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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 awareness month is ending with something of a controversy. There has been a lot of reaction to the recent changes announced by The American Cancer Society regarding new mammogram guidelines.

Margaret Flinter: Well the previous guidelines suggested that women receive an annual mammogram beginning at age 40. The new guideline suggest that routine screenings should begin at age 45 and only earlier if there is a family history or other risk factors and only every other year for women 55 and over. This new recommendation is not being fully accepted by some clinicians at very top cancer hospitals.

Mark Masselli: The American Cancer Society based the new guidelines and data that showed the average risk for women didn't seem to increase until women were closer to menopause. Meanwhile these recommendations are actually more conservative than those suggested a few years ago, by The United States Preventative Service task force, which said that women should wait till age 50 to begin annual mammograms.

Margaret Flinter: Cancer hospitals like Memorial Sloan Kettering and MD Anderson Cancer Centers say they are going to continue their policy of recommending annual mammograms starting at age 40 at least for the time being.

Mark Masselli: Yeah, but as per the new guidelines, also comes from the growing movement to reduce harm and unnecessary medical intervention for average risk women who has suspicious mammograms and then undergo invasive procedures only to discover that it was a false positive.

Margaret Flinter: The new guidelines though give discretion to patients and clinicians to choose to opt for earlier screenings saying that insurance should cover all mammograms that are ordered for whatever reason they are ordered.

Mark Masselli: This story is probably going to spark a lot of more frank conversations between women and their providers on this personal and important health screening and the more dialogue patients have with their providers, the better opportunity everyone has to achieve better health and better outcomes.

Margaret Flinter: Well that's something that our guest today is quite passionate about. Dr. Daniel Sands is cofounder of The Society for Participatory Medicine, who seeks to develop a clinical model where patients are really empowered and engaged. He has been at the forefront of this movement, which is taking hold. So we really look forward to that conversation.

Mark Masselli: Lori Robertson stops by, The Managing Editor of Factcheck.org looks at false claims made by The Health Policy in the Public Domain, but no matter what the topic, you can hear all of our guests by going to chcradio.com

Margaret Flinter: And as always if you have comments, remember to email us at chcradio@chc1.com or find us on Facebook or Twitter because we love to hear from you. Now we'll get to our interview with Dr. Daniel Sands 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 Health Care Headlines. The Head of The American Cancer Society says the new mammography guidelines are with the most honest things to come out of the organization in years. Dr. Otis Brawley saying the new guidelines recommending women don't begin annual mammograms till age 45 instead of age 40 is based on rigorous analysis of decades of data on the matter and that while increased use of mammograms saves lives, it's also caused much harm as well. The ACS recommendations are causing a cavalcadive responses including many from cancer treatment specialists you cautioned against a quick switch to the later mammography start date. Pay for performance is coming to health care a bit slowly in August, Medicare Official's released 2014 financial details showing, so far, the ACOs have not saved the Government money. The 20 ACOs in, The Pioneer, reported total savings of 411 million dollars, but after paying bonuses the ACOs recorded a net loss of 2.6 million to the Medicare Trust Fund. Another reason to get more shuteye – not enough sleep can lead to early disease and an earlier death. A recent study at South Korea shows chronic sleep deprivation of less than 6 hours per night can lead of onset of metabolic syndrome. Participants were followed during two 3-year periods. About 560 people in this study or about 22% developed metabolic syndrome. Short sleep duration was linked to about 30% increased risk of high blood sugar and access belly fat as well as 56% higher odds of hypertension compared to those who slept longer. All the times, they are changing in somewhat attitudes about marijuana use. A study done from 2001 to 2002 showed about 4% of American adults admitted to Pot use during that year from 2012 to 2013 about 10% of Americans had admitted to using Pot. Study showed especially large increases among women, Blacks, Hispanics, Southerners and Middle aged and older people. The researchers write, if the amount of US adults using marijuana increases soon will, the number of those with marijuana use disorders. I'm Marianne O'Hare with these Health Care Headlines.

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Mark Masselli: We're speaking today with Dr. Daniel Sands, Founder and Co Chair of The Society for Participatory Medicine, A Faculty Member at Howard Medical School; Dr. Sands is an Internist focusing on Primary Care Transformation. He was Chief Medical Officer at Sysco and prior to that Chief Medical Director at Zix Corporation, developing early technologies for E-Prescribing. Dr. Sands also developed some of the Nation’s first patient portals, and electronic health records. Dr. Sands is a member of The American College of Physicians and The American College of Medical Informatics. He is named one of the 20 people who make healthcare better by Health Leader’s Magazine. He earned his degree from Bryan University, Ohio State College of Medicine and Howard School of Public Health. Dr. Sands welcome to Conversations on Health Care.

Dr. Sands: Thank you very much Mark.

Mark Masselli: Yeah it’s great and you are one of the pioneers in the discipline of participatory medicine, which is now gaining some traction across the healthcare landscape and I’m wondering if you could tell our listeners, describe what you mean by Participatory Medicine Model?

Dr. Sands: Sure. We often think about healthcare as a service industry. To me, that feels like a carwash. So it’s just that, you know, healthcare is kind of like a carwash. The car is dirty and needs to be washed, goes to carwash and somehow they come out and they are healthy, they fixed, but we are not succeeding in many ways in the healthcare system, we don’t get the outcomes that we need. We meaning, doctors and patients, we need to both be engaged in the process of healthcare that is different from a service industry. I would argue that healthcare really is collaboration and collaboration depends on a number of things: open communication, sharing of information, and one of those is engagement. So this collaboration, I would say, is participatory medicine, that’s how I would define it.

Margaret Flinter: Well Dr. Sands, patients run the full spectrum. I know you are Co chair of The Society for Participatory Medicine e-Patient Dave deBronkart has been a guest on the show, but there is an exemplar perhaps of a highly motivated patient who really engaged in his own recovery doing battle was staged for kidney cancer, but I would really like to hear you prospective on what we might call the everyday patients with more typical or be sometimes quite complex healthcare management issues, and which strategies are you deploying or thinking about to engage the primary care patient population to be more engaged?

Dr. Sands: Certainly, patients who have life threatening illnesses, like they, really, you know, have an urgent need to get more engaged in their health, but I would argue that at it benefits any patient with any condition, so patients who need to exercise more need to improve their diet more. You know, how do we engage patients, who just don't want to be engaged. There are some patients who are challenged with this idea of participatory medicine, for reasons that are not related to us. There may be cultural reasons. But I think it's coming upon us to lower barriers to patient engagement whenever possible. Part of that is making sure that patients have easy access to the tool they need to take care of themselves and we should encourage them to seek out information as well as their own persona health information, that is their medical records, we should make easy for them to access that. The third kind of information they need to be able to access is access information from other patients like them, and in addition they need to be able to access care conveniently. So we make it very difficult, for example, for patients to get an appointment with us. It takes for ever and finally they just give up. So lowering barriers I think is one of the ways that you can engage patients. Patients get turned off when they are just sort of stone walled by the healthcare system. They can't stand how difficult it is to interact with the practice and yet the patients don't want to pack half a day out of their lives and come to see us if it's something that doesn't need to be done in a face-to-face visit, and God know they can't reach us by phone! So I view patient engagement as any other behavior change. In primary care we are dealing with patients who need to make behavior change, whether it's a start taking a medication they need to be taking or whether it's quitting smoking. So a model that I use in my practice for patients in behavior change situation is The Prochaska Model. It's a matter of assessing where individuals are on a rediness to change continuum. What you want to do with any behavior changes to start to assess where they are and then move them up to the next box and then prevent them from slipping back. So I do that as I look at patients in my practice and you know how willing they are to get engaged in their health? And then there are other patients who are, you know, really thinking that, yeah, they want to get more engaged to their health and so by doing that, we can, sort of move patients along through this continuum, through the Prochaska Stages and, I think we really can get patients get engaged in their health.

Mark Masselli: You know, I want to give applaud to both you and e-Patient Dave, who is not only your patient but you also co wrote a book called Let Patients help, you know, one of the things that we hear from patients all the time is about the frustration of getting access to their own health data and I am wondering sort of that cultural change, I am wondering if you could use The 5 steps to move the medical practices forward and

Margaret Flinter: That's bit of a pre calculation.

Mark Masselli: Yes, we are doing that and so wondering what you thought is about what's holding back and how is Society for Participatory Medicine cultivating conversations within the community?

Dr. Sands: Yeah, this is a really sticky problem in the society about interoperability of health records, you know if you are getting your care in New York and you happen to be in Boston seeing me, I should me, I should be able to have access to your records, your health records.

Mark Masselli: Send a care to your patient.

Dr. Sands: Right, send a care to my patient might work but, and frankly, we have a huge issue throughout The United States with that, you know, ever if they are rally close, I can't get that information, so physicians have had to rely still on fax machines, or just be content with not really knowing and just repeating whatever tests need to be done, because we could probably have a whole hour long discussion about all of the issues related to that. Patients expect that, that should happen. They believe that, that interoperability should take place. You know, I think they are frustrated by that. We, at The Society for Participatory Medicine did a national survey and we found out that vast majority of patient you know, the people out there, expected that kind of information should be available to their doctors, but there is a whole other issue, which is that what about having you have access to your records from me. That is fortunately a little bit easier than it has been in the past. So as you mentioned earlier I co developed one of the first portals that gave patients access to their records and today patients not only have access to their records, but they have access to their notes as well. You know, so if you have a patient portal up, that patient portal gives the patient the ability to have access to their records. And fortunately, it is a requirement that doctors have patient portals through which, patients can access their records and even view, download and transmit their records. But I think still, many doctors are uncomfortable with that notion.

Margaret Flinter: Well so much is transforming, in primary care, but one area that has not moved fast as forward is we might have contemplated is the way people get paid and fee for service pretty much still dominates the landscape and yet these elements of transformation, you've been so interested in care management that happens without patients coming in the office. Secure e-mail and telemedicine protocols been and yet not one of those things is associated with payment. Do you see this payment transformation accelerating?

Dr. Sands: You know, upfront, I would say that telemedicine actually is increasingly reimbursed, so that is one thing that certainly is. I've been using e-mail in my practice since 1991, perhaps a very long time ago. In 1998 I collected the very first guidelines of how to use e-mail with patients because we already knew from surveys that patient wanted to e-mail with their doctors, the doctors weren't letting them. And still today, doctors are concerned about it. So one of the objections the doctors have had from very early on has been an issue well, I don't get paid for it. You know, and you don't get paid for talking on the phone with patients either. The only thing we get paid for really is seeing patient in the office. We have to communicate with our patients somehow. We just have to and so right now your only option is the telephone. And so, would you rather talk to the patient on the phone, recognizing that it takes longer, or would you rather just exchange a quick e-mail. Years ago when I was really doing a lot of investigations in this area, there was a study showing that an average telephone communication with the patient took 5 minutes, and average e-communication with the patient took 2 minutes. So why wouldn't I want to do the e-mail with them, and the other thing doctors complain about is, "well why should I take care of patients for free?" Well in the pay for service world we bill at different levels. Wouldn't you rather use your office time for taking care of patients, who really need to be seen because they are sicker? But if I can bill at a higher lever for that time that's a better thing and maybe it's through video conferencing or maybe it's through the phone or maybe it's through secure messaging. You know, certainly, well over 50% of doctors have some element of quality reimbursements in their contract and that's going to increase in the coming years. I don't think there is anyone who really thinks that this is ending. You know, our changes in attitude when we are with the patient is not something that takes more time, admitting we don't know when a patient asks a question rather than sort of making something up or ignoring then or whatever, that doesn't take more time. Encouraging patients to read about their illness through things they find on the internet or through patient support communities online, that's the stuff that doesn't take more time either. So I think there is a lot we can do to practice participator medicine without requiring more time of us.

Mark Masselli: We are speaking today with Dr. Daniel Sands, Internist, Medical Informatics Expert, and Founder of The Society for Participatory Medicine, which seeks to promote a model of actively engaged, patients, caregivers and providers across a continuum of care. You know, when you are talking earlier about the, sort of, patient's expectation on health, interoperability and that they have all the information available and you now have over the last, half a dozen years, tens of millions of Americans now utilizing some kind of health tracking or monitoring device that data really hasn't found a home. Apple's launched it's healthcare product, other players like Google and Samsung, but you just spoke at The Health 2.0 Conference where many of these health tech entrepreneurs conversed, so what's the buzz of the conference regarding these new emerging health IT platforms especially platforms that have the power to transform care as well as research?

Dr. Sands: I think there is certainly a lot of excitement about the fact that oh, you know, patients can track their own information and they can get feedback from a computer about how they are doing and this and that, I think that the, if we want that information to be actually a part of our medical record and part of our medical care that's a whole different ball of wax, but you know, if I really want this, you know, my doctor to be part of this conversation, that’s a whole different thing. One of the things about the health Apps and there are you know, depending on what you read, there maybe 60 thousand different health Apps out there. Not that many of them you know, would acquire, really clinically useful information, and then there are the tracking devices, many of which people are buying using for a short while and putting them in the drawer and so the average user is using them from 1 to 6 months. Then there is an issue of accuracy. So let’s suppose that I am tracking my footsteps and it’s just not accurate. I mean, there was a New York Times review, maybe year or so ago, and they used, I don’t know, 5 different tracking devices and they put them all on themselves and they all got wildly different numbers about how much activity that way. So, on the other hand, we have opportunities like blood pressure cuffs and scales, and things, there are FDA certified, so I think it’s really important to think about that issue about their interface and in fact, there is a whole group of people out there that they are part of something they call the quantified self movement and they are interested in tracking everything they can about themselves and if they just have enough information and then they will be able to keep themselves healthy then, and of course if you practice medicine and you know, that that’s just not true. So if we are going to incorporate any of this information into the healthcare system, you know, as we are paid, as we are moving from pay for services to pay for value, and we need to improve the outcomes of patients who have chronic conditions you know, one of the things we need to do is we need to understand what’s going on with them all the time, not just in this 15 minutes that they are in the doctor’s office. And so one of the ways you might do that is through frequent light touches in between visits instead of visits. But then this data, needs to come back through the doctor’s office in a way that is, that we are filtering the signal from the noise. So we are identifying important trends and showing them to the practice. What we want to know is what is the significant trend so that we know who we need to reach out to.

Margaret Flinter: We have been speaking today with Dr. Daniel Sands, Internist, Medical Informatics Expert, and The Founder of The Society for Participatory Medicine. You can learn more about his work by going to his website doctordanysands.com or follow him twitter at doctordanysands or through The Society for Participatory Medicine at s4pm. Dr. Sands, thank you so much for joining us on conversations on healthcare today.

Dr. Sands: Thank you very much.

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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 Jim Bush claimed that while President Obama had promised to lower health insurance premiums by 2500 dollars per family, The President’s own team, it says premiums will increase by 2900 dollars over the next 10 years. That’s misleading. While Obama didn’t always make it clear, he wasn’t promising to cut premiums but rather promising to cut the rate of growth in premiums. As for the future, the centers for Medicare and Medicaid services project private insurance premiums per enrollee will rise by nearly 2900 dollars over 9 years, but that is moderate growth by historical standards. Bush’s comparison leaves the impression that a 2900 dollar increase would be a market departure from Obama’s promise, but it’s actually an apple to orange’s comparison. We have no problem with Bush faulting The President for his broking promise, in fact we’ve fact checked Obama’s misleading claim several time over the years. But Obama was talking about a 2500 dollar reduction compared with what would have happened without The Affordable Care Act or other changes to the healthcare system. Bush’s 2900 dollar increase figure meanwhile is a stray increase. He gets that figure from the latest National Health Expenditures Report, from the centers for Medicare and Medicaid Services. The 2900 dollar increase which is from 2015 to 2024 would be an average 5.82% increase per private health insurance enrollee per year. How does that compared to the past the rate of increase was 5% per year from 2007 to 2008 and before Obama took office from 2000 to 2008 it was 9.4%. The national health expenditure’s reports said that the growth rate would “remain modest” from 2015 through 2018 and then pick up in a delayed response to stronger economic growth, and that’s my fact check for this week, I'm Lori Robertson Managing Editor of FactCheck.org.

Margaret Flinter: FactCheck.org is committed to factual accuracy from the country's major political players. And is a project of the Annenberg Public Policy Center at the University of Pennsylvania. If you have a fact that you'd like checked email us at chcradio.com we'll have FactCheck.org's Lori Robertson check it out for you here on Conversations on Healthcare.

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Margaret Flinter: Each week Conversations highlights a bright idea about how to make wellness a part of our communities and to everyday lives. Each year more than 1 million babies die at birth and another 3 million die within the first few weeks of life, often from preventable causes. And when babies are born prematurely the risks escalate. Newborns, in particular primes have a considerable amount of difficulty regulating their own body temperature and without access to incubators babies in the third world often still come to hypothermia. That had our former Stanford MBA student Jane Chan thinking, how do we develop a low cost solution to the problem?

Jane Chan: My team and I realized, what was needed was a local solution. Something that could work without electricity, that was simple enough for a mother or a midwife to use. Give that the majority of births still take place in the home. We needed something that was portable, something that could be sterilized and reused across multiple babies, and something ultra low cost compared to the 20,000 dollars that an incubator in the US costs.

Margaret Flinter: Speaking at a recent Ted Talk, Chan said that they developed a cocoon like device called simply embrace. A thermal body wraps that encases the baby, and helps regulate body temperature for up to 6 hours.

Jane Chan: What you see here looks nothing like an incubator. It looks like a small sleeping bag for baby. It's waterproof. There is no seems inside, so you can sterilize it very easily, but the magic is in this pouch of wax. This is a phase change material. It's a wax-like substance, with a melting point of human body temperature at 37 degrees Celsius. You can melt this simply using hot water and then when it melts it's able to maintain on constant temperature for 4 to 6 hours at a time, after which you simply reheat the pouch, and it creates a warm micro environment for the baby.

Margaret Flinter: And Chan and her developers have managed to keep the cost of the embrace baby warmer at around 25 dollars per unit. So fortunately the product in 2010, they estimate that over 150,000 babies' lives may have been saved with the device, which is easy to sterilize and design for multiple uses. The Embrace and Feel Warmer has earned numerous international awards for design and efficacy, a low cost, high tech, portable temperature regulator, designed to regulate primes body temperatures to ensure that they not only survive premature birth but ultimately thrive as well. Now that's a bright idea.

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

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

Female: Conversations on Healthcare broadcast from the campus of WESU at Wesleyan University. Streaming live at WESUFM.org and brought to you by the community health center.