board, provides support and guidance for a suite of RAND research programs that confront issues ranging from climate change to police-community relations to the challenges of new technology.

“The work doesn’t become any less interesting over time,” she said. “If anything, it becomes even more interesting. Once you know what RAND is working on, you want to stay involved as much as you can.”

She points to a study from several years ago that investigated how criminal defendants fared in Philadelphia’s court system. It found that those who were represented by public defenders received sentences that were more than a year less, on average, than those who had court-appointed private lawyers. The findings raised fundamental questions of fairness and equal justice.

Research like that—independent, thorough, with an impact that can be measured in real lives and livelihoods—has convinced Hancock to commit more than $1 million to RAND over the years. Her latest gift will help extend the reach, impact, and influence of completed research at RAND.

“I left it up to RAND leaders to determine where they want to make that investment,” she said. “If it allows them to follow up on an existing research project, fine. If it’s a brand-new study for which there’s no research sponsor, fine.

“Research shouldn’t always be tied to the government or a particular company or foundation. I wanted to give RAND some latitude to conduct research they think will benefit the public good.”

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