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Mark Masselli: This is Conversations on Health Care. I am Mark Masselli.

Margaret Flinter: And I am Margaret Flinter.

Mark Masselli: Well Margaret, we're just around the corner from that great time of year when kids are heading back to school of all ages. We're excited for them and wishing them best in the New Year.

Margaret Flinter: Well I cannot believe that once again summer has flown by. It seems to go faster every year but this is a great time to remind our listeners that this is the time of year to remember to schedule those back to school checkups, update your children's vaccines and immunizations and while you are at it, don't forget to update your own.

Mark Masselli: It's also started school for folks pursuing careers in medical professions. It's a good time to know that two new medical schools are opening around the country, one in our home state Quinnipiac University's new medical school is going to be focused in on primary care.

Margaret Flinter: Well we're excited about that and a shout out to them and congratulations on their big effort and this comes at a time when we're seeing that millions of Americans will be gaining access to health coverage under the Affordable Care Act and that means we're also acutely aware that we simply don't have enough primary care providers, nor enough in the pipeline. I think we're seeing a trend towards more medical students choosing careers in primary care that's a very good thing and it can happen soon enough.

Mark Masselli: And Margaret you know well because you are the founder of our Nurse Practitioner Residency Program. We have eight new residents coming in very shortly and we look forward to them joining in the movement to increase primary care all across America.

Margaret Flinter: And a shout out to those who are graduating this year, they are going to all corners of the country to serve as primary care providers and we're very excited for them. Now, our guest has done significant analysis on the need for a better national policy to direct resources towards filling that primary care need across the United States. Dr. Kavita Patel is an internist at Johns Hopkins and is the Managing Director of Delivery System Reform and Clinical Transformation at the Brookings Institution.

Mark Masselli: She's also a co-chair of the Bipartisan Policy Center's Health Professional Workforce Initiative. Dr. Patel will be discussing the reports which examine the need for better national planning strategies for projecting health care workforce needs in the future.

Margaret Flinter: She's a terrific guest Mark and we will also be hearing from Factcheck.org's Lori Robertson who we can always count on to be out there uncovering untruths about health reform in the public arena.

Mark Masselli: But no matter what the topic you can hear all of our shows by Googling CHC Radio and as always, if you have comments, email us at www.chcradio.com or find us on Facebook or Twitter because we would love to hear from you.

Margaret Flinter: Now we'll get to our interview with Dr. Patel in just a moment.

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

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Marianne O'Hare: I am Marianne O'Hare with these Healthcare Headlines. Electronic Health Records and meaningful use, the Healthcare Information and Management System Society is looking for more time. They've asked the Health and Human Services Secretary Katherine Sebelius for a six month extension for hospitals, physicians and other health care professionals, to be federal guidelines for stage two meaning use criteria for the federal electronic health record incentive payment program. Under the current rules providers who have met stage one requirements for two years must step up to stage two level requirements by the end of the year to remain compliant with the stimulus package money supporting the switch to EHRs. Healthcare information leaders asked the Feds to leave the stage two starting dates alone but to give providers 18 months instead of one year to achieve 90 days of stage two meaningful use compliance. The EHR Incentive Program has thus far paid out more than 15.5 billion dollars to over 4,000 hospitals and more than 305,000 physicians and other eligible professionals.

America's obesity rates holding steady but we're still fat. According to a recent study conducted by the Trust for America's Health and the Robert Wood Johnson Foundation, statistics have been released on the nation's obesity rates and it's been found that after three decades of steady increases rate held steady in the last year. The report if as in fact how obesity threatens America's future, it shows that obesity rates vary region by region with the south again leading the charge in obesity rates. Louisiana has knocked Mississippi out of the long held top spot with just under 35% obesity among adults in that state and they vary by ages well. The obesity rate for boomers in Alabama and Louisiana is over 40% and sadly this is one area where there is gender parity. Men have conned up to women and now have roughly equal obesity rates. There's also a direct correlation between income and obesity, the lower the education and income, the higher the obesity rates.

One rate has gone up dramatically over the past decade though. The numbers of morbidly obese with Body Mass Index is over 40% that number has risen by 350% since the beginning of 2000. The report issues guidelines for tackling the problem,

calorie labeling at restaurants, the report cautions more efforts are needed for obesity prevention that obesity related health cost stand poised to cripple the nation's economy.

Medical residencies, a gateway to practicing medicine through a gauntlet of sleep deprivation experiments. Well at least it used to be. A pair of recent studies looked at the impact of regulations restricting the number of hours first year residents could work at a stretch during their on the job training. Critics of the new model limiting their shifts to 16 hours warned they would negatively impact the flow of their training especially as it would limit interns' actual exposure to patient overtime. Researchers at UPenn and the Boston VA among others looked at mortality rates after the new restrictions were put in place limiting residents to 80 hour work weeks no more than 24 hours per shift. Mortality rates stayed relative flat the first three years then started to decline. Another study at Johns Hopkins looked at the breakdown of how interns spent their time with a limited hour restrictions access to and actual time with the patients did drop slightly but they also collaborated more away from the patient communication more through electronic devices suggesting they were keeping one another up to speed remotely. It suggests that well these students had less face time with patients. They increase their team approach to care by some 20%.

And speaking of sleep deprivations America's got an insomnia problem. A new study shows instead of knocking yourself out with drugs try running it out but you'll have to slog it out too. Study posted in the Journal of Clinical Sleep Medicine found that for those who added at least three to four days of intense 30 minute cardio improved their sleep each night by 45 minutes which is significant but the study found it took up to four month of that steady practice cardio for that sleep benefit to kick in.

I am Marianne O'Hare with these Healthcare Headlines.

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Mark Masselli: We're speaking today with Dr. Kavita Patel, Managing Director of Delivery System Reform and Clinical Transformation at the Engelberg Center for Health Care Reform at the Brookings Institution. Dr. Patel is also co-chair of the Bipartisan Policy Center's Health Professional Workforce Initiative and co-author of two just released reports, the Complexity of National Health Care Workforce Planning and Better Health Care Worker Demand Projections. She worked in the Obama Administration as well as a committee led by Senator Ted Kennedy in drafting of the Affordable Care Act. She's a practicing primary care physician at John Hopkins University. Dr. Patel welcome to the Conversations on Health Care.

Dr. Kavita Patel: Thank you so much for having me. Please call me Kavita.

Mark Masselli: Kavita, great. So we're just months away from the implementation of the Affordable Care Act in January 2014 and we'll see tens of millions of uninsured Americans added to the system. So tell us a little bit about why workforce projections are so complex in health care and why your reports are so important in helping us

understand why the lack of relevant health care workforce date is, obvious you'll equipped to meet the coming needs.

Dr. Kavita Patel: Let me just start by telling you that when we were surprised, it was sobering to myself that when you look for supply estimates just how many health care professionals they have in this country, you'll find such a variation from one stores to another and it's because of how we count health professional so in some cases physicians are counted only as primary care doctors and don't necessarily include the specialists and then in some cases nurses are people with just an RN but if you go to some of the nursing societies they also include people with RNs as well as other advanced degrees like PhDs and so there were such a wide variety of our estimates that we thought okay, we need to first do deeper dive and what are the sources of data, what are the differences sources of the data and then we can start to talk about how do we look at a model for what kind of health care workers we might need or for example the demand of health care and it was -- as I mentioned very sobering to try to understand all the differences between some of these numbers which made it even more complex.

Margaret Flinter: It seems to me Kavita that one of the challenges you have and I thought you made this point really compellingly and one of your reports is that we keep piling lots of new data on the top, when you've made the case we really have to change the underlying assumptions if we want to make use of the new data. Can you talk a talk a little bit more about that for our audience?

Dr. Kavita Patel: Sure. Let's just take a very basic example. A lot of our data assumptions about what kind of workforce we need are modeled on our current system or old systems of team patients in office visits and having always be a physicians who leads that office visit and we also have used other assumptions about how many doctors you need for a thousand patients and we've used that model for years in fact decades and in all -- in the meantime we since had all these models at Care Patients Center Medical Homes, Accountable Care Organizations, we've seen a great proliferation of community health workers, lay health workers the use of nurse practitioners and physicians assistance in practices. But our model and the way we think about how much care we need still hinges on this very cottage like industry with a doctor in charge. Those are the assumptions we use when we start to say, well there's a shortage and I think that, that's part of what we try to tackle was, wait a minute let's not just talk about how we might need one doctor for every, you know, 5,000 people in the country. Let's actually think about what kind of care do 5,000 people need, and then what are the skill sets of the various members of the healthcare team that best suit those needs, that's almost fourth in the equation and saying what is this that we want to get to and how do we work backwards to figure out what we need to fulfill that.

Mark Masselli: You know, you're seeing the fast rise of retail clinics, lot of different ways that people are delivering and caring. You really look at the distinction between patient demand and true healthcare need, how are these needs differing in the different social economic groups as well?

Dr. Kavita Patel: We really thought long and hard about how you deal with especially the needs of high risk populations, take for example the 11 million Medicare dual eligibles and Medicare and Medicaid dual eligibles for this country really high concentration of need. And one thing that we found is that in modeling our demand side, so we talked about so far a little bit and I kind of alluded to the demand that's where the information about some populations really comes to play. What we found was that instead of looking at those location or site of care, we really need to understand how could care delivery to special populations look differently we must agree on some standardize data reporting, and then -- and these means not just on supply side but we have to have some standardize reporting on the demand side especially for populations of special interest.

Margaret Flinter: One area seems to -- me from working at the state level anyway is, we don't have any uniformity across states in terms of the kind of data we collect. What's your approach as really a national research group looking at this, what's your approach to trying to get states to agree on how to collect data in common and electronically and what the critical elements of data are to collect?

Dr. Kavita Patel: So, this is a perfect question because we actually reached out to a National Governors Association who has been very interested in this exact issue. What are the minimums state data reporting requirements? And we canvassed across the state to try to understand what is it that they currently do and then who can we effectively give them some recommendations and they are actually more than willing to adopt a little bit more of standard approach. But, I was surprised people said look we are overwhelmed, we have no idea what to do about this, we want you to tell us what to do. So, what we actually did is we went back and then went to our federal colleagues in the Health Resources and Services Administration, which is tasked with doing some of these work and through the Affordable Care Act, we actually went back to them and said listen can you tell us what you're coming up with in terms of minimum data elements, and how you're recommending those be collected. And then we will take those back to the states and that's -- that's exactly the process that we're in right now, we're actually taking what HRSA has been doing and recommending and saying to the states, we're not telling you, you have to do this. Here's what the Federal Government is trying to, here is how we could recommend you do this, and the timing could not be better because they already updating their data collection infrastructure to meet the needs of the expanded Medicaid enrolment, and health insurance exchanges. So they're willing to do this, but they just need help, I mean these are really great people inside the state who are trying to do everything at the same time. So we found that it was best to pair the work going on at the federal level and say here's the minimum and Health IT plays a big role in this. We're trying to explore right now how to get the best, how we can try to understand some health workforce staffing information based on the Health IT systems that are currently deployed across the countries.

Mark Masselli: We're speaking today with Dr. Kavita Patel, Managing Director of the Delivery System Reform and Clinical Transformation at the Engelberg Center for Health

Care Reform at the Brookings Institution. Dr. Patel served in the Obama Administration as the Director of Policy for the Office of Intergovernmental Affairs and Public Engagement. So lot's of exciting opportunities arise out of the Affordable Care Act, it's created many new incentives and innovations in health care, it's also created some new challenges, you know what through for our listeners some of those challenges in how you think we might best meet them.

Dr. Kavita Patel: I do think that we are really at a precibus of how can we leverage the data that we have and then these emerging models of care. And, so one thing I would say that we walk through this as we're thinking about restructuring care differently, and we're thinking about trying to decrease the cost of health care and then we'll also looking our patients in the eyes and saying, you know what I'm going to try to make sure that I give you the best information in a small amount of time as possible, but I will also hope that you take that information and make better decisions from it. So I see this is like a narrative of a -- kind of a cycle -- life cycle, and then we also have to look at some of these emerging innovation models and say, what are we learning about the kinds of training, the skill sets, and the response from our patients. And then how do we see that back, I mean we have a massive infrastructure of education in our country and we don't talk about it a lot. We talk about health reform a lot, we don't talk about going in and opening up our classrooms and saying, wait a minute are we actually training the types of people that we actually want on the receiving end? And I would say to you there's a great disconnect there, so I see this as a great life cycle and a true biological sense. We need to cycle it back and I think that to me that's the narrative, not just the workforce study but the Bipartisan Policy Centers doing the work on cost containment, they're doing work on Health IT, those things have to marry together.

Margaret Flinter: You know the Affordable Care Act had a number of important provisions that have not yet come to past and I noted in your report, you addressed or you listed one of them which we actually authored around the demonstration grants for family and nurse practitioners training programs which are in there but not yet appropriated but -- funded but much larger than that really is the creation of the National Health Care Workforce Commission that would have address this need from more centralized data and I think probably would have gone at that connection between education, training not just the clinical care but to models of care and what's your expectation about what will happen with that National Health Care Workforce Commission?

Dr. Kavita Patel: If I start getting brought down and what Congress can and can't do I then just having worked on the inside, it can get pretty depressing. I am optimistic that all the things we're talking about and by the way I'm a fan of your program because I think you all do a great job of bringing this complex concept to people in a very kind of digestible way. I think everything you've been talking about for months now quite honestly is going to come to ahead when we've got headlines in 2014 that say, you know, in certain parts of the country it's hard to find a primary care doctor, etcetera, etcetera. And I think that will force the issue for people to say wait a minute we have this provision in health reform what happen to it, and then we're really talking about two

to three million dollars for the workforce commission to be funded. But in the big picture and the impact it could have it's a great investment, so I'm optimistic that in the next year we're going to see enough demand for the information that the commission will have. In the meantime though, we have got to figure out how to leverage the private sector and I know we say that a lot in health care, but I'm serious. We are seeing the big insurance companies, big integrated systems like guys in Kaiser we sees them come forward with their own creative data set solutions models of care and estimates. I think we need to go back to some of these leaders in the private sector and say listen, let's actually think about what the needs could be and what you can teach the rest of the country in terms of what you found and then actually let's take that out and show how states like Texas can think about Medicaid expansion and workforce models in a different way.

Mark Masselli: I really liked it when you took us back to that big picture looking at the triple aim of the Affordable Care Act to increase access improve outcomes and reduce cost. And questioning how they come back to the educational system. So there's other --

Dr. Kavita Patel: Great.

Mark Masselli: -- there are so many different models happening and I just really worry that the educational system in our leadership for that next generation of nurse practitioners, physician assistance, physicians, all the allied health providers just aren't ready for primetime and we are at a point of reinvention and redefinition of how primary care could operate in an optimal setting, what should we be looking out for rays of hope from you?

Dr. Kavita Patel: So let me tell you that I always look for rays of hope in a lot of different pair settings. So we often talk about, you know, Virginia Mason Group Health, Kaiser they're incapacitated settings, they've got kind of a lovely bubble around them so to -- so I look for things that could actually take advantage of really amazing care in a steeper service setting. Let me give you two examples in Medicare, one is a program in Florida called ChenMed they take care of pretty much a 100% Medicare patients and they do it in Florida, one of our costliest states and they do the following, they send out a town car to pick up patients and they do auto reminders for patients and they have elderly patients but we think the elderly don't use technology they do -- they got grandchildren that they talk to on Skype and Facebook more than I do. So they meet the needs of patients that generally cost the system a lot of money but they meet the needs by dealing with things that don't get reimburse by Medicare, but what they found is they can actually make money, meaning they're not losing money on this and they do this kind of wrap around in text reminders about preventive services that are due, and I think that, that's an amazing accomplishment in the Miami area.

The second one I'll tell you about is you may have heard of because he was profiled in one of the toggle and as I says Rushika Fernandopulle started Iora Health and they take what you're talking about a little bit mark with kind of the pot design. But they take the

hot spotters and design a clinic around hot spotters needs and they're doing this in Massachusetts and Atlantic City, New Jersey and they've just opened all in a Medicaid, Medicare setting mostly dual eligibles and they sat in looked at what hot spotter's needs are when they do come to clinic and they basically structured an entirely different flow of work to address those needs. And so I think that those are rays of hope because they're entrepreneurial, they're in our current system which in a larger way is somewhat broken financially but they're doing something and they're making it work financially. And what I hope is that I really want Rushika and ChenMed to give us the data on how they've understood the staffing needs for their health care and how we can actually go back to some of the top medical schools and nursing schools and Allied Health Workers Schools in the country and say how are we training people to engage in work in this environment.

Margaret Flinter: We've been speaking today with Dr. Kavita Patel Managing Director of Delivery System Reform in Clinical Transformation at the Engelberg Center for Health Care Reform at the Brookings Institution. Dr. Patel is also the co-chair of Bipartisan Policy Centers Health Professional Workforce Initiative and the co-author of two just released reports "The Complexities of National Health Care Workforce Planning and Better Health Care Worker Demand Projections". You can access these reports and learn more about her work by going to bipartisanplolicy.org. Dr. Patel, thank you so much for joining us today on Conversations on Health Care.

Dr. Kavita Patel: Thank you for having me.

(Music)

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 non partisan, non profit consumer advocate for voters that aim to reduce the level of deception in US politics. Lori, what have you got for us this week?

Lori Robertson: Well, Mark and Margaret we receive several questions from readers about online reports that claim the IRS said the cheapest health insurance plan for families under the Federal Health Care Law would cost $20,000. But that's not what the IRS said at all. Instead this number comes from a hypothetical example in an IRS document about how it would calculate the tax penalty for a family that doesn't obtain health insurance as required by the Affordable Care Act. The Treasury official told us that the $20,000 figure was quote not in estimate of premiums. Like many viral claims this figure was taken out of context and then embellish, the IRS wasn't estimating the cost of premiums at all, the fact is no one knows exactly how much insurance plan sold on state and federal run exchanges will cost. Back in January 2010 shortly before the law was passed, the Nonpartisan Congressional Budget Office estimated that the cheapest plan would cost between $12,000 and $12,500 for family policies. But CBO hasn't updated that estimate since.

CBO did say that about 80% of the 25 million people getting insurance on these exchanges by 2023 will receive federal subsidies to help cover the cost. And the average subsidy would be $8,290 for the year. For those who are interested the Kaiser Family Foundation has a subsidy calculator on its website that gives a sense of who is eligible for subsidies and how much those subsides might be. 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'd liked checked, email us at CHCradio.com we'll have FactCheck.org's Lori Robertson check it out for you here on Conversations on Health Care.

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Marianne O'Hare: I'm Marianne O'Hare with this tech report.

Imagine the future where any object you need even in organ or on layer of skin could be grown in front of your eyes in a 3D printer. The future, it's here. 3D printing is exactly what it says, three dimensional objects are produced via any number of materials in a mechanized back and forth, back and forth layering system. And through basic computer animated design, they program to build well, just about anything.

David Flanders: 3D printing will change everything and more to the point because it's physical reality I think it's especially going to change the way we think about money and also all the opportunities for making money from these objects.

Marianne O'Hare: It's become a hot topic at the world's many head thought gatherings and implications for health care could be limitless in their potential. At a recent TEDx event in Homburg Germany, 3D expert David Flanders shared what is already being tested in tissue growth using 3D printing technology.

David Flanders: There's already several universities in the States who are actually starting to be able to graph skin cells from you, cultivate those skin cells put them in a syringe type mechanism be able to put your hand down or other body part, lay the printer over the top and actually print a new layer of skin on you this is actually happening.

Marianne O'Hare: Since technology is already working hard in generating the growth of new organs to all kinds of biological means and thousands of people die each year waiting for organ donations. There could be a time but not too distant future where you could grow your own new liver in a 3D printer from your own cells.

David Flanders: And this is where I think this can really change lives full stop, is the fact that wait for us has already demonstrated the ability to actually cultivate your liver cells, cultivate those and then print you a new liver. And that doesn't mean you shouldn't stop

signing your organ donor cards, this technology is not fully capable yet but it's well on its way and it's starting to get there.

Marianne O'Hare: There are far reaching implications for building everything from a better implant of all medical device to exact specifications to a person's own body type chemistry and shape, better prosthetics design to fit perfectly the dimensions of one's owns specific injury or the foundation for growing new body parts like ears in a matter of hours. 3D printers are being created in desktops size unit, they could be built and assembled for a few $100, expect to see a lot more technological breakthroughs in medicine and it's exciting world of 3D printing. I'm Marianne O'Hare with this tech report.

(Music)

Mark Masselli: Each week conversations highlight's a bright idea about how to make wellness apart of our communities and to everyday lives. When Jennifer Staple Clark was a sophomore at Yale and the internship at the Ophthalmology office turn out to be a life transforming experience she realize that many of the patients who had limited access to medical care were coming into the office with serious eye conditions that had gone past the point of reversing leading to unnecessary blindness. What she launched from her dorm room 11 years ago was a local initiative to improve access to preventive eye care to the neediest population in her local community. Her vision quickly grew within two year she took her organization Unite for Sight worldwide and has since turned it into one of the leading providers of global eye care in hundreds of communities around the world. Unite for Sight bring social entrepreneurs, public health experts, local eye surgeons and volunteers together to bring eye care into some of the most underserved areas of the world. The motto at Unite for Sight is that local problems need local solutions, so they use each countries existing pools of ophthalmologist to treat their local patients, they also trained community health workers in each area they served, thus removing traditional barriers and also ensure in a continuum of care for all of the patients they served. The community health workers provide education and transportation to get doctors to the patient's communities and patients to the hospital as surgery is indicated. Since its inception Unite of Sight has served 1.4 million patients worldwide and restored eye sight to roughly 55,000 people. Restoring not only their sight but their dignity and ability to be productive members of their communities as well, identifying and pressing medical need and improving the quality of life by offering basic preventative eye care to those who had previously gone without. 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.