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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 starting to see some breakdown of the number of folks who are newly insured under the affordable care act, report by the Urban Institutes Health Reform Monitoring Service showed that by March 7th of this year 5.4 million Americans who had previously been on insured gain coverage.

Margaret Flinter: Well, Mark what this report shows it so important is how many uninsured Americans have now got on coverage under this.

Mark Masselli: And it's important to know that the Medicaid expansion had an effect on the uninsured rate, not surprisingly those state that choose to expand Medicaid saw their uninsured rate drop dramatically during the open enrollment period, about 4% where state who didn't expand Medicaid also saw 1.5% drop in the number of uninsured.

Margaret Flinter: Those are the states that still have a relatively high rate of uninsured residence as a result of failing to expand Medicaid over 18% on average, and that is just a shame for those little income folks who will still have a difficult time navigating and getting access to health care.

Mark Masselli: In those states that expanded Medicaid, the uninsured rate dropped down to 12.4%, so, a real significant difference in those communities.

Margaret Flinter: The Urban Institute report really provides an interesting snapshot of the national break down of the health care laws beneficiaries, and how difficult the experience has been for Americans based just on where they live in the country.

Mark Masselli: So, the wrap-up numbers say and still counting 7.1 million Americans who gain coverage on the insurance exchanges and more than 3 million Americans gain coverage through Medicaid expansion. Anyone who qualifies for Medicaid can sign up through the year.

Margaret Flinter: All and all, more than 10 million Americans are now covered, and that is a very empowering thing.

Mark Masselli: Our guest today is seeking to empower hospitals and their quest to create some kind of interoperability among their medical devices, many of which come from multiple stakeholders and are not designed to communicate easily with other systems feeding into the electronic medical records.

Margaret Flinter: Ed Cantwell is the executive director of the center for medical interoperability and has an extensive background in developing efficient telecommunication systems and he has a very interesting perspective on how this all might work better.

Mark Masselli: We get another visit from Lori Robertson, managing editor of fact check.org.

Margaret Flinter: But no matter what the topic you can hear all of our shows by going to CHC Radio.

Mark Masselli: And as always if you have comments please email us at CHC Radio.Com or find us on Facebook or Twitter, because we'd love hearing from you.

Margaret Flinter: We'll get to your interview with Ed Cantwell, 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 Marianne O'Hare with these Health Care headlines. Advantage -- Medicare Advantage, under enormous pressure from insurance industry lobby ascend those representing seniors in the medical profession. The centers for Medicare and Medicaid services announced there will not be drop in Medicare Advantage plans payments as originally planned under the Affordable Care Act. Instead payments are scheduled to go up about 1%. Proposed cuts to Medicare Advantage plans which serve 16 million seniors about 30% of all Medicare beneficiaries. Then government subsidizes the coverage, and insurers generally offer dozens of different plans in every market. Initially the health care law sought to reduce funding for Medicare Advantage by $150 billion over 10 years, launching one of the biggest lobbying campaigns ever from the insurance industry. Big insures see tidy profits from these plans, and government pays a higher premium to practitioners, than reimbursements they provide for traditional Medicare. The American Medical Association has decided not to go to court over the CMS decision to release medical billing information for close to 900,000 physicians, though it's still strongly opposes the measure. The Medicare claims database has been off limits to the public for decades, blocked in the Courts by physician groups who argue its release will do more harm than good. Media organizations and consumer groups interested in physician quality have been pressing the government to open up those files. Last week the Obama Administration announced, it would do so. Drug overdoses now kill more adults than car accidents about 16,000 per year. And the worst culprit other than heroin or opioids' and prescription drug abuse. The Food and Drug Administration approved the long awaited emergency drug overdose treatment that family or community members can easily use to treat someone who is overdosed. The device is called the SvO a pocket sized auto injector filled with the opioid antidote naloxone. It's approval is a boon for drug

advocates who've longed sought faster response options for drug over overdoses. Naloxone is already the standard treatment for overdose, but existing versions of the drug have to be administered via syringe, and generally only employed by trained medical professionals. I'm Marianne O'Hare with these health care headlines.

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Mark Masselli: We're speaking today with Ed Cantwell, executive director of the Center for Medical Interoperability, which was launched by Garry and Mary West Foundation, West Health Institute. The center's purpose to optimize patient care by advancing the safety quality and affordability by serving as a focal point for hospitals and health systems to drive rapid widespread interoperability of medical technologies. Mr. Cantwell is considered a pioneer in the global in-building wireless space, and former director of 3M Corporation's wireless business unit. Mr. Cantwell helped spent 12 years as a fighter pilot flying F15. Mr. Cantwell graduated from the University of Michigan's Executive Training Program. He holds a Bachelor of Science Degree and Mechanical Engineering from Duke. Mr. Cantwell we're happy that you're here with us on Conversations on Health Care.

Ed Cantwell: Oh, thank for the opportunity to speak with you.

Mark Masselli: And at the West Health Institute, and the institute determine that the lack of interoperability between the electronic devices operating within a health care setting waste about $30 billion per year. You just recently put out a white paper that there are relatively few hospitals, it always surprising across the country that have got interoperability right. So, maybe for our listeners could be lay the scope of the problem out force and to find interoperability if, you will and what are the biggest challenges in making these devices talk to each other?

Ed Cantwell: Well the best definition of interoperability is ability for health information to be seamlessly shared across medical devices, in enterprise system for the purpose of optimizing health care. And it's not so much that hospitals and health systems have not gotten it right. It's more that hospitals and health systems had not had the opportunity to embrace interoperability, because of the lack of standard based technical platforms and architectures that would allow it. You know, what I love about the mission of the center is at its core its patient centered. We are the unit economic of health care, the patient. And if you think about the continuing of patient data-flow whether you are at home, whether you are at work, you want your data to flow from device to system to electronic medical record to health information exchange. So, that care is optimized and safety is the number one priority. I think everybody understands that our US health care system we've allow and ecosystem that has limited adoption of standards, which has led to pervasively proprietary ecosystem where equipment is the proprietary and data is held hostage to those proprietary systems. We have a dilemma of the impracticality of government mandates. But what was evident to us in our study is that, in event interoperability is achieved the hospital and health systems will be the biggest

beneficiary. So, that is why we're trying to rally them to step up to -- not only creating the demand for interoperability, but backing with the procurement of the equipment.

Margaret Flinter: Well, Ed you've flown fighter planes in your career system that requires a tremendous amount of interoperability and its fairly life or death. And our health care system of course is so hard to change as an entire system across the country, I wonder when you think about the changes that are needed to bring about this interoperability, where does it come from? But I think or where we were 12 years ago when the Offices of The National Coordinator took on the challenge of moving providers not so much the hospitals even but providers in practice from paper records to electronic health records. And you could see where an entire system across the country began to move forward. What are your analogous changes to bring about the interoperability that we need in healthcare?

Ed Cantwell: Well, I'll use my military flying days to -- is a very simple analogy. The U.S Air Force or the U.S Navy did not leave it up to the vendors on what kind of air plane to deliver, or what kind of ships to buy. There was a fulltime dedicated resource within the services. To define exactly why fighter or what ship was needed? So, that's a very analogous to health care. And then when then competition actually occurred, that was a very scripted way to test and certify that you actually made the requirements. So, there's been so much work done over the last 10 years by the government. We feel it's now time for the leaders of our hospitals and health system, which have the responsibility to deliver care, to take a more proactive role in creating and driving medical interoperability. So, if you look at critical infrastructure. Whether it's electricity or whether it's the telephone industry, virtually all other critical infrastructures have achieve the point of which there's an agreed upon master architecture that is based on standards and it has a proven path to show compliance of those requirements. So, imagine if electricity did not have that ability was health care transitions from a tethered health care environment to un-tethered, we need that same type of discipline.

Mark Masselli: I always thought that HL7 was sort of part of that platform to make things interoperability. It still doesn't seem like we've gotten the type of results that we want. You talked about the military and the sort of the alignment that they have with what they're trying to do, and we seemed to have missed that across the board. We've done a show on La Carte Vitale in France, where they simply sort of spect out here's what we're going have for EMR's and – but, I do want to talk a little bit about the work that you've done also on wireless system. You've developed a hospital wireless system, tell us how that functions? And how does it work differently than others?

Ed Cantwell: Well the use of wireless in a hospital environment is the most complex and life critical of any wireless environment on the planet. If you think about a hospital, it has three main use of the wireless, use by the consumer, the enterprise of health care has to use wireless to run their enterprise, and then we are seeing the explosion of medical devices that want to untether, you know, from the law that have a medical radius. So, as a young entrepreneur, I was just amazed that there was no established infrastructure specification for how do you employ wireless inside of that environment.

So, imagine if you will, what if there were no plumbing standards or electrical standards that a hospital owner could rely on to make sure that the vendors deliver the platform network with assurance. So, in the last three years when Gary and Mary established the institute, you know, I was a very vocal advocate, that health care needed to stand up and make wireless and medical grade utility. So, that the power of wireless across consumer enterprise and medical uses could be fully exploited. And the neat thing is when you do that you can master wireless in the hospital, then you more likely to trust it out of hospital on the way to your home. And then inside your home you're watching wireless absolutely transform the way we live and, that power needs to be applied to health care. So, let's get the people that can define it and embrace it that will eventually procure it, and let's drive it to become the next base building standard like electricity. And if that could be done, you are the so much of the risk, you improve safety, and you allow innovation to flourish.

Margaret Flinter: And somebody has to watch you. And obviously you've brought some of those folks together at the institute. But, you know, I can't help thinking that we're only a week out from another little foray in health care down a dead-end, which was the conversion to the ICD-10. Which was we have to do it, if the rest of the world has done it. We're absolutely doing it. There will be delays and then we kicked the can down the road for another year. What's the driving urgency at the institute? And maybe you could share that who is coming together at the institute who wants to embrace it?

Ed Cantwell: So, to be precise within the West Health Institute to the last three years we'd studied the macro level problem. It's a political problem, it's an ecosystem problem. And because of the generosity of Gary and Mary West who really challenged us to go after something big. So, from an interoperability point of view, we felt like if a force could be established to really champion interoperability that would have the greatest impact per a $30 billion per year potential savings. So, when the Center for Medical Interoperability was conceived, it wasn't conceived as a West Health Institute activity, but this has to be and will be a separate non-profit entity whose members are the hospitals and health system executives, so that the industry itself like all other industries steps up and takes control of it. The cable industry did this about 30 years ago, and they have taken their industry through waves of innovation, and it's a very financial excel model. So, like the military forces if they don't demand it via procurement the free market won't delivere.

Mark Masselli: We are speaking today with Ed Cantwell, executive director of the Center for Medical Interoperability. Give us a little more global sort of look. Are there are care delivery systems around the world that are better integrated, because they have a national health systems or they have the alignments that you're talking about and are they emerging in third-world markets, poised to sort of leapfrog over us?

Ed Cantwell: Well, certainly interoperability is a global issue. Business models and regulatory environments are different all over the world. Also cultures are different in the way decisions are made. And obviously more centralized governments, you know, we have the wonderful engineers from HS who just, you know, look at this and say why

didn't the government just mandate it. But we also know that we don't want to throttle innovation. So, I am not sure that any country has aced interoperability, even the new ones that aren't hamstrung by legacy problem, perhaps that the US has, and can start anew. Find themselves where they could produce a very connected pervasively wireless environment, but unless the devices allow the data to flow from the device to the HR, then all that connectivity really is for knot. So, I believe it's a global problem. But like the global telecom industry, it takes the global industry overtime to come together so that we can, you know, if you land in London and you have a medical emergency, it's your data flows right there with you. So, we will focus pervasively on solving the US's problem, and then certainly we'll learn from other countries, and share what we learned with others.

Margaret Flinter: Well, back in the US for solving our national permit, wonder if you just opine for us on the role of the policy and regulations here in the country with regard to this area. That we had a guest from FDA, or our guest speaking about the FDA recently with their new roles governing Apps, which have exploded into the tens of thousands of medical health care related Apps and tracking devices. Have you engaged those policy folks with your work at the institute? And what do you see is some of the key sort of regulatory policy areas that are going to be developing over the next couple of years?

Ed Cantwell: We certainly have engaged across the board the regulatory agencies, because we know that they are critical to the success of interoperability. You know the pace of changing complexities inherent to health care technology, and to the challenge of developing those same policies and regulations, and striking the right balance between protecting patient's safety, and fostering innovation will remain essential. Remember the mission of the FDA is do no harm. It's not to do innovations. So, we have to struggle in the unique relationship with the FCC and the FDA as it relates to use of wireless, is really an emerging industry. We need to purchase that focus on of learning health care system, where timely feedback mechanisms shared responsibility. So, we're a big believer that it's going to take the .gov's, the.com, and the .org's working together to optimize our health care system. We also know that a care structure in the US contributes to it, because most people really don't know what anything costs, because of the lack of transparency. We now mal practice reforms credentialing are also big buckets. So, in the formation of the Centre for Medical Interoperability we spent a good two years with the regulatory agency's understanding what role could the centre play, so that the government could play its role. If instantaneously Congress mandated interoperability, there would be no way to test and certify to it. So, it really takes the ecosystem coming together, the government playing their role, and the vendors playing their role and achieving it.

Mark Masselli: We have been speaking to say with Ed Cantwell, executive director of the Center for Medical Interoperability. You can learn more about their work by going to medical Interoperability.org. Ed thank you so much for joining us on Conversations on Health Care today.

Ed Cantwell: Thank you.

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Mark Masselli: At Conversations on Health Care we want our audience to be truly in know when it comes to the facts about health care reform and policy. Lori Robertson is an award winning journalist and managing editor of Fact Check.org a non-partisan, 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, we spotted a false attack in West Virginia, in an Ad '**The Clean's[PH]** Republican Evan Jenkins, "Vow to repeal black lung benefits". Jenkins didn't do that. Instead he vowed to repeal the Affordable Care Act. Repealing the ACA would make it more difficult for some minors and surviving spouses to prove eligibility to the eligibility for the Federal Black Lung Benefits program. But it won't repeal the benefits. Those were created under a separate law. The Ad comes from the House of Majority pack, a super pack dedicated to returning the democrats to power in the House. We could find no record of Jenkins ever saying, he would repeal black lung benefits, as a they Ad claims. A spokesman for the pack argues that Jenkins support for repealing the ACA is the equivalent of support for repealing black lung benefits. We disagree. If the Black Lung Benefits Act that provides monthly payments and medical benefit to minors found to be totally disabled from black lung diseases caused by working in or at coal mines. Repealing the ACA wouldn't change those payments. However, the ACA included two Byrd amendments, named after the former Democratic Senator, West Virginia that made it easier from mines and surviving spouse's to get benefits. The amendments shifted the burden of proof in some cases from the miners to the mining company, and ended a practice of requiring a widow to re-apply for survivor benefits after her husband died. But the Ad leaves viewers with a false impression that Jenkins would abolish all black lung benefits, that's not true. And that's my Fact Check for this week. I'm Lori Robertson, managing editor of Fact Check.Org.

Margaret Flinter: Fact Chek.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 CHC Radio.Com, we'll have Fact Check.Org's Lori Robertson to 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 well a part of our communities and everyday lives. When Chef Carl Guggenmos grew up as a kid and post-was Germany, he lived on a diet of organic and locally ground foods. Now, he's the Dean of Culinary Arts Program at Johnson & Wales University in Rhode Island. And he realized that he has responsibility to teach the next generation of chefs how vital natural and simple ingredients are, not just to creating good food, but to the health of the population as well. He watched the obesity epidemic take hold in this country, and decided to use his platform to create a new approach to chef-training. He

teamed up with a Professor Medicine at Tulane University of Medical School in New Orleans. And together they created what they believe is the first course in culinary medicine in the United States, teaching chefs and forth year medical students, how to understand the synergy between healthy eating, good food, and good health.

Carl Guggenmos: We just created this program where our students are actually going to Tulane Medical School for an internship, and they work side by side with medical students and physicians using an evidenced based approached to this whole idea of culinary medicine rather than anecdotal.

Margaret Flinter: So, in addition to learning knife skills, sauté and poaching techniques, fourth year medical students are giving a lesson in food parings, learning which foods are most poised to foster good health and to combat obesity.

Carl Guggenmos: The medical students, they have their own class work that we help them develop. And they identify ingredients as to their relationship to health. They then start basic introduction to cooking from knife skills to basically how to sauté, how to poach the roast, and then they do recipe conversions, and then have to do research. And our students are their helping in to engage, working, writing articles being part of this whole program, working side by side with the medical students and learning and exchanging information and techniques for each other. The results and the responses are incredible. We are hoping to continue that Dr. Harlan and I'd been out speaking about this as a joint -- this collaboration between the chef and a physician is really unique and it's one of its kind, and I think it's the first around the world, and we are getting more and more interaction about this.

Margaret Flinter: He strongly believes in the idea that chefs will be the pharmacist of the future. A Dean of a reputable culinary program teaming up with a medical school to train future doctors, armed with the skills and information to assist their patients in healthier eating, fostering the development of health conscious chefs who are trained to feed the next generation well with foods that can prevents obesity. 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 am Mark Masselli, peace and health.

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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 Centre.

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