Marianne O'Hare: Welcome to Conversations on Health Care with Mark Masselli and Margaret Flinter, a show where we speak to the top thought leaders in health innovation, health policy, care delivery, and the great minds who are shaping the health care of the future.

This week, Mark and Margaret speak with Dr. David Nash, Founding Dean of the Jefferson College of Population Health at Thomas Jefferson University in Philadelphia. He's a renowned expert in the growing discipline of population health, which seeks to empower primary care through better pay incentives for clinicians and leadership training that focuses on team based care delivery, all to do a better job of preventing illness across populations.

Lori Robertson also checks in, the Managing Editor of FactCheck.org, looks at misstatements spoken about health policy in the public domain, separating the fake from the facts. We end with a bright idea that's improving health and well-being in everyday lives. If you have comments, please e-mail us at chcradio@chc1.com or find us on Facebook or Twitter or wherever you listen to Podcast and you can also hear us by asking Alexa to play the program Conversations on Health Care. Now, stay tuned for our interview with Dr. David Nash on Conversations on Health Care.

Mark Masselli: We're speaking today with Dr. David Nash, internist and Founding Dean of the Jefferson College of population health. Dr. Nash serves as Principal Faculty member for quality of care programming at the American Association of Physician Leadership and serves on the national quality task force on improving population health. He's a distinguished fellow of the American College of Physician Executives and frequently named to modern healthcare's list of the most powerful persons in healthcare here. He earned his MD at the University of Rochester, his MBA from Wharton School of UPenn and completed his fellowship at the Robert Wood Johnson Foundation Clinical Scholars at the University of Pennsylvania. Dr. Nash, welcome to Conversations on Health Care.

Dr. Nash: Thank you. Great to be here.

Mark Masselli: Well, I think some people say you're the dean of population health, I'm wondering if you could just share with our listeners your definition of population health, and why is it so essential to improving health outcomes across the country?

Dr. Nash: Sure. So Thomas Jefferson University now has 10 colleges, we're the youngest of the 10 colleges that make up Thomas Jefferson University. When I came to Jefferson 30 years ago as assistant professor of medicine, I spent 18 years on the campus of the medical school. In 2003, as the Chairman of a Medical School Department, we modeled that department of health policy after Mark Chastain's first

such department at Mount Sinai Medical School, and of course Mark is now the President of the Joint Commission. In 2008, the Board of Trustees of the university, voted to create the College of Population Health and we opened the doors on September 09, 2009. So population health, I think we like to give credit to Dr. David Kindig, our colleague in his 2003 paper, 16 years ago, David called for an understanding beyond public health and labeled it population health that basically said, hey, public health is wonderful but it's too narrow and population health takes into account, are we delivering the care in a cost effective and safe manner?

Population health is the roof of the house and the house is supported by various pillars; the central pillar, being public health, and then health economics, quality and safety and health policy. So we're the first such college of its kind. There are now more than a dozen colleges of population health in the country.

Mark Masselli: Well, that's great. One of the things that I note about the Affordable Care Act is that it's done so many great things.

Dr. Nash: Indeed.

Mark Masselli: About 20 million Americans are covered by it, but there have been other benefits in addition to access. Walk us through the intersection of how the Affordable Care Act has helped building this community of people who are focused in on population health?

Dr. Nash: So as Speaker Pelosi so aptly put it, we'll figure Obamacare out after we pass it. No, so we're, we're still working on it, but the essential message is of course, roughly 20 million American citizens now have access to health insurance, therefore access to primary care and beyond. As best as we could tell research from very good people, the bill has saved lives and I think we could all agree to that. But to your question, the bill has also created the patient centered outcomes research institute, it created Accountable Care Organizations, it created an effect bundled payment. Most citizens who look at the evidence would agree that Obamacare is a major step in the right direction. From a population health perspective, certainly when we got board approval in 2008, we never could have dreamt that less than two years later the nation would adopt Obamacare, which was sort of a rocket ship to blast off the better understanding of population health. I think Obamacare recognizes that if we reduce waste, that's good for everybody, let's try to expand coverage. I mean, it's doing all these things at the same time and I think it's central to our mission to promote universal coverage and universal access.

Margaret Flinter: Dr. Nash, we've spent a lot of times since the passage of the Affordable Care Act looking at our health care system. When we look

at the rest of the world, how we do our health outcomes may be still leaving quite a bit to be desired. If you look at those comparisons, almost always you find out that there's a bigger investment upfront in primary care in population health. Maybe share some examples if you can, what countries are really executing on this idea of getting the highest value care and through a focus on primary care.

Dr. Nash: Well In most of the Western world, all of whom have better outcomes at a lower cost than us, there are typically three primary care doctors for every specialist. And of course in the United States, three specialists for every primary care doctor, countries that have primary care at the very center of the system have better outcomes, less waste, and are much safer. We're not in the top 10 of any measure of health outcome despite spending, you know, one and half times our nearest rival, roughly $10,000 per person. So I ask everyone, do you believe your family got $10,000 of value out of the health care system for every single member of your family in 2018? I've yet to have someone say, oh yes, it's been a great bargain. So the entire civilized Western world, as we know it achieves far more with fewer dollars than we do. One of the key attributes that they all share is the emphasis on primary care. How many more papers do we need that says primary care is the answer?

Margaret Flinter: Well, we think a lot about that here in our organization about the shortage of primary care clinicians. There are solutions. Certainly we have a 50 year history of nurse practitioners educated and prepared to be primary care providers but too often still not recognized as primary care providers. Certainly Telehealth, including Telemedicine, is going to make a big difference for patients and maybe solve some of the geographic and the rural mal-distribution issues that we have. And of course there's the holy grail of making our Electronic Health Records more interoperable, more friendly. Take any of those emerging trends and how are they --?

Dr. Nash: Yes. Good. How will it all help? Yeah. So let, let's start with medical school education. I've been inside the belly of the beast for 30 years. I've mentored, I mean literally a thousand medical students because Jefferson Medical College is so large. So you know, Paul Batalden said it right, Margaret, “Every system is perfectly designed to achieve the results it gets”, right? So if medical students see that the ologist has all the prestige, they will want to become an ologist when they see the implicit culture that rewards the specialist in the training environment.

So step one, change the training environment. So two, financially reward primary care in part let's do loan repayment, less of an inequality between super sub-specialist income and primary care income. I won't give away the store here, but in the faculty practice

plan, average annual, total salary x and 15x, so you know who's the x is and you know who the 15x is. Well to me that's unconscionable and we need to do way more to promote folks who are at the primary care x level.

Next step is to let folks work to the top of their license. You know, regrettably in my travels to this day, it is not unusual for me to have a physician come up to me face to face to say, there's no such thing as physician leadership. We could do a lot more to teach physicians to be the team quarterback and primary care could all be about a big team sport. All of that as a major cultural shift, but we have to start some place to really implement this kind of dramatic change in making primary care and care coordination the center of who we are and what we do.

Finally, of course, change the payment model. We know that especially primary care doctors will make traumatic changes in their clinical behavior for modest increases in marginal income. I'm all in favor of a bundled payment for congestive heart failure as a really great example putting care coordination, primary care doctors, and our cardiology colleagues in the center and paying us to go upstream, shut that faucet instead of mopping up that floors.

Mark Masselli: We couldn’t agree with you more.

Dr. Nash: Well thank you.

Mark Masselli: We're speaking today with Dr. David Nash, internist and Founding Dean of the Jefferson College of Population Health. Dr. Nash is not only an expert in population health, but is also active in leadership development in health care. We just had on a little while ago your CEO at Jefferson Health, Dr. Steve Klasko and talking about his vision for health industry leadership for the 21st century and he says it's a model built to support team-based care. You did note it was a team so that everyone in that team can practice up to the top of their license. I know that every member wants to have an equal voice in there, what are some of the other strategies that you're developing? It takes an entire team to work with the patient, you know in particular with population health, we're so much of the intervention is outside of our four walls. What are you doing to cultivate this opportunity?

Dr. Nash: Let me give you two specific examples, and perhaps Dr. Klasko talked about one of them. So Steve Created the Jefferson on Board Leadership Training or JOLT, and everything here has to start with the J, so in the previous 25 years that I was here there was no leadership training program was sort of absurd. So JOLT takes the emerging leaders from across our enterprise, now 16 hospitals, 10 colleges, brings them together every month for a year to give them leadership training, skill building, communication skills, quality improvement

skills, and all the rest. A program that we created, we've got the board of trustees in 2014 to mandate that every clinical department in the medical school must train at least one faculty member to be an expert in quality and safety. We've now subsequently dubbed this QIPS and our college is now running and implementing QIPS for the enterprise, working with a handpicked group who will have a certificate in quality and safety as another example of training emerging leaders.

JOLT and QIPS, two steps in the right direction, we still have a long way to go. If it were up to me, I would have every medical student read Peter Drucker and John Kotter and all the rest because that's what makes organizations great and enduring.

Margaret Flinter: We're very focused on training the next generation, and the ability to lead a team is something we expect of everybody who is an emerging leader in the organization.

Dr. David Nash: Wow, well, to your credit.

Margaret Flinter: One of our approaches is that it really has to be interprofessional training. Everybody has the potential to be a leader of the team or the practice, tell me what your experience is and what you're learning about training leaders in an interdisciplinary interprofessional way to be able to pass that leadership role kind of back and forth among people to have different people taking those roles, I know the folks out in Minnesota have been doing a lot with this, but we'd love to hear what your experience is at Jefferson.

Dr. David Nash: Great. We share space on this floor with probably one of the nation's top five centers for interprofessional education called Jefferson Center for Interprofessional Education. It has a physician and pharmacist, co-executive director. I'm a fan, but I also am a healthy skeptic and here's why, the trainees; medical students, nursing students, pharmacy students are very rarely in the same room together, and that is a huge challenge. It's because of accreditation and other issues, so yes, I'm well aware of the progress in Minnesota and elsewhere. On the other hand, are we collectively in the classroom really working in an early stage together? Very, very modestly.

More importantly, I think is at the bedside, how does the team function? Is there equity in the views? Are there pharmacists embedded with the house officers? Are the nurse practitioners called upon? I think there are baby-steps everybody could take that would go a long way to improving this, but this is an uphill battle. Again, it's all about the culture. When you come and you make grounds in a place like ours, it's pretty clear who's who and who's in charge. If we could improve upon the leadership training so everybody feels like they're participating and it's pretty clear that we're better together

than we are individually. That'll be a big step for physicians anyway, everybody wants to be a quarterback. Can you imagine a football team of all quarterbacks? Well, that would be a problem. That doesn't win a football game.

Mark Masselli: Well, Dr. Nash speaking of uphill battles, I want to sort of connect two points that you've made. The difficulty of shifting culture and the other for our country to promote more value based care. We had the opportunity, Margaret, the other day to have Leah Binder from Leapfrog really just talking about the -- I think the good news that there had been a slight reduction of the number of preventable deaths in hospitals, but it was still up at 160,000, it was still 500 people a day. So talk about how we're going to make this shift --

Dr. David Nash: I wonder if our listeners know right in the same building where I'm sitting is the Dean in charge of the Physician Assistant Training Programs. Training in quality and safety is mandatory for physician's assistance. If the public knew that no such mandatory rule exists in medical education, what do you think their reaction would be?

Margaret Flinter: I'm not sure I'll do that.

Dr. David Nash: Right, and imagine if you were the Chancellor of the University of North Carolina and you woke up last week and you saw that front page, New York Times story where doctors feeling so compelled that they surreptitiously recorded the meeting of the quality committee because they were so concerned of what was happening to those children in that open heart surgery program. It's 2019, let's get on with it. I have been for 30 years unwavering in total transparency as it relates to outcomes and error reporting. We wrote about this in JAMA in September of 1991 so, you know, I'm very disappointed we haven't moved this ball as far down the field as I would like. Then to see a headline like that, imagine being at UNC -- oh, and how about Jacksonville Children's Hospital just two months ago, and how about a major hospital in Texas? We could go down the list. What do you want to take out of the curriculum? That's what most medical educators ask me. Should we throw out the heart and then we could put in quality, this is what I get asked all the time.

Margaret Flinter: That conversation goes on in all sorts of disciplines, yeah.

Dr. David Nash: In all in every place.

Margaret Flinter: I think the --

Dr. David Nash: Systems training, that's what we need.

Margaret Flinter: Yup. Hearkening back to Mark's comments about Leah Binder, I think that show sent a lot of people back to looking at their states. But when you know that your own state is rated for safety, you compare

hospitals, people started asking a different set of questions and people I think want their hospital to be successful. They want everybody to have an A rating.

Dr. David Nash: I can't help but remember, we're coming up the August 14, 1991 issue of JAMA, our team here in Philadelphia and our colleagues at Dartmouth, the two lead papers, a little known Harvard pediatrician wrote the editorial Don --

Margaret Flinter: We know who.

Dr. David Nash: And Don said to admit that you could do a better job as an expert makes you vulnerable.

Margaret Flinter: To err is human, absolutely.

Dr. David Nash: We're publishing a special issue to speaking of that, of our journal, the American Journal of Medical Quality, come September of 2019, we're going to have a 20th anniversary issue. We went back and we looked at the top articles in our journal in the last two decades that most referenced. It's fascinating to see, so on a good day I feel like we have made some progress with lots of help of course. And then there are days I think University of North Carolina what's it all about.

Margaret Flinter: We've been speaking today with Dr. David Nash, Founding Dean of the Jefferson College of Population Health. You can learn more about his work by going to jefferson.edu/population-health or follow him on Twitter at @nashpophealth. Dr. Nash, we want to thank you for your groundbreaking work in advancing population health and for joining us today on Conversations on Health Care.

Dr. David Nash: Well, thanks for having me. I really appreciate it.

[**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 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: The Measles outbreak in the United States and around the world has sparked misinformation on social media. One false Facebook meme blamed illegal immigration from South America, but the virus was eliminated across both North and South America in 2016. The recent outbreak is due largely to inadequate vaccination rates in some communities. Measles was eliminated in the United States in 2000 and as mentioned from the entire North America and South America continents six years later. Elimination means cases can still occur, but

that the disease hasn't been continuously spread for a year or more.

Recently the virus has been brought into the U.S. by people who have traveled to places where there is an outbreak or where the disease is still common, such as parts of Europe, Africa, Asia, and the Pacific. From those travelers, the disease can then spread in U.S. communities that have unvaccinated people.

The measles outbreak in New York City, which started in 2018 and spread in the orthodox Jewish community, was brought on by travelers who had been in Israel where a large outbreak is occurring. The CDC has said, this year marks the largest number of measles cases since the disease was eliminated in the U.S. It said, misinformation about vaccines was “a significant factor contributing to the outbreak.”

Similarly the Executive Director of UNICEF and the Director General of the World Health Organization issued a joint statement that cited online misinformation about vaccine safety as a contributing factor in the rising number of measles cases in high and middle income countries, and that's my fact check for this week. I'm 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 like checked, e-mail us at www.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 and everyday lives. Asthma is one of the leading causes of trips to the emergency room for children and there are often a correlation between high density low income neighborhoods and more trips to the hospital for treatment and intervention. When officials at Boston Children's Hospital noticed a spike in asthma outbreaks in certain neighborhood clusters, they decided to do something about it. They launched the Community Asthma Initiative. They realized that if you could treat the environments in the patient's home that might reduce the need to treat the patient in the emergency room.

Dr. Wood: The home visiting efforts work with children and families that have been identified through their hospitalizations emergency room visits of having poorly controlled asthma and also it's a teachable moment.

Mark Masselli: Dr. Elizabeth Wood heads the program and says the first step is to identify the frequent flyers. Then they match with the community health worker who visits their home several times and assesses the

home for asthma triggers.

Dr. Wood: And they work on three areas; understanding asthma itself, understanding the medications and the need for control medications, and then working on the environmental issues.

Mark Masselli: Families are given everything from HEPA filter vacuum cleaners to air purifiers. They are told not to clean with certain toxic products and the homes are monitored for the presence of pest or rodents.

Dr. Wood: What's remarkable is that there was a 56% reduction in patients with any emergency department visits and 80% reduction in patients with any hospitalization.

Mark Masselli: The Community Asthma Initiative, a simple re-shifting of resources aimed at removing the cause of disease outbreaks in the community, leading to healthier patient populations, now that's a bright idea.

[**Music**]

Mark Masselli: You've been listening to Conversations on Health Care. I'm Mark Masselli.

Margaret Flinter: I'm Margaret Flinter.

Mark Masselli: Peace and health.

Conversations on Health Care is recorded at WESU at Wesleyan University, streaming live at www.chcradio.com, iTunes, or wherever you listen to podcasts. If you have comments, please e-mail us at chcradio@chc1.com, or find us on Facebook or Twitter. We love hearing from you. This show is brought to you by the Community Health Center.

[**Music**]