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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 there's a lot of rumblings going on in Washington and it's not just in digestion from the food they're eating down there, but it's also about the budget they're trying to deal with.

Margaret Flinter: The Obama Administration presented a budget proposal today, warning members of congress that tough decisions have to be made to jumpstart stall budget negotiations between the democrats who want the preserve social programs and the republicans who have to repeat that vow no new taxes.

Mark Masselli: You know the President seems to be setting the stage for a grand bargain that will hopefully bring about a final budget approval from a very divided congress. And that means cuts to some programs that were considered sacrosanct in the past Medicare and social security.

Margaret Flinter: The President is trying to issue a budget that both addresses the deficit and protects those social safety net programs, something that both the democrats and the republicans agree must happen. But no agreement on just how they're going to achieve that end.

Mark Masselli: He's taking on some friendly fire from democratic allies who are concerned about the propose $400 Billion cuts in Medicare that have been floated around. The President says, the cuts will come in the form of reduced fees pay the pharmaceutical companies, and by asking wealthy seniors to pay more for their Medicare coverage.

Margaret Flinter: So Mark there's another announcement last week that maybe with all the budget talking, gun control talk going and it didn't get so much air play. And that was the announcement from health and human services, that the federal government was delaying setting up multiple insurance plans on the federal health insurance exchange until 2015, a year after they're suppose to be ready for small business to shop for.

Mark Masselli: Certainly with 33 states deferring to the federal government to set up the exchanges, it's required a lot more preparatory work. So when the final Affordable Care Act kicks in fully in 2014, small businesses will have at least one plan to choose from and then in 2015 multiple plans would be tear then.

Margaret Flinter: But our guest today is a vocal advocate for improving a different aspect of Healthcare. Mark, Dr. Andrew Morris-Singer is the founder of

Primary Care Progress, a grassroots organization that he co-founded to improve advocacy and support for developing the new primary care workforce pipeline.

Mark Masselli: They promote legislation that will improve access to training for primary care, Margaret and I are both going to join Dr. Morris-Singer at a conference this weekend at Quinnipiac University School of Law on primary care and the law.

Margaret Flinter: We're expecting some exciting and innovative ideas come out of that event and generally some exciting and innovative ideas coming out of that whole campus, Mark?

Mark Masselli: Quinnipiac is also soon to open its new medical school, just a few months away in August. Its focus is on training the next generation of primary care providers.

Margaret Flinter: Also today FactChecks.org's Lori Robertson checks in on the false claim that insurance rates will swore by 30% due to the Affordable Care Act.

Mark Masselli: 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: We'll get to our interview with Dr. Andrew Morris-Singer in just a moment.

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

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Marianne O'Hare: I'm Marion O'Hare with these health care headlines. President Obama has issued his budget proposal and the President is already incurring a fair degree of pushback from his own party. The President's budget seeks to reduce a deficit by just under two trillion dollars in 10 years but will cut into some popular social programs to do it. As projected cut to Medicare spending by 400 billion dollars over 10 years, social securities benefits formula will be kept as well reflecting real growth in inflation. But analyst warned that will present seniors within unfair burden as they tend to spend much more of their income on Healthcare. Members on both side of the isle are expressing concern over the budget, democrats warning it puts an unfair burden on seniors while not raising tax revenues. Republican saying they are only interested in deals where there are no tax increases.

Marilyn Tavenner bipartisan support who had the centers for Medicare and Medicaid, Tavenner's been acting administrators since replacing Don Berwick in

late 2011. She went before the senate finance committee yesterday, and unlike her predecessor who is appointed by President Obama during a Congressional Recess, Tavenner is expected to face less resistance from opponents.

Well the University of Hartford is a backdrop President Obama appeared and did not make state to show support for strict gun control measures passed in Connecticut, the governor recently sign laws banning certain assault weapons and large capacity magazines in wake of the deadly Newtown tragedy which left 28 dead including the gunman. They're tiny but they pack a terrible punch and they're back, with a budding growth of spring comes an unwelcome menace tick season has already reared its head in certain parts of the country where spring has come early, cases of tick born disease like lyme disease already starting to crop up in hospitals and emergency rooms, bottom line if you want to avoid lyme disease cover up completely when working in the garden or hiking in the woods.

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

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Mark Masselli: We're speaking today with Dr. Andrew Morris-Singer President and Principle Founder of Primary Care Progress, an organization form to reinvigorate primary care training delivery and practices in the American Healthcare setting. Dr. Morris-Singer is practicing internist at the New Patient Centered Medical Home at Brigham in Women in Boston, he's also an instructor at Harvard Medical School where he earned his medical degree, Dr. Morris-Singer is a long time community activist and organizer and is growing the Primary Care Progress message across the country at multiple teaching hospitals and community health centers. Dr. Morris-Singer, welcome to Conversations on Healthcare.

Dr. Andrew Morris-Singer: Thank you so much for having me.

Mark Masselli: Andrew, you joined us here on Conversations on Healthcare back in 2010, your organization was just getting under way you launch Primary Care Progress while still a resident primary care as a response to Harvard Medical School defunding of the primary care division. And your advocacy has obviously led Harvard to agree to create a new center for primary care at Harvard Medical School which is exploring innovations in healthcare delivery in place of the pre-existing division of primary care. So two questions, one how is the center for primary care at Harvard Medical School different from the old primary care division, and how is the training in primary care changing as a results of your efforts there?

Dr. Andrew Morris-Singer: When we start organizing back in 2009 we thought that the community of the primary care providers and trainees really need to be a part of establishing a new vision for what primary care programming could look

like in Harvard. And when we came together as a community in a series of town halls, we needed a community space, we wanted to engage all members of that community, so the faculty, the students we wanted a different disciplines of primary care represented family medicine pediatrics internal medicine. We want a trainees engaged, we want to focus on clinical innovation, so new ways of delivering care and new ways of training and we wanted to really build a new generation leaders. And the new center embodies all of that, specific programming directed at each of those different areas, now exist many trainees came to Harvard in this most recent class because of this center. So it's created new facts on the ground and new culture that values primary care at the school, and it's been incredibly inspiring for all those of us who -- who've watched it developed.

Margaret Flinter: Well Andrew I understand you now at over 25 teaching institutions around the country, tell us about the grassroots movement as it spreads across the country. How does it look at some of the other teaching hospitals at places like Baylor or Yale or Stanford in California where maybe primary care was going down the same slop that you had observed at Harvard?

Dr. Andrew Morris-Singer: I think the bottom line is we're harnessing a basic social strategy that's been used in every other social movement in this country. So if you look at some of the basic characteristics of that movement, it's playing out in each of these communities, these 25 chapters that you'd talked about. So number one, we're engaging the full primary care team, right? All disciplines, medicine, internal medicine, pediatrics all the professions, nurse practitioners, social workers and it's breaking down the silos that previously separated this folks from each other which is fairly typical in your average academic institution. So for instance, University of Utah chapter out in Salt Lake City that team is composed to pharmacy students, physician assistant students, medial students all working together to create a new space for trainee engagement in primary care clinical innovation.

The second major aspect of what we're doing is, we're getting folks to see an opportunity to take action, right? This isn't just about people coming together to talk, it's about harnessing resources and connections to built something new. So at Baylor School of Medicine down in Huston Texas, these students are working with faculty to create new primary care innovation opportunity, so they're paring students with faculty to do patient centered medical home transformation projects, where the students is really in the driver seat of some of these innovation projects. And finally I think these chapters are engaging in strategic thinking and planning in a way they haven't done before, they're re-branding primary care practice, they're utilizing story telling as a leadership practice, so we're no longer just presenting the data on the importance of new models of care, but we're also coupling that to stories about what it's like practicing in these new models, what it's like training in these new models, where teams are

everything. And these are few skills that most trainees have previously not been taught.

Mark Masselli: Well Andrew on of the big stories obviously that's been front and center for the last couple of years as the Affordable Care Act, and on January 1st 2014, upto 30 million people will be able to enter the primary care system. When the analysts take a look at the potential for 30 million new enrollees, they're estimating about 30,000 primary care provider short fall. So tell us about some of the innovations that are being explored at your patient centered medical practice at Brigham and Women's as well as the primary care progress that are setting an example for the way the medical community should address this looming short fall.

Dr. Andrew Morris-Singer: Number one we are acknowledging the fact that there are so much to be done in primary care these days for the patient right in front of you. That are old modeled of the doctor trying to do everything and trying to be everything to everyone, it doesn't work, it's just too much to do and when I try and do everything for the patient right in front of me, I'm actually doing a ton of stuff that's actually not the best use of my skill set, right? I'm practicing below my training. And frequently I'm trying to do stuff that I'm not very good at either, for instance motivational interfering it's not something we get a ton of training on behavioral health, integration and focusing on those things. It's not something that's been a big focus of training so we're engaging other members of the care team increasingly in these practices, the social worker, the pharmacist, the physician's assistant, sharing the care with those folks in an interdependent manner that gets the patients all the stuff they need. So our practice has a social worker sitting side by side with the physician working to manage patient's depression and anxiety and connect them to community resources but the average probably doesn't know very much about it.

I'd say the second major thing is that we're no longer practicing just reactive care. When we just focus on those folks we're missing out understanding who are the diabetics in our practice, who are the people with high blood pressure, they might not come in here if require them to call. But if we reach out to them they'll actually show up, so we're creating population registries of our asthmatic, of our diabetics and we're working as a team to reach out to them, bring them in and managed them. And I'd say the final piece is we're engaging in care delivery that's much more patient centered. So we're increasingly figuring out ways to substitute telephone encounters, e-mails visits for that traditional face to face visit. It works better for patients, it works better for us and I think the pairs are a lot happier too.

Secondly we're figuring out ways to engage patients in their own care, patients are one of the most underutilize constituencies on the care team, it's what they do and don't do that makes the difference in their care. So we're finding ways to engage them with motivational interviewing or creating group visits, we're

basically working to help them become a more integrated member to care team. Patients are happier they're going to the emergency room, last the quality of care is improved and all of this for lower spending it's kind of a no brainer.

Margaret Flinter: Well Andrew, you know, we had a match day a few weeks ago across the United States where the graduating fourth year medical students met with the residency, the bright spot this year an additional 400 students were actually seeking primary care residencies up over the year before but the troubling counterpart I understand there are about a thousand medical students who weren't able to match with any residency because there just weren't enough slots available. I understand you've been looking at this problem in primary care progress and what's your perspective on this problem and the disconnect at the same time that we're saying we need more people to choose primary care and saying oops not quiet enough slots to give them all residencies.

Dr. Andrew Morris-Singer: We did see 400 more students choosing primary care residencies but in the aggregate I don't think we saw a lot more people choosing primary care careers. Still over 50% of family medicine residencies were not picked up by domestically trained students. So I don't actually think we're seeing an increase interest in primary care among the students right now. But the good news though is that over the past two weeks I've been on the phone with program directors of different primary care residencies, and they're all saying the same thing. This year they're seeing some of the best and brightest students applying a primary care, they're seeing some of the most inspired and charismatic trainees deciding that they wanted to go into primary care. And on top of that they're saying that these trainees are showing up asking really sophisticated questions about new models of care, they understand that primary care is transforming itself and they want to be a part of the solution, they understand some of the challenges of doing that work. What's exciting about that is to fix the primary care pipeline, we've got two issues to fix, we've got to get more people going into primary care but we've also got to ensure that these folks have a new set of skills. These **(14:49 Inaudible)** of folks going into primary care has a new set of skills and they are ready to rock and roll in a rapidly transforming healthcare system.

At the same time though, I think our graduate medical education funding system is very problematic and leads to a lot of the issues that you describe with the match numbers with the discrepancy between the overall number of primary care positions that exist in this country that is low compared to the shortage of primary care providers I think there needs to be more -- much more accountability in graduate medical education, financing and, you know, your average resident basically takes up $500,000.00 of tax payer money, to be trained and the fact that we do not have accountability with these training programs in terms of turning out more primary care docs and ensuring that they have specific skills for a rapidly transforming healthcare system. We got to fix that, we got to fix that soon.

Mark Masselli: We're speaking today with Dr. Andrew Morris-Singer, President and Principle founder of Primary Care Progress and advocacy organization seeking to improve primary care training delivery across the country by building a grassroots movement of primary care innovation leaders. Andrew, I want to continue to pull the thread on this notion of shortage and, you know, you've been working redefining the primary care space making it as we say efficient, effective and elegant. And I'm going to add the fourth here how do we make it enticing to move that dial because even though we have brighter people coming into it, there's a huge short fall out there and go pass your comfort zone here is it either a larger system things on how we pay providers clearly primary care providers aren't compensated like specialist. What do you see in the big systemic changes that we might need to increase those numbers above the 25 or 30% that we might be getting out of medical schools now?

Dr. Andrew Morris-Singer: Mark, what I've realized is that you cannot separate reimbursement from delivery from training. All these three things operate on each other, you know, there are so many different things operating on your average primary care trainee and payment is a huge, huge issue because, you know, on average there's between 160 and $200,000.00 worth of debt the golden handcuffs. But there are other factors playing out that are also emerging folks from the primary care pipeline for instance we have a hidden curriculum at most medical training institutions that pushes people towards inpatient hospital based procedure oriented careers and away from primary care training, we have **(17:37 Inaudible)** discouragement that goes on in these institutions, people being told don't go into primary care you seem too smart for that. We have these trainees rotating through some of the most antiquated models of primary care delivery both in their medical school as well as residency years. So it's multiple factors playing out and we didn't even talk about admissions policies, we haven't even talk about the fact that the number of students being admitted from rural environments has dropped by 50% in 10 years. So we're not even letting into the schools, those trainees that are most likely to go into primary care, so fixing this is going to require multipronged solution including loan reimbursement but we also have to fix payment we've got to insure that the trainees are rotating through functional high value patient centered primary care practices we got to fix all these things to fix the primary care pipeline.

Margaret Flinter: Well Andrew one of the things that we've done within our organization is to take a look at this issue of the team and team base training I'd be very interested in hearing how you're approaching this issue.

Dr. Andrew Morris-Singer: We are operating in the phase so many challenges that distance and device people operating in the form of a team. We have a culture of the loan provider, where trainees are actually educated to be everything to everyone, then we go into a reimbursement environment that in many practices actually doesn't even pay for the services perform by non MD

members of the care team. So we're actually disincentivising team base care, so the first step I think is number one, you got to get trainees learning together right from day one, I think some of the most innovative places around the country have figure that out they're creating spaces where social work students and MD students, you know, pharmacy students can work on a team together and really figure out how to solve clinical problems together.

Secondly, you know, practices are figuring out ways to engaged all members of the care team, they're getting their larger institutions to invest and they're retraining themselves, who should be, you know, on the frontline of managing people's diabetes, that's not the type of thing where that information should be coming from the government, that's a local team figuring out the most effective efficient way of using their existing resources to serve the needs of the community.

Mark Masselli: We've been speaking today with Dr. Andrew Morris-Singer President and Principal Founder of Primary Care Progress committed to revitalizing the primary care pipeline of workers. You can learn more about their work by going to primarycareprogress.org. Andrew, thank you so much for joining us on Conversations on Health Care today.

Dr. Andrew Morris-Singer: Thanks so much for having me.

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

Lori Robertson: Well, house republicans in the White House once again treated claims about what the Affordable Care Act would do to insurance premiums. There was a new analysis out published by the Society of Actuaries that said for the individual market that's for the exchange will operate. The cost for insurance companies per member, per month would go up to 32% but Republicans on the House Committee on Energy and Commerce claimed at the actuaries had said that the average premium would increase 32%. The report didn't say that at all. In fact it explicitly said it wasn't giving an estimate on premiums. It did say that cost for insurers would go up as a less healthy population joins the individual market. It's true that if costs go up they will likely be passed on to consumers but we don't know what exactly will happen to the premiums. The Congressional Budget Office meanwhile estimated that premiums would go up on the individual market but by 10% to 13% and most of these buying plans through the exchanges would get federal subsidies that bring their cost way down. The

White House pointed to that CBO report saying that average premiums would actually be lower in the future for the same level of benefits. And that's the catch plans in this market are expected to have much better coverage in the future than they do now because the Health Care Law require certain minimum benefits. And those increased benefits are exactly why the CBO estimated that the average premium would go up.

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'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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Margaret Flinter: Each week conversations highlights a bright idea about how to make wellness a part of our communities and to everyday lives. New York City Mayor Michel Bloomberg has been taking a number of hits lately for attempting to ban everything from Styrofoam packaging for takeout food, to large sugary drinks in restaurants and city run facilities. Bloomberg has nonetheless forged to head he sites his interest in not only improving the health of his New York City constituents but in setting an example for other public officials to follow around the country. It's been 10 years since Mayor Bloomberg launched his first controversial ban ending smoking in bars and restaurants throughout the city's five burrows. The proposed smoke free air act was met at the time with a hailstorm of criticism and dire warnings of loss business and tax revenue due to the ban. But at a recent gathering at a vulnerable old New York City Watering Hole the Old Town Bar of Union Square, Bloomberg share facts that borrow quite a different story since the ban went into a fact health officials estimate that 10,000 lives have been saved and reduce smoking rates in a dramatic reduction and exposure to secondhand smoke. And the restaurants and bar owner swept, they have apparently seen the light as well. The Mayor was flanked by Old Town's owner Gerard Meagher who was one of the band most vocal opponents at the time. Meagher compared his taverns receipts from before and after the ban and found his business actually increased by 20% turns out once the ban was in place in the perennial blue haze of smoke was gone people began to spend more on the restaurant food. Smoking bans are now come in place across the country, boarding well for the health of those working in bars and restaurants as well as the patrons. A municipal smoking ban that not only improves a health and wellbeing of workers and patrons but it has turn out to be good for the business bottom line as well. Now that's a bright idea.

(Music)

Margaret Flinter: This is conversations on Health Care I am Margaret Flinter.

Mark Masselli: And I am 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.