(Music)

Mark Masselli: This is Conversations on Health Care. I am Mark Masselli.

Margaret Flinter: And I am Margaret Flinter.

Mark Masselli: Well Margaret, the fallout continues since the Supreme Court vote, upholding the Affordable Care Act.

Margaret Flinter: And at no surprise Mark, those battle lines continue to be drawn pretty squarely along party lines.

Mark Masselli: Well, Republicans in the House have launched their latest attempt and I think it's number 31 to either overturn the law completely or to make some amendments to it.

Margaret Flinter: Well, given the numbers in the Senate that bill is likely to meet the same fate as the previous 30, but I doubt it will be the last Mark. And some governors continue to holdout as well.

Mark Masselli: I think there are now seven GOP governors who are refusing to sign the health care Medicaid expansion provisions which the High Court left to the discretion of states to comply with and maybe around 15 states in total that are still in play of whether or not they will participate in that expansion program.

Margaret Flinter: And Texas Governor Rick Perry, who we heard a lot from over the last year when he was running for the Republican nomination, are among those vowing that he will not comply with the expansion of Medicaid, who would cover more of the uninsured who live close to the poverty line in his state. That means he is going to refuse federal dollars that would have come into the state to help support that expansion.

Mark Masselli: Governor Perry is still on campaign mode and behaving true to form. It's important to look back here at history though. When Medicaid was first passed in the 1960s, only a handful of states signed up for the program initially.

Margaret Flinter: You know, that’s a really interesting point, Mark. It does take a while for these things to get fully rooted. The same is true for the CHIP Program, the Children’s Health Insurance Program, and even today, it doesn’t get full participation even though it reimburses states 65% of their cost for providing insurance for children.

Mark Masselli: Well, suffice to say Margaret, the wheels of change are turning in the arena of health care reform but some of these changes of course will not come that easily.

Margaret Flinter: Our guest today is somebody who can shed quite a bit of light. Oregon Governor John Kitzhaber is a leader in initiating health reform in his state which has made really significant strides in expanding health coverage for all of his citizens.

Mark Masselli: Margaret, Oregon has enacted some very innovative programs to ensure that state's residents have access to health care and it could provide a great model for other states to follow.

Margaret Flinter: Looking forward to hearing about that. And also, FactCheck.org's Lori Robertson explores yet another health care claim from the campaign trail.

Mark Masselli: But no matter what the topic, you can hear all of our shows by Googling CHC Radio.

Margaret Flinter: And as always, if you have a comment, email us at www.chcradio.com; we love to hear from you.

Mark Masselli: We will get to Governor Kitzhaber in just a moment but here is our producer Marianne O'Hare with this week's Headline News.

(Music)

Marianne O'Hare: I am Marianne O'Hare with this Headline News. The Supreme Court decision upholding the legality of the Affordable Care Act hasn't stopped the political haggling. A GOP measure made it to the floor of the House of Representatives this week attempting to repeal the act. The measure isn't expected to make it beyond the democratic-controlled senate. In the meantime, at Kaiser, Health News Poll shows a majority of Americans have moved on. Now that the measure has been upheld, 56% of those polls are saying they don't want to see further efforts to overturn the law. However, if it were just among Republicans, almost 70% said they would like to see those efforts continue.

One of the initiatives of the law setting up Accountable Care Organizations or ACOs is gaining steam. The Department of Health and Human Services announced the formation of 89 new ACOs that is group of hospitals and medical practices teaming up to coordinate care and reduce cost. Those ACOs receive a share of almost $2 billion in federal funds. HHS Secretary Kathleen Sebelius is saying better coordinated care is good for patients and saves money.

Another measure of the law, gaining some attention, mental health coverage. Nearly half of all Americans will have some sort of mental health crisis in their lifetime. The Health Care Law will ensure that coverage for mental health issues as well as substance abuse is available to all those who need it. Currently only a

fraction of those suffering from such disorders are able to access such treatment via their health coverage.

Global Maternal Mortality is still a big problem in developing countries and it's a topic for discussion at a family planning conference getting underway in Britain. A recent study by Johns Hopkins University shows simply meeting contraception needs in the developing world could cut maternal deaths by a third. I am Marianne O'Hare with this Headline News.

(Music)

Mark Masselli: We are speaking today with Oregon Governor, John Kitzhaber, a former emergency room doctor, who is currently in his third term as governor. Governor Kitzhaber is Former Director of the Center for Evidence Based Policy at Oregon Health & Science University in Portland, a long time advocate for health reform. Governor also launched the Archimedes Movement in 2006, an organization seeking to maximize population health by creating a sustainable system using public resources to ensure everyone has access to effective health services. Governor, welcome to Conversations on Health Care.

John Kitzhaber: Thank you very much for having me.

Mark Masselli: You know, your state is recently awarded almost $2 billion grant from the federal government for an initiative to transform health care delivery initially for the Medicaid population but potentially is a model for health care reform across the country. And your plan is to use money to develop a coordinated care organization that you expect will save billions of dollars over the next decade. Now you have been working closely with the Obama Administration on this Medicaid experiment. Can you describe for us your vision for this coordinated care system and how it will improve access to care while at the same time reducing cost?

John Kitzhaber: Well, you put your finger on it. This is sort of vanguard of an effort to try to change the larger delivery system but we are starting with the Medicaid population of 600,000 people. So essentially, the idea is to create coordinated care organizations around the state and they will essentially put under one roof mental health, physical health, long term care, dental health providers, those working in the community to try to address the underlying determinants of health and create a new governance organization. They will operate on a risk-adjusted fixed budget and they will be required to create patient-centered care with medical homes care integration. So, the idea is to shift the organizational structure and the financial incentives from after-the-fact acute care to prevention, wellness and the community-based management of chronic conditions.

If this is successful, which we believe that it will be, then we will list the CCO as a coverage option on our health insurance exchange and try to move the public school teachers and public employees in and then after that, we will put it up to hopefully small employers and eventually to Medicare.

Margaret Flinter: So Governor, we are so interested in this model of coordinated care, and one reason is that it's something that garners bipartisan support, which not much does these days, from health care providers, insurers, unions and politicians, and this plan is to connect the key providers as you said, the medical providers, the mental health and substance abuse providers, oral health to address this whole patient care. And it would seem that fundamental to this is going to be the need for these care partners to communicate electronically, certainly something both the stimulus and the Affordable Care Act has been trying to do on the national level. Tell me where do you derive your confidence that that big federal investment is going to result in even bigger savings. Are you modeling this after work that's been done other places or is this really a kind of uniquely Oregonian solution?

John Kitzhaber: Well, I would say little of both. We have one of the highest penetrations of electronic medical records already in our state. And we have created a health information exchange which is up and running and the idea is to allow coordinated care organizations not only to communicate with each other within their organizations but also between coordinated care organizations. So you can have somebody enrolled in the Portland CCO who happens to have a problem (07:33 inaudible) and there would be a way to link that information electronically. So, we are pretty far down the road on this and I think it's really creating the financial incentives inside so basically HIT is part of the global budget so there is a real incentive since they are operating on a fixed budget to improve information exchange so you can avoid redundancy (07:51 inaudible) and actually provide better continuity of care for the patients.

Mark Masselli: Governor, your state is obviously a leader in technology and you have sort of outlined your work in electronic records, your health information exchanges. And I noted the other day you were at the opening of really an innovative video health clinic where patients will be able to tap into video doctor visits. But you know, thinking about this model, really the practice of the future might be one-third by handling emails, one-third by Skype and one-third office visits. Is that how you are envisioning it as well as sort of technology as a decision making tool helping the critical thinking that a provider has?

John Kitzhaber: Exactly. So we have to change the fundamental business model of the health care delivery system which now is built on the assumption that employers and the government are going to continue to fund an inflation rate two or three times of CPI. So that's one change. The other change is that I think we need to recognize that the old paradigm of getting care in a doctor's office is really outmoded. Today, if you need to go see the doctor, you have to call, and

first of all, it's two weeks then you have to take time off work then you sit around for a while. And one of the reasons the Minute Clinics and these clinics at Wal-Mart have taken off is because of the convenience.

So essentially, what we have done is created a video clinic on the workplace so if you have a problem, you can get in within 10 minutes or on your break. There is a nurse practitioner on the other end that will make a diagnosis, obviously within certain parameters, or decide that you need to maybe go and be seen. But a whole lot of health care is minor problems and this provides a wonderful venue to extend primary care without having to actually expand provider capacity.

Margaret Flinter: So Governor, one of the concerns that often comes up with providers when we look at reform is that on the one hand I think everybody wants to pay for value and not volume, we hear that a lot, and on the other hand, people are worried that they might lose out if they are working within a system of a lump sump payment. Tell me the degree to which payment reform factors into your innovation and how is that being received by the provider community and what kind of innovation are you doing there.

John Kitzhaber: Well, I think we need to compare it to the status quo. Providers are losing out right now in Medicare and Medicaid and when the federal government raises the debt ceiling again in January, it's going to be very clear that it's Medicare and Medicaid driving the national debt. So we are looking at less reimbursement not more. So, what we have done with the risk-adjusted global budget is we (10:09 inaudible) stable revenue source that grows at a fixed rate so people would know that it's going to grow, there are incentives inside that so for example, if a hospital and a physician group make an agreement that if they can reduce admission rates for congestive heart failure by X per 1000, the savings will be shared between the physician and the provider.

Secondly, and I will just give you a great example, if you have a 90-year-old woman who lives alone with well managed stable congestive heart failure in an unairconditioned apartment and there is a heat wave and the ambient temperature goes up to say 102 degrees, that's enough strain on a heart to (10:42 inaudible) full blown CHF. On the current system, you don't know about it until she shows up in the ED. Under this system, there will be obviously an incentive to have community health workers checking on her on a regular basis to make sure she is okay. Under the current reimbursement system, under both Medicare and Medicaid, they will pay $50,000 for the hospitalization, they won't pay $200 for window air conditioner which is all she needs to say in her home and out of the medical system. So the difference there is $49,800 which could then be used to create some additional reimbursements for physicians and hospitals.

And I want to just emphasize that these CCOs, while they do have a global budget are required to be accountable for a host of metrics including access,

including clinical outcomes and including patient safety and population health metrics.

Mark Masselli: We are speaking today with Oregon Governor John Kitzhaber, a former emergency room doctor, now third-term governor, who has been a long time advocate for health care reform. Governor, you left medicine to enter politics but you have made transforming health care policies a pillar of the work since you entered public life and you fought for health rights early in your political career, coauthoring in the groundbreaking Oregon Health Plan, which passed in '93 while you were the President of Oregon State Senate, which provided low cost health coverage for working families for those in need of insurance and the program was an instant success. But today, we are seeing so much resistance at the national level for the Affordable Care Act. What happened? Why is there such of a Herculean struggle?

John Kitzhaber: Well I mean I think United States Congress is utterly broken. I mean the fact that in the senate you need 60 votes to get a majority, it's (12:11 inaudible) part of senate and I think the side about the Affordable Care Act is much more about the 2012 Presidential Election than it is about health care. And the ideology unfortunately is still up to state legislators who are voting against anything that looks remotely like the Affordable Care Act because they are somehow helping the President and it's a tragedy but it also tells us the **manual** of leadership and action has (12:30 inaudible) states and regions. In Oregon, we were successful. A, you need leadership who is willing to frame the health care issue not as a republican or democratic debate but something that's important to families, businesses and the state itself. And basically what we did is we framed it that way, we recognized it was a cost driver in the budget; we depoliticized it. And our health insurance exchange as well as the bills passed in some cases is 50 to 3 and 26 to 7, I mean huge bipartisan majorities. And I think just to comment on the fact that you have got to have a conversation based on interest rather than position. And regardless of what the Supreme Court does, I think Oregon's work will continue to go forward because it's not contingent upon the Affordable Care Act obviously who would lose out on the coverage expansions getting that bill. But I don't have a lot of hopes that United States Congress is going to lead us forward on a lot of these very important domestic issues from health care to education to transportation infrastructure.

Margaret Flinter: Governor, speaking of conversations, Mark and I obviously have had the great pleasure of speaking with so many people who are providing great leadership in health care reform. And a number of themes begin to emerge as a consensus around quality and services and coverage but also workforce. And one of the common themes that we hear over and over again when we speak about how to better coordinate care is the role of the community health worker. And yet, the community health worker, not a licensed group, not really well-defined training programs or degree programs and yet, absolutely vital as a

link in keeping high risk patients at home and avoiding those expensive re-hospitalizations. Tell us about how you have approached that in Oregon.

John Kitzhaber: Well a couple of thoughts. First of all, the health care workforce has grown right through the recession but unfortunately it's grown by people running MRIs. And so what we need to do is shift that workforce to something more productive that actually contributes to health. And that would be this community health worker who is charged with essentially managing chronic conditions in the community providing that kind of assistance. We have a curriculum for a community health worker again, a waiver request; we have our community colleges teed up to begin that curriculum. So we figure it's going to take a couple of years to build up a degree or certified health worker. That's essentially a key issue because in many communities, hospitals are the biggest employers, hospitals, health systems. So you want to basically shift that workforce to doing something that's more aligned with our health objectives.

The other thing I think is important to recognize as we are dealing with at-risk kids is these health workers essentially could do both of those functions. So the workforce element is critical; we have developed a curriculum and we are going to, and part our $1.9 billion is invested in the development of a new community-based workforce sort of trying to lead on this important issue.

Margaret Flinter: And you have also been a leader in the Archimedes Movement which you founded in 2006, an organization that seeks to advance the fundamental triple aim goals of better health and better health care and reduced costs. And a key aspect of that is engaging people and empowering people, empowering patients. How are you engaging patients in this new system that you are rolling out?

John Kitzhaber: Well, the Archimedes Movement is a key element of it. We tried to do two things with the Archimedes Movement; one was to change the frame. So, instead of having this fight about universal coverage, which is really what the focus has been on for the last 2 or 3 decades, to essentially that the objective here isn't to finance medical care, it's to produce health. So, if people can really understand that what we really want is to be healthy so changing that frame was point one. Point two is that 90% of (15:50 inaudible) life and health status has nothing to do with the form of medical system, it has to do with lifestyle, behavioral issues, socioeconomic issues, environmental issues. And people actually have the capacity to take steps to improve their own health and be empowered. So, in our work, we have something called the Health Engagement Model, which we are now applying to our public employees for example in which they are required to take about a six minute health assessment online that gives them a breakdown of sort of where they are in terms of their cardiovascular status, weight status, etc. with a series of recommendations. If they don't take it, their co-pay goes up $30 a month; if they do take it, they actually get a benefit. So the whole idea here is to change the shift to encourage the health. So I would

add also that there are health coaches that currently you can't get reimbursed for now. So, for example, if you look at the people who come to the ER over and over and over again, many of them are people with an undiagnosed or untreated mental health issue. And if you can intercede those people at the ER, hook them up with a primary care provider, you basically can give them the information they need or coach them on when they need to go in and when they don't need to go in, it dramatically improves their quality of life and health and dramatically reduces cost and over-utilization in the ED.. The real tragedy is this became so polarized and it became polarized primarily in the mid-term elections which is again all about the acquisition and expansion of political power rather than the exercise of that power to do something meaningful for the citizens of our country. Because what the people who don't like the Affordable Care Act refuse to admit is that we already have a system of universal coverage that's called the emergency room and not even the most conservative **tea bag** republican would argue that if someone doesn't have health insurance, we should let them die in the ambulance van. So what we end up doing is financing strokes in the hospital rather than paying for blood pressure control in the community, which is not fiscally irresponsible I think it's morally irresponsible. So that is even a greater argument for states to stand up and be bold and courageous and provide a beacon towards which we can take our country because it is literally health care that is pushing us over the fiscal brinks towards the fate that's being faced by Greece and some of the other European countries right now. We don't need to go there.

Margaret Flinter: Governor, often when we are interviewing new nurse practitioners for our residency program, it seems about half of them seem to have had some experience of working in ICU, critical care or the emergency room and they have been galvanized to become nurse practitioners and primary care providers by seeing the end result, the things that should not have happened but happened because all of the things we are talking about today. I was wondering if you could share with us just a little bit of your personal story of that transition from emergency room physician to politics; was that a galvanizing force for you what you saw coming in day after day in the emergency room?

John Kitzhaber: No, actually it became that. My political awakening came in 1968 particularly with the assassination of Robert Kennedy, whose campaign was really about equity and poverty. And I ran for the legislature in 1978 and my focus was on quality education in the environment. And I probably couldn't have told you in 1984 when I was elected for the senate the difference between Medicare and Medicaid. As Senate President, I chaired something called the Emergency Board that has a little fund that keeps budget balancing between our (18:48 inaudible) sessions. And our Medicaid budget was out of balance and we balanced it in part by dropping 4300 people off the Medically Needy Program. And I remember thinking at the time this was pretty easy. We were sitting in this room and **solemnly** took a couple of votes and wrote some numbers on the paper and miraculously we balanced the budget but we also just rationed 4300

people from coverage. And I went back home and started practicing the ED and about six months later, I started to see some of these people coming in who had lost coverage because of a certain actuarial decision we made in the state capital. One was a guy who had a massive stroke because he could no longer access his blood pressure medication. That was sort of an "aha" experience to me about the relationship between these decisions, these budget decisions we make and the real human consequences. And so that's when I really began to try to think about how we create more rational ways and allocate the resources we have, which led to the Oregon Health Plan, which really wasn't about controlling cost, it was about saying, look, if we only have X amount of money, let's not ration people, let's keep everybody covered and if we have to make cuts, let's remove those things that have the lowest value in terms of producing health. And so I mean I think my ability to navigate the health care world in a political environment is certainly enormously enhanced by my primary care experience particularly in the ER.

Mark Masselli: Governor, we like to ask all of our guests this final question. When you look around the country and the world, what do you see in terms of innovation that our listeners at Conversations should be keeping an eye on?

John Kitzhaber: Well again, I think particularly states that have basely recognized that they are pretty much on their own, I would say states and there is now few of them that recognize that Medicare is utterly unsustainable. So I think places that are trying to change the frame of this debate, to really look at it as it is, not as the political system has made it, and have the courage to stand up and actually have that conversation, and this includes end of life issues as well, I think that's what we are looking for.

Margaret Flinter: We have been speaking today with Oregon Governor John Kitzhaber, a former emergency room physician and long time health reform advocate, who is transforming the delivery of health care in his state. Governor, thank you so much for joining us on Conversations on Health Care today.

John Kitzhaber: Thank you very much for having me.

(Music)

Mark Masselli: At Conversations on Health Care, 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: Well, Mark and Margaret, as you know, there was big news about the federal health care law last week with the Supreme Court upholding

the law's constitutionality and politicians including President Barrack Obama and presumptive GOP Presidential Nominee Mitt Romney, quickly took to the airwaves after the ruling, both made false claims. The President reiterated an old claim saying, "If you are one of the more than 250 million Americans who already have health insurance, you will keep your health insurance". But as we said before, that's not a promise he can make. The non-partisan Congressional Budget Office has estimated that at least a few million Americans, who get their coverage through work, won't keep work-based plans. Some will do so of their own choice getting coverage from another source; for others, employers may find it easier to send lower wage employees to the state-based exchanges. Also, the President was talking about everyone with insurance including those who now get their own coverage on the individual market. But some of those individuals may have to get a new insurance plan if theirs doesn't meet minimum benefit standards. On top of that, the President can't promise that employers won't switch insurance plans just as they could before the law was passed. And that's my fact check for this week. I am 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 would like checked, email us at www.chcradio.com. We will have FactCheck.org's Lori Robertson check it out for you here on Conversations on Health Care.

(Music)

Margaret Flinter: Each week, Conversations highlights a bright idea about how to make wellness a part of our communities and everyday lives. Millions of Americans living in poverty use the 211 Info Line system to seek help for a variety of unmet needs, everything from child care assistance to housing to food stamps. A new study shows 211, a nationally designated information and referral phone line for those in need, could also be a powerful tool in the fight to end ethnic disparities in cancer prevention and treatment. The study conducted by Dr. Jason Purnell, a Public Health Professor at Washington University in Saint Louis, looked at 211 usage in four states. Callers, many of whom did not have health insurance and were more likely to be in need of primary care, were screened for their health needs. 70% of those callers were in need of at least one cancer prevention screening service and many of those callers needed two or more interventions. The study also found since the callers in this population were racial and ethnic minority groups already had a high degree of trust in the 211 referral system that they were more likely to accept cancer screening referrals for mammograms and pap smears and other basic interventions like smoking cessation programs. Purnell's study determined that with a targeted 211 messaging and outreach campaign, millions of Americans in the most at-risk groups could be effectively reached through the 211 system and referred to the prevention and screening programs best suited to their needs. The study

determined that this approach could have a dramatic impact on reducing ethnic cancer disparities by directing an underserved population sooner to prevention and screening programs. Repurposing an existing information and referral system to direct at-risk and underserved populations to the interventions they need, improving cancer prevention and early detection while greatly reducing disparities, now that's a bright idea.

(Music)

Margaret Flinter: This is Conversations on Health care. I am Margaret Flinter.

Mark Masselli: And I am Mark Masselli, peace and health.

Conversations on Health Care, broadcast from the campus of WESU at Wesleyan University, streaming live at www.wesufm.org and brought to you by the Community Health Center.