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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 just back from an invigorating trip to Capitol Hill to speak with our lawmakers and policy leaders on health reform which happen to coincide with the third anniversary of the passage of the Affordable Care Act.

Margaret Flinter: Hard to believe it's been three years, but it was an exciting conference. It's organized by the National Association of Community Heath Center better know as NACHC, which works to support the nation's 8,000 community health centers which do so much to serve the underserved of our population.

Mark Masselli: And while we were there the senate was working feverishly towards approving a budget resolution which they managed to do over the weekend, the democratic controlled senate nearly past its first budget in four years.

Margaret Flinter: But this is far different document than the Ryan Budget that was passed in the House which was attempting to fix the deficit by enacting five trillion dollars in budget cuts and those cuts with a largely bend to social programs like healthcare and education.

Mark Masselli: The senate budget took a more balanced approach with a mix of tax increases in a less sever cuts to programs, but it's not over till it's over and I expect will be some more contentious arguments over these vastly different approaches to balancing the budget so we'll keep an eye on all of this activity.

Margaret Flinter: Our guest today is taking a different approach to primary health care delivery, Dr. Rushika Fernandopulle is the Founder and CEO of Iora Healh that's a Cambridge-based startup that seeking to reinvent primary care from the ground up.

Mark Masselli: He's been loaded by several noted Healthcare industry analyst, as a real innovator with his care model.

Margaret Flinter: And we'll also be hearing from Lori Robertson the Managing Editor of FactCheck.org, she's always uncovering misrepresentative facts about health policy that appear in the public domain.

Mark Masselli: But no matter what the topic, you can hear all of our shows by googling CHCradio and as always if you have comments, e-mail us at chcradio.com or find us on Facebook or Twitter, we'd love to hear from you.

Margaret Flinter: And we'll get to our interview with Rushika Fernandopulle in just a moment.

Mark Masselli: But first here's our produce 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. On a third anniversary of the Affordable Care Act polls show Americans are either still conflicted or downright confused in understanding what the law really means. The President as well as House Minority Leader Nancy Pelosi came out on the third anniversary this week with statements in support of the Healthcare Law saying would improve access to Healthcare for a struggling middle class, and was already serving to improve Healthcare for a millions of Americans, the young adults retaining coverage on their parent's plans to the millions who are getting free preventive screenings.

Meanwhile a monthly Kaiser Family Foundation poll shows Americans just as divided or misinformed about what the Healthcare Law will mean for them, as it has been the case along the poll found the central elements of the law remain popular across party lines upto 70% approving things like providing tax credits to small businesses to help employees afford insurance, closing the Medicare prescription drug donut hole and creating insurance marketplaces where individuals and small businesses can buy that coverage. CEO of Kaiser Family Foundation Drew Altman says while the political fight around the Affordable Care Act maybe winding down the challenge still lies ahead of how best to introduce the law to a public that really still doesn't understand it.

Meanwhile one of the provisions of the law, the expansion of medicate to include more folks living close to he poverty line was not held up by last year supreme court decision on Healthcare law. A number of Republican legislates have refuse to comply with the provision but one state is creating ripples across the landscape, Arkansas they've created a third option enroll those newly eligible for Medicaid the same private insurance plans available to individuals and small businesses on the exchanges. Arkansas is led by a Democratic Governor but a Republican control legislature and it seem the only viable option, bottom line it would make impossible for another quarter million folks in Arkansas to have some health coverage.

The Baristas might be on to something several studies out about the medicinal powers of coffee reveal a host of beneficial side effects to the hot simmering bru.

Recent study finds coffee does in fact lead to more alert truckers on the road, a recent Australian studies show that long haul truckers driving big rigs or 63% less likely to have an accident if they regularly consumed coffee. And another study out shows that for folks who drink alcohol regularly, coffee seems to have protective effect on the liver keeping it from scumming so readily to the toxic side effects of regular alcohol consumption.

I'm Marianne O'Hare with these health care headlines.

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Mark Masselli: We're speaking today with Dr. Rushika Fernandopulle Co-Founder and CEO of Iora Health and innovative Cambridge-based startup that is seeking to transform Healthcare delivery in this country. Dr. Fernandopulle was the first Executive Director for the Harvard Interfaculty Program for Health Systems Improvement and co-founded the Boston-based Renaissance Health, he was featured as an innovator and Dr. Atul Gawande is New Yorker article hot spotter, Dr. Fernandopulle is on the faculty at Harvard Medical School where he received his MD. Dr. Fernandopulle, welcome to conversations on Healthcare.

Dr. Fernandopulle: Thank you very much.

Mark Masselli: So Dr. Fernandopulle you say that the Healthcare system is failing us and needs to be reinvented starting with the primary care system. So you're in the process of creating a new approach to the delivery of Healthcare, one that you say is reinventing the model of Healthcare delivery from scratch, a model that can be both effective and I'm going to add efficient and maybe elegant as well, and ultimately lowering the cost of Healthcare overtime. Describe for us how this system is failing us first and why we need to essentially reinvent the wheel in Healthcare delivery.

Dr. Fernandopulle: The gap between what we pay for Healthcare and the quality of the services we receive in this country is I think probably the biggest business problem that faces us. We spent an obscene amount of money on Healthcare it's 71 or 18% of our GDP it's two and half trillion dollars, it is bankrupting individuals, it's bankrupting companies who had compete internationally and is bankrupting the country, if you look at federal budget desk it's over the next 50 years. They're really all being driven by Medicare and Medicaid going up, and we have to get a handle on Healthcare spending, you know, we're spending so much but yet the quality we get is awful and everyone who's try to get Healthcare knows that it's the personalize, it's fragmented, it's reactive and the outcomes are embarrassingly poor 30-day readmission rate for Medicare is 21%, you know, defect rates like that would be cost for huge alarm in any other industry.

We think primary care is the right place to start if you want to fix Healthcare you've got to fix practices. The bulk of the challenge in Healthcare today is

chronic disease, it's diabetes, hypotension, lung disease and primary care is a great place to managed that, and I think there's the movement towards medical homes and accountable care, what everyone else is doing is trying to tweak existing primary care practices, take existing practices and make them a little better by changing a little thing here, giving them a computer, adding e-mail, but by and large leaving the rest the same. And our proposition is simply been that why don't we just start from scratch the system is so fundamentally broken that maybe what we need to do is actually just start over break the rules and create a new model that can really deliver care in a very different way.

Margaret Flinter: Tell us about that model -- tell us how you threw out all the rules and started all over again, what did you built?

Dr. Fernandopulle: The first part of the model is really changing the payment model, so the way that we pay most doctors in this country and virtually all primary care doctors is what we call fee for service, who get paid per sick visit. Do you come to see me as a doctor I do whatever, I do a diagnostic give you a treatment I've been assigned a code it's a thing called CPT code, very arcane set of rules, and then I bill and then I mailed and I get paid for that sick visit so we get paid per doctor sick visit. Guess what happen? We get lots of doctor sick visits and we don't at all focus on actually improving people's health. Primary care is really about a continuous healing relationship, a way for pay for relationship is like a gym membership, it's a fixed amount per month to just allow us to figure out how to take care of people. And number two is primary care in the US is typically about 4% of the healthcare dollar, that's ridiculous that means that 96% is what I call failure primary care you end up in the hospital the emergency room, so what we say is we should double down on primary care we should put at least double the resources into it, that will actually keep people out of trouble on the backend.

The second piece is that now allows us to be completely creative in changing the delivery model and so it really is about getting a team of people to work with the patient, to help them with all the blocking and tackling and takes to manager health and we have a concept of a health coach which is someone from the community who is not necessarily a nurse or a doctor but someone with good in the personal field, who's going to really help patient to make a plan know what to track, answer questions and we just think it's so much more powerful to do it from the community live in person, everyone get to shared care plan or we make a plan of how we're going to improve your health whether it's losing weight or learning to run a marathon or whatever. And then we can interact with you in a whole variety of ways so not just visits but this is 2013 we should be able to interact by e-mail, by text message, by video chat and we do all of those things.

A lot of our interactions are improved so people with diabetes, we have a diabetes club, a yoga group, ways to engage people as a patients going to engage each other, we integrate mental health into the practice because a lot of

the barriers to getting good healthcare is actually depression or anxiety and we should be helping that not just kind of send you off somewhere else. And then the third part of the model really is when start doing this completely different care delivery what I call population management you realize that the IT systems we have in typical healthcare are completely wrong, despite all the, you know, who -- about electronic medical records, but they really are a fancy building systems to allow doctors that code document and built higher, it doesn't improve care at all, and we realize we need a different sort of IT system to help us actually managed populations engaged patients in their care, and so that we've built that ourselves.

Mark Masselli: I wonder how you see the spread happen and maybe you can talk a little about Iora Health and the team that you've assembled there, but it seems that you're going to have to connect with enough business who are willing to -- or government entities who are willing to change that payment model and that really drives so much of the opportunities for the redesign and redefinition of that primary care space. And then having the technical capabilities of using managing data efficiently is this concept that you think can spread and talk to us how you think it might spread.

Dr. Fernandopulle: Yeah, you're exactly right, so the constrained in our growth at the moment is finding what I call sponsors which are people who are on the hook for healthcare spending, who are willing to pay us differently. Now again, I think that the way we're doing it now doesn't work so we should be trying all sorts of different things, but as you know change is hard for many folks. We've the most success, you know, signing up with either large sales insured employers like the Balling Company, like Dartmouth College we've have a practice up in Andover New Hampshire as well as Union Trust, so in many places a part of the country the Union Trust is who's been delegated the authority that sort of provide health benefit so in Las Vegas we work with the Casino Workers Union work with the group called Freelancers Union in New York and Brooklyn. So you're exactly right, so what we need to do find more payers who are willing to pay us differently. Now I think what's going to make this work and get this the big scale is what's happening in health reform which is really patients more and more buying healthcare themselves, as you know with this exchange is coming on board and with changes in employers, many employers are likely over the next five or so years to stop providing insurance to the folks, getting many employers they're going to start saying, instead of that's providing you health insurance we're going to give you, you know, X thousand dollars a year go buy yourself a health plan on one of these exchanges.

So now all of a sudden consumers aren't able to go and purchase a product and again I think what we're doing in New York is we're bundling our practice with the health plan together as one offering and that's something that consumers very much like.

Margaret Flinter: But I wonder Dr. Fernandopulle if you could tell us a little more about these primary care teams, we know from what you've wrote about the Atlantic City experience these were patients who beyond needing a little -- they really needed a lot, because they're using an awful lot of care in the emergency room. So tell us about the people you put on that primary care team, how did you engage those patients in their care?

Dr. Fernandopulle: You hit the nail right on the head, the most important thing we need to do is engaged patients, we are then able to sort of help them manage and help better change behavior et cetera. That's when our health coaches come in and the, you know, a quick story we had a patient at Atlantic City, and he said -- her name is Joyce and she came into the practice completely out of control, her diabetes is out of control, her blood pressure is out of control, she was in and out of the emergency room not taking her medication sort of disheveled looking, came into the practice and then six months later I saw her and she looked amazing, she would put some make up on, her hair was combed, diabetes hypotension in good control taking her meds, back to work, no ER visits, and I said Joyce what did we do different, what have we done to really help you? She said well actually doc it's pretty simple, my health coach merely cared about me, she taught me to care about myself, and I didn't want to let either of us down. So it was almost that simple, right? So all these other stuffs we're doing, all dimidiate that relationship between the patient the doctor and the health coach, to engaged people in their care, so they can get start paying attention and start making changes and that's why the team is so important. I think there's too much focus has been on the doctor, the doctor is what I called the system architect but a lot of the impact was actually not by the doctor by the other folks on the team.

Mark Masselli: We're speaking today with Dr. Rushika Fernandopulle, co-founder and CEO of an Innovative Cambridge-based startup that is seeking to transform healthcare delivery in this country. So talk to us a little bit about the IT systems that you've developed.

Dr. Fernandopulle: So we've build our system from the ground up like we built our practices from the ground up in order to mediate sort of better care. So it's built around actually cracking the things that we thing we ought to track for each patient to a maximizing health for instance you're diabetic, we have a thing called markers and there -- my number of marker we should be tracking your hemoglobin A1C or blood pressure your LDL whether you had a foot exams we program all those things and we track how you're doing. We call the care collaboration platform, and it allows everyone on the team including the patient, they see the record and interact with it and actually even put information into it, so what we do is we have task list associate with each person on the team including the patient and the health coach and the doctor, and the system keeps track of all the things we need to do, if a system -- this patients has an A1C that's

over due, it puts a task on a health coach as task list, get a hold of the patient and tell them they need an A1C checked.

Similarly if we prescribe a medicine, we get a feed from the pharmacy benefit manager and we looked to see for a fill. And if the patient didn't fill the medicine within 48 hours we put a task on the health coach a task lists for that patient reach out why didn't you picked up your medicine. We get data from everywhere, we get census data from the hospitals, from the market so we know when our patient's in the hospital or in the ER and patients can input in data from, you know, their blood pressure or their palmiter or then when things go off the rails, we then can reach out and figure out what happened. We also can create some very elaborate dashboard so we poll our patients and get patient experience data and we also get all the claims data from our sponsors, because they are the payers to know when people are on the hospital in the ER and go to specialist and get imaging test. So we can now create this 360 degree dashboard where we can see how are these patient doing, how are each health coach doing with their patients and how are this practice doing? If you look at just one of them you can get into trouble. It's in the cloud, it's ruby on rails, it's -- use the thing called actual development for every two weeks we have a new relief. And so as we figure out there are ways we can do things better, we can feed it back to our team and we can change the system so it can be made better, so every two weeks it keeps improving.

Margaret Flinter: Dr. Fernandopulle, let's put our policy heads on for just a moment and obviously cost containment is a holy grail maybe tell us a little bit about that and I want to just follow up for a minute on primary care providers to patient ratio so maybe first on cost.

Dr. Fernandopulle: I think whenever people set out to try and save healthcare cost it's to tempting to do the wrong thing and just skimp on care. What we were able to see if you take our patients and compare to them the control group, what you find is that the primary care cost go up because that's the model drugs spending actually goes up a little bit because people actually take their medications, but then there are big roughly 50% drops in emergency room visits, it's about a 25% drop in other outpatient cost and the net spending drops by anywhere from 12 or 13% up to 20% in our balling project. So it's a big drops in total spending this is, you know, better care cheaper, and it's cheaper because we're actually doing the right thing for patients.

Margaret Flinter: And if I can just ask you a quick follow-up question to that again sort of from a policy perspective we've kind of grown up in this country over the last decades thinking one primary care provider could care for somewhere between 1,200 and 2,000 patients and the concierge movement came along and people said well we can do a great job as long we're only taking care of 300 or 400, what is your sense of the impact of your model in your primary care teams

how many patients can they manage and is that a question you've even try to tackle?

Dr. Fernandopulle: It's a very important question, you know, so the game you should not be the squeeze primary care as much as possible, right primary care is 4% of health care dollars so if the right thing to do is spent more in primary care we should be doing that. I think what the concierge practice do it simply have a doctor if your patient is a dumb way to do it because much of the value can be delivered by people who is not the doctor, what we ask the question what are the things that the doctor should do, because that's what were trained to do, and what are the things that you don't need a doctor to do, and I think engaging patients and tracking things and, you know, it's actually better done by someone else, I think we can have patients do a lot more thing self service than we do now. So we actually think that we will eventually have doctors who can take care of more patients than doctors do now, again leverage by team. So to be clear in our practices for every doctor we have health coaches plus that admin person plus a mental health person, so that's a big team of non physicians who really can help with this.

You ask the question that we have enough doctors out there, you know, I think part of the reason people aren't going to primary care is not just the money which is what everyone focuses on, primary care doctors get paid about half as much as many specialist do, it really is that the job simply sucks, you know, it's a typical primary care job. I had a colleague who once said you know everyday I lose a little piece of my soul because I went into this thinking that I'd be able to take good care of my patients that I'm just not able to. And I think what we're trying to do is provide settings where doctors can take great care of their patients, and we have no problem attracting great doctor work in our practices and our doctors are incredibly happy. So I think if we do that we could have a different vision of our primary cares, we will have no problem attracting as many people as we want going into primary care.

Mark Masselli: Dr. Fernandopulle, we like to ask all of our guest's final question when you look around the country in the world what do you see in terms of innovations that our listeners at conversations should be keeping an eye on?

Dr. Fernandopulle: I think that some of the sort of engagement tools and some of the things that allow patients to track and take control of their own disease as well as particularly in communities are really interesting. So there are this community that patients who are essentially helping each other better manager help and I think allowing patient to do a lot more self service than we do in typical practices is really interesting. And you know, I think it's a great time to be doing this sort of work.

Margaret Flinter: We've been speaking today with Dr. Rushika Fernandopulle founder and CEO of Iora Healh a ground breaking healthcare company that

seeking into transform healthcare delivery by improving patient outcomes and dramatically reducing cost in the process. You can learn more about the work that he does by going to Iorahealth.com.

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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 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: Well, Mark and Margaret, last week was the 3rd Anniversary of President Obama signing the Affordable Care Act, and last week Republican Representative Michele Bachmann claim in the speech on the House floor that Congress should repeal the law, "before it literally kills women and it kills children kill senior citizens". She also claims that vulnerable women and children and seniors would, "pay more and get less under the law". The law is expected to increase the numbers of Americans with health insurance by 27 million in the next four years and study shows that they're too lack insurance have a higher risk of dying prematurely. As for women, children and seniors pay more -- well the law provides free preventive services for women such as mammograms and cervical cancer screenings, it increases prescription drug coverage for seniors and it expands funding for the children's health insurance program for two more years. Bachmann has long been suspicious of the healthcare laws independent payment advisory board which she has claim a rationing care, but the board is tasked with suggesting ways to slow the growth of Medicare spending and the law says it can't restrict benefits or care for seniors, the fact simply don't support Bachmann's claims.

And that's my FactCheck for this week. I'm Lori Robertson Managing Editor of FactCheck.org.

Margaret Flinter: FactCheck.org is committed to factual accuracy from the country's major political players and is a project of the Annenberg Public Policy Center at the University of Pennsylvania. If you have a fact that you'd liked checked e-mail us at chcradio.com we'll have FactCheck.org 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 night in Greater Los Angeles, there are a hundred thousand homeless people sleeping on the streets or in shelters. And though it may be hard to imagine there is a growing roster of UCLA students among those numbers. The down

economy and the rise in tuition in the University of California system has forced some students living on the edge to forgo basic needs, including paying for housing. A couple of years ago, awareness of the homeless student problem sparked an idea. Several student groups on the UCLA campus joined forces with the university's housing and food service departments to create swipes for the homeless.

Rachel Sumekh: Swipes for the homeless is founded on the principle that each and every student can make positive tangible change in their community.

Thach Nguyen: Every quarter students that live on campus purchase meal swipes. They could put on to their student ID and get them into the dining halls. At the end of every quarter, the students still usually have 10, 20, even one hundred meal swipes remaining.

Mark Masselli: Co-founders Thach Nguyen and Rachel Sumekh explain the concept which was pretty simple but prevented a lot of waste of end-semester prepaid food service dollars that would end up unused.

Rachel Sumekh: At the end of each quarter we collect hundreds of signatures and then collaborate with dining to turn those signatures into meals. Our team then distributes these massive quantities of food to shelters throughout Los Angeles

Mark Masselli: They launch the idea at UCLA in 2009 and as of January of this year they have spread to universities across the country. Since its inception, the program has distributed roughly 60.000 pounds of food and water to numerous homeless shelters around the country. And the added benefit the kids on the campus get a valuable lesson in the pervasiveness of homelessness, the founder swipes through the homeless have won numerous awards for their idea and were invited to the White House last year for their efforts. A simple repurposing of unused meal plan dollars, redirecting those previously wasted resources to a population right in their own community who are in need, now that's 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 wesufm.org and brought to you by the community health center.