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

Margaret Flinter: And I am Margaret Flinter.

Mark Masselli: Margaret, I am worried about those grand lands across the countryside who are wreaking havoc by blaming everything on Health Care Reform. I am a little worried about those insurance companies over the next few years who might unrealistically increase our insurance premiums and certainly those increases will surely be laid at the doorstep of reform. Currently, I am not the only one with this concern.

Margaret Flinter: I think the country should be worried about this. There is always something to worry about with Health Reform, but the possibility of major rate increases is a big one. Meanwhile, one of the things we are going to try and do is not just help keep our listeners' pulse on both public opinion and what's happening with the unveiling of Health Reform, but also to pay attention to what's missing. Senate Democrats seem to recognize that one thing that's missing is federal oversight of insurance rate increases. Senator Dianne Feinstein of California has now introduced a bill that would allow the Health and Human Services an opportunity to make sure that rate adjustments are justified and fair.

Mark Masselli: She lit into WellPoint, a health insurance company, who used a special computer program to target breast cancer patients and terminate their health coverage. She was so angry and she said it on the floor of the senate, "We have a duty to protect the American people from the corporate greed of these for-profit publicly-traded health insurance companies. Left to their own devices, companies like WellPoint will throw paying customers to the shark for the sake of profit." And that's why she introduced the Insurance Rate Authority Act of 2010.

Margaret Flinter: Well, the stories like that of which we heard a lot in the past several years that I think ultimately sway the country in the direction of the Health Reform we now have. But Mark, I want to touch on Medicaid for a moment. The experts are estimating that of the 30 million people who'd be newly insured, about 20 million, 2/3rds of them will be insured by Medicaid. That's a huge expansion of Medicaid and it's a fulfillment of its original role to ensure that low-income Americans have access to health care. But while is it going to test the capacity of Medicaid and the health care safety net for poor and lower-income families likely to be a challenges all the down the line from infrastructure at the state Medicaid offices to overcoming the tendency of private providers to not sign up for Medicaid at all.

Mark Masselli: Margaret, we talked about Massachusetts stress. When they introduced their reform bill, they just didn't have enough primary care providers in place. That's why the framers of this Health Care Reform bill committed

themselves to expanding the Community Health Center network with an $11 billion investment over the next four years to help ensure that there will be delivery points all across the country. They also provided 1.5 billion in funding for the National Health Service Core which pays for the education of health care providers. As long as they do some service in medically underserved areas or to Community Health Center, they were thinking about the problems.

Margaret Flinter: Mark, I think it's about time for us to do a show both on our Community Health Center and on the system of care known as Community Health Centers across the country, one of America's best kept secrets in health care. But for now, I am going to turn our attention to today's guest Dr. Ed O'Neil who's got a handle on creating the future of health care. Dr. O'Neil is Director of the Center for the Health Professions, a research, efficacy and training institute dedicated to educating a health care workforce that can lead the improvements in health and well-being of people and their communities. Dr. O'Neil is a Professor in the Departments of Family and Community Medicine in the School of Nursing at the University of California, San Francisco. And we are delighted, he is here to speak with us today.

Mark Masselli: No matter what the story, you can hear all of our shows on our website Chcradio.com. You can subscribe to iTunes to get our show regularly downloaded. Or if you would like to hang on to our every word and read a transcript of one of our shows, come visit at Chcradio.com.

Mark Masselli: And as always, if you have feedback, email us at Chcradio.com, we would love to hear from you. Now, before we speak with Dr. O'Neil, let's check in with our producer Loren Bonner for the headline news.

Loren Bonner: I am Loren Bonner with this week's headline news. After Reuters reported that the insurance giant WellPoint had been intentionally dropping coverage for patients recently diagnosed with breast cancer, Health and Human Services Secretary Kathleen Sebelius made a point to highlight the wrong doing in a lengthy reply to WellPoint executives that was also made public. Insurance companies have used the practice known as Precision for years, but under the new law that goes into effect later this year, insurance companies will be banned from dropping coverage for people who become sick. Reuters said WellPoint used a computer algorithm that automatically targeted patients recently diagnosed with a breast cancer. WellPoint CEO Angela Braly responded to Secretary Sebelius in a letter saying that the Reuters report was inaccurate and misrepresented the insurance company's efforts to help patients to tack and treat cancer. In any case, the situation signaled the administration's aggressive approach toward insurers who unlawfully deny health care to Americans. This news is also a chance to talk about how women will benefit under Health Care Reform. In 2009, The National Women's Law Center, an advocacy group that worked hard to get the new law passed, found that insurance companies charged women up to 84% more for individual and small group policies than men, even

without coverage for maternity care. In other cases of unfair practice, some women simply can't find an insurer to cover them. And for women who have insurance, sometimes it just doesn't cover certain scenarios like pregnancy. Secretary Sebelius says women being charged more for being pregnant will change in the new marketplace.

Kathleen Sebelius: They won't be able to charge women two and three times what you can charge their male counterparts because they might get pregnant.

Loren Bonner: Provisions in the new law will help women in several other ways. Midsized employers will be required to provide a place and time for nursing mothers to lactate. New insurance plans that start up five months from now and later will have to allow women to go directly to an OB/GYN without a referral from a primary care doctor and insurers won't be allowed to charge co-payments and other upfront costs for preventative services like mammograms and pap smears.

This week, we are discussing the health care workforce and its importance in moving the country toward meaningful health care reform. Our guest today, Dr. Ed O'Neil, is the Director of the Center for the Health Professions at the University of California, San Francisco, an organization that has done a tremendous job to ensure that the current workforce as well as the next generation can lead the way forward. One way this center achieves this goal is through numerous leadership programs for nurses. Certainly, a lot of attention has been focused on initiatives to address the nursing shortage. Since 2005, Governor Schwarzenegger has been funding the California Nurse Education Initiative to provide funding for a nurse training that can directly help the critical shortage of registered nurses. The nurse leadership programs at the center for the health professions aim to do more and draw on the larger role that nurses play and can play in our health care system. Mary Dickow is the Deputy Director for the Robert Wood Johnson Foundation Executive Nurse Fellows Program at the center, an advanced leadership program for nurses with the overarching goal to lead and to shape the health care system for the future. She says, "Nurses have an important role in Health Care Reform."

Mary Dickow: The nurses are primarily the ones delivering the care or in the _____ 8:11, the ones really shaping those that will deliver the care. So in the case of nursing education, they have a direct impact on how the curriculum is shaped or what the student's experience is. And in the hospital systems, they would have of course an impact on what the role of that nurse on the frontline is. And in public health, they are out delivering the care to a great extent in the community.

Loren Bonner: All of the nurses in the program work on a project that actually influences the way care is delivered. And just to highlight how such a program can influence Health Care Reform, our very own Margaret Flinter, a Robert Wood Johnson Executive Nurse Fellow herself, refined her idea for a family nurse

practitioner residency program during her work as a fellow. The first such residency program of its kind in America started here at the Community Health Center and it's now a model for a National Training Demonstration Program and the Health Care Legislation that was just passed in March. Let's listen now to the interview with Ed O'Neil to learn more about meaningful Health Reform for our future.

Mark Masselli: This is Conversations on Health Care. Today, we are speaking with Ed O'Neil, Director of the Center for Health Professions and Professor in the Departments of Family and Community Medicine and the School of Nursing at the University of California in San Francisco. Welcome, Ed.

Dr. Ed O'Neil: Thank you.

Mark Masselli: You are both historian and a futurist, a great combination of perspectives as we move forward to the implementation phase of the National Health Reform. You stress the importance of finding a midpoint between government and the marketplace recognizing that health care can't be left to the sole province of either and you have talked about the genius of American middle where the pragmatists come together to create good policy that leaves enough room for individual action and responsibility. How does that middle way translate to the future of health care in the context of this national legislation?

Dr. Ed O'Neil: We have to reinvent the practice models in a way that builds in that kind of public support when necessary, but individual accountability and engagement involvement throughout. And that's going to require us to think differently about how we understand the professional role, what we finance, how we regulate, how we educate beginning in the earliest years so that there is this sort of expectation of responsibility on the part of the consumer. And we are also going to have to think about policies that shift some of that responsibility back to the patient, consumer, public as well. But the kind of responsibility that looks at behavior, that looks at contribution, that looks at material effect, and then prices your share of health care accordingly. So continued substance use, tobacco, alcohol and someone refuses to seek any kind of assistance to change that behavior, all of those things are things that we are going have to reconsider and how we think about individual responsibility. But we also then, backing it up, have to be prepared to have a public system, whether it's delivered privately or publicly, it's kind of unimportant, but we have to have a publicly supported system that will help those individuals be more accountable.

Margaret Flinter: The kind of health care system transformation that you are talking about obviously requires leadership and maybe at a level we just haven't seen before in health care. Now, you have done a lot of work both with emerging and season leaders in California and also nationally, and you have identified these three core domains and you can tell that we do redo work that you see as the task of our leaders in our new reality, coherence, efficacy and community.

Can you elaborate on those domains and how do we train the next generation of leaders in them?

Dr. Ed O'Neil: The health care in the U.S. is the sixth largest economic undertaking on the base of the globe and it's complicated. But it's complicated in part because that's how we have made it. So to change that means that we have to be able to say, with some very clear first principle, this is what we are trying to achieve, this is what success will look like, and it's got to be coherent to the providers, it's got to be coherent to the public. But we need broader public discussion around that to give that kind of coherence. One of the concepts that I have been trying to push for a decade is this idea of health commons. What I mean is that tradition in America of communities coming together to do things in common, whether it's raising a bar or it's building and supporting a public school system, but we need that same kind of ethos for health care in which I have taken the responsibility as a citizen, as a consumer, as a patient to actually learn what I need to do to take care of myself. Efficacy means that it's got to work, it's really got to be able to demonstrate that we are using the resources wisely, that we are selecting the treatments that have the greatest probability of a positive return. And it's also being candid about what we can and cannot do. And then on the community, we do need broader definition of how we participate in health care. We actually know that that kind of engagement actually produces health in and of itself. That's not what I am advocating for, but it's that community engagement and involvement that I think is just essential. It's a system that is understood and valued by the entire community.

Mark Masselli: Speaking of promoting health and things that have to work, the primary care setting is really where the focus is in the Reform Legislation and there are many incentives in the bill that reward primary care providers, those in practice and those who are applying to the field. Do you feel these incentives are aligned with our goals for prevention?

Dr. Ed O'Neil: I do think that. I don't think there is a last word in it but it's the beginning of a redirection of our health care system. A Dutch M.D. physiologist, a guy named Bernard De Vries, wrote an article many, many years ago called Unraveling the Mystery of Health. What De Vries said was "You know why don't we look up from the tissue in the organ to the system, to the human, to the human in relations and the broader community, and look for health there, not just in correcting the chemistry." So primary care gives us the beginning to move care back to prevention and management. And management is probably just as important in primary care as prevention. In fact, in some ways, prevention really is the domain, the responsibility of the individual assisted by the professional. But once we have the onset of disease, managing that disease, keeping that person out of the hospital, out of the treatment modalities is really an important part of what we need to do for the future.

Margaret Flinter: So, Ed, let's stay on the health care cost for a minute and certainly there has been lots of criticism that the Reform Bill won't lower cost quickly and they are probably justified. But the point wasn't made strongly enough I think that one person's cost is another person's income. So we see options like curtail access or cut the prices, neither of them very popular. So let me just ask you a bit of the futurist's perspective. Do you think there really are significant cost savings that we can achieve by covering the uninsured, managing those chronic diseases, and investing in prevention as you just said? Or if you are making a prediction, will we still see runaway cost at least for another decade?

Dr. Ed O'Neil: So the only option really is to reengineer or redo or refocus, re-imagine the way we organize and deliver care. I think there is some money to be saved long term in prevention but that's a very long term, that's a couple of decades before I think we begin to see big material returns. I think that the bigger and more readily available, accessible option for us to save money is to look at this large burden of chronic care, so diabetes, arthritis, congestive heart disease. Today, what we do predominately is we tell somebody they have this chronic disease and then we manage that care in the old acute care setting, a visit to the physician for 15 minutes every six months or so, a hospitalization when things get out of control. So, the option, Margaret, is to actually say now how do we use these resources, and there are a lot of resources once we look at how much all that acute care treatment costs, how do we use those resources to manage that care a different kind of way. Maybe we need new kinds of professionals, promotoras, and community health workers, or medical assistants working in an extended fashion. We need to think about changing behavior once the diagnosis is in. We need to think about wraparound supports. And while some people look at those and say well, that sounds very costly, the few studies that have been done in these different areas would indicate that yes, it's a different kind of expenditure but it's a lower expenditure. The only thing is we have 20 years of research from the Agency for Healthcare Quality and Research that would point to all of these well-established evidence-based ways to manage that care differently. And we need to incentivize people's movement to those.

Mark Masselli: Today, we are speaking with Ed O'Neil, Director of Center for Health Professions and Professor in the Departments of Family and Community Medicine in the school of nursing at the University of California in San Francisco. I want to sort of pick up on that theme about managing things a little differently. There is no doubt that the big question out there over Health Care Reform concerns health care workforce. Covering more people means that we need to find a cure for our health care workforce shortage and I am sure this was on your mind well before the Health Care Reform Legislation passed. It was certainly the experience out of the Massachusetts Reform Effort. Can you break down for our listeners how critical this issue of health care workforce shortage is and what initiatives have you been promoting to provide access to better training and education in health care?

Dr. Ed O'Neil: It's important for us to think about what are the resources that we have currently, not just do we staff with our personnel to the old model of care but how do we think about the resources that we have, institutions and professions, what do we want to achieve for the future, that's why this Health Commons idea is so important, and then how do we staff that, what do we have in abundance of, what do we have too few of, and how can we make up that difference in some creative and different kind of ways not just building new capacity, not just taking what we have done in the past and projecting a straight line into the future.

Margaret Flinter: So, Ed, one more factor I would lay into that is the demographics of the workforce we have got and let's just say the average age of physicians and nurses is up there, somewhere in the high 40s. But equally important, it seems to me, we have a generation of young adults and kids who are not likely to want to get their health care the same way that their parents did. Instead, we see a push for they want it electronically, virtually, using lots of different media than coming into the office. So maybe we have a gap in expectation that we need to bridge. Who is doing that successfully? Have you seen any examples out there of this?

Dr. Ed O'Neil: I think two places that are doing it a nice job of that. One, in the spectrum, is Kaiser Permanente. They have been the largest organized system in the country and they don't operate across the country. But in those places where they do operate, they have instituted a medical record. And they have not only used that medical record to administer health resources more efficiently and then to provide clinical information to the professionals more efficiently and effectively, most importantly, they have rather aggressively used that information tool to change the way the consumer thinks about and interacts with their own health, their own health information, and their practitioners. It's almost like banking 25 years ago when banks made these all own **tellers** and now we do a whole array of financial services using those online resources. And the other place, the other end of the continuum I would say, is in community clinics where we are actually seeing, in part because they don't always have every resource available to them, beginning to think about how that practice model can change using paraprofessionals, using community members, having individuals help each other in self-help groups and group visits to the clinic, and thinking about health within the community contact.

Mark Masselli: Let me pull on this right of innovation. When you look around the country and the world, what do you see that excites you in terms of innovations and who should our listeners of Conversations be keeping an eye on?

Dr. Ed O'Neil: The State Medicaid Program in Colorado has been one of the tremendous thoughts of innovation in terms of hospital care. Virginia Mason up in Seattle has been particularly outstanding. I think Virginia Mason has very aggressively pursued the route of changing itself with unflinching courage, that is

to say, change what we do even if in the short run, it negatively impact our bottom-line and hospitals are going to have to confront that and live with that reality but much better to lead it I think than that to have it push back on you. And then in terms of medical group out our way, the Palo Alto Medical Foundation has demonstrated, to me, a kind of consistent fairly strong set of innovations.

Mark Masselli: Today, we have been speaking with Dr. Ed O'Neil, Director of the Center for the Health Professions, and Professor in the Departments of Family and Community Medicine in the School of Nursing at the University of California, San Francisco. Thank you for joining us today.

Each week, Conversations highlights a bright idea about how to make wellness a part of our communities into everyday lives. In past weeks, we brought you stories about walking school buses and trayless cafeterias. Today, the bright idea focuses on a broader initiative to make schools healthier places for our children to learn and develop. After spending years working to make their three daughters' schools in Illinois healthier and safer, Chevy Chase and his wife Jayni founded the Green Community School Initiative with the goal of using their personal experience to improve schools around the country. Although their chosen name more readily aligns them with traditional environmentalist, the main impetus behind the initiative is children's mental and physical wellness. The Green Initiative focuses on several environmental factors, both inside and outside the classroom, that frequently compromise or endanger students' health, such as transportation students to and from the school, indoor air pollution, reduction in recess and PE time, as well as limited food choices in the cafeteria. Green Initiatives are powered by students' research in designing and implementing plans with teachers' assistance. For example, this year, students at Al Raby High School in Chicago have taken on the task of making their school healthier and safer. They organized a community trash pickup day for school's playground and surrounding streets. They have begun to research their school's air quality with the help of science teachers. Green Community School Initiative programs have begun to make a real difference in students' health. Children whose schools are part of the Green Initiatives are less likely to be overweight or to experience pollution-related respiratory illnesses. The Green Initiative has also succeeded in improving the social atmosphere in schools. Instead of sitting in class all day without interacting with each other, the students are taking charge of their school environment and working together to implement projects of their own design. This increased sense of community and purpose has led to decrease levels of violence and aggression by students. The Green Initiative has worked to make these changes long lasting by partnering with the Marilyn G. Rabb Foundation which works to reduce socioeconomic and educational barriers for low-income students. The Foundation conducts violence prevention workshops in participating schools. All of these changes mean that students are better able to focus in class and retain what they learn. The Green Community School Initiative is now active in several Chicago and Detroit schools and

programs elsewhere in the United States are on their way to becoming a reality. With its comprehensive approach to student wellness and its use of student input, the Green Community School Initiative is helping communities take control of their children's health by making their school safer places to learn and grow. Now, that's a bright idea.

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

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

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