(Music)

Mark Masselli: This is conversations on Healthcare. I am Mark Masselli.

Margaret Flinter: And I am Margaret Flinter.

Mark Masselli: Well, Margaret believe it or not, it has been 5 years since the passage of The Affordable Care Act. So much has changed in just a few short years.

Margaret Flinter: And the numbers tell much of the story. Since the passage of The Affordable Care Act, more than 60 million Americans have gained coverage through the insurance market places through Medicaid expansion and the number of uninsured Americans is at its lowest in years.

Mark Masselli: Roughly 75 million Americans have since gained access to preventative care and screens at no cost to them, 30 million Americans under the age of 65 cannot be denied coverage due to a pre-existing condition.

Margaret Flinter: And it does not mean that the law doesn't continue to be controversial and politically divisive, but it is gaining in popularity among the American people with 70% Americans who prefer some kind of repair versus repeal measure.

Mark Masselli: Things can always be made better but there are some significant changes that have happened in the year of health reform about 88% of the nation's hospitals have switched to electronic heath records as well as about 50% if the nations practices.

Margaret Flinter: But we want to note while the transition to electronic health records and expanded, health IT operations has been tough for many practices. No one disagrees that it paves the way for better data collection and better access to health data for healthcare consumers and researchers as we move forward.

Mark Masselli: And that is something our guest today knows quite a bit about, Dr. Rajeev Bhatia is the former director of Occupational and Environmental Health for the city of San Francisco and created many innovative health impact assessment tools that utilizes data to improve the health of the entire community. He has since taken his model nationally having founded The Civic Engine which helps municipalities strengthen the economic foundations of their health of their communities.

Margaret Flinter: And Lori Robertson Managing Editor of FactCheck.org stops by. She is always on the hunt for misstatements spoken about health policy in the public domain and no matter what the topic you can hear all of our shows by going to CHCradio.com.

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

Margaret Flinter: Now we will get to our interview with Dr. Rajiv Bhatia in just a moment.

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

(Music)

Marianne O'Hare: I am Marianne O'Hare with these healthcare headlines. It is crunch time for the so called doc fix and in a rare show these days there is a bipartisan effort underway to repair the outdated and dysfunctional system for reimbursing physicians who treat Medicare patients. The house likely to vote on the plan to scrap the old Medicare reimbursement formula before the March 31st deadline which is when they scheduled 21% drop and reimbursements goes into effect. According to the summary of $200 billion deal, the current system would be scraped and replaced with payment increases for doctors for the next 5 years as Medicare transitions to a new system focused more on quality and accountability. The American Medical Association urged Congress to and make these changes and seize the moment while it's here. A total of 16.4 million non-elderly adults have gained health insurance since The Affordable Care Act became law 5 years ago this month. Those gaining insurance since 2010 include 2.3 million young adults aged 18 to 26 able to remain on their parents health insurance plus another 14.1 million adults who obtained coverage through expansions of Medicaid, new market place coverage and other sources. Officials says the percentage of people without coverage has dropped by about a third from 20.3% to 13.2% in the first quarter of 2015. And finding a good night's rest in the hospital seems next to impossible for many. Well the study in Shiner [PH] showed a few inexpensive interventions could do the trick in improving sleep greatly. A natural sleep aide melatonin, an eye mask, and ear plugs greatly improved the time sleeping for most patients in the study. It turns out all the three help but the melatonin had the most significant impact. I am Marianne O'Hare with these healthcare headlines.

(Music)

Mark Masselli: We are speaking today with Dr. Rajiv Bhatia Founder and Director of The Civic Engine. They are providing civic literature with strategies to strengthen the economic foundations of health in their communities. An internist, data scientist and social medicine practitioner, Dr. Bhatia was Director of Occupational and Environmental Health for San Francisco's Department of Public Health where he created the program on health equity and sustainability. He co-founded the non-profit organization of Human Impact Partners. Dr. Bhatia has received several awards including the Homer Calver Award from the American Public Health Association. He earned his maters in Public Health at UC Berkeley and his medical degree at Stamford and now he has served on the Clinical Facility at the University of California, San Francisco. Dr. Bhatia welcome to Conversations on Healthcare.

Dr. Rajiv Bhatia: Thank you so much for having me on the program.

Mark Masselli: You have had a great perch during your 10 year as Director of Occupational and Environmental Health for San Francisco's Department of Health. During that time you saw the need to expand the development of data points to be gathered to ensure public health creating a system that had not existed before and you learnt what a vital tool open data could be actually improved public health by fostering more transparency and could you start off by telling our listeners what made you look at public health issues from this new perspective?

Dr. Rajiv Bhatia: Mainly the universal consensus but the fact is most important for protecting health and to managing chronic diseases aren't the things that healthcare systems provide. The basic human needs like financial self sufficiency, education, safe neighborhood. I mean if basic needs aren't met, people don't have the resources they need for healthy living. After my residency, I worked at a clinic where I saw all those patients with asthma who were living in run down house who did not feel secured enough to complain about their landlord. So we were taking care of problems that could be prevented and as a doctor I did not have the tools to help my patients. When I joined the health department, I saw the same thing but at the neighborhood. What I saw was community residents and organizations doing the work needed for public health but at that time they had a little meaningful support from the public health department.

Margaret Flinter: Well Dr. Bhatia, I think we often think of areas like San Francisco as an exception perhaps to the world, there is a level of affluence that perhaps mitigates against the social determinants of health. Tell us as you began to identify them, what about that experience that you had focused on new areas of data collection in your assessment of this public health issues?

Dr. Rajiv Bhatia: Well when I started my public health work in the late 1990, some neighborhood like **Davey Hunters Plain** were isolated from job opportunities, had poor transportation, lack of basic neighborhood services like banks and supermarkets. Other San Francisco neighborhoods were bit more stable but working class jobs were evaporating and residents were being sliced out. The gentrification perhaps was real and stressful. For some families, the only affordable housing options were living in single room occupancy hotel without a bathroom, kitchen, poor ventilation. The fundamentally illegal and substandard occupancies, the city tolerates because they don't provide any other option. San Francisco has one of the highest rates of pedestrian injuries in the county. Many people thought the streets and intersections are really for the safety and convenience of cars and in San Francisco all the questions of money and resources that rather a question of priority or political will. Most health departments don't have a real power or authority to deal with these problems. So if saw if we can inform the debate, we might be able to generate accountability and needs of that. And that's what led to the idea of measuring health at the neighborhood level holistically. The health department and the collaboration of community organizations decided simply to measure what the people wanted and needed to be healthy at every neighborhood. We wanted to do that in a way that informed policy debate and held city agencies accountable to health needs.

Mark Masselli: You know I am quite excited about the development of your health and back assessment tool because it really connects the dots at the neighborhood level. But it also requires a sort of a new change or thinking by the leadership and it needs sort of talked about the lack of political will that might exist in communities and obviously your initiative created some friction amongst some of these guards. So talk about that intersection and on the other hand sort of the acceptance that this -- and the residents this has in the neighborhoods.

Dr. Rajiv Bhatia: So you are exactly right. I mean health impacts assessment with how reform is kind of carried forward. You just need to have a really simple common sense to frame it. The decision maker should be informed about the health consequences of decisions. It resonated with community members because we are now talking about the real need and we were talking about the (inaudible 9:10) we weren't chopping them up and dealing with them in a siloed way that governments normally dealt with them. But adding health decision outside the healthcare sector upset the calculus. Decision makers now have to consider a new issue. The existing stakeholders who have power share the decision making table, so it's disruptive. You know tons of data was embarrassing to agencies in the city. Like when we showed that having economically segregated lunch times created stigma and reduced school lunch participation. The ideas with data when they were challenged, it was just embarrassing. And at other

times it forced greater responsibility like when we demonstrated that 5% of the city streets accounted for 55% of the serious and fatal injuries. That caused a change in the way the cities operate. The planning and transportation agencies eventually adopted the matrix and used them to target investment in traffic segment. The land developers even accepted and welcomed the new data driven health regulation protect buildings on health.

Margaret Flinter: One area that was particular interest to you was the issue of wage and income security and I understand that you developed an innovative strategy and your role in Environmental Health which includes of course the purview of conducting restaurant inspections to help ensure the workers were not only safe but they were also safe economically in terms of earning their fair wage. Tell us more about that, what were you able to accomplish with that approach?

Dr. Rajiv Bhatia: I cared about income and financial self sufficiency probably more than any other single issue. I mean it is just to fundamental that like a diabetic who cannot afford fresh fruit and vegetables, who does not have kind of cook because she is working multiple minimum wage job, did not have a really hard time managing diabetes and so I felt (inaudible 11:03) assessments to support a number of wage campaigns over the years for minimum wage increases and (inaudible 11:12) law in the county, bringing a health frame to these policy debates was really powerful in changing the political conversation. I can't say we were the sole cause of these laws happened but I think we may have helped. With the labor rules need somebody to credible enforcers too. In 2008, work organizations in San Francisco China Town came to us the problem of wage staff. Immigrant workers were the most vulnerable to this kind of abuse. The (inaudible 11:42) since we inspected and permitted the restaurant could we do something that take action against the bad actors. So we did a few things. We had inspectors monitor the employee notification and we enforced the city's new rules. We also threatened to revoke the permits of the restaurants that were involved in wage stuff by sanctioning restaurant to violators who were able to get the restaurant to pay back wages and penalties more quickly and we send a strong message that our inspectors are watching and willing to act on any violation.

Mark Masselli: We are speaking today with Dr. Rajiv Bhatia founder and director of The Civic Engine dedicated to providing civic leaders with strategies to strengthen the foundations of health in their communities. Dr. Bhatia was director of Occupational and Environmental Health for the San Francisco Department of Public Health where he created the program Health Equity and Sustainability. Dr. Bhatia as you have noted open data is the key to generating public health improvements. You know that so much reminds me on the national level of the work of Todd Park who has really been on the

show talking about liberation and data but it is also essentially determining the best practices moving forward. Tell us about more compelling data you have collected during your 10 year in San Francisco and data around land use. You have talked a little bit about that, population displacement, improved income, how effective were these programs in truly protecting the public's health and how replicable? Is this approaching other parts of the country?

Dr. Rajiv Bhatia: It is definitely more replicable and it is becoming easier and easier to sort of generate and share a data. So only thing we have the specific examples of in San Francisco like no city, we monitor air pollution really once late in the city and we left that point speak to the air quality exposures of the entire city. So using some computer tools, we were able to show that there were particular locations where we are actually violating the air quality standards and in 2008, this data led to a new city log requiring buildings in these hot spots to have better ventilation system between the portion. I mentioned that pedestrian hot spot data that shows 55% of the serious and fatal injuries happen on 5% of the street. So what this shifted was the way that city managed traffic and police enforcements. Before that data, the police were targeting enforcement efforts to the high injury location. But then that changed the focus of the police department and city's traffic common program agreed to dedicate more on this and most of their resources to these hot spots of pedestrian injuries. Data does not change the world by itself. It takes people using the data and science can support good arguments to make healthy change in things. So neighborhood advocates were the ones really able to use the data on disparities in parks, in schools and other infrastructure to win confessions from developers for community directed investment fund and for a more affordable housing. I think we were very successful in using data to change the rules in the game and now we are seeing some of the changes in the environment in San Francisco. But to be honest, it is going to take some time to see the results in terms of better health. You know that takes generations and it is very hard to attribute health improvement to any single factor.

Margaret Flinter: Dr. Bhatia you have made an eloquent case in the past that true democracy is a pre-requisite for good health and we certainly see that reality played out in the world of community health centers where boards are comprised of community representatives where no one has turned away for lack of ability to pay and there are rules and policies in place to ensure access, and also certainly we have seen community health centers increasing the centers of advocacy and innovation in public health. Can you speak to that reality and how it applies to the work you are doing now?

Dr. Rajiv Bhatia: I think there is a tremendous opportunity to community health center to bring political extension to non-medical problems. They are on front line. They are

seeing these problems show up as symptoms and disease in their patients. They are trying their best to help with limited resources, but the health centers aren't the problem and the healthcare system isn't the problem, we need to sort of change the policies and structures that are leading to the lack of good housing and low wage jobs. It is important for quality makers to hear what failures are happening, you know, in the other sectors in the housing sector includes that and how they are profiting healthcare. Doctors and health professionals can be very credible communicators of that perspective. The community health centers are not trained and skilled in that political translation and that is something that I would really like to help and work on the next phase of my career.

Mark Masselli: Dr. Bhatia it's a two part question, first I want our listeners to know more about The Civic Engine which is your effort to extend and scale up the practices you have applied in San Francisco during national level through partnerships with public and private organizations and the second part is really about how have the recent advances in technology allowed you to scale up the goals behind health impact assessment and other tools and where are they being deployed across the county?

Dr. Rajiv Bhatia: Yes when we created the San Francisco indicator system, we have to get data from individual offices and individual city agencies and it was slow and painful. The open data movement championed making public data sharable. Now this is in the public to make all of the data findable, accessible, and legible. And what all this means I think that very soon all of those measures that we use to measure health in San Francisco and more are going to to be easily accessed and computed through every neighborhood in the country. Main studies are sort of applying neighborhood indicators and every city has its own way of doing things and there could be real power in a common language in a measurement system. The next step I think is developing the consensus and what are the top neighborhood measures (inaudible 17:48) country wide to assess community health. There is a project being funded by the department of housing and urban development right now which I have been supporting to develop and test the course that a neighborhood health indicators. It is called the healthy community index and it has built the national open data resources, EPA resources, central resources, and local open data resources that we think are fairly uniform across the country. Minneapolis, San Diego, Albuquerque are planning to trying this and having these measures are going to support the lining of public investment to health that I think if we can get to a uniform number of these priority measures that it would really make a difference. So an example of the work I am doing, trying to take this to the next level with the national center for healthy housing (inaudible 18:34), we have proposed a national dashboard to measure how well it is enforcing on housing you know a lot of people live in sub-standard housing and that is affecting their health. We have written

an open data standard to make each city's inspection data interpretable in the same way, and we are asking cities to report their inspection data following this format. Once that is there we can have a dashboard that measures the frequency of common housing problems, the timeliness of the response. It enforce greater responsibility not only on the landlord but also on government agencies to attend to it fast. It is going to show housing safety might vary from neighborhood to neighborhood and what some of these environmental factors behind poor quality housing are. What I would like to see most is the data on health claims cause an outcome connected to economic and social factors at the individual level. How much what we have spent on healthcare today is due to factors like food and security, overwork and exposure to violence. We actually know these factors affect health. We don't have an answer to the question of how much we are spending in the healthcare system to treat these correctable problems. So whatever it takes to get there is that healthcare systems would have to routinely access these non-medical risk factors just like they do smoking and blood pressure and then we need to make the identified data on both outcome and risk available to research. Then the policies and programs to increase financial security and increase affordable housing, had added value to cost saving health and some legislators might decide to shift some of the resources that they are using to treat the symptoms to the upstream solution.

Margaret Flinter: We had been speaking today with Dr. Rajiv Bhatia founder and director of The Civic Engine dedicated to providing civic leaders with strategies to strengthen the economic foundations of health in their communities. You can learn more about his work by going to civicengine.org. Dr. Bhatia, thank you so much for joining us today on Conversations on Healthcare.

Dr. Rajiv Bhatia: Thank you very much for having me.

Mark Masselli: At conversations on healthcare, we want our audience to be truly in the know when it comes to the facts about healthcare reforms 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 US politics. Lori, what have you got for us this week?

Lori Robertson: In early March, US Supreme Court heard arguments in King versus **Burwell**, a case that could lead to loss of Affordable Care Act insurance subsidies in many states. We have seen several numbers being used for how many would lose subsidies and how many could become uninsured. What's the best estimate? To an independent analysis put the number who could become uninsured at 8 million. In the case, the plaintiff argued that the language in the ACA stipulates that insurance subsidy

should be available in the states that set up their own exchanges not states that rely on the federally run healthcare.gov. The government argues that the law as a whole makes clear subsidy should be available whether there is a state or federal exchange. Most states, 34 of them still use the federally run exchange. In those states, 7.5 million people qualified for subsidies in the latest open enrollment period. But the number who could lose subsidies isn't the same as the number who could become uninsured. Some would still keep insurance without a subsidy particularly those who most need coverage for health condition. But as the risk for those insurance markets change considerably others who did not get subsidies would see their premiums go up making them unaffordable. So how many could become uninsured, the urban institute estimates that 8.2 million would become uninsured in 2016, if the court rules in favor of the plaintiff. These are of course only estimates and they are based on the 34 states of federally run market places not taking action to set up their own exchanges. 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 chcradio.com, we will have FactCheck.org's Lori Robertson check it out for you here on Conversations on Healthcare.

(Music)

Margaret Flinter: Each week conversations highlights a bright idea about how to make wellness a part of our communities and everyday lives. Primary care providers have their work seeing patient after patient all day long. In brief visits, it can be difficult to cover all of the important bases and often signs of drug and alcohol dependence can get overlooked and many patients are put off by lengthy questionnaires that are aimed at determining whether you have a problem with drinking or using drug. Researchers at the Boston University School of Public Health have determined that asking one simple question could actually determine the level of the patient's possible drug or alcohol dependency. For alcohol use, participants were asked how many times in the past year they have consumed 5 or more drinks in a day. For other substance use they were asked, how many times in the past year they have used an illegal drug or used a prescription medication for non-medical reasons. The researchers compare alcohol screening responses with alcohol dependence reference standards and drug screening questions with drug dependence standards. The single alcohol screening questions detected 88% of those with alcohol dependence. The drug question detected 97% of those with drug dependence. Lead researcher Dr. Richard Sate says this could provide a valuable rapid assessment for primary care providers to help patients and get them to

treatment options they need. A single simple question aimed at revealing drug or alcohol dependency that could help primary care providers diagnose the problem more readily, getting patients sooner to the help they need. Now that's a bright idea.

This is Conversations on Healthcare. I am Margaret Flinter.

Mark Masselli: And I am Mark Masselli. Peace and health.

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