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Margaret Flinter: 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 healthcare of the future.

This week, Mark and Margaret speak with Dr. Steven Woolf, Distinguished Chair in Population Health at Virginia Commonwealth University and Health Equity Director Emeritus and Senior Advisor at the VCU Center on Society and Health. He talks about the just released report, showing a decline in life expectancy among working aged adults in the U.S., a result of the lingering effects of the recession, the opioid crisis and other so-called deaths of despair.

Lori Robertson also checks in, Managing Editor of FactCheck.org, looks at misstatements spoken about health policy in the public domain, separating the faith from the facts. We end with a bright idea, that's improving health and wellbeing in everyday lives.

If you have comments, please e-mail us at chcradio@chc1.com or find us on Facebook, Twitter, or wherever you listen to podcast. You can also hear us by asking Alexa to play the program Conversations on Health Care.

Now, stay tuned for our interview with Dr. Steven Woolf of the VCU Center on Society and Health here on Conversations on Health Care.

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Mark Masselli: Welcome to Conversations on Health Care. I'm Mark Masselli.

Margaret Flinter: I'm Margaret Flinter.

Mark Masselli: We're speaking today with Dr. Steven Woolf, Distinguished Chair and Population Health at Virginia Commonwealth University and Director Emeritus and Population Health and Health Equity at VCU Center on Society and Health where they conduct in-depth research on social epidemiology. Cleared his MD at Emory University and his Master's of Public Health at Johns Hopkins University and did his residency in both Family Medicine at Fairfax Family Medicine and in prevention and public health at Johns Hopkins. Dr. Woolf, welcome to Conversations on Health Care

Dr. Steven Woolf: Pleasure to be here.

Mark Masselli: Well, your study is the straw that stirring the drink I think in conversations around the country, and you just released this, I think very concerning report indicating this substantial decline in life expectancy in America, and the report is life expectancy and mortality in the United States 1959 through 2017. It really lays out this rise in

mortality among working aged adults from 25 to 64 years of age. I wonder if you could share with our listeners the more important findings and what it bodes for the overall life expectancy in the United States?

Dr. Steven Woolf: Well, you stated one of the most important findings, which is that the working age population is experiencing this increase in mortality, which basically means American adults are more likely to die before age 65 than adults in other countries. That's pretty alarming. The life expectancy decrease also is actually not a new phenomenon. It's decades in the making. Life expectancy is supposed to be increasing and that's been the case for the past century in most industrialized countries and in the United States as well. Ours has been increasing for many years. In the 1980s, the pace at which we were increasing began to fall off. It plateaued in 2009 and it's been decreasing for the past three years.

Margaret Flinter: Well, Dr. Woolf, I think there's no other word to describe it, but shocking, right? It's not really a new onset phenomena, the wheels that have been driving this drop in life expectancy actually probably began moving backwards in the 1980s. I think you've said that the Great Recession and the wake of the Great Recession, the pace accelerated and certainly some regions were hit much harder than others. There's been a saying for a while that your zip code may have more to do with your health than your genetic code. Maybe if you could help us and our listeners understand, let's just take the recession. How did that impact population health, and how has that actually been manifested in some of these higher mortality rates for middle aged Americans?

Dr. Steven Woolf: Well, the recession did not help matters. I can say that. Certainly it had a severe impact on the whole country, but it's one that's really lingered for marginalized communities and populations that have been historically disadvantaged. I think it's actually important to emphasize that the economic stresses that middle class and low income families have been facing in this country predate the recession. It really does go back to the 1980s that you mentioned, when our economy underwent this major transformation that resulted in the loss of manufacturing jobs, steel mills close, coal industry and so forth, were really deeply affected and a lot of middle income workers who had depended on those industries for their livelihoods and the communities in which they live, began feeling the strain. We feel that these health trends that we're reporting now are really the symptoms of the long-term exposure to those economic stresses. The recession certainly hurt those folks even further, but I think the health insult was already underway well before that.

Mark Masselli: It's going to be interesting to listen to the conversations going on, on

the political trail certainly, the conversations about income inequality is also a public health conversation. Speaking in public health, certainly the devastating expansion of the opioid epidemic, which has led to hundreds of thousands of deaths. Thank God for something like Narcan, which we saved tens of thousands, if not more lives. I'm wondering if you could just focus in now, moving from the income inequality to the opioid crisis. I think you've called these whether it's alcohol abuse or suicide or opioid really deaths of despair, how they've played a role in the increased mortality?

Dr. Steven Woolf: Well, it might be helpful to start just by unpacking what's behind this increase in working age mortality. Drug overdoses filled by the opioid epidemic are the leading contributor for that increase by far. There are many other factors, but it's the major player in driving the trend. There's also been an increase in deaths from alcoholism and suicides that was reported over several years, and it was not me actually, but other researchers who coined this term Deaths of Despair in an attempt to try to weave together some explanation for those three causes. Our study found increases in 35 causes of death in this age group and it extended well beyond substance abuse and suicides to include a variety of chronic diseases. While clearly opioids and drug addiction are major priorities in trying to solve this problem, it's actually more pervasive.

Margaret Flinter: Well, Dr. Woolf, one of the tenants of the work that we're doing in Community Health Centers is that you will find disparities and health status based purely on racial and ethnic grounds. Your study is little more nuanced and is really looked at this, I think in a very sophisticated and complex way. I wonder if you could talk a little bit about where racial and ethnic disparities fall on this, as well as the role that economic disparities play? How do we begin to look at this across our very varied society in the United States?

Dr. Steven Woolf: Historically, communities of color, particularly African-Americans and other minority groups have experienced disproportionately high mortality rates and shorter life expectancy than non-Hispanic whites in our country. That's obviously been a focus not only at Community Health Centers, but public health at large and trying to close that gap, and actually, some great progress has been made.

Margaret Flinter: Yeah, absolutely.

Dr. Steven Woolf: The initial studies reporting this increase in middle aged mortality, which was around 2015 that a lot of press attention went to it, claimed that it was only happening in whites that it was not occurring in African-Americans or other groups. The reason I said that though, is because data that had not yet become available showing that it is in fact increasing in other racial and ethnic groups as well. We have so many people, just in absolute number that are white in this country.

Also there may be some differences in how this is playing out across cultures and across groups with different histories in terms of privilege and disadvantage. The important point to realize though, is that even with this increase in white mortality, it doesn't even come close to the mortality rate in African-Americans. The sad thing is that although we were making some progress in lowering the black white mortality gap in recent years because of this trend now affecting communities of color, we're seeing a reversal and some of the progress that we had made is now being erased by this trend of increasing midlife mortality.

Mark Masselli: We're speaking today with Dr. Steven Woolf, Distinguished Chair and Population Health at Virginia Commonwealth University and Director Emeritus in Population Health and Health Equity at VCU Center on Society and Health. I pull the thread on that a little because a little counterintuitive in the sense that we've had the Affordable Care Act out there for a number of years, 20 million Americans gain coverage. I think we saw some positive results [Crosstalk] studies that showed that it had an uptake. Are you able to measure that impact about the expanded health coverage and how Medicaid might have impacted Medicaid now it's grown to about 75 million, 76 million people covered? What's correlation between coverage and outcome?

Dr. Steven Woolf: First, I should just emphasize that there's evidence from other studies not ours, about the health benefits associated with Medicaid expansion, and of course, the broader health benefits for closing the gap and in the uninsured. The disconnect, however, has to do with two factors. There's only so much importance to healthcare and this I'm saying, as a physician, research has shown that healthcare only accounts for about 10% to 20% of our health outcomes. Even if we were to arrive at the perfect healthcare system, we would probably still be seeing this health trend because it's really being driven by conditions outside the clinic that are responsible for this increase in morbidity and mortality, we have to have access to good care, but the root causes of this lie in the conditions that we're living at.

The other thing I want to emphasize is that although it's only been apparent in recent years that life expectancy is decreasing, the process was underway, as we said some years ago and what happened was that although death rates were increasing from causes like drug overdoses and alcoholism and suicides and the other ones we've mentioned, we were making important gains in other areas so death rates from Ischemic Heart Disease, from HIV AIDS, from cancer were decreasing. They were offsetting those increases in mortality from those other causes. What's happened in recent years is that we've reached the tipping point where the increase in drug overdoses or the others has become so large and so voluminous that it has overwhelmed the health gains that we achieve. Now we're starting to

see that rise and all kinds mortality, but it's a mistake to think that to draw some correlation, for example, to the Affordable Care Act, or to any recent policies, and assume that those are responsible for this trend when clearly the dynamic was in play some years ago.

Margaret Flinter: Well, you've referred to this as a distinctly American phenomena, and while life expectancy in this country is declining, the opposite is true in all other affluent nations, which I think is you've said and your colleagues in this area of research, say that we've got to pay more attention to social determinants of health. I think you were once quoted as saying that we would do better to make sure that teens graduate from high school that it would have more impact than any new blockbuster drug that might come on the market. The changes that we need in terms of population health and the social determents of health all seem to me come out of policy. I wonder if you'd like to highlight some of the ones that you and your colleagues think are the most important when it comes to reversing this trend.

Dr. Steven Woolf: I think there's great opportunity in improving the social conditions, not only for our health, but for economic mobility. When I talk about this, it's not like the solution to this health problem is some new medical discovery, some new drug that we need. The very policy changes that we talked about for helping the middle class promoting social mobility, economic development of our marginalized communities are the same ones that will improve our health. It's getting access to a good education, jobs that pay livable wages, affordable housing, transportation, infrastructure. Those are the things that communities need and families need to thrive economically, and to provide security for their children. I don't think those all come from government necessarily. There's an important role for government policy at the federal, state and local level, but a lot of it comes from the private sector in terms of creating economic opportunity, and we see examples of that across the country.

Mark Masselli: I want to pull the thread on Margaret's – first part of Margaret's question, which dealt with other countries and I'm wondering to what extent you can look at best practices or what are we seeing that's different in those countries? Is it really on the opioid side? Or is it because they have less of an income difference going on in the population? What are you seeing and there's any best practice that we can try to contemplate?

Dr. Steven Woolf: Well, I mean, one of the first things to say is that sometimes people push back on the comparison between the United States and these other countries because they are so different. We're not Finland, we're not Norway, we're not Japan. They feel that because we have such a diverse population, there's some who incorrectly assume that our health disadvantage is due to this diversity. As we just discussed,

the largest increase in mortality is in non-Hispanic whites. Other studies that we've done over the years have shown that Americans across many different subgroups do worse than their peers in other countries so rich Americans have worse health than rich people in other countries, insured Americans do worse than average in other countries.

One possible explanation for that might be that these other countries provide stronger support systems for families and communities that fall on hard times. It's not that people aren't unemployed or poor in other countries, but programs and services are in place so that they can get through those times without it affecting their health as deeply as it does in this country where there's more of a culture of expecting people to fend for themselves when times get rough. There are other differences. You mentioned the opioid epidemic, which does not exist in most of these other countries. The marketing of Oxycontin and other prescription opioids that was so pervasive in this country was not allowed in many of these other countries. There are other regulations and advertising contexts that may also explain some of the differences we're seeing.

Margaret Flinter: Well, there are some bright spots in the reports kind of an odd one that people living in our coastal areas in the United States have seen some slight improvements in life expectancy, but it really does point to some of the widening disparities, urban versus rural. You're determined to get to the root cause of this disparity and outcomes and we want to cheer you on and that work and we'd love to hear more about the partnership that your institute is participating in a national committee funded by the National Academy of Sciences and the Robert Wood Johnson Foundation to really dig down in greater depth.

Dr. Steven Woolf: I'm a member of a committee that the National Academy of Sciences has established to look at this trend of increasing mid life mortality, and it's brought together experts from around the country to sort of put their heads together and review the evidence and try to get a better sense of what's behind this trend and what explanations might be brought to bear to understand what to do about it. I do want to go back, though, to the point you made about the areas of the country that are doing well. Our study was a state level analysis so we looked at the state. The Pacific states, as you mentioned, California, Oregon and so forth, did relatively well. As you mentioned a few minutes ago, our zip code is very important to our health, zoom in on any of the states that like they're doing well. If you're in South LA or areas of Sacramento or Oakland, you're not seeing those positive health trends and so we see this pervasively across the country 15 or 20 year differences in life expectancy across census tracks that are just separated by two or three miles. We need to have that broader

national perspective and see what states and regions are doing well and not doing well. Also think about local neighborhood level solutions that are really powerful influence our health.

Mark Masselli: We've been speaking today with Dr. Stephen Woolf, Distinguished Chair and Population Health in Virginia Commonwealth University, and Director Emeritus in Population Health and Health Equity at VCU Center on Society and Health. You can find his report on the recent edition of the Journal of American Medical Association JAMA, and you can follow his work by going to www.societyhealth.vcu.edu. Dr. Woolf, thank you so much for your contribution to public health, animating the conversation for so many people, I think this is a conversation that really everybody needs to be engaged in, and also thank you for joining us Conversations on Health Care.

Dr. Steven Woolf: My pleasure and thank you for bringing attention to this issue.

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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 healthcare reform and policy. Lori Robertson is an award winning journalist and Managing Editor of FactCheck.org, a nonpartisan, nonprofit consumer advocate for voters that aim to reduce the level of deception in U.S. Politics. Lori, what have you got for us this week?

Lori Robertson: In the November Democratic Debate, Senator Bernie Sanders said that the United Nations is projecting, “Hundreds of millions of climate refugees in the years to come as a result of climate change.” The UN, however, doesn't currently endorse a particular estimate and the term climate refugee is in many ways problematic. His remark is similar to a comment the UN Deputy High Commissioner for Refugees made in 2008. Well at a Climate Change Conference, the official said that between 200 million and 250 million people would be displaced by 2050 because of global warming, but that figure is likely flawed, and it was also more than a decade ago. More recent statements from UN officials do not indicate the agency endorses an estimate. In 2011, for instance, the High Commissioner for Refugees said there was no consensus on a number and a 2016 FAQ available on the agency's website says quote, “It is hard to say,” how many people will be displaced by climate change.

Scholars in the field don't use the term climate refugee because refugee has a very specific meaning in international law. For one the term refugee applies to those crossing international borders. Research shows people affected by climate change usually move within a country first. In 2014, the UN International Organization for Migration stated in a report that there was great uncertainty about the figures, noting that the forecast for the number of environmental

migrants by mid century vary widely between 25 million and one billion. The actual figure the report explained will depend on a host of factors that are largely unknowable at this point. For more see our website at FactCheck.org. I'm Lori Robertson, Managing Editor of FactCheck.org.

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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.

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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. It's estimated that the majority of a person's lifelong health expenditures are often spent in the final months of life. Death is one of those topics that generates the least amount of conversation in the clinical setting. For folks who end up critically ill or facing a terminal diagnosis like late stage cancer, this can often lead to poorly communicated end of life wishes being discussed with the clinician who then often resorts to extreme interventions.

Dr. Manali Patel: There's this unspoken misconception that by having honest conversations about prognosis that we are somehow removing the hope that patients are coming to us looking for. Actually, most studies that have evaluated this have shown that when you provide honest prognostic information to patients and allow patients to be part of the decision making about their goals of care, they actually have more understanding of their disease process and better satisfaction with their care overall.

Margaret Flinter: Dr. Manali Patel is a Clinical Researcher at Stanford University School of Medicine. Her earlier research at Stanford Edu did an interesting finding. Late stage cancer patients felt more comfortable talking about end of life issues with a layperson as opposed to a clinician. She and her fellow researchers followed patients at the Veterans Administration Palo Alto Healthcare System for 15 months after they were diagnosed with stage three or four or recurrent cancer. Half the people were randomly assigned to speak with a lay worker about the goals of care over a six months period and the lay workers were given a rigorous 80-hour course and clinical observations before being assigned to the study.

Dr. Manali Patel: She learned as she went and as the project went through the cycles of

starting the implementation and ramping up and then at the end, she came to that realization that these conversations really are not scary. We had hired her specifically because of her service orientation and because she had a very supportive ear and that's really the main crux of this intervention was finding the right person.

Margaret Flinter: 92% of the participants who received the layperson intervention, compared to only 18% of the control group, were likely to have end of life directives in their Electronic Health Record, and more likely to have communicated their wishes to their clinicians as well. Often choosing hospice over emergency room interventions, the health costs of both groups varied as well. The average cost of care for the intervention group in the last month of life was about $1,000 versus $23,000 for the control group. Dr. Patel said one of the more interesting findings was much higher patient satisfaction.

Dr. Manali Patel: We found that the satisfaction scores went up for the patients in the intervention arms that they went down for patients in the control arm as well as the satisfaction with the decision making across all six scores of dissatisfaction with decisions fail, we found overwhelmingly that the patients in their invention arm were very satisfied with the decisions that they had made regarding their medical treatments that the patients in the control arm really did not have much movement at all in terms of how satisfied they were.

Margaret Flinter: A low resource compassionate, patient-centered intervention that assist terminally ill patients, their families and their clinicians to have a frank discussion about end of life wishes, improving patient satisfaction as such a sensitive and challenging time. That's a bright idea.

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

Margaret Flinter: And I'm Margaret Flinter.

Mark Masselli: Peace and health.

Margaret Flinter: 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.

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You've been listening to conversations on healthcare, I'm Mark the salad and I'm Margaret planter piece of health conversations on healthcare is recorded it w e su at Wesleyan University streaming live at ch ic radio.com iTunes or wherever you listen to podcasts. If you have comments, please email us at ch IC radio at ch e one.com. or find us on Facebook or Twitter. We love hearing from you. The show is brought to you by the community health center.

Mark Masselli: We're speaking today with the Retired Three-Star Navy Admiral Joe Sestak, a Candidate for the Democratic Presidential nomination. He represented Pennsylvania's Seventh Congressional District from 2007 to 2011 in the U.S. House of Representatives. Admiral Sestak served as Director of Defense Policy at the Office of National Security under President Clinton, and served in the U.S. Navy for 31 years. Thank you for your service. He is a graduate of the U.S. Naval Academy, earned his Master's in Public Administration and his PhD in Political Economy from the John F. Kennedy School of Government at Harvard University. Admiral Sestak, welcome to Conversations on Health Care.

Joe Sestak: Mark, it's good to be with you and with Margaret and please it's Joe.

Mark Masselli: Joe, that’s correct, Admiral Joe, if you don't mind, I think that's how people are on the trail refer you to and you came into the process late, you had reasons of course your teenage daughter was recently treated for brain cancer for a second time and you say that really shaped your experience as you thought about engaging in politics. I'm wondering the factors that drove you to enter the race and your thoughts on the American healthcare system as well.

Joe Sestak Right, got married late in life and come back from the war and my daughter was four years old and had brain cancer. After the first operation at Walter Reed Military Hospital, the doctors took U.S. aside and said we couldn't get a total resection, and they said, we think it's Glioblastoma. That probably means only about 90 days, and because of the military health care system, we were able to take her elsewhere. From children's the Mass General to one of the two proton beam therapy machines at the time, all of a sudden I truly understood The National Security begins at home in health security. I changed from being an independent to being an independent happens to be a Democrat. I ran in nearly two to one Republican District on one refrain. National Security begins at home in health security.

I taken in 2005, the soon to be called Romney Care, Massachusets Health Care Plan, and I ran on that. I knew everybody needed accessible, affordable health care, do the same thing I had, and we passed the Affordable Care Act. When my daughter's brain cancer

came back last year, however, I wasn't planning on getting in this presidential race. We were taken aback. Only percent of children ever survived Glioblastoma. She was into the end zone and all of a sudden, there it was. We went through it all again and after we had the proton beam therapy, the surgery, she couldn't go through the same chemotherapy. They had one of these new drugs. It only been approved by the FDA with Metastatic breast cancer, but it had the same element, same chromosome so to speak, that's up in her brain. FDA hadn't approved it for that and so we were denied. We eventually appealed and wanted not took two lessons from it. It was chromosome cancer or gene cancer, and yet government hadn't caught up with that. Government needs a better type of relationship with the healthcare community.

Number two, is I began to wonder if the middleman was really necessary where, why did I need someone wasn't even a medical doctor to be saying what could or could not be? I got into this race for different purpose obviously than healthcare to try to unite our country and help the country in the world again with someone who understands global affairs but I'm so still driven by National Security begins at home, and how those lessons I just learned the second time around, move me towards a different approach to health care for universal healthcare.

Margaret Flinter: Well Admiral, I think it's fair to say that you're somebody who walks the walk and I read the during your political career in Pennsylvania, you are known to have walked across the entire state. That's a pretty big state –

Joe Sestak: 122 miles.

Margaret Flinter: -- in an effort to truly connect with voters in your state, which has so many very diverse regions, and you wanted to slice of victory there, I understand you've walked across New Hampshire. I imagine you have a lot of stories about what you've learned from these experiences and what are you learning from the walking **towards/tours** this time?

Joe Sestak: Well, the very first event I did was actually across the U.S. Navy Seabee Bridge, which connects Vermont with New Hampshire.

Margaret Flinter: That’s right.

Joe Sestak: And I wanted to go before I started the official walk into what's called Brattleboro Retreat, which takes care of 5,000 individuals who have challenges in mental health. Once again, it struck me. The biggest disease we have in America is mental health. We have less psychiatric beds today than we did in 1850. In fact, the largest psychiatric hospitals Rikers **Prison**, and I wrote it for this Mental Health and Addiction Equity Parity Act, but we aren't enforcing it. As I walked, I

met with social workers or others who work in this area, and I would always go into prison on Veterans Day to visit my fellow veterans. Again, there's so much last assets and this prison was the most progressive prison I've meant where the superintendent says you can't control as we're taught as corrections officer to control human nature, you can manage it with incentives and disincentives. When you're brought in, if you behave and you sit down, no handcuffs or anything, nobody sitting around you and you get up and sign in and wait for somebody behind the desk to call you forward for check in, or do not behave and you're slowing into a small little slammer right there, and he begins to treat with respects or **an app**, and with that type of approach, the reentry and recidivism programs are so much better and I saw wonderful people. I call them heroes from small business women trying to start up a brewery to stop by a gun show, because I wanted to say that I respect the Second Amendment right, the **Heller** Decision said, but I didn't want assault weapons fans there, all those experiences I treasure having walked across me.

Mark Masselli: We had the opportunity to talk with some of your fellow candidates around Health Reform and we have different camps. Some folks are embracing Medicare for all but you say that there's a better approach focusing in on the Affordable Care Act as well as creating a public option, and I'm wonder if you could tell us what sets your health strategy apart.

Joe Sestak: In fact, I think it's a worthy goal Medicare for all, but in the military, you learn piss poor planning is piss poor execution. After you had a government that decades ago could be in four years, Japan and Germany, but yet that same government was unable recently to roll out a healthcare website so you want to pause for a moment and say what is the best approach to achieve it gaining the trust of Americans? So what I want to do is as president is immediately fix the Affordable Care Act with all those horrible executive orders that have been issued, and have taken away, what made it work, very fine engineering model that did give coverage not only to so many, but it also began to cut down upon the cost to our economy. As you all know, according Institute of Medicine, because of the younger and uninsured, we lose somewhere between $100 billion and $140 billion a year.

I tell everybody Obamacare was actually passed as one of the first or second piece of legislation in 1789 with our first Congress. They mandated that all the sailors had to have health care, and actually had to pay for part of it. They didn't want scurvy at sea to destroy the one solid economy keel ships that were going to bring raw material from America to England to be turned back into finished products. As I tell the Tea Party patriots your forefathers the Tea Party is actually established Obamacare –

Margaret Flinter: So that goes over well.

Joe Sestak: It's not just for the individual, it's for the common good of America. We don't lose that $100 billion, $40 billion in our economy as they go to emergency room, sicker rooms more days. Then, as I voted for on Congress, you want to have a public option. We need to make sure it works because 255 million Americans have some sort of private healthcare. What we need to do is have it be a transition of choice initially, to where if it does provide better access, better care at lower costs, to where your company's paying directly to a private hospital, a for-profit hospital like Johns Hopkins or Mass General, more and more people will jump into it as it proves itself. Then, after four to six to eight years or so you can start saying it's worth and we begin to get an idea of what the cost is, but we need to test it out then you can move towards that Medicare for all.

People still want to select private health care code, but more important than that is what about the world county and my speech here to the Polk County Democrats, they said, you're going to be losing 20% of your hospitals in rural counties over the next few years. In fact, the same percentages in New Hampshire where they're going to lose five of their remaining 70. What happened with all these world hospitals all their for-profit, no for-profit is possible is ever going to go back to the rural county is what I believe the second track should be one towards the VHA the Veterans Administration Hospitals, which the New England Journal of Medicine despite the bad news you see at contra or public institution as compared to like Mayo Clinic. You find New England Journal of Medicine has rated it equal to or better than any private or public healthcare provider in American 11 major industry. Therefore, you should have another track with an option that moves itself towards this government hospital, government doctors to see if that's what can survive in the world hospital. Here in the rural counties as they lost their hospitals, they pay like $8 premium each month to have a medevac committing a helicopter for an emergency. But they still get stuck with a $36,000 bill. We need to step back in my party and say, wait a moment. One size doesn't fit all. My party needs to make sure we don't forget those in the world.

Margaret Flinter: Well Admiral, looking back on your career, you've certainly been engaged in passing some of the most significant legislation, the Affordable Care Act that we talked about already, and you also mentioned the Mental Health Parity Act. There's another act that maybe doesn't get talked about as much now but was really very instrumental, The American Recovery and Reinvestment Act in its support for practices moving large scale, from paper to electronics, but it's been costly in some of the burdens that have placed on providers and healthcare systems that weren't there before. I'm sure

you're also hearing that this is also a big concern for people within healthcare around the cost and the burden of the technology. Why don't you share with us your thoughts on that transition and where we are in the country?

Joe Sestak: I was a large proponent of the electronic medical records. In fact, I had to go to the VA and this was back like in 2005 time period, and as the VA was the first to do electronic records. I sat there in the doctor's office, he was doing one check up on me and all of a sudden someone calls me said just a moment that that -- tell I've just put in the medical order or something and I was back then that was like getting your first Xerox machine on a ship in the early 70s. I have heard whether it was from the New Hampshire Medical Society or whether as I met with doctors out here in Iowa, exactly what you said. What has happened is this has become almost more overly done because of billing issues. Getting the right codes or the right payments are made these are being the insurance companies have it to where the original purpose of this, hey, everything's there quick slips, you can see the past history, you see all the past results and everything and there it is. If it's become overly burdensome, and everyone says it has because of that we need to streamline this. This could actually be part of the benefit of eventually getting to Medicare for all to where you don't have that insurance company that is worried about profit and payments. That's the central complaint I've heard about this system, part of it just might have to be to make sure this Medicare fall system works because the burdensome that every doctor has had.

Mark Masselli: We're speaking today with Retired Three-Star Navy Admiral Joe Sestak a Candidate for the Democratic Presidential nomination, Former Director of Defense Policy at the Office of National Security under President Clinton. He also represented Pennsylvania Seventh Congressional District in the U.S. House of Representatives. Well Admiral, it's probably easier to navigate the democratic landmines than it was navigating the battles that you as a commander of the aircraft carrier your battle group during Afghanistan?

Joe Sestak: Don’t be so certain about that.

Mark Masselli: Well, I'm not sure. I was going to ask if there are some similarities, but you also were somebody who made waves during your time in the Bush Administration recommending a larger share of the military budget be diverted towards enhancing Cybersecurity and really sort of thinking about the 21st Century technology. Talk to us about your sort of plan for how we strengthen and harden our important data that we're trying to protect.

Joe Sestak: I have been in this area ever since 1995 where I was handed a folder by my boss National Security Council and said, You're the one who's going to set up the portfolio on protecting critical infrastructure,

damn from being hit by cyber attacks, and this is 1995 or others types of facilities that we rely upon, Wall Street being taken down and our health records, all of a sudden the best of them and/or the damage done to them. In fact, as you mentioned, I carried it forward to the Navy and as a Three-Star Admiral, I said, we don't need 375 ships. We're still measuring ourselves unfortunately in this modern era on how many pieces of units we have. It's the broadband capability that shows you how good you can be. In the military, I advocated that this go to about 260 shifts, we can go from about 12 carriers to nine and I were game this was about 120 staff, with using computers for all this and say, Look, if you're able to do a strike, like we did with into the centrifuges of Iran take down their centrifuges where they could use them, wow, how less expensive and how much more effective that is and trying to drop thousands of potentially bombs to get through 300 feet of rock to destroy that facility. That's the change we need.

In fact, that plan met with a great opposition not just from the military industrial complex because President Eisenhower said it's really a congressional military industrial complex. As one senator said, when he met me and I was running for Congress, he said, Joe, I remember you, you're the admiral that wanted to cut my submarine fleet, but the man who worked for me is now in charge of the Civic and has actually said, America is the first loss of command of the Seas by the U.S. Navy since World War II, China has it, and we need more cyberspace. With regard to our records, this is an immense issue. In particular, the 5G network is being developed. As you know, you've seen it in the newspaper about Huawei and others like President Trump and what's going on here. The truth of the matter is this 5G network wireless will revolutionize economy and warfare by different means. China's to its belt road initiative has already had 70 countries that take its predatory who's it enforces him to buy digital road, which is you will buy our 5G network.

Whoever build the 5G network will own it, and only three companies do. When you put that piece there everything that you say the wireless will go through this piece of equipment, and you don't have to hack anymore and so if you have a medical meeting, if Artificial Intelligence development for medicine, if electronic records are passed via wireless, they will see everything. All they have to do is download off their server and they can go down and take down any critical structure that's connected to wireless without having to fight through. This is probably except for climate change the greatest threat to America's dream today. Yet, we aren't doing anything about it from our side. There's only two things we need to do is remember much like President Eisenhower said we need a road system or President Lincoln said we need an intercontinental railroad. Wall Street wasn't going to build, it was too expensive in so he finished it up. We need someone to understand this new infrastructure. The 5G

network needs a public private venture to be done with it. Then, second, we need to do what America's greatest strength is to convene the world of allies and friends in a rules based world order that stands together and says this is fairness and justice of how this equipment will be used or not used. Everything that will be in that medical record as it's passed on wireless will be copied and done with. Never mind the kind of warfare that can be done by taking down Wall Street just because the 5G network has to be connected by Huawei.

Second, we have to keep in mind and anything that doesn't go over wireless goes to underground cables, and Huawei and other Chinese companies have now laid about a third of them 98% of intercontinental communication goes by undersea cables. This critical infrastructure, this cyberspace, it is actually giving China all the commercial intelligence it needs at no cost and all the military capability it needs in order to hide potential damage. It's what it's doing to its rigorous citizens today. If you go to my website you can see how they've all been incarcerated not just physically but by digital incarceration wherever they walk, they have a government phone and their faces are copied on street lights, etc. Sounds daunting, but that is really cyberspace the new domain of warfare and why another aircraft carrier isn't worth its cost when you can have this whole capability to either use or protect yourself from.

Margaret Flinter: We've been speaking today with Retired Three-Star Navy Admiral Joe Sestak, a Candidate for the Democratic Presidential nomination. You can learn more about his very distinguished military career and his contributions to political life by going to www.joesestak.com, or follow him on Twitter @JoeSestak. Admiral, thank you so much for your service, for your dedication to this country, for your insights and for joining us on Conversations on Health Care today.

Joe Sestak: Thank you Margaret and Mark for having me aboard. It's a real pleasure.

[Music]

Mark Masselli: At Conversations on Health Care, we want our audience to be truly in the know when it comes to the facts about healthcare reform and policy. Lori Robertson is an award winning journalist and Managing Editor of FactCheck.org, a nonpartisan, nonprofit consumer advocate for voters that aim to reduce the level of deception in U.S. Politics. Lori, what have you got for us this week?

Lori Robertson: A popular Instagram post falsely claims that more than 1,100 people died from reactions to the flu shot in 2018 and suggest that the immunization gave some children polio. The flu vaccine cannot give anyone polio and there is no evidence to support the 1,100 figure. Flu shot is the single best way to protect against seasonal influenza, a

viral disease that in some years kills tens of thousands of Americans. Flu shots have a good safety record. As the Centers for Disease Control and Prevention explained, the most likely side effects are mild and include soreness or redness at the injection site, headache, fever and nausea. A more concerning side effect is a serious allergic reaction, which could lead to anaphylaxis. An analysis of CDC data identified just 33 instances of vaccine triggered anaphylaxis after more than 25 million vaccine doses. Of those cases, only one person was hospitalized and no one died. The Instagram posts claim that 1,100 people died from the flu vaccine in a single year has no basis. Published studies rarely, if ever observed deaths plausibly tied to the flu vaccine.

The post second claim that the flu shot may give children polio is also false. Polio is a potentially deadly and highly infectious disease caused by the polio virus. Flu vaccine has nothing to do with polio and does not contain any polio virus. Since 1979 no cases of polio have originated in the United States, and that's my fact check for this week. I'm Lori Robertson, Managing Editor of factcheck.org.

[Music]

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. In the emergency room, clinicians are confronted with a myriad of unpredictable medical crisis that sometimes can be challenging to diagnose.

Dr. Josh Landy: And this is really hard, especially if you're in a busy tertiary care hospital and you're there and it's 4:00 a.m. and there's almost nobody else to talk to you unless you have a specific question to wake somebody up to ask them and that's the existential dread of medicine.

Mark Masselli: ICU Physician Dr. Josh Landy was noticing a growing trend of image sharing via smartphones to crowdsource second opinions from friends and colleagues across the country. He created figure one a sort of Instagram for doctors in which images can be de-identified, but shared across a dedicated social media platform that would allow input from clinicians within their network.

Dr. Josh Landy: And what the network does is it lets you take a picture of a case and submit it for conversation for learning, for teaching and for any other reason why you might need to take a picture of a case.

Mark Masselli: Doctors are using the app to communicate not only with colleagues within their hospital settings, but around the world where someone might have superior expertise with a certain condition.

Dr. Josh Landy: A nurse in Haiti put up a picture of a little baby. When this baby was born with an unusual skin condition, she didn't know what it was and if it was safe to let the baby leave. She put up a picture and within a few hours 16,000 people logged hundreds of responses. What that means is we can change what is the traditional way of a patient accessing medical care.

Mark Masselli: A free downloadable app offering secure HIPAA compliant image sharing among clinicians around the world, tapping the collective expert instantly. Now that is a bright idea.

[Music]

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

Margaret Flinter: And I'm Margaret Flinter.

Mark Masselli: Peace and health.

Margaret Flinter: 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]