(Music)

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

Margaret Flinter: And I'm Margaret Flinter.

Mark Masselli: Well Margaret as expected congress led the deadline come and go, March 1st deadline to reach a budget deal or let $85 billion in discretionary spending cuts go into effect across the board and here we are.

Margaret Flinter: We are and what a challenge for the White House to manage expectations and reality on this one. Analyst are predicting that the budget sequester could go on for weeks even for months and we have programs that are faced with I think some very harmful cuts.

Mark Masselli: If you are listening to Health and Human Services Secretary Kathleen Sebelius, she's warning there are some **(0:36 inaudible)** that will be impacted in health care.

Margaret Flinter: That's right and her offices issued a report on the sequester cuts. They predict that about 3000 fewer patients will be admitted for inpatient procedures and maybe as many as 800,000 fewer outpatient visits will be covered now that the sequester cuts are coming through.

Mark Masselli: Well Medicaid and child health insurance programs are exempt from the cuts, Medicare is not. The cuts could lead to a 2% reduction in Medicare reimbursements for health practices which may not seems like a lot but it would be a real hardship for practices in hospitals with high concentrations of Medicare patients.

Margaret Flinter: Well that's right and remember many of these hospitals were also looking at reductions at the state level so we can only wait and see what kind of agreement may be reached. But speaking of physician reimbursement there's a very interesting report out this week, the national commission on physician payment reform is urging an end to the fee for service payment model in health care and in end to the sustainable growth rate model for compensating physicians treated under the Medicare payments, such big news.

Mark Masselli: It is and that's an interesting report because it suggest a complete overhaul of the way public and private funds are used to compensate for health care delivery and that unless these systemic problems are addressed we won't adequately be able to address the cost containment issues in health care.

Margaret Flinter: Now, our guest today is well versed in another area of health care that needs work. That's the lack of a national program to adequately plan for the healthcare workforce needs of the future in the United States.

Mark Masselli: Dr. Kavita Patel is Co-Chair of the Bipartisan Policy Center, Professional Workforce Initiative and we'll discuss their recent report on ways to improve health care workforce projections for the future.

Margaret Flinter: It's actually very exciting, the work that they're doing. She'll be telling us about their recommendations for creating a national system that better assist the government, teaching hospitals, universities and school and the health professions to build that skilled workforce that we need to meet the growing health care demands in this country and to do it to a new model.

Mark Masselli: We're getting here from our favorite friend Lori Robertson, Managing Editor of Factcheck.org 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 comments, e-mail us at chcradio.com or find us on Facebook or Twitter because we love to hear from you.

Mark Masselli: We'll get to our interview with Dr. Kavita Patel in just a moment but first here is our producer Marianne O'Hare with this week's headline news.

(Music)

Mariano Hare: I'm Marianne O'Hare with these the health care headlines. The budget sequester is continuing through its first week with opposing members of congress showing little will to shift their positions on budget reduction measures. In the mean time automatic spending cuts are in effect across the board and they're starting to impact health care coverage across the country. Community health centers are expected to be particularly hard hit. A study by the school of public health at George Washington University projects 900,000 fewer patients will be treated at the nation's 8000 community health center locations due to the automatic spending cuts. The projections are based on $120 million and projected grant spending cuts to assist in paying for that care. Meanwhile, politics are also impacting the Medicaid expansion call for in the Affordable Care Act. Florida governor Rick Scott has joined a growing list of GOP governors who switched earlier positions refusing to expand Medicaid but the Florida House Panel deciding the matter is signaling they won't go along with the expansion of Medicaid to include a million more Floridians under the health care law. That was opposing the expansion voted along GOP party lines.

And in a medical first, a baby born HIV positive in Mississippi has been cured according to confirmed medical reports. The infant was heavily treated with retroviral drugs beginning at 30 hours old, something that had not been tried before. This gives great hope to those treating children with HIV and AIDS. 330,000 infants were infected in 2011 alone.

Need another reason to stick to your diet, starting next year under the health care law, companies with 50 or more employers can charge employee more for health care if they

don’t incorporate exercise into their preventive routine. Companies borrowing from the biggest looser model are designing financial incentives to get their overweigh employees to move more.

I’m Marianne O’Hare with these health care headlines.

(Music)

Mark Masselli: We’re speaking today with Dr. Kavita Patel, Managing Director of the Delivery System Reform and Clinical Transformation at the Engelberg Center for Health Care Reform at the Brookings Institution. Dr. Patel is also Co-Chair of the Bipartisan Policy Center, Health Professional Workforce initiative and co-author of two just released reports, “The Complexities of National Health Care Workforce Planning” and “Better Health Care Worker Demand Projections”. She worked in the Obama administration as well a committee led by Senator Ted Kennedy in drafting of the Affordable Care Act. She’s a practicing primary care physician at John Hopkins University. Dr. Patel welcome to Conversations on Health Care.

Dr. Kavita Patel: Thank you so much for having me in. Please call me Kavita.

Mark Masselli: Kavita, great. So we’re just months away from the implementation of the Affordable Care Act in January 2014 and we’ll see tens of millions of uninsured Americans added to the system. So tell us a little bit about why workforce projections are so complex in health care and why your reports are so important helping us understand why the lack of relevant health care workforce data is leaving us ill equipped to meet their coming needs.

Dr. Kavita Patel: Let me just start by telling you that when we were surprised sobering to myself that when you look for supply estimates just how many health care professionals we have in this country, you’ll find such variation from one stores to another and it’s because of how we count health professional. So in some cases physicians are counted only as primary care doctors and don't necessarily include the specialist and then in some cases nurses are people with just an RN and but it if you go to some of the nursing societies they also include people with RNs as well as other advanced degrees like PhDs. And so there was such a wide variety of our estimates that we saw okay we need to first do a deeper dive in what are the sources of data, what are the differences in the sources of data and then we can start to talk about how do we look at a model for what kind of health care workers we might need or for example the demand of health care. And it was -- as I mentioned very sobering to try to understand all the difference between some of these numbers which made it even more complex.

Margaret Flinter: It seems to me Kavita that one of the challenges you have and I thought you made this point really compellingly in one of your reports is that we keep piling lots of new data on the top I mean you’ve made the case, we really have to

change the underlying assumptions if we want to make use of the new data, can you talk a little bit more about that for our audience?

Dr. Kavita Patel: So let's just take a very basic example. A lot or our data assumptions about what kind of workforce we need are modeled on our current system or old systems of seeing patients in office visits and having always be a physician who leaves that office visit and we also have used other assumptions about how many doctors you need per thousand patients and we've use that model for years, in fact decades and in -- all in the mean time we've since had all these new models of care patients that are medical homes, accountable care organizations. We've seen a great proliferation of community health workers, lay health workers, the use nurse practitioners and physicians assistance in practices but our model and the way we think about how much care we need still hinges on this very cottage like industry with a doctor in charge. Those are the assumptions we use when we start to say well there's a shortage and I think that that's part of what we tried to tackle was wait a minute. Let's not just talk about how we might need one doctor for every you know 5000 people in the country. Let's actually think about what kind of care do 5000 people need and then what are the skill sets of the various members of the health care team that best suit those needs. That's almost flipping the equation and saying what is it that we want to get to and how do we work backwards to figure out what we need to fulfill that.

Mark Masselli: You know, you are seeing the fast rise of retail clinics, lot of different ways that people are delivering care and you really look at the distinction between patient demand and true health care need. How are these needs differing in the different socioeconomic groups as well?

Dr. Kavita Patel: We really thought long and hard about how you deal with especially the needs of high-risk populations take for example the 11 million Medicare dual eligible and Medicare, Medicaid dual eligible for this country, really high concentration is need. And one thing that we found is that in modeling our demand sides that we talked about supply a little bit and I kind of alluded to the demand, that's where the information about the sub populations really comes to play. What we found was that instead of looking at those -- both the location or site of care, we really need to understand how could care delivery to special populations look differently. We must agree on some standardized data reporting and this means not just on the supply side but we have to have some standardized reporting on the demand side especially for populations and special interest.

Margaret Flinter: One area seems to me from working at the state level anyway is we don't have any uniformity across states in terms of the kind of data we collect, what's your approach as a really a national research group looking at this, what's your approach trying to get states to agree on how to collect data in common and electronically and what the critical elements of data are to collect.

Dr. Kavita Patel: So this is a perfect question because we actually reached out to a National Governors Association who has been very interested in this exact issue. What

are the minimum state data reporting requirements and we canvassed across the states to try to understand what is it that they currently do and then how can we effectively give them some recommendations and they are actually more than willing to adapt a little bit more of a standard approach but I was surprised, people said look we are a overwhelmed, we have no idea what to do about this, we want you to tell us what to do. So what we actually did is we went back and then went to our federal colleagues in the health resources and services administration which is tasked with doing some of this work and through the Affordable Care Act, we actually went back to them and said listen, can you tell us what you're coming up with in terms of minimum data elements and how you are recommending those to be collected and then we will take those back to the states and that's exactly the process that we're in right now. We're actually taking what HERSA has been doing and recommending and saying to the states, we're not telling you, you have to do this, here's what the federal government is trying to do, here's how we could recommend you do this and the timing could not be better because they are already updating their data collection infrastructure to meet the needs of the expanded Medicaid enrollment and health insurance exchanges. So they're willing to do this but they just need help I mean these are really great people inside the states who are trying to do everything at the same time. So we found that it was best to care the work going on at the federal level and say here's the minimum and health IT plays a big role in this, we're trying to explore right now, how to get the best, how we can try to understand some health workforce staffing information based on the health IT systems that are currently deployed across the country.

Mark Masselli: We're speaking today with Dr. Kavita Patel, Managing Director of the Delivery System Reform and Clinical Transformation at the Engelberg Center for Health Care Reform at the Brookings Institution. Dr. Patel served in the Obama administration as the director of policy for the Office of Intergovernmental Affairs and Public Engagement. So lots of exciting opportunities arise out of the Affordable Care Act, its created many new incentives and innovations in health care. It also created some new challenges, you know what, through for our listeners some of those challenges and how you think we might best meet them.

Dr. Kavita Patel: I do think we are really at a precipice of how can we leverage the data that we have and then these emerging models of care and so one thing I would say is that we walk through this as we're thinking about restructuring care differently and we're thinking about trying to decrease the cost of health care and then we're also looking our patients in the eyes and saying you know what I'm going to try to make sure that I give you the best information in a small amount of time as possible but I will also hope that you take that information and make better decisions from it. So I see this is like a narrative of a kind of a cycle, a life cycle, then we also have to look at some of these emerging innovation models and say what are we learning about the kinds of training, the skill sets and the response from our patients and then how do we see that back. I mean we have a massive infrastructure of education in your country and we don't talk about it a lot. We talk about health reform a lot. We don't talk about going in and opening up our classrooms and saying wait a minute are we actually training the types of people that we actually want on the receiving end and I would say to you there's a

great disconnect there. So I see this is a great life cycle in a true biological sense. We need to cycle it back and I think that to me that's the narrative and not just in this workforce study but the Bipartisan Policy Center's doing work on cost containment, they're doing work on health IT. Those things have to marry together.

Margaret Flinter: You know the Affordable Care Act had a number of important provisions that have not yet come to pass and I noted in your report, you addressed or you listed one of them which we actually authored around the demonstration grants for Family Nurse Practitioner Training Programs which are in there but not yet appropriate --

Dr. Kavita Patel: Funded.

Margaret Flinter: -- but funded but much larger than that really is the creation of the national health care workforce commission that would have addressed this need for more centralized data and I think probably would have gone at that connection between education training not just a clinical care but to models of care and what's your expectation about what will happen with that national health care workforce commission?

Dr. Kavita Patel: If I start getting bogged down in what congress can and can't do I've been just having worked on the inside it can get pretty depressing. I am optimistic that all of the things we're talking about and by the way I'm a fan of your program because I think you all do a great job of bringing these complex concept to people in a very kind of digestible way. I think everything you've been talking about for months now quite honestly is going to come to a head when we've got headlines in 2014 that say you know in certain parts of the country, it's hard to find a primary care doctor, et cetera, et cetera and I think that'll force the issue for people to say wait a minute we have this provision in health reform, what happen to it? And then we're really talking about 2 to $3 million for the workforce commission to be funded but in the big picture and the impact it could have, it's a great investment. So I am optimistic that in the next year we're going to see enough demand for the information that the commission will have. In the mean time though we have got to figure out how to leverage the private sector and I know we say that a lot in health care but I am serious. We are seeing the big insurance companies, big integrated systems like Geisinger, Kaiser, we're seeing them come forwards with their own creative data set solutions, models of care and estimates, I think we need to go back to some of these leaders in the private sector and say listen let's actually think about what the needs could be and what you can teach the rest of the country in terms of what you found and then actually let's take that out and show how states like Texas can think about Medicaid expansion and workforce models in a different way.

Mark Masselli: I really liked it when you took us back to that big picture looking at the triple aim of the Affordable Care Act to increase access, improve outcomes and reduce cost and questioning how they come back to the educational system. So there's other so many different models happening and I just really worry that the educational system

in our leadership for that next generation of nurse practitioners, physicians assistants, physicians, all the allied health providers just aren't ready for prime time and we are at a point of reinvention and redefinition of how primary care could operate in an optimal setting, what should we be looking out for rays of hope from you?

Dr. Kavita Patel: Let me tell you that I always look for rays of hope in a lot of different pair settings because often talk about you know Virginia Mason Group Health, Kaiser, they're incapacitated settings, they've got kind of a lovely bubble around them so to -- so I look for things that could actually take advantage of really amazing care in a fee for service setting. Let me give you two examples in Medicare. One is a program in Florida called ChenMed. They take care of pretty much a 100% Medicare patients and they do it in Florida, one of our costliest states and they do the following. They send out a town card to pick up patients and they do auto reminders for patients and these are elderly patients. But we think the elderly don't use technology, they do with they've got --

Mark Masselli: Oh, yeah, absolutely.

Dr. Kavita Patel: --grandchildren that they talk to on Skype and Facebook more than I do. So they meet the needs of patients that generally costs the system a lot of money but they meet the needs by dealing with things that don't get reimbursed by Medicare but what they found is they can actually make money, meaning they're not losing money on this and they do this kind of wrap around and text reminders about preventive services that are due and I think that that's an amazing accomplishment in the Miami area. The second one I'll tell you about is something you may have heard of because he was profiled in one of a **(18:37 inaudible)** as I say is Rushika Fernandopulle started Iora Health and they take what you're talking about a little bit mark with kind of the pod design but they take with the hot spotters and design a clinic around hot spotters' needs. And they're doing this in Massachusetts and Atlantic City, New Jersey and they've just opened all in a Medicaid, Medicare setting mostly dual eligible and they sat and looked at what hot spotters needs are when they do come to clinic and they basically structured an entirely different flow of work to address those needs. And so I think that those are rays of hope because they're entrepreneurial, they're in our current system which in a large way is somewhat broken financially but they're doing something and they're making it work financially and what I hope is that I really want Rushika and ChenMed to give us the data on how they've understood the staffing needs for their health care and how we can actually go back to some of the top medical schools and nursing schools and allied health workers schools in the country and say how are we training people to engage and work in these environment.

Margaret Flinter: We've been speaking today with Dr. Kavita Patel, Managing Director of the Delivery System Reform and Clinical Transformation at the Engelberg Center for Health Care Reform at the Brookings Institution. Dr. Patel is also Co-Chair of the Bipartisan Policy Center, Health Professional Workforce Initiative and the co-author of just released reports, "The Complexities of National Health Care Workforce Planning" and "Better Health Care Worker Demand Projections". You can access these reports

and learn more about her work by going to by bipartisonplicy.org. Dr. Patel, thank you so much for joining us today on Conversations on Health Care.

Dr. Kavita Patel: Thank you 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 healthcare 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: Well, Mark and Margaret, we received several questions from readers about online reports that claim the IRS said the cheapest health insurance plan for families under the Federal Health Care Law would cost $20,000 but that's not with the IRS said at all. Instead this number comes from a hypothetical example in an IRS document about how it would calculate the tax penalty for a family that doesn't obtain health insurance as required by the Affordable Care Act. A tertiary official told us that the $20,000 figure was "Not an estimate of premiums". Like many viral claims this figure was taken out of context and then embellished. The IRS wasn't estimating the cost of premiums at all. The fact is no one knows exactly how much insurance plans sold on state and federal run exchanges will cost. Back in January 2010, shortly before the law was passed, the nonpartisan congressional budget office estimated that the cheapest plan would cost between $12,000 and $12,500 for family policies but CBO has an update of that estimate since. CBO did say that about 80% of the 25 million people getting insurance on these exchanges by 2023 will receive federal subsidies to help cover the cost and the average subsidy would be $8,290 for the year. For those who are interested, the Kaiser Family Foundation has a subsidy calculator on its website that gives the sense of who's eligible for subsidies and how much those subsidies might be. And that's my factcheck 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'd liked checked e-mail us at chcradio.com, we'll have factcheck.org's Lori Robertson check it out for you here on Conversations on Health Care.

(Music)

Mark Masselli: Each week conversations highlights a bright idea about how to make wellness a part of our communities in everyday lives. When Jennifer Staple-Clark was a sophomore EL in the internship at the ophthalmology office turned out to be a life transforming experience. She realized that many of the patients who had limited access to medical care were coming into the office with serious eye conditions that had gone

pass the point of reversing leading to unnecessary blindness. What she launched from her dorm room 11 years ago was a local initiative to improve access to preventative eye care to the neediest population in her local community. Her vision quickly grew, within two-year. She took her organization Unite for Sight worldwide and has since turned it into one of the leading providers of global eye care in hundreds of communities around the world. Unite for Sight brings social entrepreneurs, public health experts, local eye surgeons and volunteers together to bring eye care into some of the most underserved areas of the world. The motto at Unite for Sight is that local problems need local solution, so they use each country's existing pool of ophthalmologist to treat their local patients. They also train community health workers in each area they serve, that's removing traditional barriers and also ensuring a continuum of care for all of the patients they serve. The community health workers provide education and transportation to get doctors to the patient's communities and patient to the hospital if surgery is indicated. Since its inception Unite for Sight has served 1.4 million patients worldwide and restored eye sight to roughly 55,000 people, restoring not only their sight but their dignity and ability to be productive members of their communities as well. Identifying a pressing medical need and improving the quality of life by offering basic preventative eye care to those who had previously gone without now that's a bright idea.

(Music)

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

Mark Masselli: And I'm Mark Masselli, peace in health.

Conversations on Health Care broadcast from the campus of WESU at Wesley University streaming live at wesufm.org and brought to you by the community health center.