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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 are celebrating 50th anniversary this year.

Margaret Flinter: That's right Mark, it has been 50 years since the Surgeon General's first report on the harm of cigarette smoking and its direct link to lung cancer was revealed.

Mark Masselli: Well the Surgeon General's Report back in 1964 ultimately lead to sharp drop in the number of peoples smoking is still the leading cause of preventable deaths in this country just under a half of million people here die from smoking related illnesses.

Margaret Flinter: And it is interesting to know Mark that the numbers have declined more in recent years, thanks to the smoking bans now in place in most public spaces. New York City just celebrated 10 years of a public smoking ban and noted an estimated 10,000 lives have been saved in that city alone as a result.

Mark Masselli: As well as other states across the country have increased the taxes on cigarettes smoking. I think that maybe one of the reasons there has been a dramatic decline in the recent years to the number of young to middle aged adults being diagnosed with lung cancer. These are certainly preventative interventions that worked.

Margaret Flinter: We still have opposition, hard to believe, but the tobacco industry is still working on its business and a recent study showed that cigarette being manufacture today are actually made with more addictive levels of nicotine and as the Institute of Medicine's Dr. Harvey Fineberg recently told those greed is definitely one of the seven deadly sense when it comes to negative impacts on health. Our guest today is Dr. Rushika Fernandopulle, the founder and CEO of Iora Health, that's a Cambridge based start up, that's seeking to reinvent primary care from the ground up.

Mark Masselli: He has been loaded by several noted health care industry analysts 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.

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

Margaret Flinter: Now, we will get to our interview with Rushika Fernandopulle in just a moment.

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 Health Care Headlines. There is a doc fix in the mix. So rare bi-parties in agreement has been reached in committees and both the house and senate that would permanently do away with the SGR formula which controls the reimbursement for a doctor's treating Medicare patients but there is a rub finding the funds necessary to repeal the so called doc fix SGR formula that was put in place in 1997 and install a new system which would guarantee doc reimbursements of half a percent per year for five years allowing for the time it will take as Medicare transitions to a payment system designed to reward physician based on the quality of care provided rather than the quantity. For more than a decade, Congress has struggled to find a permanent solution to the SGR, but it's ended up passing temporary patches and punting the issue to the next following year. American Medical Association president Ardis Hoven urged law makers to take action before the current SGR patch expires April 1st. Doctors face a 24% cut in their Medicare reimbursements if congress doesn't change current policy as they have every year for the past several. Meanwhile back in the states, they are still working out kings in the exchanges. Massachusetts has brought in a top gun from blue cross to fix the problems plugging their exchange which launched October 1st. Oregon, Maryland and Minnesota are also experiencing ongoing growing pains with their exchanges. Meanwhile, [inaudible 00:03:45] law makers have reached across the aisle to find agreement on Medicaid expansion in that state which is fully funded by the federal government for the first three years. Meanwhile, a study shows that more than any other social program, the affordable care act is poised to give the bottom fifth of the economic pool in the United States, their first real economic boost by some 6%. While the upper middle class will likely shoulder a bit more of that burden and CVS is earning kudos for a recently made policy adjustment. The nation's largest pharmacy chain will stop selling cigarettes entirely by October of this year. The company leadership is saying they couldn't reconcile their quest to promote better health with a knowledge that cigarettes are the leading cause of preventable death and disease in this country. I am Marianne O'Hare with these Health Care Headlines.

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Mark Masselli: We are speaking today with Dr. Rushika Fernandopulle, co-founder and CEO of Iora Health, an innovative Cambridge based startup that is seeking to transform health care 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 in Dr. Atul Gawande's New Yorker article hotspotter. Dr. Fernandopulle is on the faculty at Harvard Medical School where he received his MD. Dr. Fernandopulle, welcome to Conversations on Health Care.

Dr. Rushika Fernandopulle: Thank you very much.

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

Dr. Rushika Fernandopulle: The gap between what we pay for health care and the quality of the services we receive in this country is I think probably the biggest business problem that faces us. We spend an [inaudible 00:06:00] amount of money on health care. It's 17% or 18% of our GDP. It's $2.5 trillion. It is bankrupting individuals and bankrupting companies who had competed internationally and it's bankrupting the country. If you look at federal budget that fits over the next 50 years, they are really all being driven my Medicare and Medicaid going up and we have to get a handle on health care spending. You know, we are spending so much but yet the quality we get is awful. Anyone who is trying to get health care, knows that's it's depersonalized, it's fragmented, it's reactive, and the outcomes are embarrassingly poor. A 30-day readmission wait for Medicare is 21%, you know, defect rate like that would be a cause for huge alignment in any other industry. We think primary care is a right place to start. If you want to fix health care, you have got to fix practices. And the bulk of the challenge in health care today is chronic disease. It's diabetes, hypertension, lung disease and I think the movement toward medical homes and accountable care when everyone else is trying to tweak existing primary care practices, if existing practices make them a little better by changing a little thing here, giving them a computer but by and large leaving the [inaudible 00:07:08] same. And our proposition has 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 they can really deliver in a very different way.

Margaret Flinter: Tell us about that model, how [inaudible 00:07:26] threw out all the rules and started all over again, what did you built?

Dr. Rushika Fernandopulle: The first part of the model is really changing the payments model. So, the way we pay most doctors in this country and virtually all primary care doctors is what we call fee for service, we get paid per sick visit. Do you come to see me the doctor, I do whatever, I do a diagnostic, give you a treatment, I then sign a code, it's been called CPT code, very arcade and set of rules, we get paid per doctor's sick visit. Guess what happens? We got lots of doctor's sick visits and we don't at all focus on actually improving people's health. Primary care is really about a continuous healing relationship. The way for pay for a relationship is like a gym membership. There is a fixed amount per month to just allow us to figure on how they care people. And number two is primary care in the US is typically about 4% of the health care dollar, that means that 96% of what I call failure primary care, you end up in the hospital or the emergency room, so what we say if we should double down on primary care, we should put at least double the resources into it and 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 that takes to manage their health and we concept of a health coach which is someone from the community, someone with good interpersonal skills, who can really help patients 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 [inaudible 00:08:54] shared chair plan or we make a plan of how we are 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, not just visits. We should be able to interact by email, by text message, by video chat and we do all of those things. Lot of our interactions are improved. So people with diabetes, we have a diabetes club and a Yoga group, ways to engage people as the patients can engage each other. We integrate mental health into the practice because a lot of the barriers getting good health care 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 you start doing a completely different care delivery what I call population management, you realize that the IT assistance we have in typical health care, completely wrong. Despite all the, you know, who had about electronic medical records but they really are fancy billing systems to allow doctors to code document and bill higher. It doesn't improve care at all and we realize we need a different sort of IT system to help us actually manage population, engage patients in their care and so that we build better self.

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

Dr. Rushika Fernandopulle: Yeah, you are exactly right. The constraint on our growth at the moment is finding, what I called sponsors, which are people who are on the hook for health care spending, who are willing to pay as differently. Now, you and I think that the way we are doing it now doesn't work. So we should be trying all sorts of things. But as you know, change is hard for many folks. We have had the [inaudible 00:10:52] signing up with either large ensured employers like the Boeing company and like Dartmouth College. We have a practice at Hanover, New Hampshire as well as union trusts. So in many places apart from the country, the union trusts who has been delegated, the authority doesn't provide health benefits. So, in Las Vegas, we worked with the casino worker union and worked with a group called the freelancers union in New York in Brooklyn. Now, I think what's going to make this work and get this to big scale is what happening in health reform, which is really patients, more and more buying health care themselves. As you know, with these exchanges coming on board and with changes in employers, many employers are likely over the next five or so years to stop providing insurance to folks. Many employers are going to such things [inaudible 00:11:38] that's providing you health insurance, we are going to give you, you know, "X" thousand dollars a year, go buy yourself a health plan. So now all of a sudden, consumers are able to go and purchase a product and again I think what we are doing in New York is we are

bundling our practice with the health plan together at one offering and that's something the consumers very much like.

Margaret Flinter: But I wonder Dr. Fernandopulle if you could tassel 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 were using an awful lot of care in the emergency rooms, so tell us about the people you put on that primary care team? How did you engage those patients and their care?

Dr. Rushika Fernandopulle: You hit the nail right on the head. The most important thing we need to do is engage patients. We are then able to sort of help them manage and help better change behavior, etc. That's where a health coach is come in and a quick story, we had a patient in Atlantic City and her name was Joyce and she came into the practice completely out of control, her diabetes is out of control and her blood pressure is out of control, she was in and out of the emergency room, sort of disheveled looking, came into the practice and then six month later I saw her and she looked amazing. Her hair was combed, diabetes and hypertension 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, Millie, 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. All this other stuff we are doing call to mediate that relationship between the patient, the doctor and the health coach to engage people in their care, so they start paying attention and start making changes and that's why the team is so important. I think there is too much focus has been on the doctor. The doctor is, what I call, the system architect but a lot of the impact is actually not by the doctors, it's by the other folks on the team.

Mark Masselli: We are speaking today with Dr. Rushika Fernandopulle, co-founder and CEO of an innovate Cambridge based start up that is seeking to transform health care delivery in this country. So talk to us a little bit about the IT systems that you have developed?

Dr. Rushika Fernandopulle: So we have built our system from the ground up like we built our practice from the ground up in order to mediate sort of better care. So, it's built around actually, tracking the things that we think we are to track for each patient to maximize their health. If you are diabetic, we have a team called markers and there are a number of markers could be tracking your hemoglobin A1c, your blood pressure, your LDL, whether you had a foot exam. We program all those things and we track how you are doing. We call the care collaboration platform and it allows everyone on the team including the patient to see the record and interact with it and actually even put information into it. So what we do is, we have task list associated 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 to use that patient's had an A1c that is overdue, it puts a task on the health coach's task list to get a hold of the patient and [inaudible 00:14:41] A1c checked. Similarly, if we prescribe a medicine, we get a feed from the pharmacy benefit manager and we look to see for a fill. We get data from everywhere. We get census data from the hospital and from the market so we know when a patient is in the hospital or in the

ER and patients can input in data from you know their blood pressure or their glucometer or when things go off the rails, we then can reach out and figure out what happened. We offer to create some very elaborative dashboard so we pull 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 in the hospital, in the ER and go to specialists and get imaging test. So, we can now create these 360 degree dashboards, so we can see how are these patients doing, how is each health coach doing with their patients, and how is each practice doing. It's in the cloud, it's rub on rails, [inaudible 00:15:31] actual development where every two weeks, we have a new release and so as we figure out their 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 hats on for just a moment and obviously cost containment is a holy grill, maybe tell us a little bit about that and then I wanted to just follow up for a minute on primary care providers to patients ratio, so maybe first on cost.

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

Margaret Flinter: And if I can just ask you a quick followup question to that again from a policy perspective, what is your sense of the impact of your modeling your primary care teams? How many patients can they manage? Is that a question you have even tried to tack up?

Dr. Rushika Fernandopulle: So the game, it should not be the squeeze primary care as much as possible, right. Primary care is 4% of the health care dollar, so if the right thing to do is spend more in primary care, we should be doing that. I think what the conscious practice to do is 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. [inaudible 00:17:13] what are the things that the doctor should do because that's we are trained to do and what are the things you don't need a doctor to do and then I think engaging patients and cracking things and it's actually better done by someone else. So, we actually think that we will eventually have doctors who can take care of more patient than doctors do now, again leverage by team. So to be clear, in our practices for every doctor, we have four health couches plus an admin person plus a mental health person, that's a big team, known physicians who really can help with this. I think part of the reason people aren't going to primary care, it's not just money which everyone focuses on, primary care doctor get paid about half as much as many specialists do. It really that the job simply sucks. I had a colleague who once said, you know, every day I lose a little piece of my soul because I went into this

thinking that I'll be able to take good care of my patients, I am just not able and I think what we are trying to do is provide settings where doctors can take great care of their patients and we have no problem attracting great doctors working in our practices and our doctors are incredibly happy. So I think if we do that, we create a differentiation of our primary cares, we will have no problem attracting as many people as we want going into primary care.

Mark Masselli: Dr. Fernandopulle what you see in terms of innovations that our listeners at conversation should be keeping an eye on?

Dr. Rushika 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 these communities [inaudible 00:18:40] essentially helping each other, better manage their health and I think allowing patient to do lot more self service than we do in typical practices is really interesting.

Margaret Flinter: We have been speaking today with Dr. Rushika Fernandopulle, founder and CEO of Iora Health, a groundbreaking healthcare company that seeking to transform health care delivery by improving patient outcomes and dramatically reducing costs in the process. You can learn more about the work that he does by going to www.iorahealth.com. Thank you so much for joining us on Conversations on Health Care today.

Dr. Rushika Fernandopulle: Thank you very much.

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

Lori Robertson: Well, the Congressional Budget Office released a new report on the care act's impact on jobs and we quickly saw politicians distorting what the CBO said. House majority leader, Eric Cantor, claims in Twitter messages that the report confirms what Republicans have been saying for years and that millions of hard working Americans will lose their jobs. Actually, the CBO said that more than 2 million people will decide to not work or decide to work fewer hours because of the law, not that they would "lose their jobs." The report estimated a reduction in fulltime employment of about 2.3 million by 2021 and said that's almost entirely due to a drop in the amount of labor that workers choose to supply. CBO released a similar analysis back in August 2010, but the estimated reduction in employment was much lower, the equivalent of around 800,000 jobs. So, why would folks decide to work less, CBO explain that the subsidies and Medicaid coverage in the law effectively give people more financial resources. Also, those nearing retirement will retire earlier because the law offers protections for health insurance limiting price increases for older people and guaranteeing coverage of preexisting conditions. In other words, older Americans don't have to hold onto a job just for the insurance.

The report does provide [inaudible 00:21:02] for republic and to criticize the law for providing these incentive to work. CBO says that the sliding scale of insurance subsidies will prompt some do not work or work less in order to avoid losing out on the subsidies, but it's a distortion to claim a CBO report on workers choosing to work less is the same as workers losing their jobs and that 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 www.chcradio.com, we will have FactCheck.org's Lori Robertson check it out for you here on Conversations on Health Care.

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Margaret Flinter: Each week Conversations highlights a bright idea about how to make wellness a part of our communities and everyday lives. Smoking continues to be the number one preventable close a premature death in this country leading to over 440,000 deaths per year and while quitting remains a challenge to most smokers, the tobacco industry continues to spend billions of dollars on promotion and lobbying. A new study released by the international tobacco control policy evaluation project shows that putting graphic warning labels on the outside of cigarette packs leads to significant reduction in the number of smokers.

In the late 90s, there was a concerted effort to really put the graphic images of what it's really like to get a smoking related disease onto warning labels on cigarette packs.

Dr. Jeffrey Fong of the University of Waterloo in Canada conducted the study analyzing Canada smoking cessation rates some near 2000 when Canada began ordering that a third of the cigarette pack be reserved for graphic images of disease hearts and blackened lungs through 2009. The data showed a mark decrease in the number of smokers during that time attributed largely to the presence of the graphic images in conjunction with strict smoking laws.

We examined the period of time in Canada, nine years before the graphic warning labels came out at the end of 2000 and then compared it to the nine years afterwards and what we found was there was a sharp decline in the smoking rate after the warning labels compared to before and we compared it to that same period of time in the United States were there was no change in warning labels and it showed that the decline in smoking rates after the warning labels in Canada were much greater than for that same period of time in the United States.

Fong and his colleague estimate that a similar program in the US would lead to a dramatic reduction in the number of smokers here as has been shown in Canada and other countries around the world who have initiated a similar practice.

The relative reduction was between 12% and 20%. So if you take the smoking rates in the United States in 2012, the smoking rates were 23% and so if you reduce that

percentage by 12% and 20%, you get between 5.3 and 8.6 million fewer smokers in United States if they were to apply graphic warning labels.

Placing graphic images of body parts that have been damaged and diseased by smoking providing a visual determent to regular smokers and the graphic visual warranty young people considering smoking something that could potentially lead a millions of Americans quitting and very likely prolonging their lives, now that's a bright idea.

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 www.wesufm.org and brought to you by the Community Health Center.