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Mark Masselli: This is Conversations on Health Care, I'm Mark Masselli.

Margaret Flinter: And I'm Margaret Flinter.

Mark Masselli: Well Margaret, we're ending the year on something of a somber note, the number of mass shootings in the country continues to escalate with no signs of abating.

Margaret Flinter: While the proliferation of gun violence continues to dominate the headlines, Mark, little if anything is being done about it and especially at the congressional level. Pretty alarming when you consider that an estimated 32,000 people a year die from gun related causes in this country.

Mark Masselli: And, you know, with any public health threat of this magnitude we need to have good data to back up some policies. There's been a 20-year ban in placing congress so called Dickey Amendment which bans the use of federal funds to study the impact of gun violence in this country. And there's a growing call to end that ban from the medical professions in a growing number of members of congress.

Margaret Flinter: Well, we're just missing something from this narrative, an estimated 89 people a day die from gun-related causes in this country and domestic violence incidents, and suicides, accidental death and violent crimes. And those daily occurrences don't make the headlines. So we need to support sound federal policy on gun violence, Mark, including studying the issue, and that's going to take some solid data.

Mark Masselli: Our guest this week is something of an expert on data surrounding Universal Health Coverage in the United States, Dr. Stuart Altman is a noted Health Economist at the Heller School at Brandeis University and his long involved in the issues of universal coverage going back many decades.

Margaret Flinter: And Dr. Altman is also the Chair of a National Academies Committee which has been analyzing progress since the IOM or Institute of Medicine's ground breaking Future of Nursing report released in 2010 which seek to enhance all aspects of the nursing profession. And his committee has just issued their five-year progress report.

Mark Masselli: Lori Robertson stops by the Managing Editor of FactCheck.org is always on the hunt for misstatements spoken about health policy in the public domain.

Margaret Flinter: But whatever the topic you can hear all of our shows by going to chcradio.com.

Mark Masselli: And as always if you have comments please email us at chcradio@chc1.com or find us on Facebook or Twitter we love hearing from you.

Margaret Flinter: We'll get to our interview with Dr. Stuart Altman in just a moment.

Mark Masselli: But first here is our producer Marianne O'Hare with this week's headline news.

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Marianne O'Hare: I'm Marianne O'Hare with these Health Care Headlines. Health care cost on the rise, health care cost in the U.S. hit the $3 trillion mark for the first time in 2014, up about 5.3% in spending from the year before. When the spending growth rate was at its lowest in 55 years, just 2.3%, what's behind the increases comes as more notable. In 2014, the fastest growing line item in the national health expenditures was prescription drug spending which grew dramatically 12.2%. Expanding coverage under the Affordable Care Act was a driving factor behind the rise, allowing more people access to medical care and prescriptions that might have previously been out of reach. On that note, the majority of Americans now believe the government should be responsible for ensuring all citizens have health coverage albeit a slight majority 51% overall. Those under 50 were more likely to be in favor of government supported coverage than those over 50 and a vast majority of democrats about 80% were in favor.

Fitness wearables were one of the hottest ticket items on Black Friday this year. Apparently some 50 million Americans use some kind of health tracking device. After this Christmas that number could go significantly higher.

And genetically engineer or not to, the international summit on human gene editing convened debate another conundrum how far should scientist go, when editing human DNA. The main focus was whether scientist should be allowed to use powerful new genetic engineering techniques to edit genes in human eggs, sperm or embryos an extremely controversial step that raises a host of safety and ethical issues. The committee recommends intensive basic researches clearly needed and should proceed so they can explore the safety and potential benefits of editing that kind of DNA. I'm Marianne O'Hare with these Health Care Headlines.

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Mark Masselli: We're speaking today with Health Economist, Stuart Altman PhD, the Sol C. Chaikin Professor of National Health Policy at Brandeis University, where he also served as Dean of the Heller School of Social Policy and Management. Dr. Altman serves as chairs of both the Health Industry Forum and the Council on the Economic Impact of Health System Change, also chair of the IOM committee on assessing

progress and implementing their recommendations of the Institute of Medicine's report on the Future of Nursing. He served on President Clinton's Bipartisan Commission on the future of Medicare and he's a member of the National Academy of Sciences and their committee on the future of emergency care in the United States. He earned is MA and PhD degree in Economics from UCLA. Dr. Altman, welcome back to Conversations on Health Care.

Dr. Altman: My pleasure.

Mark Masselli: Yeah, you know, I really want to get to the question of how you rank the ACA's success now that we've had five years. And you have such an interesting perch [ph] and I think you go back to the early 70s in the Department of Health Education and Welfare, you served in the Clinton Administration critical in the -- in Massachusetts' Health Policy Commission and yet you've called the Affordable Care Act a complicated override of a complicated health system. So tell our listeners about where we stand.

Dr. Altman: Well, there's no question that the implementation of the Affordable Care Act has been complicated beyond what most of us expected. I think there are reasons for the complication, and in general let me state from the beginning that I'm a big supporter of the overarching outline of the Affordable Care Act. I think it's -- since I believe that all American should have a good financial protection against high cost health care and I don't -- and I think for the most part Americans are not ready for a more revolutionary program like a single payer. I think this was the only kind of plan that we get past nevertheless it has turned out to be quite a rocky road.

Margaret Flinter: Well, professor maybe one of the places we could start is some of the changes that we're actually seeing in the care delivery system. And you've noted in the past that the system of reform that we enacted with the ACA is mostly one of payment reform not care delivery reform. And yet we are seeing some transformation on the ground and some of it is tied to payment reform such as in Medicare which you have such a long history with. Maybe you could talk to us a little bit about how some of these payment reforms like bundle payments for outcomes, how are these things impacting care delivery systems and how do you think these changes might pave the way for other sectors to follow?

Dr. Altman: Well first, many of these changes are related to the Affordable Care Act but independent of the Affordable Care Act. And there's no question that in the Affordable Care Act they set up demonstrations to do both what I call accountable care organizations and bundle payment. But much of it was happening anyway. So if we're going to make any significant inroads in terms of slowing the rate of growth and health care cost, so spending, you know, we have to change the payment system. But fee-for-service system is a great system for understanding what you buy and what you don't

buy and rewarding people and provide more services which is the way we normally pay for most things. When in the area of health care, it just turn out to be a way of overpaying for services and promoting too many services, and more importantly, too many very expensive services when less expensive would do. So, we need to change the payment system. And bundle payments and the accountable care organizations is a way of doing that and allowing the health care system to adjust itself rather than having outside forces like government or the insurance companies dictate what services are available.

Mark Masselli: Well, I do want to shift gears and illuminate the work that you've done as chair of the committee of National Academies which was formed to assess progress on implementing the recommendations of the IOM's groundbreaking report, the future of nursing leading change in advancing health. And this was released back in 2010 it called for major overhaul of our approach to training and development of the nurse workforce. You just came out with a five-year progress report, tell our listeners about your key recommendations.

Dr. Altman: Just to refresh your listeners, the 2010 report really was a very path finding report of the role of nurses in our health care system, how they should be trained. And more importantly how they should be used. Just to summarize, the two or three most important recommendations, one was that states should be legislating allowing nurses to practice up to the full scope of their training and allow them to provide care independently, if necessary, and to do it in a way that's consistent with good quality care. And a number of states have implemented that law.

A second recommendation was that as nurses are being asked to do more in a more complicated health system they need to be better educated and therefore the recommendation was that by the year 2020, 80% of the nursing workforce should be baccalaureate or more. We've relied very heavily on what we call associate degree trained nurses, these are individuals who have mostly gone to community colleges and two-year institutions or three-year. And they have provided the bulk of nursing graduates. So this report says over time we ought to be moving more and more to four-year schools. It didn’t say that associate degree program should end, rather they should continue but then there should be paths that allow individuals trained in this associates degree programs to get advance training so they get a baccalaureate.

We've seen amazing progress. We've substantially increased the number of what are called pathways from associate degree to baccalaureate. So, we are seeing a growing proportion of new nurses who have a baccalaureate trained degree. And as a matter of fact last year the number of baccalaureate trained new nurses has exceeded the number that come from associate to the first time we've had that. There also was a strong recommendation for a more diverse nursing workforce. And here too we've seen

substantial progress, the proportion of new nurses who come from backgrounds of Asia, Afro-American or Hispanic has really grown. And it is by far the highest percentage of any health profession.

If we're going to have the nursing workforce better reflect the population that it serves, we need more Afro-American nurses and we particularly need more nurses who come from Hispanic backgrounds. So, substantial progress has been made but more work needs to be done.

Margaret Flinter: I wonder, if we could ask you to comment on another domain and that was the recommendation for residency programs for both new nurses after the baccalaureate degree but also for new advance practice nurses when they're transitioning to a new specialty area. How has the progress been on that? And what's the assessment of five years?

Dr. Altman: Another important area of the commission was the value of having one nurse residency program. We have a number of programs around the country and they are growing, but there's no one model and while there is good evidence to substantiate the value of residency training to have a kind of a transitional year while they're providing care but also in a semi-learning experience is good for the new entrants into the field. And it's also shown to improve quality of care. So, these are valuable programs, the problem is there are not enough of them and there is no clear model. So we really encourage more evaluation of what model works best. You need better funding, we think it adds value to the health care system.

Mark Masselli: We're speaking today with Health Economist Stuart Altman, the Sol C. Chaikin Professor of National Health Policy at Brandeis University, Heller School of Social Policy and Management. Dr. Altman chairs the IOMs Committee and assessing progress on implementing the recommendations of the Institute of Medicines report on the Future of Nursing. Dr. Altman, you know, we're less than a year out from electing a new president and I wanted to sort of get back to some of your thoughts about the Affordable Care Act. We had David Gergen on a little while ago who was supportive of the ACA but felt -- where it felt short was it just could not garner bipartisan support. What are your thoughts about how we get there?

Dr. Altman: One of the reasons for this rocky road is the unwillingness. When I was really involved in governmental at the real legislative level in the early 70s you had much more cooperation of cross party lines. You know, the democrats and the republicans will much more likely to work together. They didn’t know would [ph] agree, but once there was laws out there they worked to implement them whether it was Medicare or attempts to slow the growth of health care cost. Now you have this I think unfortunate split between the democrats and the republicans. Congressman Ryan, the

new speaker is talking about changing every word and -- and, you know, this is just bad policy.

The Affordable Care Act was compromised legislation to begin with, it built very much on a republican model in the Nixon Administration and the one that was created in Massachusetts by republican Governor Romney. It is not an advocacy position only from the left side, and yet you would think listening to the right wing republicans that it's, you know, the devil reincarnate. I'm really looking forward to what Congressman Ryan wants to propose and, you know, he's a smart guy. And, you know, there may be a number of proposals that he's coming up with that really would make the Affordable Care Act better. So I don't want to be the only critical about changes and I do think the democrats need to listen to him. But if he's just going to throw the whole thing out and really not accept the idea of universal coverage then, you know, we're in for a very stormy period.

Margaret Flinter: But Dr. Altman, two things that certainly strengthen the Affordable Care Act were the support for the expansion of community health centers now serve 23 million people but also the expansion of Medicaid. What's your sense of the impact on the investment both in expanding community health centers but also in perhaps more importantly an expanding Medicaid coverage in the states where that's happened?

Dr. Altman: This is the largest ambulatory delivery system in the world and it's been very important for the health care system particularly for serving low income populations. I chaired in 2000 an Institute of Medicine study on the future of the safety net. And here's a case where this has been a bipartisan plan, it's an important program that needs to continue, Medicaid itself is sort of designed to give individuals who are on the program a kind of a card that allows them to go anyplace. And so some people say well, if we have Medicaid we really don't need these community health centers, but that's just not correct.

I think that they work together, for many people these community health centers, neighborhood health centers are really the best place for them to get care. So the expansion is working in many parts of the country. So on one side we need to expand it in the states that haven't expanded. On the other, I do think that the administration needs to be as flexible as possible in allowing individuals state to tailor their programs. We shouldn't acknowledge that all states are not the same.

Mark Masselli: You've noted in the past that we've made a mistake by not including physicians and surgeons in health reform in your futures of nursing recommendation suggest as well that the nursing profession should be part of their care delivery system. And I was thinking about all of those in the context of the redesign of the health care system. In the context of, you know, professional collaboration, right, how do you really

get at this sort of paradigm shift where you sort of need all of the key players talking to each other? Talk to our listeners about the larger concept of -- we need to put these professional groups together, working together, so we can get good outcomes for our patients.

Dr. Altman: That was the central focus of much of our recent report. The health care delivery system is moving away from a fee-for-service individual practitioner model towards a more collaborative team base system. And so some of, if not much of the argument against the expanding scope of practice for nurses, well, it's fair to say that increasingly that argument is sort of unnecessary because our delivery system is moving away from the fee-for-service individual practitioner any way. And so in these team base chair models you do find physicians much more willing to allow nurses to practice up to the level of their license and to do it in a more independent way. And you have supervision in the sense that it's part of a team effort. So, as we expand these accountable care organizations I think a lot of this antagonism will just go away. And that's what we found as we went through the literature in this recent report.

Margaret Flinter: We've been speaking today with Health Economist Dr. Stuart Altman, he's the Sol C. Chaikin Professor of National Health Policy at Brandies University's Heller School for Social Policy and Management. And he's also the chair of the Institute of Medicine Committee assessing of the IOM report on the Future of Nursing. You can access that report at NationalAcademies.org. Dr. Altman, thank you so much for joining us on Conversations on Health Care today

Dr. Altman: Thank you very much for asking me.

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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 U.S. politics. Lori, what have you got for us this week?

Lori Robertson: Hillary Clinton said at the democratic presidential debate in November that nearly 3,000 people had been killed by guns including 200 children since the democrats had last debated about a month before. Some of our readers asked us if that was correct, comprehensive data on that specific timeframe isn't available instead Clinton extrapolated the numbers based on figures on gun deaths from past years. In 2013, there were 33,636 gun deaths, according to the Centers for Disease Control and Prevention, that averages to about 2,800 gun deaths or nearly 3,000, as Clinton said, each month of the year. These are the most recent numbers from the CDC, they include suicides which made up 63% of gun deaths that year, homicide 33% of gun

deaths and unintentional discharges, legal interventions or war and undetermined causes.

As for firearm deaths of children, the Clinton campaign relied on figures from 2010. The 2013 CDC figures for children 19 and younger back or up those gun deaths average 205 per month. But if we look only at those ages 17 and under the average killed by month was 105. We won't know the number of gun deaths for 2015 for another year or so and even then we won't be able to look at the number for a specific time period as Clinton cited.

A group called the Gun Violence Archive seeks to provide near real-time tracking of gun incidents through media government and other sources. For 2015, it counts 11,633 gun deaths through November 18, but that number doesn't yet include suicides which the group says are not reported the same way as other incidents. The group executive director told us Clinton's 3,000 figure would likely be right, once suicides are included. 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 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.

Mark Masselli: Each week Conversations highlights a bright idea about how to make wellness a part of our communities and everyday lives. For all the people in the world without limbs acquiring prosthetics can be costly and out of reach. It's especially challenging to make prosthetics for children since they are in constant state of growth. Rochester Institute of Technology scientist Dr. Jon Schull stumbled upon a clever and affordable solution, provided online open source templates to anyone, anywhere in the world who has access to a 3D printer and provide prosthetic hands for next to nothing.

Dr. Jon Schull: I've made this Google Maps Mashup, if you have a 3D printer and you'd like to help put yourself on this map. And if you know someone who needs a hand, put yourself on this.

Mark Masselli: So he founded the e-NABLE Network which has massed thousands of volunteer makers in upwards of 40 countries around the world, providing cheap but functional prosthetics for children in need.

Dr. Jon Schull: We know that we've delivered about 800 hands devices. And we suspect that is comparable number have been downloaded by people we can't track because we put all of our design on the Internet.

Mark Masselli: The movement has grown so rapidly, the simple limb designs have become more sophisticated as recipients of the prosthetic devices provide feedback for designers to make more efficient devices.

Dr. Jon Schull: These things grip or ungrip that's all they do. So they are much less functional than our biological hand and they are also less functional than a fancy Myoelectric hand. But for kids it's huge, because those expensive devices are typically out of reach for children who are now below them so it doesn't make sense for those to get a $5,000 or $10,000 hand. And, you know, our hands don't even pretend to look like regular hands they look like super hero, Iron Man hand and for that very reason they're very popular with kids.

Mark Masselli: e-NABLE a global collaborative network of open source designs linking to makers with 3D printers to provide low cost prosthetic limbs to children and adults around the world who might otherwise not be able to afford them, now that's a bright idea.

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Margaret Flinter: This is Conversations on Health Care. I'm Margaret Flinter.

Mark Masselli: And I'm 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.