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

Margaret Flinter: And I am Margaret Flinter.

Mark Masselli: Well Margaret, here we are; another year over and a new one just beginning.

Margaret Flinter: And what a year it should be Mark. We are looking at some incredibly interesting changes in health care in the coming year. It's expected that by the end of 2014 there will be millions of Americans newly insured and many of them newly entering the health care system.

Mark Masselli: Margaret, I think it's also interesting to know that some 15 million low income Americans will be covered by Medicaid expansion. That will be a significant number.

Margaret Flinter: And perhaps will have a profound impact on things like use of the emergency room and bad outcomes to chronic illness, the consequence of lack of prevention. So a terribly important aspect to the Health Care Law because it really aims at protecting the most vulnerable populations, and I do believe this will have an impact on the public health.

Mark Masselli: The White House also announced another option for those Americans whose insurance plans have been canceled and they can't find coverage. They can opt for a catastrophic coverage plan that was reserved for Americans under 30 years of age.

Margaret Flinter: I want to remind people that you really are much better off finding a plan that covers all the essential benefits that the Health Care Law calls for. That way you really get value for the dollar and much more comprehensive coverage including prevention.

Mark Masselli: All these changes in health policy are affecting the medical profession as well and our guest today has a keen insight into that side of the equation.

Margaret Flinter: Dr. Harvey Fineberg has presided over thousands of public health studies in his role as the President of the Institute of Medicine. Dr. Fineberg was the long time Dean of the Harvard School of Public Health and he will share some unique insights into the progress that they have made at the Institute of Medicine in developing evidence-based recommendations for policies that will improve health care delivery, training and public health.

Mark Masselli: Lori Robertson, Managing Editor of FactCheck.org stops by, uncovering misstatements spoken about health policy in the public domain.

Margaret Flinter: And no matter what the topic, you can hear all of our shows by Googling CHC Radio.

Mark Masselli: And as always, if you have comments, e-mail us at www.chcradio.com or find us on Facebook or Twitter; we love hearing from you.

Margaret Flinter: We will get to our interview with Dr. Harvey Fineberg of the Institute of Medicine in just a moment.

Mark Masselli: But first, here is our producer Marianne O'Hare with this week's Headlines News.

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Marianne O'Hare: I am Marianne O'Hare with these Health Care Headlines. It was something of a year-end rush. In the waning weeks of 2013, hundreds of thousands of Americans scrambled to sign up for health coverage to meet the deadline for coverage to begin January 1st on the Health Exchanges. On the Federal Exchange, the White House announced a million Americans had successfully signed up for coverage by Christmas week and that the heavy volume would continue. On the state exchanges, business was also brisk. California topped the list in the nation with over 400,000 enrollees now signed up for insurance through Covered California. More than 35,000 folks did so in Colorado, approaching 200,000 in New York. Some states extended deadlines for coverage to begin January 1st because of the problems with the online exchanges.

Meanwhile, in Ohio, the State Supreme Court upheld the governor's expansion of Medicaid in that state to include an additional 275,000 low income folks. The measure was being challenged by several GOP lawmakers and right to life groups. 100 million, that's the size of the settlement. A Massachusetts pharmacy has agreed to pay for deadly pain medications that were tainted with a meningitis causing fungus. This settlement will go to victims and their families.

And the winner of the 2013 Vertebrate of the Year according to the Science Magazine, it's the Naked Mole Rat chosen for its longevity. The buck tooth, hairless rodent has an estimated life span of 30 years, nine times that of a typical mouse. The Naked Mole Rat has been lauded for its natural resistance to cancer. A pair of studies looked at their unique properties and found a higher concentration of a compound called hyaluronan. When this substance was removed, they lost their tumor resistance. The Naked Mole Rat, not much of a looker but ripe with potential for cancer researchers.

I am Marianne O'Hare with these Health Care Headlines.

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Mark Masselli: We are speaking today with Dr. Harvey Fineberg, President of the Institute of Medicine, the health branch of the National Academy of Sciences, an independent nonprofit organization that works to provide unbiased and authoritative advice to decision makers in the public on matters of public health. Dr. Fineberg served as the Provost at Harvard University from 1997 to 2001, following 13 years as Dean of the Harvard School of Public Health. Dr. Fineberg, co-founded and served as President of the Society for Medical Decision Making, and is an author of several books including Clinical Decision Analysis and Innovators in Physician Education. Dr. Fineberg earned his MD and PhD at Harvard and is a recipient of several honorary degrees and numerous awards including the Frank A. Calderone Prize which is the highest prize in public health and has the 2013 Friesen International Prize in Health Research. Dr. Fineberg, thanks so much for joining us on Conversations on Health Care.

Dr. Harvey Fineberg: My pleasure to be with you.

Mark Masselli: You oversee the efforts of nine boards and 15 standing forums and roundtables, managing some 3,000 volunteers, all engaged in IoM's quest to improve public health in this country. Could you give us some insight into the work, your task at IoM and highlights of what you think some of the most important areas of research are?

Dr. Harvey Fineberg: The Institute of Medicine is the nation's advisor to improve health. We are the health arm of the National Academy of Sciences, an independent non-government organization dedicated to improving decision making and helping policymakers, professionals and the public come to better choices about health. We work on the needs of disadvantaged populations on children, on elderly, for our veterans. We work on the problems of prevention of disease and population health. We are deeply immersed in the challenges of health care and improving the practice of medical care. And we have groups working on health science and policy as it relates to all manner of activities that bear on health whether it's nutrition. So the **writ** of the Institute of Medicine is quite broad. It's domestic, it's also global but all of it is focused on the goal on improving health.

Margaret Flinter: Well Dr. Fineberg, you realized that maybe there has been no time in the history of health care in our country where the potential at least for transformation is so great, and you have said that to achieve greater public health, we have to align the incentives for all the stakeholders. So in this moment in time, you are someone who scrutinized the creation and the implementation of public health policies for the better part of your career. Share

with us and our listeners what's your take on the Affordable Care Act and its potential for this transformation.

Dr. Harvey Fineberg: The Affordable Care Act is one step along a long trajectory in the United States about increasing access to health care. Literally, this goes back to before the Great Depression of the 1930s and the early discussions about widening access to health insurance. There were proposals that President Roosevelt made, President Truman, President Kennedy, President Nixon, President Reagan, all put forward various proposals related to health. And President Obama and the administration did succeed in putting forward and having enacted our current extension of insurance through the Affordable Care Act. But from a health care point of view, its core contribution is that it does increase access to services for millions of Americans who otherwise lack insurance. And it also has provisions that strengthen the preventive services in our country including for example, mandating that certain preventive care be available without copayment. So it's a step forward. It will continue to be politically controversial and I believe that we will continue to see in our country efforts to intensify and expand availability of health care to everyone in the country.

Mark Masselli: Dr. Fineberg, you have focused much of your work on prevention, which you see as critical to creating a high functioning health care system and healthy society. However, you have noted in the past that there are seven deadly sins that impact public health everyday that you think pose a real challenge to those tasked with creating sustainable public health policies. And tell our listeners, what they are and what you see the solutions to be.

Dr. Harvey Fineberg: It's inspired obviously by the original seven deadly sins that were first annunciated by Pope Gregory I back in the 6th Century.

Margaret Flinter: Haven't changed much.

Dr. Harvey Fineberg: Well, you know, lust, sloth, gluttony, greed, wrath, envy and pride, the seven deadly sins. So yes, they are all still with us. For public health, I adopted some of them. I said, well sloth blocks us from doing the things everyday that would keep us healthy. Gluttony cajoles us into eating more even when we are not hungry and a contributor to the obesity problem. Greed is certainly a driver on some corporate settings to market and profit from things that are bad for health, such as cigarettes. So I adopted additional sins. I said well ignorance is an important deadly sin for public health that always colors judgment and leads to poor decision making. Complacency, I thought was responsible for so much of accepting as normal, things that we really should be struggling to prevent, or that are avoidable. And then timidity which prevents us from demanding those changes in policy and practice that would actually improve our health.

Now for the seventh deadly sin of public health, I chose obstinacy, which is the refusal to accept evidence on what would actually be best for our own health. Interestingly, I did a little exercise with the community here at the Institute of Medicine, our staff, and I asked them what would they choose as the seventh deadly sin of public health if they had a choice. And we got some very interesting answers, for example, arrogance, hypocrisy, denial, procrastination and selfishness and then someone suggested the deadly sin of silence. And I thought these were really quite suggestive. I might add that we decided to do a little exercise on what would be the seven living virtues of public health that could counteract these deadly sins. I started out with suggesting moderation, prevention, science and then I asked our staff what would they suggest as the seventh living virtue, and they came up with collaboration, leadership, partnership, and someone said if only we could adopt the golden rule.

Margaret Flinter: So Dr. Fineberg, the Institute of Medicine has produced so many seminal reports on so many areas within health care. But your most downloaded report, as I understand it, in the history of issuing these reports is the report published in 2010 on the future of nursing. And the team that led that just unveiled a follow-up to that report. Take us to that future of nursing. What were the recommendations aimed at transforming nurse education and training, some of the actions that have been taken since then to move us forward and also some of the reactions within the health care community?

Dr. Harvey Fineberg: The key recommendation was to enable nurses to practice up to the full extent of their training and ability. Many states still had on the books limitations that restricted the ability of nurses to contribute in the ways that they should in primary care settings, for example, in nurse practitioner roles in a variety of settings. By now, every state and the District of Columbia has established what we call action collaborations that are intended to help foster the adoption of changes in regulation and rule and to establish the principles for nursing practice. And in the ensuing several years, at least seven states have actually modified their rules and regulations that give wider latitude of practice for nursing. This report, three years after it's released, continues to be actively downloaded from the Institute of Medicine website but what’s more gratifying than the readers of the report is the actions that have adopted the recommendations.

Mark Masselli: We are speaking today with Dr. Harvey Fineberg, President of the Institute of Medicine. Dr. Fineberg has served as Provost of Harvard University and Dean of the Harvard School of Public Health. Dr. Fineberg, one of your specific areas of study over the years has been in clinical decision making and let’s look at the decision making on the policy side for a moment. What might politicians learn from your work in clinical decision making that might help them make more decisive policies aimed at improving the public health?

Dr. Harvey Fineberg: One of the things that you learn as you study decision making that failing to decide is also a decision. In the case of an individual and clinical decision making, the choice is about that one person, whereas policy makers are choosing and deciding for a nation or for a state or for the whole body politic. One of the key features of all these decisions is that there is uncertainty about the future, and a second feature of all decisions is that they take account of our values and preferences. In the case of an individual in a clinical setting, it's the patient's values and preferences. In a body politic, in a legislature you have got many values and contending preferences that are obviously working sometimes jointly but often against one another. So the key I think for policy making is really the notion of compromise. Everyone has to be willing to participate in the give and take that results in an agreement where each side gets part of what they want and gives a part to the other side so they get what they want.

Margaret Flinter: Dr. Fineberg, I think we look at you certainly as somebody who has a particular interest in the education and training of health care professionals and I wonder if you could share maybe your vision for this recalibration of the education and training of health care professionals as we move into the future.

Dr. Harvey Fineberg: Well, health education is fundamental if we are going to have the future workforce to meet the health needs. And that's a workforce that is across the whole spectrum of preparation. There was a very interesting report of Lancet Commission about three years ago on the future health workforce that emphasized the idea of learning across the disciplines and team-based learning. And when you couple that with reports like our recent nursing report, I think you can identify certain key principles that are going to be very, very important going into the future. As any practitioner begins their career, the knowledge base that they have is going to be turning over multiple times if they are going to remain current, and so the capacity for continuous learning has to be built into learning from the beginning. The idea of teamwork that I mentioned is the second aspect that is not always realized in practice.

We know that patients with chronic disease particularly require team-based care to have optimal management of their conditions. Learning together across the professions is a really good way to help reinforce the kind of practicing teamwork that is needed and is important preparation. A third really important challenge I think for the future is going to be the combination of Information Technology and maintaining the personal touch contact and relationship that healing requires. So practitioners of the future are going to have to be adept simultaneously with the more technological world and at the same time retain the capacity to establish, promote and strengthen those personal relationships that are at the heart of clinical care and healing. I think it's going to be very important for everyone to keep patients centered as the heart of our focus and attention because it's more than just the moment when an individual is a patient; it's about their needs at every stage in relation to their health and how does the health system, the public

health system serve to reinforce positive aspects of health. And on top of all this, we are going to have to find ways to make education, like everything else, ever more efficient and cost effective if we are going to have a sustainable system. And all of it will help us shape a health education system that will prepare the clinician leaders for delivery of better care in the future.

Mark Masselli: You recently gave a very popular TED Talk about the era of neo-evolution we are entering. So in many ways, the future is here. But you are also concerned at the Institute of Medicine with ensuring that these technologies are studied for the potential to do harm as well as to do good. So how do we accelerate the pace of research in these areas? Talk to us about how we bring about this power to health care while we are still protecting the population.

Dr. Harvey Fineberg: When it comes to the data explosion, I think we need to be able to apply that data but in an interpreted way to give us the knowledge base and ultimately, the more sensible choices for the benefit of people that powers patients to take more control of their own lives, to have more mastery of available knowledge, to be more actively engaged in the management of their own conditions, to give a voice to their preferences at every stage of life and illness including the end of life. When it comes to specifically this problem of the long delay between discovery and availability of new technologies, we do have I think a very serious policy and technological task ahead of ourselves. We do need to find ways to continue to reinforce invention to harmonize regulations and make it possible for innovators to produce their new ideas and convert those into technologies that will benefit patients.

So this can only be accomplished if we develop and optimize regulatory science as well as basic and clinical science. We need to focus on translation, and from a policy point of view, we need to find ways to provide better incentives for investors and entrepreneurs in this critical period when the technology is promising but not yet a product so that it's advantageous to develop genuinely novel advances and not simply work on the me-too substances that make only marginal improvement.

Margaret Flinter: We have been speaking today with Dr. Harvey Fineberg, President of the Institute of Medicine and Former Provost and Dean of the School of Public Health at Harvard University. You can learn more about his work by going to www.iom.edu or by following the Institute of Medicine on Facebook or Twitter. Dr. Fineberg, thank you so much for joining us on Conversations on Health Care today.

Dr. Harvey Fineberg: It's been my pleasure to talk with you.

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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: Well, we have seen both sides in this debate over Obamacare distorting the facts about premiums. We caution our readers to be wary of claims about big premium rate decreases or increases, and it's important to ask compared with what when politicians make such claims. For instance, days before the health care exchanges launched on October 1st, President Obama said that average premiums for the Illinois exchange were 25% lower than what individuals were able to get previously buying insurance on their own. The Illinois officials used that figure in comparing exchange rates with what the Federal government had predicted premiums would be. It wasn't a comparison with individual market pricing. Obama made a similar comparison with California, saying that exchange premiums in that state were about 33% lower. But California officials said premiums were up to 29% lower compared with rates for small employer plans not individual market plans. Officials said they gave that comparison because both markets wouldn't deny applicants based on preexisting conditions, but the President didn't explain that. Obama also mentioned New York, and he was right in that comparison. The Governor's Office said exchange premiums were at least 50% lower on average than 2013 individual market rates. And that's my fact check for this week. I am Lori Robertson, managing editor of FactCheck.org.

Margaret Flinter: FactCheck.org is committed to factual accuracy from the country's major political players and is a project of the Annenberg Public Policy Center at the University of Pennsylvania. If you have a fact, that you would like checked, email us at www.chcradio.com. We will have FactCheck.org's Lori Robertson check it out for you here on Conversations on Health Care.

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Margaret Flinter: Each week, Conversations highlights a bright idea about how to make wellness a part of our communities and everyday lives. Fast food is fast becoming a numbers game. While McDonald's is the largest chain to do so, more and more fast food restaurants are posting their calorie counts for menu items, and that trend is going to continue. A recent study shows that some 35% of fast food consumers never bother looking at the calorie count even when it's provided, but another study showed that of the 33% who do read them, many lean towards healthier or at least lower calorie options much of the time. And overtime, that awareness of calorie counts actually impacts a lasting shift in consumer behavior.

Now there is a little known measure in the Affordable Care Act that will be expanding upon that theme. Starting in 2014, vending machines are required to post the calorie counts of all the items being sold, something that has the vending machine suppliers up in arms. The machines will have to be modified to adapt to all new food items being placed inside week after week. But government officials say that if this move can help the average consumer save just 100 calories a week, the long term savings in health care cost could be significant overtime. The Food and Drug Administration is releasing its final rules early in the year, and the calorie counts of things like that bag of potato chips, Chips Ahoy or M&Ms, the typical vending machine fare, will be posted right by the selection number for each item. Using ubiquitous food dispensing systems to educate consumers about the calorie count of their food choices, allowing them to make a more conscious and hopefully more helpful food choice, now that's a bright idea.

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

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

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