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Margaret Flinter: 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 health care of the future. This week, Mark and Margaret speak with the former CMS administrator, Don Berwick, who's also founder of the Institute for Healthcare Improvement, a global organization dedicated to improving health care and health systems around the world. He'll talk about decades of work towards reform of the health care system and how to make it more accessible, higher quality, and less costly.

Lori Robertson also checks in, the managing editor of FactCheck.org, looks at misstatements spoken about health policy in the public domain, separating the fake from the facts. We end with a bright idea that's improving health and well-being in everyday lives.

If you have comments, please email us at chcradio@chc1.com or find us on Facebook, or Twitter, iTunes, or wherever you listen to podcasts. You can also hear us by asking Alexa to play the program, Conversations on Health Care. Now, stay tuned for our interview with Don Berwick on Conversations on Health Care.

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Mark Masselli: We're speaking today with Dr. Don Berwick, President Emeritus and senior fellow at the Institute for Healthcare Improvement, and former administrator of the Centers for Medicare and Medicaid Services. A pediatrician by training, Dr. Berwick has served on the faculty of Harvard Medical School and Harvard School of Public Health. He was vice chair of the U.S. Preventive Services Task Force and served on the Institute of Medicine's governing board. He earned his MD cum laude from Harvard Medical School.

Dr. Berwick, welcome back to Conversations on Health Care.

Dr. Don Berwick: It's a real pleasure to be with you. Thank you.

Mark Masselli: Yeah. We had you back in early 2012. Affordable Care Act had been passed in the spring of 2010. You were on that ground floor of the policy development. You've recently published a powerful article in The Journal of American Medical Association, in which you lay out some of the political challenges that have long been embedded in the American health policy. I'm wondering if you can just give our listeners an update on the ACA and really sort of where it stands. I'm thinking about the two lenses that you've used to describe the Affordable Care Act. One that it was to give people more insurance, and two is to make the health care system better. What's currently going on there, if you could just give us a lay of the land?

Dr. Don Berwick: Yes. I have, as you said, conceded the Affordable Care Act as actually kind of two laws in one. One to get more people covered with better coverage, and the second to help health care change and improve, so it does a better job. On the first grounds, the Affordable Care Act's potential was to cover about 32 million people, 16 million by expanding Medicaid coverage and 16 million by setting up these affordable exchanges with subsidies to people, so they can afford insurance, if they're not eligible for Medicaid, but are lower income.

Unfortunately, we're back-paddling on both. The Trump Administration is doing everything it can to slow progress in coverage. They want to dial back the Medicaid expansion. They have made it possible for Medicaid benefits to now be much less valuable to discourage states from expanding and to eventually end up with what it called block grants, that is instead of the federal government being the coinsurer in Medicaid, they just give money to states and states to do whatever they want with that money. As a result, Medicaid expansion has slowed. There are people now, especially under the new work requirements, who have had Medicaid who are going to lose it.

This is hurting people badly at the lower end of the economic spectrum. On the expansion of exchanges, in order for the exchanges to be vibrant, the federal government has to step up and make sure that the exchanges are offering insurance policies that cover what they should, so that people aren't going to be surprised to find themselves not covered and the subsidies have to stay in place. There are a number of maneuvers the government is now made to cut back on the subsidies to make it possible for insurance companies to offer a far less valuable insurance coverage. You're going to buy insurance and discover it doesn't cover something you really need. Effective coverage is going backward. It's a toxic trend. I think we're backing away.

By the end of the Obama Administration, we had about 20 million people coverage of the 32 million that could have been. That's decreasing now, unfortunately. On the make health care better front, there's also some dialing back. There's been some wonderful experiments done with new forms of payment that help health care providers offer far more continuity. Those experiments could have been cut back on. I think we're seeing less progress than otherwise would. We lack the kind of federal leadership we need to have universal coverage in health care reform. It concerns me.

Margaret Flinter: Well, Dr. Berwick, for all of us who were deeply engaged in health care before the ACA, there are certainly so many things which we thought clearly in a very tardy way addressed some of the persistent problems that people in this country faced in getting the coverage

and the care they needed. You laid out in your article, Politics and Health Care, some of the political challenges that we've grappled with. You chart the rise of these new potential threats to health reform, some of which you've referenced and in the context in the environment of changes in the makeup of the Supreme Court.

I wonder if you could just help our listeners understand how the makeup of the High Court really has the ability to significantly affect the health reform progress that's been made, and also how state government could play a strong role in determining health policy as we go forward.

Dr. Don Berwick: Yes, that editorial in The Journal of American Medical Association, it was actually an editorial about two articles that were in that issue. One was an analysis of the probable effects of a shift in center of gravity in the Supreme Court and the nomination, and confirmation of Brett Kavanaugh we have on health care. First of all, the Affordable Care Act itself requires support from the Supreme Court. There are interpretations that matter that say that it's okay for Congress to set up a system, which expands Medicaid, and which provides more coverage to people. I think there's a threat now that the ability of the agencies in HHS, CMS, and others to actually protect beneficiaries will be decreased under a Supreme Court that where the center of gravity has shifted.

The basic fundamental idea here is health care human right. The question is do we have a court that actually wants to make sure that people have access to care as a matter of justice. I'm worried about that. Obviously, the well-being of women is at stake here. Certainly should Roe v. Wade be overturned, we're going to see a wave of serious harm to women of childbearing age. I think we could see contraceptive coverage decrease as well. I think there's enormous harm possible with a court with a shift in the center of gravity.

The bigger picture in my editorial was kind of speaking to doctors and nurses. If you're a doctor, you want to see patients. You really would prefer not to have to deal with politics. Let me see my patients. This political circus go on. What I'm saying is that's not possible. Politics is in health care in America as well as other countries, but in America especially because with $3 trillion of the economy at stake, vast forces enter the picture. I'm really urging clinicians to step up and protect patients, and become politically activated. I think we've got to do it rather than being naïve.

Mark Masselli: Your article really is a clarion call. In particular to the young practitioner who's starting off their career, you know that physicians ignore politics at their own [inaudible 00:07:29], and those of their patients as well. I'm wondering what your advice is. What do you think a meaningful engagement will be for someone who's also got a

full-time clinical practice? What's the practical advice that you have?

Dr. Don Berwick: I don't want to be glib about it. There are tiers of engagement where people have their lives to lead. First, vote. The turnout in American politics, the voting turnout is dreadful. The very people that are being hurt the most aren't the ones that are voting. I'd say physician, nurse, you vote and get people to vote, and be part of that call. Doctors are respected. Nurses are respected. When they take positions, patients listen. They're trusted. I think that it's your judgment call as to whether you want to bring that in the consulting room. I think speaking out now about the idea that if we don't protect health care as a human right, we're all going to get hurt.

I believe physicians should run for office and nurses too on the left. We have a number of members of Congress who are doctors. They are almost all on the right wing side that I disagree with. I think we need activation. I'm seeing that there are more and more clinicians running for office, especially women. I celebrate that. I really encourage people to consider doing that.

States stepping up is key. The biggest difference in this realm between the state and the federal government is the federal government can print money. It can borrow money. It can have a deficit budget. States cannot. That's a big inhibitor. That doesn't mean states can't take highly protective acts toward protecting access. I'm seeing attorneys general around the country step up and say that they're bringing a suit against the administration to protect human rights.

On benefit structures, there are some more subtle things to do. A very important one is that as any doctor or nurse knows, health is not really determined by health care. It’s determined by social factors, education, transportation, housing, income inequality. When state legislatures and state leaders act on issues like that, they actually are working on health and they need to. Housing and transport, and education are very important contributors to health and well-being. Doctors need to speak about that as well.

Margaret Flinter: When we first came to know you, it was really through your work on patient safety. You've taken that work all over the world. I know you were called upon by the National Health Service in the United Kingdom. I think Queen Elizabeth knighted you for the contributions that you've made. Love for you to comment on the big advances we've made in patient safety in health care.

Dr. Don Berwick: Well, the progress has been tremendous. We now know the problem. You can't work on a problem you can't see. The evidence base is now showing how much error there is in medicine, how many people are harmed by care. That's in a way, good news. Now that we know about it, we can pour point attention to it. That's happening. Just this

month, three reports appeared on the global health scene, one from the Lancet Commission, one from the WHO, one from our own National Academy of Sciences, which I report that I co-chaired, called Crossing the Global Quality Chasm. They are three important reports laying out the dimensions of the problem.

We also have examples of success. I'll take for example the Country of Scotland. Amazing what's going on there. The entire country has been mobilized to make patient care safer. The results are stunning. They've got well over a 20% decline in surgical mortality. They've got a major decline in errors in care that they can document. When you get mobilized, we can do stuff. The science is advancing really fast. We've woken up. We understand the science is a safety. Now we need leadership. The big deal here is with boards of trustees, CEOs of hospitals, chief medical officers, chief nursing officers, please understand that making patient safe is job one.

Mark Masselli: We're speaking today with Dr. Don Berwick, President Emeritus and senior fellow at the Institute for Healthcare Improvement, and former administrator of the Centers for Medicare and Medicaid Services.

Dr. Berwick, you've talked about these inherent challenges in the American health care system. We're seeing big players coming in. You've got Amazon partnership with Berkshire Hathaway, JPMorgan, Chase coming in, you've got Apple, and other technology giants entering into the personal health technology space, but also looking at how do you control cost here. I'm wondering what you think about these disruptive innovations and business models that are entering the health care space? What's good about it and what keeps you up at night?

Dr. Don Berwick: Health care is -- it's really, I guess, broken is the way to say it. The way we book the health care system in our country is far too expensive. It way underserves populations for all sorts of reasons. It's like asking a tank to fly. You need airplanes. Some basic restructuring is going to be needed. We need to work much harder on continuity of care, on reliability, on safety. The health care system has had trouble doing that. It's had trouble changing. There are too many changes in store.

With these new entrants, like the Amazon, Berkshire Hathaway, JPMorgan entry, the combination of CVS and Ensure [PH 00:12:18], the work I think developing in Google and IBM, and others, I think we're going to be seeing some really wonderful innovations, basically new ways for people to find help, to get care, more immediate, lower cost, more responsive, customized to them as individuals, more adaptable, more portable. There is really good news here.

Of course, the downside risk is we better do it with discipline. Some of these innovations are not going to work. We need to make sure they

are subject to proper scrutiny and evaluation, and regulation when needed. Back to the mainstream, we're still going to have hospitals. We're still going to have doctors' offices. They're not going to go away. We have to work on quality within the mainstream system as well. I'm pretty excited about what's happening. My recent encounters with telemedicine and telehealth for example, where you can take consultations and project them virtually, it's amazing. The miles between has dissolved. Suddenly we can help each other in ways we didn't think possible before.

Margaret Flinter: Well, Dr. Berwick, we are also very excited about all those things and the possibility of relationships between patients and their care providers being enhanced and augmented, not replaced necessarily by virtual care. A lot of very interesting work going on. A really big issue of concern and we're reading more and more about it in the literature is the epidemic of clinician burnout. We're hearing that people are kind of at the end of their wits, the people who are providing care, that they're exhausted, that the work demands outpace what they can do, that they're challenged by everything from some of the additional responsibilities that have come with electronic health records, which we embrace on the one hand, that have made things difficult somewhat on the other hand.

What are your thoughts on this? We see this as a patient safety issue obviously. You want your clinician to be satisfied and filled with joy and practice, not feeling burned out. What are your thoughts about what we should be doing in that arena?

Dr. Don Berwick: Well, the problems of clinician burnout are serious and dangerous, and pervasive. Half the doctors in the United States now say on a survey that they would not advise a young person to become a doctor. That's terribly sad, if you consider how wonderful this profession has been and can be. We're asking people to do impossible jobs now. We've taken health care and we've layered in administrative burdens, reporting burdens, measurement burdens, payment systems, productivity targets that make no sense. We will never ever get excellence by trying to drive doctors and nurses, and other workers in health care harder and harder. They will burnout. Of course they will.

What we need is different care, care that supports them, and doesn't stand in their way. Part of this is getting out of this current wave of way excessive metrics. Everybody's spending all their time reporting measures. Yeah, we want transparency, but we need doctors to spend their time talking to and being with patients. The electronic health record, which has tremendous promise, it's now pervasive. Almost all hospitals have it. More and more doctors do. It isn't working right. The way we built the electronic health record is actually adding work.

It's adding nonsense to care. Doctors and nurses know it. We need a whole round of revision of the way we're looking at electronic records, so they actually support the care instead of standing in the way of it. There were actually more bills often as the billing systems than these care systems.

We need a change of attitude. We're not going to fix this by yelling at doctors and nurses. It's not going to happen. They're doing their best. We're going to fix it by creating systems in which people really can focus back on the needs of individual patients. Part of it is changing financing. I am publicly in favor of Medicare for All global payment, in which we finally give health care organizations budgets to health care for populations, so they don't have to keep running on a durable cage and doing more and more in order to survive financially. We need them to focus on what matters to patients. That's going to require a different financing.

Mark Masselli: I was thinking about your comment about Scotland and the work that's going on there, and talking about Medicare for All. We see a lot of these European systems where their government is financing them. What are we seeing around the globe that you think can crosswalk over to the States? Or I think we had David Gergen on the show. He really talked about we need an American solution. I'm not sure that's always the case. Are there best practices that can be integrated into our system that could flourish here? What are you seeing as you look around the globe?

Dr. Don Berwick: Your question is right on target. When you say best practices, we -- like for almost any question, we do have an answer. The problem is the answer is not everywhere. Even if we just look within the United States, I'll take for example Kaiser Permanente's focus now on well-being and upstream work on housing and transportation, and risks in their population. It's quite thrilling to watch. On the environmental responsibility, health care has a big role to play in stopping global warming. We see examples like the Gundersen Lutheran System in Wisconsin, which has -- it's become not just carbon neutral, it's actually -- it's a carbon reducing part of the health system. That's exciting.

With respect to patient-centered care, we have plenty of examples where patients are getting tower in health systems and changing the systems like Cincinnati Children's Hospital in Cincinnati, Ohio. Patient safety breakthroughs, we've seen zero. We've seen actually reaching zero in infection rates and complication rates in places that are dedicated to it. Outside the United States, I'd say even more innovation in delivery because of a different financing system. Not all are single payers. Some are multi-payer systems. They have government as an insurer of last resort, so everyone is covered. In

places like Scotland and Sweden, and Singapore, and even Malaysia now, you're seeing innovations toward moving to much more health and well-being in care systems. We can certainly learn from those.

Margaret Flinter: We've been speaking today with Dr. Don Berwick, the President Emeritus and senior fellow at the Institute for Healthcare Improvement, an independent, not-for-profit organization, seeking to improve health and health care worldwide. You can learn more about their work by going to ihi.org or follow Dr. Berwick on Twitter @donberwick.

Dr. Berwick, thank you so much for your dedication to improving the health care system here around the world, for all you've contributed to our advances of recent years, and for joining us on Conversations on Health Care today.

Dr. Don Berwick: You're very kind. Thanks for having 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: The Department of Justice is siding with plaintiffs in a lawsuit that it said, if successful, would end Affordable Care Act protections for those with preexisting conditions. Yet President Donald Trump claimed that “preexisting conditions are safe.” He said that he “will always fight for patients with preexisting conditions.” The lawsuit in question was filed in district court in Texas in February by 20 states. It argues that because Congress eliminated the tax penalty associated with the ACA’s individual mandate, that the mandate itself is now unconstitutional. Without the mandate, the entire health care law must go. The suit bases this argument on the Supreme Court's 2012 decision that Trump’s mandate was lawful under Congress' power to tax.

In June, the Department of Justice said this was a rare case, where it would not defend the federal government in the lawsuit. Instead the DOJ largely agreed with the plaintiffs. Attorney General, Jeff Sessions, wrote in a June letter to Congress that he had made this decision “after careful consideration and with the approval of the President of the United States.” Sessions explained that the administration didn't agree that the entire ACA would have to go. Two provisions would need to be eliminated. Those guaranteeing that people can't be denied coverage by insurers or charged more based on certain

factors. Those provisions protect those with preexisting conditions from being denied a policy or charged higher premiums. Before the ACA instituted these protections, insurers could deny coverage or charge more based on health status on the individual market.

In early September, the district court judge in the case heard oral arguments on a preliminary injunction against the ACA, requested by the plaintiffs. It's misleading for the president to say he "will always fight for and always protect patients with preexisting conditions" when his Justice Department with his approval has decided not to fight.

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 would checked, email us at chcradio.com. We'll have FactCheck.org's Lori Robertson check it out for you here on Conversations on Health Care.

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Mark Masselli: Each week, Conversations highlights a bright idea about how to make wellness a part of our communities and everyday lives. Over the past few decades, kids have been getting less and less physical activity throughout the school day. As budgets have been tightened and achievement requirements have increased, Phys Ed. has become less prevalent in many schools. University of Michigan researchers wanted to find a creative and effective solution that would increase kids' movement without disrupting the school day.

Dr. Rebecca Hassan: We looked at the scientific literature in terms of prolonged sitting. They have demonstrated that if you just two minutes of activity, get up, do some movements, sit back down, activity in that small of a doze can have dramatic improvements on health, on cognition, on learning. We decided to develop an intervention, a program, that would allow children to get these small bursts of activity throughout the day.

Mark Masselli: Dr. Rebecca Hassan [PH 00:22:31] wanted to find out just two to three-minute short bursts of physical activity five times a day done right at the student's desk would impact the kid's cumulative movement.

Dr. Rebecca Hassan: We typically see in PE or recess lower participation in girls compared to boys. In classroom activity breaks, you actually see similar rates of participation, if not higher rates of participation, in girls compared to boys. We also saw that for children who are carrying few extra

pounds that those children also were exercising at a high intensity. We did not see any differences by weight status. Even children with asthma, they were even able to do the activity breaks.

Mark Masselli: Dr. Hassan said they wanted to design the intervention that would be easy for teachers to adopt and manage.

Dr. Rebecca Hassan: Our lab, we created a compendium of 200 activity breaks that are just three minutes long. We got a lot of positive responses, particularly for the videos from the teachers because it was really easy to implement. There's no rules that you have to explain. It's quickly, get the children up, press the button, move, get the kids back down, and then we're back on task.

Mark Masselli: Dr. Hassan said that the most promising results were in the cumulative effects of the multiple burst of activity throughout the day. Kids burned on average about 150 more calories per day and at the end of the week had accrued a significant amount of physical activity.

Dr. Rebecca Hassan: The kids, when they went home, they still continued to be physically active. We had these little accelerometers. It tells us how much physical activity were they getting.

Mark Masselli: A low cost, easily adoptable fitness intervention for kids, allowing short bursts of physical activity throughout the school day, enhancing fitness, empowering kids to move more, now that's a bright idea.

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

Margaret Flinter: 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 email 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.

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