Mark Masselli: This is Conversations on Health Care I'm Mark Masselli.

Margaret Flinter: And I'm Margaret Flinter.

Mark Masselli: Well Margaret we're well into the month of August the noted dog days of summer but it's an important time in the world of community health centers.

Margaret Flinter: This year's theme is celebrating America's health centers innovators and community health. I think we'd agree innovation is one of the essential hallmarks of our mission as well.

Mark Masselli: And the National Association of Community Health Centers The Robert Wood Johnson Foundation and so many other organizations have given us the kind of support required to improve our care models, it's helped us to develop best practices that we can share with our colleagues around the country and around the globe as well.

Margaret Flinter: And speaking of community health centers in other countries Canada now has a growing community health center movement which our guest today is very familiar with. Scott Wolfe is the Director of the Canadian Association of Community Health Centers which is also focused on ensuring the needs of that nation's underserved population and ensuring everyone has access to great primary care. And Lori Robertson will be checking in the Managing Editor of FactCheck.org she's looking at misstatements made about health policy in the public domain.

Mark Masselli: And always if you have comments please email us at CHC Radio@chc1.com or find us on Facebook or Twitter, we love hearing from you. And we'll go to our interview with Scott Wolfe in just a moment.

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

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Marianne O'Hare: I'm Marianne O'Hare with these health care headlines. The Centers for Disease Control has expanded a warning area to be avoided by pregnant women because of the Zika virus outbreak first limited to a small section of Miami-Dade County in Florida more than a dozen Zika cases has been reported in that region as a direct result from mosquito bites. The greatest threat is to pregnant women's unborn fetuses that can suffer severe birth defects if exposed.

Florida Governor Rick Scott has weight in urging congress and the president to take action immediately. The president had asked for 1.9 billion dollars in funds for research and emergency funding for eradication. Congress left for a seven week recess before acting on that request. Meanwhile, Virginia senator and vice presidential candidate

Time Kaine is joining a growing course of law makers urging congress to return from recess for a special session to address the Zika crisis. Meanwhile the National Institute of Allergy and Infectious Diseases is already testing a potential Zika vaccine which a number of companies are also working on this particular clinical trial centers on a so called DNA vaccine being given to about 80 volunteers. Phase one will test its safety which those strength might work best as well as what kind of immune response can be provoked. Dr. Anthony Fauci head of the NIAID warns if congress doesn't act quickly on funding they may not be able to make it to phase two of the clinical trial.

There may be a solution to the growing number of American children suffering from asthma. Currently more than 10% of the overall school aged population, and the answer just might be found in an Amish barnyard. Researchers have been working on a so called hygiene hypothesis for some time the notion that too many children are being born and raised in environments that are too sterile denying them a chance to develop a healthy immune response. Scientist studied school aged Amish children who have extremely low asthma rates live without electricity and live adjacent to barns where they play alongside cows and horses frequently compare to Hutterite children similar lifestyle but farm animals are housed in industrial barns far from the living space. The Hutterite children had a far higher rate of asthma, researchers are zeroing in on what compounds in Amish farmyard dust or triggering the growth of neutrophils in the blood which stimulates an immune response to allergens often a trigger for asthma and when they apply the compounds to lab mice, the same response occurred in a mice expose to Amish dust. Asthma experts see this discovery as a potential breakthrough for staving off the development of asthma in the first place.

And to floss or not to floss that may no longer be a question. Study at the National Institutes of Health the Institute of Dental and Craniofacial Research found little evidence that regular flossing has any real protective effect against cavities and gum disease other studied had shown a modest impact on the development of gingivitis from both brushing and flossing together versus brushing alone but the effect was negligible. Recent Department of Health and Human Services guidelines are focusing more on the destructive impact of sugars on the teeth rather than flossing effect to reverse that. I'm Marianne O'Hare with these healthcare headlines.

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Mark Masselli: We're speaking today with Scott Wolfe Executive Director of the Canadian Association of Community Health Centers. Mr. Wolfe also serves as Acting Coordinator of the International Federation of Community Health Centers. He served as Director of Global Health Policy for the International Association of Providers in AIDS care. Mr. Wolfe serves as a Senior Policy Advisor for the Association of Ontario Health

Centers, he earned his master's in political science from the University of Toronto. Scott welcome to Conversations on Health Care.

Scott A. Wolfe: It's my pleasure to join you.

Mark Masselli: Yeah, you know, you really keep a keen eye on what -- what's happening both here in the United States and obviously in Canada and but I think Americans may not have as good of a lens on what's been happening with Canada's health systems which has a universal access to care for all citizens. I'm wondering if you could help our listeners understand how the Canadian health system has evolved overtime and what are some of its key features today?

Scott A. Wolfe: I'd start by saying that we see our Canadian health care system has an evolving entity. The first attempt at a universalize a single payer system in Canada was achieved in -- in the province of Saskatchewan in the early 1960s immediately followed by a doctor strike there was resistance to the implementation of a single payers system. From that point 1962 through to 1984 at the federal level of a Canadian government implemented the Canada Health Fact which outlines the core principles and requirements of the universalized public health care system across all of the provinces and territories in Canada. They covered a basic number of services in fact 70% of total spending on health care in Canada is achieved through our public health care system and what we refer to generally as Medicare here so not to confuse that with Medicare of the United States. What's covered is basic physician and hospital services as well as a variety of -- of other services what's not included within our -- our universalize system eye care, dental care, physiotherapy is a common one. And so there's a major gap in access to -- to all of those.

There are essentially two stages to Medicare the first stage of Medicare is to bring everyone and everything within coverage a single payer system. You're still working towards pharma care and publicly funded dental care for -- for example, those are two priority issues for many groups across the country. The second stage and I know we might tough on this a little bit further is really to focus not exclusively on -- on insuring coverage but what the best models for service delivery are so that we can do a better job at actually preventing need for health care services.

Margaret Flinter: Well Scott I -- you know, what you hear in the United States is Canada universal access to primary care almost, you know, lot of pocket cost for things like prenatal and child birth or basic surgeries but the common reframe we also hear long delays for some services and then the growing out of pocket expense. How is that trend impacting overall care delivery in Canada and are you seeing the kinds of delays or avoidance of even necessary care because people feel so constrained by those out of pocket expenses?

Scott A. Wolfe: There are many individuals who despite having a access to a single payer system here don't have access to a routine primary health care provider. So there are definitely challenges, governments in Canada are not required to actually move beyond, you know, those limited services. Many of the challenges we face are owing to inappropriate delivery of services, access to physician services alone is -- is inadequate primary care response. What people need is access to team based care where not only are we attending immediate medical and biological concerns but also people lived realities, the determinants of health because as we know 80% or more of what effects an impact have life outside of the health care system. And so what we're faced with is a problem of orientation we are not alone in advocating reforms to the way that services are delivered throughout the country. To touch on the way that this relates to the privatization of services, yes there is an increasing trend towards privatizing fund services, the introduction of user fees by some provinces, the emergence of boutique health care services, the demand for some privatize services such as MRIs, paid for plasma etc.

There's a legitimate demand for these services because there are challenges within our public service it's just that we've got to do a better job at delivering services in the right places at the right times and through the right models. And so when segments of our population demand access to private services and say well, you know, I as a relatively well to do individual or family can afford to pay for my private MRI why don't you allow me to do that, take my demand out of the public system and create increase space within the public system, that's actually an incorrect assertion. The ability to access services out of pocket it does not mean that you added new health infrastructure etc, what in fact you're doing is you're exacerbating the pressures on -- on the public system.

Mark Masselli: Scott speaking of the public health system I thought we focus little on community health centers. Many of our listeners know that they've been providing quality primary care to underserved and uninsured populations in the US real focusing on economically vulnerable immigrant populations but really also there are voice and vehicle for social change in terms of how they are organized. Majority of the board of directors are the patients themselves as you mentioned earlier a real focusing on team base care. Could you illuminate for our listeners what's happening with the community health centers in Canada the role that they play in serving the underserved population across the provinces in the country?

Scott A. Wolfe: Unfortunately, we in Canada don't benefit from the thing federal angle that you do in the United States, community health centers in the United States benefit from federal legislation and funding which enables not only a degree of public awareness about community health centers but a degree of similarity in mission approach and so forth across the country. Now, here in Canada health care as it's

understood and it's primarily a responsibility of the provinces. It means that the provinces are left to their own devices to determine how to ensure access to primary care services. And so there are varying levels of progress across the provinces in terms of moving from a medicalized model to a team based care approach and integrating into that attention to determinants of health. There is no similar model through which community health centers are funded from province to province. The way that community health centers have come into being very quite significantly, what I think it says is that there's something virtuous and organic about the community health center that regardless of how the soil is fertilize the -- the desire to make access available to services that meet people where they're at and that understand that in order to improve health outcomes we've got to provide more than just health care services but they don't have a framework in -- into which to fit. So it's quite a desperate movement throughout the country but we've achieved a great degree of success and I would say the future is incredibly bright. And I think public awareness is increasing around what community health centers are, why they are so vital and why they are necessary.

Margaret Flinter: Well I think you've captured the evolution and -- and I would imagine that you are finding yourself at one of the pressure points at community health centers in the whole health care system in the US and I'm betting in Canada are facing as well and that's the training of the clinical workforce that's prepared to work in a team base model of primary care, that's a big focus area for primary care in the US. And we would be curious about what the workforce development strategies are that are evolving in the Canadian health system.

Scott A. Wolfe: It's a little bit of a different story here in that in principle our universal health care system provides for universal access to primary care, and so it -- it has already been previewed and built into the system that we need to train and fund health care workforce that -- that attends to the needs of the entire population. I think the -- the major challenges here in Canada are the shift from the medicalized model to a -- a mixture of complimentary models which would include team based clinical services that might be, you know, serving some of the population and then more robust services like community health centers that are required to meet the needs of a different segment of the population. So I think it's really around the shift in how primary care services are delivered as oppose to training up the number of providers. There's a lack of policy in many provinces to actually enable allied health staff to work within the primary care setting. You know, nurse practitioners are licensed in all the provinces, however the majority of the limited for nurse practitioners tend to filter into acute care settings because they're just not the funding mechanism for them to practice in primary care. The other area I would say that is discuss such in frequently is the need to actually shift training programs providers from different disciplines do a lot more in-training collaboration with practitioners from other disciplines.

Mark Masselli: We're speaking today with Scott Wolfe Executive Director of the Canadian Association of Community Health Centers. Mr. Wolfe also severs as Acting Coordinator of the International Federation of Community Health Centers. Scott, you know, I'd really like to learn more about the work that's going on there and as Margaret said earlier everybody sort of at a point in time but they all have teachable moments for each other or about the work they're doing in providing primary care for the underserved and tell us what are the goals and aspirations of the larger global movement?

Scott A. Wolfe: We establish the International Federation of Community Health Centers in 2012 and so we're still quite young as a federation. Among our key achievements over the past few years as two or three formalized global exchanges among community health centers so really building the -- the knowledge exchange and learning program for the international federation. We've had the opportunity for community health center representatives from Australia, throughout Europe, United States and Canada at different points to participate in global exchanges with each other. It's really developing a mechanism for ongoing information exchange and enabling each other to access examples of success. And so to be able to relate back to our respective funders, policy makers and -- and other partners that there is a rich community health center movement to another jurisdiction we for instance are tremendously thankful for the -- the rich supply of evidence that you have in the United States regarding the community health center model, why governance is important. The impact of health services on local economic developments reduction in avoidable hospitalizations and so forth, but our realities are similar enough that we can extrapolates from your experiences and your evidence to make the case here and likewise I know that others are looking at what we do have in Canada to be able to further support their own local efforts in their countries and -- and I think this is a tremendous trajectory for -- for international federation of community health centers and for our global movement.

Margaret Flinter: I'm going to also ask you just comment area we haven't talk so much about and that we certainly learned a lot from looking around the world as well as in United States and the capacity of low cost intervention such as mobile apps for community health workers armed with a smart phone, being deployed in regions with little on the way the health care infrastructure and any thoughts about what you've learned from your global partners and from the work that's going around the country that you think is a high value or high priority for implementation in your system?

Scott A. Wolfe: I came to the community health center movement in Canada after work internationally and largely focused on HIV prevention care and support. And -- and throughout my travels in the Caribbean throughout Latin America and Southern Africa for instance what struck me is that wherever there was a successful program that not only was -- was reducing incidence of HIV but was successfully introducing antiretroviral therapy and resource poor settings. There was something special about those places

where it was working well and it was working well because there was a integration of a clinical component with all of the other wraparound components that we know through community health centers are essential to -- to improving outcomes and so -- a local community garden to ensure that people had access to the nutritious foods that they require. Local -- microenterprises to ensure that we're not only providing the care and support for people we're helping them to -- to rise out of poverty and so forth. None of these examples as I can recall were articulated as community health centers but they were in essence community health centers. And many of them was being done at lower no cost, well we want to keep our eyes on the need for funding through our respective health care systems in those more affluent countries such as ours, we really do need to take inspiration from locations around the world where innovative providers groups that are being trained to achieve specific goal such as community health workers, local cultural peer educators and others have been introduced to the health system -- are adding tremendous benefits to it. I think in witnessing how this is done in resource limited context that it inspires us to think of how we might achieve something similar in our own setting.

Mark Masselli: We've been speaking today with Scott A. Wolfe Executive Director of the Canadian Association of Community Health Centers and the International Federation of Community Health Centers. You can learn more about their work by going to CACHC.CA or you can follow him on Twitter @ Scott A. Wolfe. Scott thank you so much for joining us on Conversations on Health Care today.

Scott A. Wolfe: It's been my pleasure.

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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 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 US politics. Lori what have you got for us this week?

Lori Robertson: Donald Trump has said that enhanced interrogation works but scientist have shown that the stress and pain induce by techniques like water boarding can impair memory and therefore inhibit a person from recalling information. Trump has made the claim a few times. In a report released in 2014 the Senath Selects Committee on Intelligent said that the CIA use of enhanced interrogation wasn't effective in acquiring intelligence. But we took a look at what scientific research on that topic has shown. Enhanced interrogation can entail technique such as sleep deprivation, cramps confinement and water boarding which triggers the feeling of drowning. A 2009 review paper in trends and cognitive science found that the idea that suspects would be

motivated to end enhanced interrogation by revealing truthful information from their long term memory isn't supported by the scientific evidence and in fact that evidence suggest that the opposite can occur, suspects may give incorrect information. Research has looked at how increased stress affects brain regions prolonged and extreme stress having negative effect on brain regions needed for short and long term memory function. Information presented by the captor can accidentally become part of the suspect's memory, 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 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 Health Care.

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Mark Masselli: Each week Conversations highlights a bright idea about how to make wellness a part of our communities and to everyday lives. On any given day about 4 million Americans can be found utilizing their local library. An estimated 15% of the daily patrons at the San Francisco main library held from the city's homeless population of about 7000 people. Often this population not only lacks access to safe housing but to much needed social services as well. So they decided to capitalize on the opportunity to help their homeless patrons by hiring the nation's first library based psychiatrist social worker.

Leah Esguerra: It's easier to do outreach on the streets because it's a neutral territory but here it's a -- it's their safe place, it's their sanctuary. So we try to be very respectful. My way is hi I don't know if you know that there is a social worker at the library, okay, to say, you know, we have these services if you think you might want to know more about it I'm available, I'm always here.

Mark Masselli: Social worker Leah Esguerra speaks to a reporter from PBS recently, she understands the challenges of leading the homeless population to behavioral health interventions and social services that will best meet their need.

Leah Esguerra: I do the full clinical assessment and then I make a presentation to my colleagues at the San Francisco Homeless Outreach Team, they provide case management and also housing.

Mark Masselli: Since they launch the program at the San Francisco library hundreds of homeless patrons have benefited from behavioral health and addiction services and many have also found themselves with permanent homes. Some two dozen libraries

across the country have initiated similar programs following San Francisco's novel model, a responsive strategically situated behavioral health clinician being made available to those most in need using the opportunity to leave the population to the care and shelter they most need, now that is a bright idea.

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Margaret Flinter: This is Conversations on Health Care, I'm Margaret Flinter.

Mark Masselli: And I'm Mark Masselli, peace and health.

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