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Mark Masselli: This is Conversations on Healthcare, I'm Mark Masselli.

Margaret Flinter: And I'm Margaret Flinter.

Mark Masselli: Well Margaret we're starting to see some corrective actions being taken at the VA with new secretary of Veterans Affairs Robert McDonald has vow to fix the systemic problems playing the VA that led to the long wait times on untimely deaths at several facilities. The emergency VA bill has been put in place to improve care practices and pay for veteran seeking care outside the VA to be treated in private practices if they are force to wait too long.

Margaret Flinter: Well Mark private providers may not be thrilled with a lower reimbursement rate for their services than it is provided by other payers. And hundreds of thousands of veterans are expected to see care outside the VA system.

Mark Masselli: You know, it could actually create more confusion for many veterans trying to navigate the healthcare system outside the VA. It's a situation that will continue to unfold Margaret but this does look like forward motion for the VA.

Margaret Flinter: Well the secretary is determine to eradicate the underlying issues that led to this culture of secrecy and delays those responsible for cover ups of various VA facilities around the country are already being disciplined or let go and disciplinary actions are being taken at VA facilities in Colorado, Wyoming and elsewhere. More expected to follow.

Mark Masselli: It's going to take some time to restore the public trust in the VA's credibility and reliability when it comes to caring for the health needs of the nation's millions of veterans.

Margaret Flinter: Well credibility and reliability are great concern and in other area Mark, in states where the insurance exchange is fail during the first open enrolment under the Affordable Care Act efforts are underway to not only fix those problems but also to assure the public that the second open enrollment will run much more efficiently.

Mark Masselli: Maryland is a casing point, it's one of the handful of states that chose to expand Medicaid and create their own exchange and by their own admission it was a disastrous rollout but they've since partnered with AccessHealthCT Connecticut exchange that work so well as well as Delloitte Health Systems to revamp their exchange.

Margaret Flinter: Well our guest today is Dr. Joshua Sharfstein the Secretary of Health and Mental Hygiene for the State of Maryland. He's not only presiding over the state's

insurance exchange but also some sweeping reforms and hospital payments they've been allotted to some of the most innovative healthcare payment reform measures in decades.

Mark Masselli: We'll also have our weekly visit with Lori Robertson, Managing Editor of FactCheck.org. She's always on the hunt of misstatements spoken about health policy in the public domain.

Margaret Flinter: No matter what the topic you can hear all of our shows by going to chcradio.com.

Mark Masselli: Or as always if you have comments please email us at chcradio.com or find us on Facebook or Twitter we'd love hearing from you.

Margaret Flinter: We'll get to our interview with Dr. Joshua Sharfstein 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'm Marianne O'Hare with these Healthcare Headlines. A major of security hack has occurred compromising private information for four and half million American patients hackers believe to be from China stole patient data including social security numbers, birth dates, telephone numbers and other information from Community Health Services, Inc. The Tennessee based community health is one of the largest hospital groups in the US. The company claims no medical or clinical information were breached in the hack attack. Well overall economic growth continues at a rather anemic pace not so the healthcare industry, the still evolving Affordable Care Act has made many companies hire thousands and plow millions into their businesses. The healthcare sector expected a post-revenue growth of 12.2% the highest of any sector.

And another area of expected growth health insurance rates though not at the pace of a half dozen years ago when insurance rates rose by double digits annually projected rate increases for the coming year hovering between 3% and 7% in many states and in states where there's more transparency of insurance rates that number skews even lower.

As Ebola continues to spread across Southwest Africa, computer scientist of Virginia Tech are using the epidemic as a teaching tool. Computer scientist have been tracking the outbreak virtually trying to determine the anticipated spread of the virus and have done so far with a fair degree of accuracy. Computational epidemiologist Bryan Lewis a Virginia Tech points to the use of known data to predict the duration and scope of the

outbreak. The models he's creating with others help will be on hand for use in future outbreaks if this or other infectious diseases take hold. I'm Marianne O'Hare, with these Healthcare Headlines.

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Mark Masselli: We're speaking today with Dr. Joshua Sharfstein, Secretary of Health and Mental Hygiene for the State of Maryland. He was the Principal Deputy Commissioner of the Food and Drug Administration under President Obama. A pediatrician who also served as Commissioner of Health for the City of Baltimore. He campaigned against the marketing practices of large drug companies. He received his medical degree at Harvard School of Medicine and conducted his pediatric residency at Boston Children's Hospital in Boston Medical Center. Dr. Sharfstein welcome to Conversations on Healthcare.

Dr. Joshua Sharfstein: Thanks for having me.

Mark Masselli: You know as a public health official you have that enviable front row seat for the rollout of the Affordable Care Act. And you had somewhat of a rollercoaster ride in Maryland you are one of the handful of states who chose to open the insurance exchanges and there were some well-known problems that have occurred. But you've now partnered up with the state of Connecticut adopting the AccessHealthCT's model and technology, it seem to work rather well in that state. So tell us where Maryland is now with the partnership in advance of the next year open enrollment and what did you learn in that first go around. And what worked in the Maryland exchange in that first year.

Dr. Joshua Sharfstein: Sure, along with the -- a few other states and a federal government we had some major IT challenges out of the gate. But we were able to work around that and there was just an enormous effort in Maryland that involved the insurance producers, the brokers, community, a providers and organizations across the state to do a lot of what we called manual work around. And as a result we were able to enroll more than 400,000 people in coverage exceeded our original estimates which were really around 260,000. So I mean incredibly despite very, very frustrating IT challenges we were able to get a lot of people enrolled and the results of that we're seeing our hospital system reported that the number of admissions that were uninsured charity admissions drop by more than 50% in the first quarter of this year compared to the previous year. And a lot of the safety net providers are reporting that where they used to have 80% of the people coming through their doors uninsured it's now down to 20% or 30%. So just enormous gains in coverage despite the IT problems.

Now we took a pretty hard look at what went wrong and we really concluded that we had essentially implemented the wrong IT system and we looked around for who had

done it a lot better. The Connecticut system really was working better and so we're making a shift this fall to the Connecticut system and that project is going well, it's on schedule. And we are looking forward to a much better web experience for people and even further gains in coverage.

Margaret Flinter: So well that I'm sure took enormous attention. I think what many people may not know about is the efforts that are underway and have been underway to transform the Maryland health system behind the scenes. Maryland has -- had this innovative hospital payment system that's been held by noted Princeton Health Economist Uwe Reinhardt as the boldest proposal in the United States in the last half century to grab the problem of cost growth by the horns. And he's not giving to exaggeration and Maryland Governor Martin O'Malley has called for a sweeping set of payment reforms in the state's healthcare system that might incentivize reduction and preventable hospitalizations and thus save significant money in health expenditures. Can you share these payment strategies with us, what's the big innovation here that other states can learn from?

Dr. Joshua Sharfstein: So what -- Maryland is unique in some ways, one of the ways is that we're the only state in the country where we have an independent commission that sets the rate for hospitals. And basically the way that works is that each hospital gets essentially a rate card, each hospital only gets one rate card. And all of the insurers, all the payers pay the rates on that rate card whether it's blue, cross blue shield or Kaiser or Medicare or Medicaid or even an uninsured person they all are going to be charged the same rates set by an independent commission. And we have been doing some different types of pilot projects with that and one of those projects is we can basically tinker with the rates. So that hospitals are no longer paid on a fee for service basis, they are paid a set budget. And in the rest of the country generally speaking the majority of hospital finance is paid by the bed or the MRI sometimes the governor said it's like they're paid like a hotel is paid if the bed is stilled and they get paid.

The way -- there's a process that the rate setting commission Maryland has used to basically tinker with those rates so that over simply it a bed. If your budget is a $100 and you have 20 admissions well then the rates setting commission will allow you to charge $5 per admission because 5 times 20 equals a 100 but if you have 5 admissions then you can charge $20 per admission and you still have that same budget. So now the hospitals have a very different incentive instead of trying to keep their beds filled, they're trying to keep their community healthy. And the healthier their community is the few admissions that come in and the more margin they make. I was really out at Western Maryland with the Governor of Maui and we visited Western Maryland Regional Medical Center which is one of the hospitals that is on a this kind of global budget. And you'll see it's not like any hospitals you're used to visiting it's very quiet. When I was there and it was about two thirds of the fall they have a team in the ER that

meets with every patient to make sure the person is a good plan for leaving the hospital so they don't come back. They send nurses out to all the nursing homes to make sure the transitions are right, they even have a clinic for anyone in the county who's got heart failure or diabetes doesn't matter whether they are insured or not they don't charge. They have pharmacist, they have nurse practitioners and they have dieticians all to help the patients and to work with the patient's primary care physician. Just to keep them healthy and out of the hospital and they've saved so much by in fact reducing unnecessary hospitalization. So the idea is to use the rate setting system change the incentives have it be about keeping the community healthy. And we've taken that models essentially and working with the center for Medicare and Medicaid services adopted at statewide starting in January of this year.

Mark Masselli: Talk to us a little bit about how this partners up with the Medicare waver system and how that functions in Maryland. I believe you've reduced a hospitalizations about 11%, how does the partnership that the state set up at its rate setting and the Medicare waver work together.

Dr. Joshua Sharfstein: Sure so when people talk about the Medicare waver in Maryland what they're really talking about is that Medicare participates in the rate setting system. Medicare pays the rates on the rate cards for hospitals. In every other state in the country Medicare pays Medicare rates in Maryland Medicare pays Maryland rates. And that participation is really important to the overall system and it allows us to do these creative things with healthcare financing. Not only our admission's going down but the preventable admissions are really going down. And in Maryland we're focusing not just on reducing the number of admissions and re-admissions but on improving quality, reducing complications. I think we're really at the beginning so this particular model that we've worked out with the federal government is a five year program starting in January and, you know, if you judge by what you can see it places like Western Maryland Regional Medical Center. There's a lot of room to move, let me just give you a couple pretty interesting examples, there's a hospital in Maryland that is working with the local mental health advocates to set up a diversion centers so people who are having crisis don't need to go to the emergency department and they can get handled and helped in a setting that's much, much easier for them and less traumatic. We have another hospital that's actually taken over the school health program because they feel like they could run the school health program (inaudible 12:48) but with medical records and outreach could really help control the asthma in children so that they can save money by having fewer emergency department that sits in the hospitalization. So you see this very interesting partnerships there's one in Baltimore City where they're sending home visitors out to the frequent visitors to the ER to figure out what can be done outside the hospital to keep people from needing to come back again and again and again. Under a fee for service model the old system, you know, all those unnecessary ER visits and

hospitalizations were the, you know, life blood of hospital finance. But now in Maryland it's the reverse and the hospitals can be real partners in keeping people healthy.

Margaret Flinter: So Dr. Sharfstein let me take a look at something so many states have struggled to get a handle on, and that's the use of health information exchanges. You know, we talk to so many states where the health systems are still really disconnected from electronic information that cannot be easily shared among the partners but by all accounts the system you deployed in Maryland the Chesapeake Regional Information System for a Patient CRISP I like that acronym is working very well. So if you would tell us how that functions for hospitals health systems community health centers?

Dr. Joshua Sharfstein: So if you're a physician you're seeing a patient in the hospital and you want to see whether they've been seen in another hospital you can check CRISP. In fact in Maryland some people say we're going to CRISP the patient like it's a verb. And they check and they say oh looks like they already had a CT scan or here is where their live results were before. And that's not only saves unnecessary test but it can point the way to diagnosis and the doctors are really appreciative. And CRISP will send out an immediate secure email the moment anyone o their patients gets to the ER. And we have built a prescription drug monitoring program to identify problems with pain medicine prescribing and we put it inside CRISP so that doctors can easily access that information about patients. So they have the great list of the doctors in Maryland. So we built on that infrastructure we had all the health plans and the managed care plans and the Medicaid program send information to CRISP about which plans each doctor is signed up for. And then we created a website which I think is providersearch.crisphealth.org where people can go and search for providers and their health plans. Instead of going to like, you know, ten different websites which are all confusing by the providers you go to one website you say I want a rheumatologist exist insurance in the zip code and it will tell you who is there. So we think we're just scratching the surface of what's possible but in general it's very secure system that provides a lot of value to patients as well as doctors and the public health officials.

Mark Masselli: We're speaking today with Dr. Joshua Sharfstein, Secretary of Health and Mental Hygiene for the State of Maryland. You know, the Affordable Care Act laid out money for health information exchanges and I think a lot of people felt short of the mark. Maybe similar to the federal exchange is there something that would not allow this to scale up outside of, you know, you obviously have different hospitals, different providers has anybody come to you and said let's see if we can scale this up in other states as well?

Dr. Joshua Sharfstein: There's a lot of interest in this. So what we've been able to do is get all the major medical record providers to participate, in other places it may be hard

because the medical record providers may not be as open to doing it at this point in time. So I can tell you when I present about this in national meetings people are really interested and there's a lot of works that the CRISP team does with other states. But it really requires a lot of effort to get it done, I mean the governor (inaudible 16:27) personally wrote the CEOs of hospitals to get them to participate. But now it's kind of something that's sold itself.

Margaret Flinter: Dr. Sharfstein you gave us just a little bit of a teaser on how you're improving the health of people with chronic illness helping them manage their illness, stay out of the hospital with your reference to the work in Western Maryland I think is that your center for clinical resources where the chronic disease management is going on?

Dr. Joshua Sharfstein: You know, there's a -- obviously every state the country is facing a tidal wave of chronic illness that is extremely expensive and debilitating doesn't really help, you know, only to have insurance if you're just sitting around waiting for a heart attack or stroke to happen, you've got to figure out how to prevent that heart attack and stroke. And I think changing the payment incentives is incredibly important and I'll tell you below the -- all the politics of the Affordable Care Act there's a broad consensus that we really can't keep paying for healthcare for every surgery and every admission we've got think about ways to pay for value as you said. And we intend to continue to move that forward in different ways in Maryland.

Margaret Flinter: But tell me just a little bit more about the centers for chronic illness where patients in the community I think you said with congestive heart failure or diabetes can go it's on a no charge basis and there's a team of people there to help them manage their illness. Who is behind that is this functioning like a community utility that is funded at the level of the health system?

Dr. Joshua Sharfstein: It's funded by the hospital because when someone doesn't come to the hospital as a result of good interventions then the hospital is going to still keep that money in their budget. So they may pay a few million dollars for the clinic but then they save more than that in reductions in hospitalizations. And I'll tell you, you go into the clinic and there's a little key **ASK [PH]** and it just says, you know, do you have heart failure, diabetes or asthma and you press the button and it brings you back and there's a one little pot that's look few nutritionist and there are a couple of nurse practitioners a pharmacist and they go to where they keep files. And the doctors might say, you know, there's someone who's had a really hard time and been admitted a lot, you know, let's get you some extra help and refer you to that clinic. They told me for example that for someone with heart failure whose body is at risk of retaining fluid they may have the person call in everyday with their weight. And if their weight jumps in a day it's not from eating it's from the fluid and a sign of the heart failure could be a

problem. So before that fluid starts to affect their breathing they're in and they may got a diuretic or something to bring their weight right back down. So they're able to do a whole bunch of things through a lot of follow up. And, you know, it's just really hard when you're dealing with a fee for service system to find a way to pay for something like that. But in the global budget the hospital gets the savings they're ready to invest and I give a lot of credit to bury around in the CEO out there and the team for setting something like this up.

Mark Masselli: We've been speaking today with Dr. Joshua Sharfstein, Secretary of Health and Mental Hygiene for the State of Maryland. Follow him on Twitter at DRJOSHS, Dr. Josh S. Dr. Sharfstein thank you so much for joining us on Conversations of Healthcare.

Dr. Joshua Sharfstein: Great it's been a pleasure.

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

Lori Robertson: Well a new ad from the conservative group clustered GPS offers a twisted tale about the Affordable Care Act and its impact on one family. It leaves a false impression that a Colorado woman had to go back to work to pay for health insurance mandated by the ACA. It turns out as she told the local TV station her decision to get a job had nothing to do with the healthcare law. We've seen other ads in this genre, ones that feature real people but not so real anecdotes. In this one a woman name (inaudible 20:38) says the ACA has hurt families and small business owners. She says her husband took a list to start his own company. The family needed healthcare but because they had a single income they "couldn't afford our plan" she says. As she speaks text appears on screen saying she "had to go back to work" the ads deceptive framing leaves a false impression that she had to go back to work in order afford insurance on the state's market place created under the ACA which requires all legal US residents with some exceptions to have insurance by 2014 or pay a penalty but that's not the case. A local Colorado TV station KDVR reported that the woman's LinkedIn page showed she had worked outside the home continuously since May 2010 more than three years before the ACA is mandate. She told the TV station that her decision to go back to work wasn't because of the ACA, she said it was simply a financial burden living on a single income. The family has insurance through her

employer. But that’s not the story told in the ad nor the impression left by it, 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 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 Healthcare.

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Mark Masselli: Each week conversations highlights a bright idea about how to make wellness a part of our communities and to everyday lives. Childhood obesity has reached epidemic proportions in this country and it's reaching into the most vulnerable population toddlers and pre-schoolers. The trend was particularly disturbing to Louisiana State University, Behavioral and Community Health Professor Dr. Melinda Sothern who said the numbers of obese children in Louisiana preschool is particularly distressing.

Dr. Melinda Sothern: Currently on average across the United States 15% of children zero to five years are obese or overweight. And in the minority populations it's actually one third so it's much greater and in Louisiana it's actually in that population greater as well. And then as they approach adolescent their risk for developing type two diabetes and high cholesterol and high blood pressure also increases.

Mark Masselli: Dr. Sothern conducted an analysis and discover that a majority of the children in Head Start Programs across the state are spending much more time in sedentary activities almost 90% of the time. With a grant from the National Institute of Health nutrition and physical activity self assessment for child care knapsack program. They devised a program that brought dietitians into a series of Head Start daycare centers and created opportunities for the children to increase their movement every day. Using accelerometers they were able to get accurate assessments of increased movement among the children.

Dr. Melinda Sothern: So we actually strapped an apparatus around the children that measured how long they were being physically active and how hard or how intense. And about 80% of the time these zero to five year olds were sitting or lying they were not specifically active we were very surprised by that. what we found was the only in the interventions centers that we see an increase in physical activity. It was in 22% increase in total physical activity and what was even more amazing was a 50% increase in the vigorous activity that we really want those pre-schoolers to engage in.

Mark Masselli: The study was published in the journal childhood obesity a low cost intervention that has the potential to have significant impact on one of the underlying causes leading to childhood obesity which is sedentary lifestyle, now that's a bright idea.

Margaret Flinter: This is Conversations on Healthcare, I'm Margaret Flinter.

Mark Masselli: And I'm Mark Masselli, peace and health.

Conversations on Healthcare, broadcast from the campus of WESU at Wesleyan University, streaming live at www.wesufm.org and brought to you by the Community Health Center.