(Music)

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

Margaret Flinter: And I am Margaret Flinter.

Mark Masselli: Well Margaret the numbers have been enrolled that Americans continue to climb. The administration announced that over 8 million Americans have signed out for coverage of their insurance exchanges.

Margaret Flinter: And there is another estimate Mark, that about 8 million Americans signed up for coverage with private insurers, and of these enrollees it's believed that about five-and-a-half million were previously uninsured, lot of new customers.

Mark Masselli: But there were millions of Americans who are now covered as well under the expanded Medicaid program. In 25 states that chose to expand it. However, in states like Virginia and Florida, there are louder drum beats tardying the merits of expanded coverage for those living near poverty. It's becoming a more consistent theme and more red States who refused to consider the Medicare expansion.

Margaret Flinter: Well as our listeners might remember Mark, we have been predicting that among others, the health care industry professionals in these States would be exerting pressure on the politicians to tap into the billions of health care dollars that are available to treat this uncovered population. That's real money and it's being left on the table by those States that refuse to expand Medicaid.

Mark Masselli: On another note Margaret we are marking something of a milestone this year. It was 30 years ago this month that a press conference was held announcing the virus that was believed to be causing this new epidemic 'AIDS', were far from a cure on this epidemic.

Margaret Flinter: There is a powerful article in Time Magazine featuring Dr. Robert Gallo who figures so prominently in the discovery of the virus and the initiation of treatment back in 1984. And you know he remains skeptical 30 years later that we will zero in our cure anytime soon.

Mark Masselli: HIV positive folks are living longer with the advancement of better drugs, Margaret. But the rate of new infections continues to pose a great global health challenge. Prevention and testing are the best weapons at the moment and will continue to be so.

Margaret Flinter: And the best hope according to Dr. Gallo remains a workable vaccine but we are nowhere there yet.

Mark Masselli: This scourge has a great impact on the economically challenged in greater numbers, and in minority populations as well.

Margaret Flinter: And minority populations -- are population that our guest today is very focused on. Dr. Chileshe Nkonde Price is a cardiologist at UPENN. She has developed a digital platform to assist African-Americans in tackling their higher rates of cardiovascular disease, and beginning to reduce their risks.

Mark Masselli: We are also have a visit from managing editor of factcheck.org Laurie Robertson. She is breaking down some of the rumors about enrollment numbers on the insurance exchanges.

Margaret Flinter: Remember 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 www.chcradio.com or find us on Facebook or Twitter because we would love to hear from you.

Margaret Flinter: We will get to our interview with Dr. Price 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 Health Care Headlines. Another high ranking health official is leaving his post at the Centers for Medicare and Medicate. CMS Principal Deputy Administrative, Jonathan Blum is stepping down after five years. Under Blum's leadership CMS moved ahead with programs creating accountable care organizations, and revisiting Medicare Advantage to promote competitive bidding. And recently, Blum helped oversee the unprecedented release of detailed Medicare payment data for 880 firms and physicians. Meanawhile another CMS news, officials are looking to smaller vendors to take over the healthcare .gov website once the one year contract is up with the original vendor Accenture. They are specifically looking to create an RFP for smaller vendors who are more highly specialized in web portal development and management. The latest tally of the numbers of new release on insurance exchanges across the nation created under the Affordable Care Act 8 million and counting, add to that the roughly 8 million Americans who sought insurance in private market places. That's a significant number of Americans who have gained coverage. Although only a percentage of those were previously uninsured. Just say no to Moxduo, a key government panel voted unanimously against approval of a powerful opioid prescription painkiller intended to provide faster relief with fewer side-effects. The Food and Drug Administration

voted 14 to 0 against recommending the agency approve Moxduo, the first drug to combine morphine and oxycodone in one capsule. Prescription drug overdoses are responsible for thousands of deaths per year and are proving a gateway to an up-take in heroin abuse. Addiction experts fear Moxduo would simply add flame to that fire with its acute potency. I am Marianne O'Hare with these health care headlines.

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Mark Masselli: We are speaking today with Dr. Chileshe Nkonde Price a cardiologist at Robert Wood Johnson Foundation. US Department of Veteran Affair Clinical Scholar, Dr. Price is a research fellow at the Social Media Lab at the University of Pennsylvania School of Medicine. She's also a Senior Fellow at Penn's Leonard Davis Institute for Health Economics. And is a creator of the digital health project 'Change My Steps' program utilizing gamification in social media to improve heart health among African-American women. Dr. Price earned her medical degree from the University College in London and then worked for the National Health Services in England for three years, before continuing her training in US. She was Chief Resident at Drexel University and served her Cardiology Fellowship at Yale School of Medicine. Dr. Price welcome to Conversations on Health Care.

Chileshe Nkonde Price: Thank you. It's a pleasure to be here.

Mark Masselli: You know April is a national minority health month, and obviously an area that you are quite passionate about, and you see the negative effects of health disparities and disproportionately higher rates of cardiovascular disease in early death amongst African-American women. Help our listeners understand the nature of cardiovascular health disparity and paint a picture for us if you will about the successes that we have had and also the road that we have to travel?

Chileshe Nkonde Price: It's important to realize that cardiovascular disease in the US is actually a success story. Over the past 30 years, there have been dramatic declines in mortality and morbidity from the cardiovascular diseases when you look at the population as a whole. But when you break it down by gender and race groups, you see that it really isn't a success for all patient groups, and it's here that I am really emphasizing that when you look at black patients as a whole, we are not making those dramatic declines. And we really find that in cardiovascular disease when it comes to black patients especially black women there is a higher prevalence of cardiovascular risk factors. I am talking about smoking, diabetes, physical inactivity and healthy diet. The American Association publishes a statistical updates every year. And it says if you know copying and pasting the same paragraph, but it's not. It's just that this isn't new information. And this is really why I started to place a little bit of my interest, and little bit of my work, thinking about how can we be creative about the response to this long standing fact? How can we think outside of the health care

system? And it's in that kind of thought that I decided to do community based work. And when we think about agencies surrounding the hospital four walls, that could maybe move the needle on the risk factors issue. So that's where I think the creative responses stand.

Margaret Flinter: Well Dr. Price as a Research Fellow at the Social Media Lab at The Centre for Healthcare Innovation at PENN, you've really been able to take your own creativity and your interest in using social media and mobile technologies as a strategy and innovative strategy to promote better health practices among minority populations. And I want to talk about one of them that you've been gaining quite a bit of attention for, and that's the digital project you developed called 'Change My Steps', which seeks to engage black women in the dialogue about finding solutions that work. I think, I've heard that you conceived this project while sitting in a hair-saloon where so much social interaction and bonding occurs. So, tell us the story of the genesis of the program, who you are reaching with it? And maybe a little bit about the kind of technology and social media platforms that you are enlisting?

Chileshe Nkonde Price: What I was really looking for was really trying to get to the fabric of what is it about African-American women and cardiovascular disease. I wanted to think about where I am going to get the truth? Where am I going to be able to have the opportunity to talk with a demographic diverse sample of African American women? I attended a seminar at the University of Pennsylvania called the 'Politics of Black Hair' and I heard Melissa Harris Perry speak there, and I also heard Dr. Gil speak there too. Dr. Gil has done a lot of work on the physiology of the American beauty shop, and really talked about the hair-saloon as like a central place of social activation in the African-American community, a place where ideas are naturally exchanged, where African-American women gather, naturally share secrets and solve problems. Concurrent with that experience and then listening to Regina Benjamin who was a surgeon general at that time --

Margaret Flinter: Of course --

Chileshe Nkonde Price: -- **MPR[PH]**. And she is something really wonderful about the impact of the obesity epidemic in African-American women and she, I think it was quote where she said, "We have to go to where the people are at. And it's with those two kind of experiences that I am sitting in the hair-saloon myself. I am hearing these conversations of barriers and access. I am also hearing conversations of solutions. And I put those three things together and I thought this is where the truth is. That this is a place where naturally black women gathers and that's where the genesis of the program came from. And that's where I made the decision that I would as a cardiologist go outside world of the hospital and seek this real world sample, and we decided that we would try and gain the concept of local density, and select a few hair saloons to identify areas in Philadelphia that were high, middle, and low income and then actually

going in ground choosing those zip codes. And actually I managed to partner with three hair salons. And I spent a lot of time before they changed my steps but it actually got going, spending time within these communities. You can't just walk into a community and start asking questions. There really had to be some agency from the hair salon owners and stylist themselves, and also the client, and getting to know the influences. What I mean by the influences are those people who are directing conversations not just about health but about commerce and about finances and about relationships. It's a market place of ideas, and an original study design was to go and ask African-American women and ask them about these cardiovascular risk factors. Ask them what it would take to change your steps? But it's really together that we created - how can we use something a piece of technology that were already all using to create more healthy behaviors, and that's where the second project, the change my steps walking challenge was developed. Where social support was a huge aspect of what allowed people to live a healthy life. And by official support I mean if somebody else is eating healthy, then you are more likely to do it yourself. So we got the women to go into groups of their own social networks. So they picked the network. We got them to download digital pedometers on to their smart phones, and then we gamified the experience by using the internet and Twitter and me and my research (inaudible 12:13) emailing them not to encourage them, to try and walk 10,000 steps a day.

Mark Masselli: We are sort of at intersection of technology and patient engagement, and that is an exciting place to do it in. Talk to us a little bit more about what you've learned, and tell us about your research about older participants in the study? How does this project blossom in the works that you are doing at the social media lab at UPENN Medical School as well?

Chileshe Nkonde Price: Sure. So, our experience was that it was really a range of tech savviness. You know, not just constrained to the younger element, but some of the older women actually adopted the technology and did great. And some of them struggled. You know, we actually know from empirical data that pew internet life and research project has looked at older adults than has looked at the internet use. And has shown that internet use amongst the older adults is actually on the increase, and, you know, once older adults do get engaged in internet use, they tend to use the internet on a daily basis. But one thing that I found especially interesting was to not assume that older adults are not engaged. Those older adults that are engaged tend to be the healthy ones. The pew data does show that those older adults that have disabilities or health conditions are less likely to either have internet "activity" is not same for access to digital applications. So, you asked me a question about scaling. And that I was fortunate to capture older ladies who did a great job in the most part. But when we're really scaling into the health care setting it's really important to understand the empirical data across especially representative samples of older adults that we are all going to face challenges. And think about that before we design studies that they will be target population. You know the concept of if we build it

will they come, don't just build and ask people what they need arranged? I found a similar experience that we've had in the Social Media and Health Innovation Lab when a merchant who leads that **Labrone[PH]** project called 'The My Heart Map Challenge'. They were trying to map AEDs automatic external disability across – in the city of Philadelphia, where they had digital applications, used geography to identify them. And they ran a contest and the winners of that contest were in the older age group. So, you can't really assume that smart phones and digital Apps are just the things for younger folks.

Margaret Flinter: We are speaking today with Dr. Chileshe Nkonde Price a cardiologist at Robert Wood Johnson Foundation, US Department of Veteran Affairs clinical scholar. Dr. Price is the creator of the digital health project 'Change My Steps'. So Dr. Price I want to pull the thread on geography a little bit. You recently participated in a TEDMEDd Great Challengers webinar, on the way population health can be identified by something as simple perhaps as zip codes, and how that data can be used to create very targeted solutions to health disparities? How do we move the needle using zip code based data? Then maybe you could share with our listeners some of the programs discussed during that TEDMED Great Challenges webinar?

Chileshe Nkonde Price: Your zip code is more than a string of digits. It's really a analogy for your community. Those things that you have access to that are creating health opportunities for you. And you know the second thing that we came across there was a really lot of what Dr. Gail Christopher emphasized a number of times across the webinar was something that's really difficult to measure, which is really having that conversation about asking our old populations worth interventions. I mean I was really challenged by her comments on the webinar and it really got me thinking afterwards, that we can do a lot of things, we can ask a lot of questions, we can design creative challenges. But there's something really tough that is a fabric behind this. The fabric of -- there has been a lot of inequality here in the United States. I think, she used the term 'A Heart to Change' where people say that the most vulnerable populations are worth the interventions. So let's use a specific example that means that when we are designing mobile applications and digital technologies targeted at the least privileged population. We need to think about number 1 going and asking them, what they want? Number 2 representing them on every level and is about giving vulnerable population the worth in every step of the conversation. Some of the projects -- and the main project that we talked about was the concept of promise that were developed by the US Department Health and Human Services. And the promise being one of those areas where the government has really defined that it's going to create opportunity across agencies to improve and help education and the concept of promise own just to say well can we create promise through opportunity and can opportunity then translate into better outcomes.

Mark Masselli: You know I want to get your thoughts Dr. Price not only about across subgroups or across agencies, but really across the pond, because you were raised in England, where you did your early medical training and you were steeped in the National Health Care system, where access is not the issue that we faced here in the United States. So share with our listeners how health matrix differ between the two countries when it comes to access and outcomes?

Chileshe Nkonde Price: Yes. The National Health System as you said, that universal access to health care for all. But still when you look at national data in the United Kingdom, there are disparities across social class and economic lines which is to be expected. One thing that you find living in the United Kingdom, working within the National Health Services is that there really is by having this single system, greater integration with health care and the social care or patients interact with the health care system. And it's just something that when I first came to United States, I noticed was present but fragmented, less universal, and it's actually if I am really honest with you one of the reasons I stayed in the United States, because I felt like, this could be better. I've seen it done better. And I'll give you an example just from my --you know, from my own specialty cardiology. Recently new guidelines produced for the definition of cardiovascular risk. The US calculator used standard matrix that we know for risk factors, which were, you know, a patient's age and their cholesterol and their gender and their race. But the joint British Cardiovascular Society recently released their calculator, and one of the things within that calculator – if you can press the button where you define what your health looks like, that's with the risk calculator. And the reason why that's extremely powerful as it goes back to my point about where you live and your community to find your help. That's not in the US calculator. The UK gets that. I felt that that really crystallized the idea that social care and health care are very tightly integrated. And the point being there is it's something I've often said is that it takes everybody. It takes the doctors, it takes the health care system, it takes government, it takes community leaders. The last thing I'll say is my experience working in the NHS. When I was there, you could see that having a single healthcare system, you can imagine the healthcare records are more readily available across hospitals. It is easier for health care professionals and people in the community to communicate. But recently the United Kingdom has decided to make this health care records available for research. Information we already have in the medical record. We can understand the predictors of disease. And we are not there yet in the United States. I am giving you a glimpse to my vision of how we can think about, what are the key determinants of poor outcomes. I think the United Kingdom is ahead of the game.

Margaret Flinter: We have been speaking today with Dr. Chileshe Nkonde Price cardiologist at Robert Wood Johnson Foundation, US Department of Veteran Affairs clinical scholar. You can learn more about her work by going to www.changemysteps.com. Dr. Price thank you so much for being with us today.

Chileshe Nkonde Price: Thank you so much.

(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: It's well known by now that President Obama's claim that if you liked your health care plan, you can keep your health care plan, wasn't true. And we've seen many ads in 2014 saying that millions have lost their health insurance. But how many millions of insured Americans have their plans cancelled and how does that compare with the millions of uninsured Americans who have gained coverage under the law. There is evidence that far more have gained coverage than have their policies cancelled. Those how had policies cancelled were on the individual market. Many of these individuals were likely eligible for federal subsidies if they brought plans on the exchanges instead. How many have their policies cancelled? Researchers from the Urban Institute say roughly 2.6 million people based on a nationwide poll how many have gained insurance. One survey conducted by the Urban Institute says 5.4 million of the previously uninsured gained coverage between September and the beginning of March. Another said 9.3 million adults had gained coverage as of mid March. The Obama administration has said that 8 million signed up for insurance on the exchanges but that total would include both the previously uninsured and those who already had coverage. And that's my fact check 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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Mark Masselli: Each week, Conversations highlights a bright idea about how to make wellness a part of our communities and everyday lives. Outgoing New York City Mayor, Michael Bloomberg is leaving his post with another public health feather in his cap. Launched in May of 2013, the city bike sharing program has in a few short months reached a milestone. In the first 5 months since the program launched, city bike users have logged over 10 million miles and over 5 million rides far outstripping similar programs in other cities throughout the United States. It's a program funded by Citibank allow

subscribers to join either on an annual fee of $95.00. They are reaching an average daily ridership of 35,000. The estimated number of calories burnt since the program began in May is 403 million. Since taking off as Mayor, Bloomberg has launched the first citywide smoking ban in buildings and lounges, the first in the nation ban on transfat in restaurants. Both programs have had a dramatic impact on the health of the population reducing exposure to a secondhand smoke and dangerous food additives. The city has plans to scale the program up to all 5 boroughs adding 100s of miles bike trails and 1000s of bikes to newly developed bike stations. Chicago and Washington DC have similar programs and have plans to scale up their efforts as well. An affordable bike sharing program that has encouraged hundreds and thousands of city dwellers and visitors to exercise their way to their destination. 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 www.wesufm.org and brought to you by the Community Health Centre.

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