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

Margaret Flinter: And I am Margaret Flinter.

Mark Masselli: Well Margaret, could the broken SGR formula finally be on amend?

Margaret Flinter: It does look that way Mark and I think we may soon have the illusive dark fixes they call it.

Mark Masselli: The reimbursement rates set by Congress back in 1997 plummet every year forcing Congress to pass emergency spending bills to keep the rates at market level. It's been very disruptive force in many practices.

Margaret Flinter: Hard to believe, in this current political environment we are actually seeing some sort of bipartisan consensus. That just seems to be what's happening now.

Mark Masselli: That certainly does, but this deal was worked out behind the scenes and the President said he is ready to sign it. But I think we are seeing some real momentum on this issue which should have been resolved a long time ago but will take it now, and another bill signed recently, this one was in Colorado, where Governor John Hickenlooper had approved a new extensive telemedicine bill. It significantly expands the reach of tele health services.

Margaret Flinter: And that law now requires insurers to reimburse tele health providers across the state.

Mark Masselli: The digital health movement is full of promises Margaret but it's also flogged with growing pains which could lead to harm if not carefully managed. That's the premise of a book written by our guest today. Dr. Robert Wachter is associate chairman of the department of medicine at U. C. Sanction Francisco is one of the world's thought leaders on The Hospice Movement and the author of The Digital Doctor, hope hype and harm at the dawn of medicine's computer age.

Mark Masselli: Lori Robertson, the Managing Editor of FactCheck.org. stops by, she is always on the hunt for misstatements spoken about health policy in the public domain but no matter what the topic, you can hear all of our shows by going to www.chcradio.com.

Margaret Flinter: And as always if you have comments, email us at chcradio@chc1.com or find us on Facebook or Twitter because we love to hear from you.

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

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Marianne O'Hare: I am Marianne O'Hare with these Healthcare Headlines. There is a duck fix in the works but it won't be finalized for weeks. The house has come to bipartisan agreement on a 200-Billion-Dollar Bill to fix The Medicare Reimbursement Formula for clinicians treating Medicare patients. Not everyone is happy with the agreement, which according to the summary scraps the current reimbursement system and gradually increases reimbursements to clinicians over 5 years. The House Package places more burden on seniors to shoulder the cost of their care AARP another organizations representing seniors have registered displeasure with the bill saying seniors bear too much of the brunt of the cause. President Obama has indicated he will sign the bill. And now for the extended open enrollment, which goes to the end of April by more than 16 million Americans have gained some kind of health coverage under The Affordable Care Act in 2 years of open enrollment millions had chosen for one reason or another to remain uninsured even though they qualify for significant tax subsidies to offset the cost of purchasing insurance. According to a survey by (inaudible 3:10) only 41% of those whose income was between 151% and 200% have probably already signed up and someone who had been more most adversely opposed to Obama Care is now perhaps one of its most celebrated customers. Presidential hopeful Ted Cruz had to go on The Healthcare Plan. He has publicly land based it from its inception after losing his wife's employer coverage, she resigned her post at Goldman Sachs to work on her husband's Presidential Campaign. Another reason to get off your duff and get moving; a study shows exercise actually changes the chemistry of tumors making them more vulnerable to treatments. A study being done between Mass General Memorial (inaudible 3:48) looked at what happens when tumors become hypoxic essentially chocked off by the network of vessels that initially go to feed that tumor, when exercise was added blood flow increased to the tumors allowing drugs a better access route to attack the cancer. I am Marianne O'Hare with these Healthcare Headlines.

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Mark Masselli: We are speaking today with Dr. Robert Wachter, Associate Chairman of The Department of Medicine at The University of California San Francisco. He is also Chief of Hospital Medicine and Medical Services at the UCSF Medical Center. Dr. Wachter coined the phrase hospitalist. It is considered to be an academic leader of The Hospice Movement. Dr. Wachter is a prolific writer on Patient Safety and Healthcare Quality. He is the editor of several journals and he has written several books including the latest The Digital Doctor Hope, Hype and Harm in the dawn of medicine's computer age. He earned his M.D. at UN. Dr. Wachter welcome to Conversations on Healthcare.

Dr. Wachter: Thank you so much for having me.

Mark Masselli: You're saying that we're at the dawn of medicine's computer age but you cautioned that technology is neither the silver bullet nor the panacea that will fix what's ailing modern healthcare and you say despite being staffed with mostly well-trained and committed doctors and nurses our system delivers evidence based care only about half the time you love medicine and technology but you feel so strongly about the potential harm of the emerging use of digital technology in healthcare and

why clinicians and patients alike should be concerned. Can you tell our listeners more about that?

Dr. Wachter: For someone like me who studies patient safety, we have been waiting for computers for over a decade to come in and solve all the problems with healthcare and then when computers finally entered our world and it's been remarkably recently, I began noticing funny things and doctors and patients not looking each other in the eye anymore and changes in workflow that were surprisingly didn't go down to radiology rooms anymore because we didn't have to and so I have been thinking kind of a lot about what went wrong and what these changes were and then about 2 years ago at UCSF which is a fabulous place we gave a kid a 39 fold overdose of a common antibiotic. At that moment, I came home and I said I need to understand this better and then need to write about it and the challenge of course is writing about it in a way that doesn't dismiss the technology but really looks at the moment that we are at an healthcare and ask why is it not reaching its potential.

Margaret Flinter: Share with us how people come together after a sentinel event like that to say how do we make this technology work for us?

Dr. Wachter: When an error like that happens, in some way it's easy to point your finger at Cerner or whichever company built your technology and so like they need to fix that, we came to realize that there were a series of policies that we created when we implemented our computer systems that were perfectly well maintaining and worked reasonable well most of the time but in this case it made the work more complicated than it needed to be. We also came to realize the system of alerts which sounds like a great idea. This is one of the great promises of technology when I am about to write for a medicine that a patient's allergic to the thing is going to pop up and show me, you know, the patient's allergic to this, do this, but we find that we have 100s of 1000s of alerts going off a month just within the computer order entry system. Adding the alerts in the rest of the system, someone designing the system says well what a great idea to alert the doctor or the nurse if there is an overdose, if these two drugs might interact with each other but no one has flipped the classroom and looked at it from the standpoint of what is it going to feel like to be a doctor, a nurse, or a pharmacist in an environment where you are getting alerts every 2 minutes and the answer is you are going to ignore them and then there were other issues that involve culture which is a young nurse sees an order for 39 pills when the correct dose is 1 and says to herself this is really weird but I know to get to me it had to go through a doctor and a nurse and a pharmacist and a doctor and I will check it my technology and so she barcodes it and by that stage with the medication process the barcode's job is to send the order and the barcode confirms that that's correct order. So we had work to do on trying to convince people that when your speedy sense tells you that something seems really kind of buzzard trust it don't over trust the technology and don't hesitate to pull the cord and say it's time to stop the assembly line, let's ask a question here. So these are in some ways predictable problems. But I think for many of us in healthcare they surprised us and we are just beginning to address them.

Mark Masselli: You have talked and written about The High-Tech Act. You have some real concerns about The High-Tech Act. Was it too much money all at once? Where did we go wrong?

Dr. Wachter: The High-Tech Act has actually an amazing back story in 2004 President Bush announced in the State Union Address a set a goal of computerizing healthcare system and healthcare there are differences that made it such that healthcare was not going digital on its own but the initial budget to do that was 42 million dollars, so that's to try to transform the 3-trillion dollar healthcare economy that's like trying to change the direction of the battle ship by sticking your feet in the ocean and kicking hard. It's not possible. And then what happened in 2008 was the economy imploded and they were coming up the 700 billion dollar stimulus package to revive the economy and some smart health policy leaders adhere that at one chance they will, it will ask for about 5 minutes and then go away forever and that was High-Tech so that was the 30 billion dollars of Federal incentives that got us to go digital. And I am actually not critical of those decisions more of High-Tech I think the idea of a federal incentive program to try to push a sliver line hit a tipping point where doctors and hospitals would go from analog to digital I think was smart, it was happening on its own but unbelievably slowly and I think it has worked so we are up to 70% EHR adoption in hospitals and doctors office as we were 10% 6 years ago. Where I get critical of the Government here is when High-Tech was passed they quite sensibly said, we better have another set of policies that ensure that people just don't accept The Federal Money and stick the thing on the shelf and so we are going to create another set of policies that's called meaningful use. So basically if you were going to give you federal money you need to demonstrate that you are using the computer in a meaningful way that's not silly because the risk was real but what happened with that was that Federal Government got very deeply into the weeds of essentially prescribing what your computer system should and shouldn't do. A lot of that is not okay and I think we are in the weeds now. You know, there is a model of The Feds getting it right and the model is internet where in the early days the internet was invented by you know, Federal Researchers with Federal dollars and then they realized very quickly that it's time for us to pull out and it's worked spectacularly well. The market forces through the ACA and other mechanisms that are driving healthcare systems to me are good enough that if you have a computer system, you will tweak it in the way as you need to, to meet those ultimate goals.

Margaret Flinter: Well let's stay in those weeds for a few minutes, it is a fascinating area and we've had the pleasure of talking over the years with David Brailer and Dr. Blumenthal, Dr. (inaudible 11:25) meaningful use was the first phase of that. A tremendous boon to practices who were trying to shoulder to the cost of implementing Electronic Health Records really helped to get people out of those paper charts and on to an Electronic Health Record, you know, the second and third phases are really about trying to use the electronic health record to drive a change in the model of care. It doesn't seem to me it's likely that your average independent small practice can meaningful use two or three and wonder if you would like to comment on that and start the gains and losses when we do that?

Dr. Wachter: I think there is a general bias in Federal policy making, the healthcare should run more like a business in the set of incentives that allow the creation of a Google or an Apple or another high-functioning company, and not to be in existence

in the healthcare and if they were in existence they would drive toward larger and more systematic kind of organizations with better use of data. I am probably a little bit biased because I live in San Francisco and where Kaiser permanently such a dominant system and I think it works pretty well. I mean I think that the model of a true system of the doctors and nurses and hospitals and they are all being part of the system getting a dollar and distributing it as they see fit to deliver the best outcomes at lowest cost. I think that makes more sense as an organizational principal. I guess my hope is that with new IT tools and with an increasing focus on the matrix that we care about that there will be a way to create sort of the best experience or patients in the context of the benefits that larger system can bring. Increasingly, people will get some of their healthcare or maybe lot of their health from their home or their workplace enabled by new technology tools or tele medicine but it all has to sit together in this pretty complicated jigsaw puzzle and I think it's more likely that we will succeed in achieving the goals that people are glued together in larger system.

Mark Masselli: We are speaking today with Dr. Wachter, Associate Chairman of The Department of Medicine at The University of California San Francisco. Dr. Wachter coined the phrase Hospitalist and is the author of *The Digital Doctor, Hope, Hype and Harm at The Dawn of Medicine's Computer Age*. You know, you make a case for the emerging healthcare system that's not only based on man versus machine but rather on 2 elements working together in tandem. Tell our listeners more about where the medical profession might be heading in our newly wired world?

Dr. Wachter: (Inaudible 13:58) a year and half ago that I needed to write about this but I am not a techie person at heart and so my wife is a journalist who writes for The New York Times and she suggested to me that the only way I was going to get this right was to do it journalistically and that meant I interviewed about 90 people including all the offices of national coordinator directors decided and went to see primary care doctor doing their work (inaudible 14:20) so when I asked them where does this all end up if we get it right? The vision that almost everybody had was about the same and it was actually quite nice and you know, the patients are getting digitally enabled care in their homes, in their work places, we are using big data. Technology brings us closer to patients and brings patients closer to each other. So I profiled one of these peer to peer sights called smart patients where patients get a diagnosed with cancer and they go on the web and they talk to other patients with the same cancer and they learn tremendous amount from that. Care will be better and more patient-centric and less expensive. It's sort of man versus machine I think is in some ways an artificial argument that when you get it right, it's not, these two were not in competition, these two weave together in new and wonderful ways and I think that it takes 10 or 15 years for the technology to settle into a new industry and make things really measurably better, we are at the stage in healthcare where I think we broadened the technology and we didn't re-imagined the work or why it shouldn't look like Facebook or twitter where there is sort of a stream of information that everybody contributes to including the patient. I don't think we have thought deeply enough about what are our goals and how does technology help us reach those goals.

Margaret Flinter: I think may be given your leadership in the area of developing the role of the hospitalist and not giving an opportunity to comment on that as well because certainly for a generation those really physicians who were disrupted by this

in primary care and in community medicine, spent years and decades in many cases with the hospital it's kind of their daily social mailer before they went back to the relative isolation of their practices and the hospitalist movement as it developed for all the very good reasons it developed really was a big dislocation what's the jury verdict on the gain and the loss around the almost complete transition not to The Hospice Movement around the country?

Dr. Wachter: I have a strong belief and I think the evidence supports that the organization of care with a separate hospital doctor achieves more gains and losses. The old notion of your doctor and your regular doctor taking care of you in the hospital was attracted and all sort of ways but in the era of patients who were in the hospital being really sick the pace being incredibly fast I think you need a doctor there all the daylong and my model to this when I am quite determined kind of began thinking about this, in the old, old days there were no critical doctors and people realized that you need a physician a general physician who is essentially a specialist in the place and ultimately now the hospital has become as complicated place where the stakes are that high you can have a patient being managed by someone who has a different job, 10 hours of the day. I think the data say that on an average quality and safety are at least neutral if not better. Well I think these really get exciting is the maturation of the hospitals field because what we did was position the field as being a new kind of doctor. A doctor who would not only take care of the individual patients but also has been a steward of the system and pay a lot of attention to this other sick patient meaning the healthcare system. And as I look at my group at UCSF, we are the unquestioned leaders in the organization in improving the system and have almost remarkable number of leadership roles at UCSF. It's not a coincidence I believe that the surgeon general is now a hospitalist and the top physician at Medicare is now a hospitalist. To young field, but I think we have bread a disproportionate number of leaders, in these areas because we have a deep belief that we did need a different kind of physician who paid attention to improving the system as well as individual patient care. But it means we have to pay a lot of attention to how do we move information back and forth but in a good system, people actually speak to or e-mail each other to make sure there is a personal connection. When I look at a high-functioning multi-specialty group, when I look at Keizer Permanente or (inaudible 18:23) or Palo Alto Medical Clinic, I think what they have done is they have created environment in the ambulatory setting where physicians get much of that joy and benefit and collegiality so I think it's in some ways another argument against the one or two person practice. I think we need larger organizational units for one reason to kind of re-imagine the environment in which the physicians will get that kind of professional benefits.

Mark Masselli: We have been speaking today with Dr. Wachter, Associate Chairman of The Department of Medicine at The University of California San Francisco. Chief of hospital medicine and medical services at UCSF medical center and author of The Digital Doctor, Hope, Hype and Harm at The Dawn of Medicine's Computer Age, you can learn more about his work by going to the-hospitalist.org, Dr. Wachter thank you so much for joining us on conversations on healthcare.

Dr. Wachter: It's been a great pleasure.

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Mark Masselli: At Conversations on Healthcare, we want our audience to be truly known 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: President Obama recently said that the Affordable Care Act is reducing the overall cost of healthcare including putting “1800 dollars in people’s pocket” but the President’s 1800-dollar figure isn’t a reduction in insurance premium but rather it’s the difference between the cost of the average employers sponsor plan in 2014 and what the average premium would have been if based on average rate increases from 2000 through 2010. The calculations were done by White House Economic Advisors but even they say The Affordable Care Act isn’t responsible for the full 1800-dollar difference. Employer sponsored premiums have been growing at low rates for the past few years and The White House council of economic advisors looked at what premium growth would have been since 2010 it’s the growth rate have been as high as they were in the decade before. That calculation showed the average family premium for employer sponsored plans would be 1800 dollars more than it actually is. But does the ACA get credit for that as Obama said it should, it could be responsible for some of the slower growth but experts largely attribute it to the sluggish economy. The Council of Economic Advisors said “a significant fraction of the slowdown in healthcare inflation could be linked to the ACA but it didn’t say how much. Also the 1800-dollar difference is the total premium amount that would have been paid by both employers and employees so not all of the 1800 dollars would amount to money in people’s pocket. And that’s my FactCheck 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 chcradio.com, we will have FactCheck.org’s Lori Robertson check it out for you here on Conversations on Healthcare.

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Mark Masselli: Each week Conversations highlights a bright idea about how to make wellness a part of our communities and everyday lives. Pregnancy is normally an exciting time for most women but according to the research an estimated 10% of prenatal women experience some kind of depression during their pregnancy and many are reluctant to treat their depression with medication for fear of harming the fetus.

Margaret Flinter: In fact a higher percentage are experiencing lower-grade depressive symptoms so they might not meet a full criteria for major depressive episode but they are having significant symptoms that are getting in the way of a feeling good and perhaps even getting in the way of engaging and the kind of healthy behaviors that are going to support a healthy pregnancy and left untreated those mild-to-moderate symptoms can progress and can lead to a more serious depression.

Mark Masselli: Dr. Cynthia Battle is a psychologist at Brown University with a practice at women's and the infant's hospital in Providence. She and her colleagues decided to test a cohort of pregnant women to see if a targeted prenatal Yoga Class which combines exercise with mindfulness techniques might have a positive impact on women dealing with prenatal depression.

Dr. Cynthia Battle: We worked with these experts to really come up with a program that was similar to what you might find in the community of prenatal yoga that would include physical postures, meditation exercises and we enrolled 34 women who were pregnant who had clinical levels of depression on average over the 10-week program that came to about 6 classes, and we measured their change in depressive symptoms over that period of time.

Mark Masselli: Not only were women able to manage their depressive incidents, they also bonded with other pregnant women during the program and found additional support from their group.

Dr. Cynthia Battle: So we found that women on average were reporting both on their self-report questionnaires and in the observer-rated interviews that we did that they were reporting much less.

Mark Masselli: A larger study with controlled groups is being planned with the assistance of The National Institute of Mental Health.

Dr. Cynthia Battle: Women who are depressed during pregnancy unfortunately do often have some less ideal birth outcome. So one thing we are interested in seeing is when we provide Prenatal Yoga Program can it improve mood and then can we even see some positive effects in terms of the birth outcome.

Mark Masselli: A guided Non-Medical Yoga Exercise Program designed to assist pregnant women through depression symptoms, helping them successfully navigate those symptoms without medication ensuring a safer pregnancy and a healthier outcome for mother and baby, now that's a bright idea.

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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.