[Music]

Moderator: Welcome to Conversations on Health Care with Mark Masselli and Margaret Flinter, a show where we speak to the top thought leaders in health innovation, health policy, care delivery, and the great minds who are shaping the healthcare of the future.

This week, Mark and Margaret speak with Dr. Ashish Jha, Director of the Harvard Global Health Institute, an internist and Professor of Global Health at the Harvard TH Chan School of Public Health. He's a leading advisor to state, federal and international governments addressing the COVID-19 pandemic. He says poor rollout of testing across the US has led to worse outcomes and warns that without adequate testing and contact tracing moving forward, we could see a real problem unfold when the economy reopens. Lori Robertson also checks in Managing Editor of factcheck.org looks at misstatements spoken about health policy in the public domain separating the fake from the facts and we end with a bright idea that is improving health and wellbeing and everyday lives. If you have comments, please email us at chcradio@chc1.com or find us on Facebook, Twitter, or wherever you listen to podcasts and you can ask Alexa to play the program. Now stay tuned for our interview with Dr. Ashish Jha here at Conversations on Health Care.

Mark Masselli: We're speaking today with Dr. Ashish Jha, Director of the Harvard Global Health Institute or practicing general internist. Dr. Jha is the K.T. Li Professor of Global Health at Harvard's TH Chan School of Public Health. He's a member of the Institute of Medicine at the National Academies of Science, Engineering and medicine. He'll begin his work as dean at Brown University School of Public Health in the fall.

Margaret Flinter: Dr. Jha's research has focused on improving the quality and the cost of healthcare systems with a particular emphasis on the impact of public policy. He has led groundbreaking work on public health responses to epidemics like Ebola, and now leading a national analysis of the COVID-19 pandemic and advising our state and federal policymakers on the crisis. Dr. Jha we welcome you back to Conversations on Healthcare.

Dr. Ashish Jha: Thanks for having me back.

Mark Masselli: And congratulations on going to Brown. I guess you'll be going there virtually, or maybe you'll be there in person as well but.

Dr. Ashish Jha: I'm hoping that I'll be there in person since we are starting in

the fall, we'll see how it all goes.

Mark Masselli: You've been such a great spokesperson and expert on the COVID-19 pandemic. You've been testifying in front of congressional hearings on what needs to be done to get ahead of this global threat and you have a pretty unvarnished assessment of the actions taken by the United States government, since the Coronavirus began to take hold. And you say the actions are really inadequate, particularly around testing and the United States seems to have fared far worse than countries around the globe and I'm wondering if you could talk to our listeners a little bit about where we stand in that. What's your prescription for how we can improve the testing? Testing is foremost on many people's mind.

Dr. Ashish Jha: And so this really has really quite an unfortunate response by our federal government. I think it's sort of borders on, a disaster just really badly handled. And if you ask the question, well, why do I use strong words like that? What does that mean? You know, one of the things that we've learned from almost every disease outbreak, but boy, this virus more than most, is that if you fall behind, and if you don't take it seriously, it is a punishing virus. A lot of people have gotten sick. As of right now, more than 90,000 Americans have died. That's a bit of a disaster. And I think much of it was preventable. It wasn't going to be easy. People say, well, you know, wouldn't have been hard. And the answer is yes, it would have been hard to prevent those 90,000 deaths. So, what should have happened is we should have developed a testing scheme early by kind of mid January WHO had a test kit we could have used that, we could have developed our own and when we when we try to develop our own and it didn't work, we should have moved quickly to harnessing the private sector. There are lots and lots of opportunities, we basically wasted about six to eight weeks, not developing a test and two months is a long time to lose in a pandemic. So that was really the original sin in many ways, and driven partly by bureaucratic incompetence. But a lot by leadership at in the White House that didn't want to see testing that really saw testing as somehow an enemy because it would reveal the number of cases we had. And one of the things I've tried to point out, testing doesn't give you cases, the virus gives you cases, testing helps you identify them and do something about it. And this has been like, instead of dealing with the fire, we put it under the bed and hope that it would go away and now the entire bed is on fire. And we're wondering how did this happen? We know how it happened. And the failures are not just in testing. They're really much broader than that. And I

don't want to be only negative they've been a fabulous work by Governor's Democrats and Republicans, other political leaders. But really the hallmark of this outbreak has been the failure of federal leadership.

Margaret Flinter: Well, Dr. Jha, you're not alone in that somewhat grim assessment of where we haven't done well, you recently testified before congressional hearing on public policies needed to now help us safely reopen the economy. And you're joined by experts who served administration's from both sides of the aisle, Scott Gottlieb, the recent FDA Commissioner under President Trump and Mark McClellan, who of course served in the Bush administration, no disagreement about the need for more testing as a fundamental precursor to reopening the country and the economy. And you've now released a series of recommendations to follow for to meet the criteria for safely reopening, share those with us.

Dr. Ashish Jha: In terms of reopening, I actually think the there have been of various different guidelines on how best to do it. But in many ways, I'm actually going to go back to the White House guidelines, which I still think in some ways, the most important, the Whitehouse put out the opening up America again guidelines. And I had some disagreements with parts of it, but largely they were right. They were scientifically grounded. And if you want to think about how to open up safely, you want 14 days of declining cases, you want a relatively low number of ongoing new cases happening. And then you want a robust testing infrastructure of testing and tracing. Our assessment is that you need about 900,000 tests a day in this country. Others have suggested we need like 5 million tests a day. There are plenty of disagreements among experts, but the one area we all agree is everybody agrees we need a lot more than that. And so then people say, well, does that mean we can't open up and my answer is you can always open up. The question is can you stay open and in order to stay open, you have to have a strategy that includes ongoing social distancing. Probably universal mask wearing, testing tracing and isolation. The less testing you have, the more of the other things you have to do. So testing is a way to reduce your caseload. And if you don't have much testing, then you have to put in much more in the way of social distancing and stringent policies. And what I have been encouraging states to do and municipalities to do is really build up their testing capacity, so that we can get more of our economy back more of our lives back. We're not going back to normal anytime soon.

Margaret Flinter: Yeah.

Mark Masselli: Yeah. Just wondering conceptually about, you know, it seems like the government had a rudder on the boat and then took the rudder out. But how are you viewing the country as a whole though? It is it should it be driven but really, it's such a large country? How do you approach it conceptually? Do you think about states that are in various stages of ability to stand things up? How should they proceed?

Dr. Ashish Jha: Yeah, so we are a vast country and this is why we've always had a very interesting structure and approach to health, which has always had a very prominent role for states. And I always say that, Montana has got a very different set of challenges with COVID, than Manhattan does. And the idea that the same policy that would work in New York would be the same policy that would work in Montana, almost surely not true. There are a lot of important differences. So there has been a long standing agreement in public health between states and the federal government. And the agreement goes something like that states lead on public, but the federal government provides technical expertise, intellectual resources, financial resources, because states just can't do all that stuff by themselves. And what we've had is really a silencing of the CDC in a way that has left the States alone. And what we've also had is a federal government on testing that has basically said to states you're on your own good luck. Don't call us we won't call you. What that has meant is that states are out there on their own trying to sort this all out. The challenge of that is not the states can't do it, some states can. But the supply chains for tests are national and international supply chains. And so there is a reason we have a federal government and it's not that the federal government should do everything and they should run all the national testing programs. I prefer states doing a lot of this, but with support, help aid and coordination of the federal government, and that's what's been really lacking.

Margaret Flinter: Well Dr. Jha, you will be teaching this pandemic for years to come in your school of public health schools of public health around the country and everybody who comes of age in this period will have learned what it means to live through COVID. I think for your average person in the street, one of the kind of belaying things that made no sense to them was we were sending our healthcare workers into the fire without enough PPE and the stories you would read having to reuse and wash your mask and keep working for eight hours straight because you don't want to use up a set of the PPE, that caught the

public's attention in a way that not a lot of things do about in America. How can this be true that we have such a problem of getting the right resources to the right people at the right time, and you've long advocated for a more cogent and efficient system of allocating resources across this ecosystem? healthcare? What do you see going forward? It seems like beyond the state or the federal government, there's just got to be a whole different way within areas within the country to get what's needed to the people who need it.

Dr. Ashish Jha: Yeah, so there's a couple of things. One is we have been thinking a lot about efficiency in healthcare over the last decade, and that has meant that we have reduced the sort of extra capacity and surpluses that we've had, and this pandemic is making us pay a price for that.

Margaret Flinter: Yeah.

Dr. Ashish Jha: And then the second is that we assumed again, that while hospitals and states we're going to be very, very important that under and a national crisis and really a global crisis. The federal government was going to come to the aid of states and hospitals. And I think no moment better captured the absurdity of where we were than when the president's son-in-law stood up and said, these are not state stockpiles, this is a federal stockpile. And I thought, oh, what does that mean? Because the federal government is supposed to help all of us. It's not that the federal government's only supposed to help people who don't live in states. That doesn't make any sense. But it was a moment, whatever he meant by it, it perfectly captured for I think, for state leaders, for hospital leaders, a sense that the idea that we could rely on our federal government to help us out in a moment of national crisis was probably not a wise one. And so I think what we're going to see for the fall, so we're essentially recreating the union in different ways. So we're going to have a conglomeration of northeastern states.

Margaret Flinter: Right.

Dr. Ashish Jha: A conglomeration of Midwestern states, one of western states, and they're all going to go out and create their own reserves. And so you'll see reserves of PPEs in the northeastern states and they'll share, you'll see something similar for the Midwest and maybe the south, and this was the job of the federal government. We don't we shouldn't have to create super state structures of 10 states working together, how about 50 states working together? But I think in the future after this pandemic is over, my sense is that states and

hospitals are going to build their own reserves, because they're going to work with the assumption that they can't rely on our federal government to help at a time of crisis, and that's both inefficient. It's costly.

Margaret Flinter: Yeah.

Dr. Ashish Jha: It's unfortunate, but I think that will be the one of the major results, a re examination of why we have a federal government and whether we can expect that under crisis situations the federal government is going to be a helpful player or not.

Mark Masselli: We're speaking today with Dr. Ashish Jha, Director of the Harvard Global Health Institute. He's the K.T. Li Professor of Global Health at Harvard's TH Chan School of Public Health and he begins work as the Dean of Brown University of public health in the fall. Now I want to pull the thread on this conversation which is having with Margaret on the role of the federal government and early on in the crisis, you wrote that you thought the US response to the pandemic would be fine, largely because of the sound infrastructure at the Centers for Disease Control and Prevention. And you mentioned obviously the snafu around the getting the testing. Right. And you now say that you were really wrong to make that assumption, as many experts have been muzzled recently ousted epidemiologist, Dr. Bright testified before Congress, with the stark warning that if we don't correct our public health response, soon, we face the darkest winters ahead. I'm just wondering, how does the CDC get back to the role that we've all looked to it to play or is this an unraveling of an institution that valued in our society and plays such an important role. What's your thinking now? Of how do they regain some trust? I think it's so important because this isn't the only event that we're going to face.

Dr. Ashish Jha: Yeah. So I think there are two things. I mean, the good news is that the CDC continues to have all of its great scientists, they have not left in large numbers. So the CDC is kind of intellectual horsepower is still there. That is the good news. And the bad news is obviously they need to be liberated. They need to be. We need to let them speak. We need to let them act. The American people have paid for the CDC and the American people deserve to benefit from the CDC. And the administration has clearly I mean, it's very clear talking to folks at the CDC that the administration has clearly muzzled the CDC has said they can't speak up or do things for states that are not cleared by the White House. And we've just never seen a

situation in the past, where a state CDC, a person, a CDC, expert sitting at a State Department of Health isn't allowed to really help that State Department of Health without getting clearance from the White House. But that's essentially where we are. So first and foremost, that needs to stop, that kind of muzzling. Second, is I do think the CDC has taken a credibility hit and really in many ways through no fault of their own. I mean, they've done some things that are really unfortunate some of their recommendations, some, but they really need so they do need to kind of regain that trust. But I think that I don't think that's a hard road for them. I don't think it was going to be very difficult. I think people still respect the CDC. And I think the CDC was allowed to do its job. They could quickly regain that trust. That may has been lost a little bit among the American people, American people I think are very forgiving of the CDC. If the CDC laws is a lot to get back to it, if we have an entire year if an entire next year, is the CDC being as ineffective and muzzled in the way that it is now, then we may be a long road to recovery before the CDC gets its trust back. And the trust is, as we all know, built over the years and lost within seconds and days. And certainly over a year in a pandemic, it can be lost very, very effectively.

Margaret Flinter: Well Dr. Jha, I know we share a passion for training the next generation, and the education of the next generation of physicians has been very much a part of your work and will continue to be. But when you contemplate all of these students and their future, I think about former US Surgeon General, Dr. Vivek Murthy joined us saying they hope that public health would become much more integral to the training of our frontline medical patients professionals. And I think that was kind of lost somewhat from the curriculum over the years in all the health professions, not just in medicine, and I think everyone's kind of gotten a good realization that you can't really separate them. How do you see the pandemic, really factoring into how we train the health professionals of the future? And will the walls and the lines between public health and primary care and tertiary care maybe really shift because of this, at least at the training level?

Dr. Ashish Jha: Yeah. So to answer a slightly different question. I actually think public health will become much more integral to training people all over the, in all sorts of different fields. It's going to be hard for people to study economics without understanding some basic.

Margaret Flinter: Yeah, absolutely.

Dr. Ashish Jha: Right, because one of the things that we have learned is you can cause massive economic devastation through a public health crisis that no economic model helps you out of and helps you understand. So I think that Public Health Education will become a more important part of all education for some period of time, but to get to your question more directly, there's no doubt in my mind that it's that the importance of public health has really been made playing, I think, in the middle of this pandemic. And it's unfortunate that in some ways, it took a pandemic. But I, so what that means to me is physicians, nurses, I think, who have been at the frontlines not just in taking care of patients, but advocating for policy, being a voice for public health, and will want and need training in those issues. So they can be more effective advocates for public health. Because when we fail on public health, it is doctors and nurses who then have to clean up the mess and have to deal with the consequences. They clean up the mess we really have to deal with the consequences of that. So all of that in my mind is really setting up a rich environment for that cross-sectoral or cross-disciplinary training, and the question will be, are we going to use that fertile ground to make sure that that kind of training is happening, that medical students are learning the basics of public health. And public health students are learning more about the clinical aspects of the aspects of clinical medicine that are going to be necessary to manage this. I hope that that is what comes out of it. And that is definitely part of my agenda at Brown, will be to make sure that the basics of public health are being taught all across University.

Mark Masselli: We asked you to pull the thread on that and sort of a crystal ball about the health system itself. What are we learning we, we realized that we were ill equipped to address this? The old model, a fee-for-service left people scrambling for resources and couldn't provide it? We found that the inability to make an impact on chronic diseases left so many people exposed. We also saw the lack of spending that we make on special populations impacting on us. How do you hope that when we sort of recast what we have to do, what it might look like, in the context of so many things that we've lost, where we probably took our eye off of the end results that we needed to have.

Dr. Ashish Jha: Yeah. So let me answer that question in two ways. I mean, one is a very short term answer to just how do we get through the rest of this pandemic? And how do we rethink our health system? Part of what happened in March, April and May is we essentially shut down large chunks of our health system to try

to prepare for the influx of patients with COVID. In many places that influx happened in some places that didn't, but there was an enormous cost to everybody else, including an enormous cost to the financial viability of the health system. So I think on a short-term basis as we think about the fall, we're going to have to do a lot better preparation for making sure that doesn't happen. That “elective surgeries” can continue that we are able to continue take care of heart attack and stroke and kidney failure patients. And we don't have the same, I think really negative effects on all the rest of the health system. So we have to develop a strategy around that but that's not really getting at your question. Your question as I heard it was, okay so let's say we're through this, what is the new world of healthcare look like?

Margaret Flinter: Right.

Dr. Ashish Jha: And I would say a few things. So first of all, everybody always used to talk about disruption or disrupt healthcare. And you know, most of that was really very, it was tweaking around the edges on a good day. Well, now we have real disruption around, and this is an opportunity for us to rethink and redo things. So I think there have been a bunch of temporary policies that have been put in that I think are going to become permanent. I think the idea that telemedicine will somehow go back to the old policies of not paying for telemedicine, that's absurd, and more virtual medicine, that stuff is going to become, I think, much, much more common, because it's not, it doesn't always replace a doctor's visit the in person visit, but a lot of people going to say I like it. I like this way of doing things. And there's a lot we can do that way. And it's got some efficiency. So I think there are important regulatory and other types of changes that we've put in temporarily that will become permanent. I do also think that it is a chance to think about issues, about we talked about this a little bit around how much extra slack do we want in the system for surges and for unusual things that we have not prepared for. And then I think the issues around financial model, payment model, fee-for-service capitation, all of those transitions we've been making, I think are going to get accelerated. Because if a disruption means you can't do elective surgery, and that means hospitals basically go bankrupt. That's not a very good model. And so we have to think about financial models for hospitals and healthcare system that are and we've been thinking about it for a while. I just think it accelerates that journey much more, but a lot of it is, there's going to be how we, I mean, as long as we don't go back to business as usual, but I don't think we will. I think this is enough of a change. I

think it would be hard to go back to a pre COVID life and say, All right, that's done. Now let's go back to maximizing billing.

Margaret Flinter: We've been speaking today with Dr. Ashish Jha, the Director of the Harvard Global Health Institute, who began a new role as dean of the Brown University School of Public Health in the fall. You can follow his important work on COVID-19 and other global health issues by going to globalhealth.harvard.edu and follow him on twitter at ashishkjha Dr. Jha, we want to thank you for dedicating your intellect and your talent to the great issues impacting global health for advancing the discipline of public health and joining us today on Conversations on Healthcare.

Dr. Ashish Jha: Thank you so much for having me on. I really enjoyed it.

Mark Masselli: At Conversations on Healthcare, we want our audience to be truly in the know when it comes to the facts about health care reform and policy. Lori Robertson is an award winning journalist and managing editor of factcheck.org a nonpartisan, nonprofit consumer advocate for voters that aim to reduce the level of deception in US politics. Lori, what have you got for us this week?

Lori Robertson: The United States has one of the highest rates of COVID-19 deaths per capita in the world. However, President Donald Trump made the false claim that “Germany and the United States are the two best in deaths per 100,000 people. As of May 11, the day Trump made the claim the US had 24.66 deaths per 100,000 people more than two times higher than Germany, which had 9.24 deaths per 100,000 people. The US had the 11th highest rate out of the more than 140 countries. tracked by Johns Hopkins University, Germany's was the 18th highest. Neither country is anywhere near the ”lowest rung of that ladder”, as the President said in a press briefing at the White House. It's possible Trump meant to refer to a different statistics on the John Hopkins University website, the observed case fatality ratio, that's COVID-19 deaths divided by confirmed cases among the 10 countries, the University said have been most affected by the global coronavirus outbreak. By that limited measure, Germany at 4.4% had the lowest case fatality ratio and the US at 6% has the second lowest among those 10 countries. But that's not what Trump said. The President gave the false impression that the US has one of the lowest per capita death rates of any nation. It doesn't. And that's my fact check for this week. I'm Lori Robertson Managing Editor of factcheck.org.

Margaret Flinter: FactCheck.org is committed to factual accuracy from the

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

[Music]

Margaret Flinter: Each week's conversation highlights a bright idea about how to make wellness a part of our communities and everyday lives.

Margaret Flinter: Childhood Obesity is a national epidemic but in the south is far more prevalent. In Louisiana for example, over half of the children are either obese or overweight, with many experiencing symptoms such as high blood pressure, high cholesterol, and pre diabetes. Louisiana State University researcher Dr. Amanda Staiano has been studying protocols to tackle childhood obesity, tapping into readily available resources that make it easier for kids to adopt better exercise and activity habits. And since video games are ubiquitous in children's lives, she thought that would be a great place to start.

Dr. Amanda Staiano: I was trying to think of a way to meet children where they are to leverage their interests so that they can be more physically active and hopefully lose weight or attain a healthy weight. Children now are spending seven to eight hours every day using screen technology. Video games are still very popular. So with these new active video games that require physical activity to play, I thought this might be an innovative way to make physical activity and exercise fun.

Margaret Flinter: Her team at the Pennington Biomedical Research Center at LSU developed an intervention called game squad, giving prescriptions for playing movement video games for a full hour three times a week.

Dr. Amanda Staiano: In addition to giving the kids these extra game, we gave them a few others support. We gave them a challenge book, and this would help them to gradually increase the intensity of their physical activity. We gave them a fitness coach that they would talk to over their video game. This was a remote support, and the coach would check in with the parent child once a week and basically help hold them accountable. And we also gave the kids a step tracker.

Margaret Flinter: And kids were encouraged to have other family members join

them in the movement video games, which added yet another level of engagement like this young 12 year old boy who enjoyed gaining a competitive edge over his mom, who was often dancing right alongside him.

Kid: I give the credit to my coach, team motivates me, my mom motivates me.

Kid: I have to say like 60% of the time I will be there. I love to do disco with my mom.

Margaret Flinter: Dr. Staiano says during the six month game squad trial, over 90% of the kids who are given video game prescriptions and a fitness coach intervention stayed active throughout the study. The gaming group reduced their BMI by about 3% while the control groups saw an increase in theirs and Staiano says the added bonus was that kids gained confidence and improve self esteem with their newfound activity, game squad an effective intervention to increase exercise in sedentary and overweight kids leveraging already existing video games that are designed to get kids up and moving, improving health and fitness for kids in a fun, engaging and sustainable way. Now that's a bright idea.

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

Margaret Flinter: And I'm Margaret Flinter.

Mark Masselli: Peace and Health.

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

[Music]