(Music)

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

Margaret Flinter: And I am Margaret Flinter.

Mark Masselli: Margaret, the seasons are changing, fall is just around the corner, yet the decisions on the legal challenges to Health Reform still remain the same, unchanged. The appellate court weighed in on the Affordable Care Act last week affirming the administration's argument about the individual mandate being a tax in ruling that plaintiff's lack standing.

Margaret Flinter: And you know, I think it's the start of our third year of this show and that's a good title, this is the Third Appellate Court to voice its opinions this year. So it was back in June when the six-circuit in Ohio ruled that the individual mandate was constitutional and then in August the 11-circuit in Atlanta ruled it was not and not to be outdone. The Federal District Court in Pennsylvania just struck down the individual mandate as unconstitutional. This is going to suffer us.

Mark Masselli: I don't know if it will. Certainly, it's headed towards the Supreme Court who has the final say on this. It will be interesting to see when they decide to weigh in.

Margaret Flinter: And always remind each other and our readers that far beyond the contentious individual mandate and much in the Affordable Care Act seems to be contentious these days. It's good to remember that the Affordable Care Act also had a big focus on job creation and on Health Information Technology both of which are potentially inspiring to our economy.

Mark Masselli: It involved the president is traveling around the country trying to build support for his new job bills. He has also declared this week Health Information Technology Week.

Margaret Flinter: That's right. And as part of Health Information Technology Week, the Health and Human Services division of our government held a firm on Monday and they announced some new rules expanding patients' rights to access their own health information, and as we have come to expect from the folks that HHS relative to Health Information Technology, there are actually some exciting, dramatic moments in that Mark.

Mark Masselli: And it was Todd Park wild and crazy guy that he is what energy he has. Many of the participants at the event were there to announced the Blue Button program and the Blue Button program which was announced last October

really got its groundbreaking kick-off at this event with many organizations signing up in sort of a public display of unity.

Margaret Flinter: And I think I heard Todd Park inciting United and Aetna insurance giants to compete with each other by how many millions of people they could get using that Blue Button to access their own health information. And right here, in our Community Health Center, we have also been encouraging our patients to sign up and use our patient portal so they can their own health information. We look forward to more innovations in bringing our patients into the fold.

Mark Masselli: And certainly, with Don Berwick, the Head of CMS, we are certainly bound to get more focusing on patient access to health information as a cornerstone to improve quality and safety of our healthcare system.

Margaret Flinter: And you know, and another way to approach quality Mark is through something that people still call Patient Satisfaction Service but I think we started really thinking of them as understanding the patient experience. And our guest today, Dr. Cleary has led many efforts over the years to increase our sophistication and our ability to use the experience of patients and tools that measure that to directly improve the quality of healthcare in our healthcare systems. Dr. Cleary is the Dean of the Yale School of Public Health and the Chair of the Department of Epidemiology and Public Health at Yale.

Mark Masselli: We are happy Dr. Cleary with us. We would also like to welcome our new friends at WQUB-FM in Quincy, Illinois who starts broadcasting Conversations this month and for people who are listening to us and who want to know more about us, go to Google and just type it CHC-Radio and see what you find.

Margaret Flinter: Welcome to our friends at WQUB, and as always, if you have feedback, e-mail us, we would love to hear from you. Now, before we speak with Dr. Cleary, let's check in with our producer Loren Bonner for the Headline News.

(Music)

Loren Bonner: I am Loren Bonner with this week's Headline News. In its latest report, the census bureau released new data that indicates a rise in the number of uninsured Americans. The number rose to 49.9 million in 2010 from 49 million in 2009. The percentage of uninsured 16.3% did not change. Also, despite the economic downturn in the percentage and number of people covered by Medicaid 15.9% and 48.6% did not change in 2010.

(Music)

Mark Masselli: Today, Margaret and I are speaking with Dr. Paul Cleary, Dean at the Yale School of Public Health and Chair of the Department of Epidemiology and Public Health. Welcome, Dean Cleary.

Dr. Paul Cleary: Thank you very much for having me.

Mark Masselli: Since the 1980s, you have been actively involved in research focus in a person living with HIV and a sociologist who invested the ways in which HIV affected people's lives. You and your team have looked at physician and clinic characteristics to predict the quality that patients receive. I think it's fair to say that one word that keep showing up in everything we read about you is quality. How do you have to find and measure the quality of care that patients receive not just in the HIV space but in medical care generally?

Dr. Paul Cleary: Well, as you can imagine especially may be in an academic there are a lot of ways of defining quality but certainly a very simple heuristic I often use is that people should be getting the care that they need. People shouldn't get care that they don't need and the care people do receive should be preferred by correctly and appropriately. So you and I should not receive a cardiac procedure, we don't need, and you may say well that's a silly example but it happens all the time. People who don't necessarily need certain procedures or activities we see them. What we are more familiar with is a lot of people don't receive what the care they need. So for example, you mentioned I do a lot of work in HIV, many people and I were aware of their HIV status those who don't get care and so on. And then the third of course, if any of us goes to the physician or the nurse or the clinician who is providing care, we would like that care to be provided correctly. We would like the right drugs, we would like the right treatment and so on and like that I have done appropriate research. Obviously when you get down the devils in the details when you started doing studies, you are trying to get very, very precise measures because of the basic concepts.

Margaret Flinter: Dr. Cleary you are founding members of the Picker Institute which is a major force in promoting the idea that routinely monitoring the patient experience and I emphasize that's the experience from the patients' view is a critical element of quality assessment and you have done some very important work in developing survey protocols for quality assessment and patient satisfaction, as one strategy that might actually improve healthcare and thus health. So tell us a little bit about the state of the art and science around measuring the patient's experience and how does that translating into practice and even into policy with some of our major programs like Medicare if it is.

Dr. Paul Cleary: Sure. So you just ask me broadly about quality of care and there is a lot of aspects of quality of care. I mentioned access in technical quality you know if you are getting a pharmaceutical that should be the appropriate drug; it should be the appropriate dosage and so on. But there is what we call another

one facet of quality is patient centered care, patient's care should meet their expectations and be appropriate and patient should be treated with dignity and respect and so on and there are varieties of aspects of care. So let me just start there, so that's in addition to technical care I think you and I, if we went to the doctor and we would think a quality interaction and the physician would think of quality interaction was a situation where got the information we needed, we were treated with dignity and respect, we were given an opportunity to express our reasons for the appointment and so on. So that's how we think of quality of care and then you say, well how do you measure that? Well, there are a variety of aspects of care and I would argue and I think almost, most people would now agree with that patients are the best and only source of information about the quality of care. So for example, you and I go to the doctor and someone says to the doctor, well did you explain to them how to treat their hypertension, he or she may say, oh I did a fabulous job. On the other hand if they ask you or me we might say I got an explanation but I didn't really understand it, so I am the only person who can say whether I was given information in a way that I understood where I was given an opportunity to express my needs whether it was repeated with respect and so on. So to get it back as you mentioned I was one of the founding members of the Picker Institute, we at that time, this is a institute that was started by Harvey Picker, he is very concerned about the quality of the interpersonal aspects of care for it United States began developing specific questions to ask patients to understand what are their experiences and I use the word experiences not satisfaction because there is a gazillion satisfaction surveys but again cut the chase I could be satisfied with lousy care and dissatisfied with good care. What we try to move towards was questions that get that specific experience of things that should have happened or shouldn't have happened. So I just gave you one example, were your questions answered in a way that you could understand that might be a question we would ask.

Mark Masselli: This is Conversations in Health Care. Today we are speaking with Dr. Paul Cleary – Dean of Yale school of Public Health. Dr. Cleary would be little remised not to mention that you also received the Picker Award for Excellence in the Advancement of Patient-Centered Care. So congratulations on that.

Dr. Paul Cleary: Thank you.

Mark Masselli: And you were recognized for your tireless effort to illicit patients experience through well designed surveys and success in demonstrating that quality patient experiences are linked to positive patient outcomes. Now Margaret and I are particularly fascinated with this level of work in part because we run a community health center where patients are at the core of the organizational design and delivery model. So tell us who out there is translating this focus on patient centered care into public health? Where do you see it happening where are the best practices.

Dr. Paul Cleary: You know this is going to sound obvious but one of the fundamental principles of quality improvement is you need to know what the quality is before you can improve it and so getting the data out there, it's necessary, obviously not sufficient. I have to do many things after we get the data out there, but it's a necessary condition for this. And now that we have national data this is really very, very facilitative and groups like CMS various purchasers are what we think encouraging for example, MCQA through their efforts they made enormous impact on the quality of care to the United States, by measuring and publicizing variety of indicators of care quality and managed care plans. One of those indicators is the cap survey, different purchasers using what they call pay for performance so they are basing part of their reimbursement on their scores right now. For example, CMS has a program called Value Based Purchasing where they are actually basing some of the reimbursement hospitals on their cap scores. So you know for example, I know people I have known for years, I know many people in the healthcare industry as you might imagine and they have nominated these surveys for many years and now increasingly I would get a call, Paul you know that just was really a priority but that isn't, I don't want to say it great because now there is money on the table which we are particularly interested.

Mark Masselli: It's more important.

Dr. Paul Cleary: Now, you know I should say my personal opinion is most providers most of the time provide superb care and they are motivated more by professional norms and goals and their own standards than money but the point is there is a lot of leverage now and tools out there for trying to improve the patient experience.

Margaret Flinter: And we have certainly learned amazing amount and continue to through ongoing surveying of our own patient's experiences. So we appreciate your leadership in this field. And Dr. Paul turn to the issue of community engagement if you will Dr. Cleary during your tenure as Dean of the Yale University School of Public Health, you have certainly make community engagement an issue for the school and the university and I think it's fair to say that historically there has been tensions in some urban centers that are home to major academic institutions where the local residents may feel they are often the focus of the study but not the beneficiaries of the outcomes of the research. So tell us a little bit how you have made research and interventions available to your New Haven Connecticut Community and your goal of being a good neighbor and your goal of being a good neighbor and I will be particularly interested in hearing a little bit if you will about the community alliance for research and engagement or the care initiative.

Dr. Paul Cleary: Sure and let me just quickly say not only is that a fair statement that there is not often an ideal relationship. I think it's sadly very, very common and some of the first meetings I went to when I became Dean here was with

community groups and with individuals in the community and there was quite a bit of tension and they said things like well Yale wanted us to study we never even heard the results of it and so not only did the study now contribute to the community, people didn't even have the courtesy of letting them know what happens and I often summarize the school public health mission is research education and service and I think we are best at providing service based on the research we did. That's what we are really good at. We learn about prevention and about healthcare and that's what we can translate most effectively and I just very, very early on tried to make it clear that we have a moral obligation to really communities throughout the world to translate some of what we know into better health. We have healthcare programs throughout the world but of course our closest neighbors are New Haven residents and I often sort of said just to be provocative that if when my term of dean was ended New Haven was not healthier than it was when I got here everyone in the University should consider my tenure a failure. And remember President Levin looked at me when I said you might not succeed at that right and I said, well of course, that's a hard task but I think we should set that kind of goal. And you mentioned care, the community alliance or research engagement one of the reasons I think academic institutions don't do as much as they should or as well as they should with respect to the communities is sort of it's not their normal routine it's hard to have what we call sustainable program, you know you got to do one study the grant ends and (inaudible 16:24) the investigated the money is gone, you have to move on to the next project and so on. So it seemed to me one of the fundamentals for making this is a better relationship to have an ongoing relationship not study A and study B and study C, but to develop a relationship whether it was engagement or you could consider research and so on.

Mark Masselli: But in addition to training leaders to make significant contributions to global health research you are personally recognized for your work with students to develop their re-interest in skills and health and health service research, what leaves you optimistic about the next generation of public health professionals and healthcare providers?

Dr. Paul Cleary: Well, two levels of answer – one is just sort of my experience of the field of healthcare, so we were talking about patient centered care before we were talking about quality measures. I have been in this field long enough such that I remember when you would have a discussion with a group that you had an idea about measuring quality of care that people would sort of look at you almost like well who do you think you are that you can define quality of care where quality of care is. Virtually no one reacts that way now. It's just part of the it's in the air, it's part of the culture that there are quality problems that people make errors and that we need to improve those. So that's a dramatic improvement and when I first started doing patient centered care, people would look at you like well that's not serious and I give you one example. The first national survey we did at the Picker Institute of Patient Experiences of Care I was very excited, we got funds do a national survey it was the first time we had looked at this issue

nationally and submitted it to a very prestigious journal and didn't get into that. Eventually got into health affairs but it didn't get into the first journal and I will never forget two separate reviewers set our job just to get patient side of the possible reply. This is not basically this is not important and now it's my phone literally rings up for her. There are people are constantly trying to measure and improve care. So that's the – sort of that's the environment. Why am I optimist, kind of incredibly optimist is because of sea change, there is so much interesting quality, groups like CMS are now watching initiatives and have financial incentives purchasers, buyers etc so and the Affordable Care Act finally after decades and decades of trying to get some kind of comprehensive insurance program, you know people insure we can address the basics and move on so that's the sort of the system answer. But you asked about the people and all I can tell you or people often ask me what's the worst part of your job what's the best part of your job. Hopefully there is no bad parts in my job, but the best part of my job, the answer always comes almost instantaneously is the students and people start to look at me because you know students require attention. Sometimes they have issues that need to be addressed and so I say, well why do you say that. And I said the students I made virtually to a person are just incredibly bright, they are incredibly motivated, they are creative, it just boggles my mind. They go off and do internships throughout the world, they come back and these days it's very easy to become cynical especially when we are talking about sort of the disparities in income which I think are unconscionable right now. Basically every student in our school has decided to pursue a profession where it's almost certain their income will be less than new professions they could pursue. These are really, really smart and really motivated students and are really motivated to make a difference. So when I have the opportunity to meet with those students every year and see how smart they are, how motivated they are, how creative they are I just have almost unlimited optimism and that's one of the things I tell them every year that's I say the best day of my year's commencement because I see those students, I see their parents, and I go around the country so I see our alumni, I see them in China and Russia and Brazil and South America, other parts of South America and Canada and United States and I see them in real towns and cities and they are just doing an incredible work. So when your job is interacting with people like that I just can't help to be optimistic.

Margaret Flinter: Well Dr. Cleary we share your optimism about the next generation and speaking of their creativity we have one final question we would like to ask all of our guests, when you look around the country and the world what do you see in terms of innovation and who should our listeners at Conversations be keeping an eye on?

Dr. Paul Cleary: The change that I am seeing now is – may be this is now you are asking about in terms of innovation but in the past we used to do study X and study Y, whether it was bio medical or social science or whatever. The change now is that people are starting to think about broad systems of care, in another

words you can't just go into a community health center like you have and tell the nurses to do X in terms of answering questions really need to think about the whole community health center and similarly at New Haven you can't just go in and want to know HIV screening program, you need to think about how is the neighborhood affecting that, how are individuals affected and how are the policies affected and so that the innovation if you will and I don't think this is what you are asking but I will answer it anyway, innovations is really thinking about broad systems so for example the head of our global health initiative Betsy Bradley is working in several countries throughout the world. Recently she launched a program in Ethiopia where she was engaged with everyone from the minister of health on down to nurses and hospitals really transformed the way hospitals were managed, to rethink how they were approaching it and so I think that was so successful it was asked by the Clinton Foundation they got at Liberia and so what's different there is it's really a very comprehensive approach. We are just thinking about the entire system and the multiple facets that affect this.

Mark Masselli: Today, we have been speaking with Dr. Paul Cleary – Dean of the Yale School of Public Health and Chair of the Department of Epidemiology and Public Health, Dr. Cleary thank you so much for joining us today.

Dr. Paul Cleary: Thank you very much for having me. I appreciate the opportunity to talk to you about these issues.

Mark Masselli: Each week Conversations highlights a bright idea about how to make wellness a part of our communities into everyday lives. This week's bright idea focuses on an initiative that could change the way we think about delivering preventative care. In 2007 Dr. Bert Peterson, a prominent New York cancer surgeon, approached leaders at Harlem Church about creating a program to address health disparities affecting African American man in Harlem. As a champion of the under privileged, Dr. Peterson wanted to do something about the fact that African American men specially those living in urban areas, disproportionately suffer from many chronic diseases like diabetes and heart disease. Dr. Peterson's Church – the Abyssinian Baptist church also Harlem's largest took action. It partnered with Harlem Hospital Center and St. Luke's-Roosevelt Hospital to launch the Barber Shop Quartet. Mobile medical units staffed by medical professionals park outside different Harlem neighborhood Barber Shops on Saturdays during the spring and summer months. Then, from the barber shop or from off the street come in and receive free screening for diabetes, hypertension and prostate and colon cancers. It's first come first served with no eligibility requirements. Men also receive free education about the screening and follow up care if needed. Program staffs follow up by phone with the results and St. Luke's provides free treatment if the person can't afford it. According to the agency for Healthcare Research and Quality the program is increased access to need its screening and treatment since it began five years ago. Targeting preventative healthcare to minority population in the context of the community, 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.

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