Mark Masselli: This is Conversations on Healthcare, I am Mark Masselli.

Margaret Flinter: And I am Margaret Flinter.

Mark Masselli: Well Margaret, we are back from a couple of days at the Democratic convention this was quite exciting to see the first woman in US history become a major party nominee for president.

Margaret Flinter: So many important issues addressed at the conventions but since we are passionate about healthcare and we believe in healthcare for all, we were particularly interested in issues related heath. Certainly the mayor of Flint, Michigan talking about the lead poisoning crisis, the references to the creation of the children's health insurance program that was the forerunner to the ACA and has provided care to so many children, the intensely powerful stories about the need to have a better handle on gun-control all very powerful all tied to health. Our guest today attorney Daniel Dawes participated in the creation of the Affordable Care Act and has written a historical treatise on the pathway across a century and a half that led up to what he calls the most comprehensive legislation to date addressing health disparities in this country, really looking forward to hearing his unique perspective.

Mark Masselli: And Lori Robertson also stops by, she is the Managing Editor of FactCheck.org, who looks at misstatements spoken about health policy in the public domain.

Margaret Flinter: And no matter what the topic, you can hear all of our shows by going to chcradio.com.

Mark Masselli: And as always if you have comments, please email us at chcradio@chc1.com or find us on Facebook or Twitter; we love hearing from you.

Margaret Flinter: We will get to our interview with Daniel Dawes in just a moment.

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

(Music)

Marianne O'Hare: I am Marianne O'Hare with these healthcare headlines. The Centers for Disease Control and Prevention has issued a warning urging pregnant women to avoid the Miami-Dade County area of Florida for the time being as more than a dozen people had become infected with the zika virus through locally acquired mosquito bites in a small part of that region over the past week. And those numbers are expected to rise, a particular concern the number of pregnant women already living in the region

who could become infected as well as those travelers who might become infected then pass the virus onto their partners.

The CDC is urging pregnant women in the affected areas to take precautions to avoid mosquito bites and if they practice safe sex to prevent sexual transmission of the virus. The CDC also suggests that those men and women who traveled to the area should wait at least eight weeks before trying to conceive a child, and men who have had symptoms of zika should wait at least six month. For now, the physical outbreak area but is relatively small however public health officials are bracing for outbreaks in other geographical areas as the mosquito population continues to move into the continental US.

And it calls to mind in urgency according to some lawmakers in Congress to set up dedicated fund always available to appropriate funds to respond to public health crises in disease such as zika or Ebola. Connecticut Congressman Rosa DeLauro is calling for $5 billion permanent fund to be set up to respond to outbreaks when they occur. There are several other proposals being considered from both sides of aisle that create some smaller funds but have the same idea.

A positive outcome from an open source collaboration amongst scientists around world Geneva based Medicines for Malaria Venture handed out a Malaria Box containing 400 diverse molecules to labs in 30 countries making them accessible to academic researchers who normally wouldn't have access to such compounds. Scientists say the effort has spun out more than a dozen drug development projects including a colon cancer drug that the National Cancer Institute is now working. In part, those discoveries are thanks to a simple solution to bridge the gap between industry and academia.

E-cigarettes have taken off being charted [PH] by some as less toxic alternative to smoking actual cigarettes but a study out of the University of California Berkeley should prove a cautionary tale, researchers tested two solvents commonly used in e-cigarette liquid, heated them and checked the vapor for signs of toxins. The solvents transformed when heated creating emissions laced with dozens of harmful chemical compound. The scientists said their findings could be an important tool for the Food and Drug Administration which will start regulating e-cigarettes on August 08. I am Marianne O'Hare with these healthcare headlines.

(Music)

Mark Masselli: We are speaking today with Daniel Dawes, health law attorney and author of a "150 Years of ObamaCare", he is the Executive Director of Health Policy

and External Affairs at Morehouse School of Medicine. He is cofounder of the Health Equity Leadership & Exchange Network. Mr. Dawes server on the newly established Health Equity Leadership Commission providing guidance to Members of Congress, the Obama Administration and for Department of Health and Human Services. He earned numerous awards for his work including the Congressional Black Caucus Leadership in Advocacy Award. He earned his law degree from the University of Nebraska College of Law. Daniel welcome to Conversations on Healthcare.

Daniel Dawes: It's great to be on today.

Mark Masselli: You wrote the book “150 Years of ObamaCare” as a tutorial for students of health policy and health equity activists to understand the ACA role within the larger context of health reform. You are looking back as far as reconstruction after the Civil War and how the Affordable Care Act fits into that historical context.

Daniel Dawes: I know many of you have heard the President Obama and VP Joe Biden saying that we have been trying to accomplish health reform for a century. But the Affordable Care Act is much more comprehensive in the context of previous reform efforts so it includes robust provisions addressing inequities in mental health and minority health. And that's really what we are trying to do is to get people to understand that we brought the independent reform movement together under one umbrella that has taken us a 150 years. Because when you look at what Mental Health Reform has did in the 1850s one campaign led by Dorothea Dix and others you know it took decades of their lives to go around the country to highlight the abuses that people with mental illness were experiencing they were jailed or imprisoned.

And so this mental health reform champions finally got Congress to pass a bill called the Bill for the Benefit of the Indigent Insane only to have the president at the time veto it. And that President should've been the most sensitive President when you talk about mental health issues because he and his wife travelling on the day of his inauguration, they were traveling with their only son. The train crashed tragically and the only person to die that day was his son, the wife experienced it, she saw and witnessed it, he also saw it. And she fell into depression, clinical depression, terrible anxiety and instead of signing the bill he will he wrote one of the longest veto messages where he made the case for the federal government not getting involved in human welfare.

So it took 100 years before you saw piecemeal legislation coming up, but never anything comprehensive like this first attempt until Pres. Carter comes into office and he and his wife Rosalynn Carter attempted to get comprehensive mental health reform passed. And it took them all four years of his administration to make that happen and

they finally did two months before the 1980 election. And what happened with his administration they actually prevented further implementation of those reforms and they repealed the rest of that in the next several months. And it wasn't until we started negotiating the Affordable Care Act when we saw another opportunity to include these mental health reforms mandating mental health coverage ensuring that we continue to build upon the Mental Health Parity Act and providing ability to revere those health covers. So we have got all of those provisions, those principles and provisions from those two efforts into the Affordable Care Act.

And then when you look at the minority health provisions, what's interesting about this group of health reforms, the minority health champions actually got their bill passed and signed into law it was the Freedmen's Bureau Act and it actually created incredible access for freedman, the former slaves or freed people, poor whites. But because there was no appetite at parallel the racial tensions were seen today again so what you saw happened then was there was a comprehensive health reform but it only lasted seven years, it was very short-lived. And so what we did was to take many of the strategies and tactics that were used to pass that bill we used to pass the Affordable Care Act 150 years later and include provision from that bill into the ACA.

Margaret Flinter: You actually kind of have a sit at the table in the room as Hamilton would say as the ACA was actually being drafted and it has always seemed to me that the framers of the ACA [Inaudible 00:09:21] it in legislation but not in stone that this legislation would have to adapt and evolve over time. How did the framers make a legislation that could adapt and evolve over time?

Daniel Dawes: So I wanted to write a book that drew back the curtains put readers in the front seat so to speak so they could get a clear view of the incredible turning points in this sausage making. And as I spoke with individuals who had been around for decades Congressman Louis Stokes, Sen. Ted Kennedy, Congressman John Lewis you know it really dawned on me that this was the most inclusive bill ever crafted by the US Congress. When we brought together this incredible group of 300 national organizations representing diverse stakeholders you had women's groups, children's groups, racial and ethnic groups, LGBT groups, disability groups, and then you have the payers and the providers all coming together saying, you know what we agree that that was the time to get health reform pass and to advance this health equity notion. You had so many moving parts with the White House and Congress but when we were trying to push a robust health equity agenda in the bill, I will tell you there was some uneasiness with folks because every time that folks that tried health reform opponents of this effort try to introduce race and gender into the negotiations to undermine the attempt.

So we had to really push very very hard to say listen there had been 7000 peer-reviewed articles have been published on this, we have the numbers showing that it's costing us $300 billion every single year when we don't address disparities among different racial and ethnic groups so we have got to do something if we are going to call the comprehensive health reform. But then when the Tea Party movement with heating up and that when August Town Halls were heating up and we had you know folks heckling lawmakers who were pro-health reform that we saw the White House again change course and call it health insurance reform taking a very myopic view on this. And so we had to steer them back and say, wait a second you promised President Obama that this is going to be a comprehensive health reform bill because this is the serious enough issue worth addressing.

Mark Masselli: Well certainly we ended up with a lot of folks on the other side who saw so many polarizing aspects of the legislation from the mandatory health insurance coverage to the so-called essential benefits which covered things like birth control. There were a lot of things that really didn't get discussed, the 62 provisions of the law that ensure greater a degree of health equity in the country, I am wondering if you can just illuminate that for our listeners.

Daniel Dawes: You know one of the things that we were looking at was disparities in terms of cancer and it dawned on us that women in wheelchairs had a higher rates of disparities than breast cancer screenings because the medical equipment wasn't accessible or we noticed that black women they were dying at higher rates it just didn't make sense. If the screenings were showing that they didn't in fact have breast cancer why were they dying at higher rates? Come to find out that the equipment was never developed with black women or Latina women in mind who tend to have more dense breasts.

And so we wanted to put in provisions in there requiring medical device companies and the pharmaceutical companies to look at how their drugs their medical devices impact all groups. So there is this push in the law now to increase the diversity of the clinical trials including all groups that have been traditionally been outright discriminated and prevented from doing so. The law also actually elevated the health equity and created Office of the Minority Health and Health Equity at six different agencies so every regulation now, every sub-regulation, any policy coming out of these agencies are supposed to employ an equity lens.

And then there were provisions in there, the nondiscrimination provisions. And what we wanted to do was to give individuals a private right of action because you know not

every law provides an individual with the opportunity to go and sue in court on their behalf. Let's say women have been discriminated in coverage just because of their sex because their reproductive age they now would have a private right of action to go in a court of law, as an LGBT individual goes into a hospital or to a healthcare facility. And so provider refuses to use their preferred pronounce those providers could be in a lot of trouble and we wanted hospitals to stop their aggressive debt collection practices. So those are some of the provisions in the law that we are very proud of we talk about the 62 provisions.

Margaret Flinter: Maybe just one of your – just perhaps a significant piece of the 62 provisions, I think one is the creation of PCORI, the Patient Centered Outcomes Research Institute really sought to improve the value of care by focusing on outcomes and making sure that patients were telling us what the outcomes that we needed to focus on –

Daniel Dawes: That's right.

Margaret Flinter: --what was important to them. And the second was an "I" [PH] to improving workforce development particularly in terms of fostering of coordinated models of care and maybe just a brief comment on both of those measures.

Daniel Dawes: You know providers are moving towards quality, increasing their quality and accountability and what we try to do was to educate our policymakers during these [PH] negotiations to make sure that the states with the higher quality scores actually were employing equity lens. So as this law pushes to increase quality we wanted to make sure based on the Institute of Medicine on equal treatment report and the crossing the quality chasm report and so we are moving full speed ahead with the Medicare Access and CHIP Reauthorization Act, MACRA which passed last year. But what we are concerned is that it will exacerbate the disparities if they don't get this right.

Mark Masselli: We are was speaking today Daniel Dawes, health law attorney and author of a "150 Years of ObamaCare", he is the Executive Director of the Health Policy and External Affairs at Morehouse School of Medicine and he found and chaired the National Working Group on Health Disparities and Health Reform as is cofounder of the Health Equity Leadership and Exchange Network. You want to connect a couple of dots because you have spent a long time, a lifetime of focusing on health equity in the health equity arena, you are a data guy as well you are looking very much at outcomes. And I am wondering how are you charting the impact on the law on underserved populations especially what do you focus and what are your metrics?

Daniel Dawes: We are very very pleased that we have now achieved the lowest uninsurance rate ever in this country at 9.1% and 20 million new Americans getting insurance, so that's incredible. And what we have been tracking of course is from the 1950s we are looking at Medicare and Medicaid and when that law was passed and the effect it had on the uninsurance rates. So moving our uninsurance rate from 24% down to 14%, imagine how much more of a decline we would see in the uninsurance rates if every state expanded Medicaid? So today what we are seeing is, yes the uninsurance rates among Blacks has decreased by 50% but when you look at Latinos they still suffer the highest uninsurance rates, only 25% of uninsured Latinos have gained insurance.

We actually did a series of roundtables last year to meet with leaders from these various communities to figure out what was going on. And a lot of these Latino folks have been told that you know health insurance is like having auto insurance if you use it you are going to be penalized, it's so unfortunate. And there of course churches around the country that refused because of what you had said Mark earlier about the preventive care for women and that that issue with the clergy. And so we are really working with our Health Equity Leadership and Exchange Network this is exactly why we established it. A lot of these health equity provisions what the Obama Administration has done is the pump it to the state governments but it means that champions in those states are going to have to work a little bit harder now to effect the changes that they need for their communities.

Margaret Flinter: And you know Daniel that reminds me I think one of the strengths of the Affordable Care Act was it recognizes that there is intersection, right, between public house and primary care and mental health and tertiary care, and you can't just separate these all out into individual parts. And certainly that is so true when it comes to mental health issues to things like addiction, exposure to gun violence and focus recently again on what happened with lead poisoning in Flint. But I want to speak specifically about mental health parity for just a moment, maybe just comment for us about why addressing the gaps in mental health coverage remains such a big challenge in that health equity arena and your thoughts on how we can improve the Mental Health and Addiction Parity Act?

Daniel Dawes: What a lot of folks don't realize is that mental health community, the Behavioral Health Advocates were instrumental in helping us create the strategy to pass the ACA because of the stigma and the gaps in mental health coverage you know that we all need a checkup from the neck up as Patrick Kennedy has said, right.

Margaret Flinter: Great expression.

Daniel Dawes: And so what we have been trying to do is to you know raise awareness especially in communities of color about the stigma, we have been trying to get and I tell

you we actually were trying to push the Obama Administration to get the mental health parity regs out and thankfully we did. But yet what we do continue to find is that mental health, community mental health centers and other provider groups, community health centers have done a fantastic job when you talk about the gold standard when it comes to integrated care. But community mental health centers are having a hard time trying to figure out how to integrate care, and they haven't been given the resources even with the US Preventive Services Task Force you know the task force give a score something in A or B then it's most cost-sharing to the individual, right. And yet for 20 years we have been trying to get violence counseling screened as an A or B but the task force continues to say there is insufficient data. And yet many African-Americans with all of the violence when you talk about police perpetrated violence and others, many of them would benefit from this type of counseling and yet the task force still refuses to do that.

And so we are on a campaign now to figure out what are the challenges in communities across the nation to figure out how we can make sure we reach all communities and how we can use that to inform the actual Mental Health Parity Act. So we have gotten data to inform MACRA which is going to impact every clinician's reimbursement from Medicare. And we are making sure that the folks that are creating MACRA understand that psychologist, counselors, social workers and others are critical components of a primary care medical home. So we want to make sure that they too have some of their reimbursement tied to many of these quality indicators.

Mark Masselli: We have been speaking with Daniel Dawes, Executive Director of Health Policy and External Affairs at Morehouse School of Medicine and author of a "150 Years of ObamaCare". You could learn more about his work by going to www.150yearsofobamacare.com you can follow him on Twitter @DanielEDawes. Daniel thank you so much for joining us today on Conversations on Healthcare.

Daniel Dawes: My pleasure, thank you both so much I appreciated it.

(Music)

Mark Masselli: At Conversations on Healthcare, 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 US politics. Lori what have you got for us this week?

Lori Robertson: Well we have been fact checking the republican and democratic conventions and there have been a few false claims about healthcare. In Donald Trump's speech at the GOP convention he said that he would repeal the Affordable Care Act and "you will be able to choose your own doctor again". But the healthcare law didn't take away the ability to choose the doctor.

The ACA expanded Medicaid and also expanded private insurance coverage, and as most Americans know -- since 55% of them have private insurance -- the insurers usually have a network of doctors to choose from, the ACA didn't change that.

On the democratic side former Vermont governor Howard Dean said, Trump's whole plan for healthcare was to replace Obamacare with "something so much better". Dean added, six-word plan for health care. In fact, Trump has more than 1,000 words on his plans for health care on his campaign website. Dean was referring to comments from Trump at a debate in February, when he said, "We are going to replace Obamacare with something so much better." But in March, he released a seven-point plan that calls for allowing the sale of insurance across state lines allowing individual to buy their own health insurance to take a tax deduction and changing Medicaid to a to a block-grant program, and that's my fact check for this week, I am Lori Robertson Managing Editor of FactCheck.org.

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

(Music)

Mark Masselli: Each week Conversations highlights a bright idea about how to make wellness a part of our communities and everyday lives. Each year more than 1 million babies die at birth and another 3 million die within the first few weeks of life, often from preventable causes, and when babies are born prematurely the risks escalate. Newborns, in particular premies have a considerable amount of difficulty regulating their own body temperature and without access to incubators babies in the Third World often succumb to hypothermia. That got former Stanford MBA student Jane Chan thinking, how do we develop a low cost solution to the problem?

Jane Chan: A local solution, something that could work without electricity, that was simple enough for a mother or a midwife to use, something that could be sterilized and reused across multiple babies, and something ultra low cost compared to the $20,000 that an incubator in the US costs.

Margaret Flinter: Chan said that they developed a cocoon like device called simply Embrace, a thermal body wrap that encases the baby and helps regulate body temperature for up to 6 hours.

Jane Chan: But the magic is in this pouch of wax, this is a phase change material, it's a wax-like substance with a melting point of human body temperature. You can melt this simply using hot water and then when it melts it's able to maintain one constant temperature for 4 to 6 hours at a time.

Margaret Flinter: Since launching the product in 2010, they estimate that over 150,000 babies' lives may have been saved with the device, a low cost, high tech, portable temperature regulator, designed to regulate premies' body temperatures, now that's a bright idea.

(Music)

Margaret Flinter: This is Conversations on Healthcare, I am Margaret Flinter.

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

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