(Music)

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

Margaret Flinter: And I am Margaret Flinter.

Mark Masselli: Margaret, was there any surprise to the news that the super committee made up of equal number of democrats and republican law makers did not approve the plan to reduce the deficit by at least $1.2 trillion, now am I right, the majority, they only need it seven out of 12?

Margaret Flinter: That's what I understand. And I'm getting the feeling that our leaders like to keep us on the edge because they do a lot of it these days. As usual, the two sides cannot bridge the taxes versus the entitlements divide and without an agreement or some sort of postponement worked out a set of automatic cuts are going to kick in to reduce the deficit over the next 10 years and we've introduced a new word to the vocabulary "sequestration" not one that I think the American public was familiar with before this debate.

Mark Masselli: Well, there is the old adage that 'less is more'. I have heard the analysis that if Congress doesn't act either in this case or on the Bush tax cuts there will be about $6 trillion in savings or new revenues brought into the system. One hopes that these cuts aren't in the healthcare area but I have a feeling that it's on the top of many people's list.

Margaret Flinter: I think so. And some people believe a way to avoid having healthcare cost cut is to transfer those costs from the federal budget on to individuals, insurers and healthcare providers but I think we've already been there and tried that. Others suggest this just fails to address the underlying healthcare cost issues. But you know back to this resolution, I heard some members of Congress saying, 'well, those automatic triggers maybe they aren't so automatic and we can put those aside.' But the president has been pretty clear. He is going to hold those triggers in place if they fail to reach an agreement.

Mark Masselli: And hold their feet to the fire. But well, there are a lot of dismal thoughts happening in Washington, it is the time of celebration. Thanksgivings is right around the corner. It's a day of 'thanks' and we hope everyone is surrounded by family and friends and good food, not too much of that food.

Margaret Flinter: That's right. And I think today's guest can also set an optimistic tone for us today about real people solving real problems. Dr. Sanjeev Arora is the founder of Project Extension for Community Healthcare Outcomes or Project ECHO. It's an innovative model of care that links primary care providers with specialists in both rural and underserved areas of the country as a way of eliminating barriers to specialty care and improving health outcomes. And I think

he has the potential to be a game changer for the way primary care providers can treat patients with complex illness.

Mark Masselli: We are very excited to learn more about Project ECHO. But no matter what the story, you can always find out more about our shows and hear more about us by googling chcradio.com.

Margaret Flinter: And as always, if you have feedback, e-mail us at chcradio.com, we love to hear from you.

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Mark Masselli: Today Margaret and I are speaking with Dr. Sanjeev Arora, founder of the Project Extension for Community Healthcare Outcomes known as Project ECHO, a model of care that's linking primary care providers with specialist to improve healthcare in rural and underserved areas. Welcome, Dr. Arora.

Dr. Sanjeev Arora: It's a pleasure to be here.

Mark Masselli: You know, the New England Journal of Medicine published your study about Project ECHO describing how primary care providers can treat patients with complex illnesses, usually managed by specialists and you've established a very innovative model some would say a disruptive innovation, one that takes advantage of technology to provide expert consultation and support via video conferencing. Tell me, what's the story behind the start of Project ECHO and what are your outcomes to date?

Dr. Sanjeev Arora: So Project ECHO was started about seven and a half years ago and the problem we were facing at that time in New Mexico as your audience is probably aware that New Mexico is a very rural state. And about 28,000 patients with in the State of New Mexico had this very common disease Hepatitis C. And there were very few specialists in rural areas to treat these patients. So most of these patients didn't have access to treatment, in fact, less than 5% have been treated and they would be -- have to travel 200-250 miles each way to see me. And so there was so much pressure on my schedule. There was an eight-month wait to see me in my clinic. Now, Hepatitis C is a very serious disease and it can cause liver cancer, it causes cirrhosis. The Center of Disease Control has recently estimated that in the United States with the current rate of – rates of treatment for Hepatitis C about 890,000 patients would die from this disease in the U.S. alone. So, this was the problem we were trying to tackle and there weren't enough specialists in the rural areas to manage this disease. So, we developed a new model and the goal of the model was to bring access to best practice care for Hepatitis C to all the patients in New Mexico wherever they lived. And we felt that if we could do that then we would have a model that could treat Hepatitis C everywhere but not only that be applicable to many, many other

chronic diseases for which patients didn't have adequate access to specialists. And as you mentioned, we set up this program and we have been able to demonstrate in the New England Journal Medicine article that you were mentioning that after participating in the ECHO Project these rural clinicians can manage Hepatitis C as good as we do with – as well, sorry, as we do in the University of New Mexico and get similar outcomes. In fact the outcomes that we got in our study were significantly better than other community-based trials for treatment of Hepatitis C even by specialists.

Margaret Flinter: Dr. Arora, I want our audience to fully appreciate just how valuable Project ECHO is and also what the potential of the model. And it's important to understand those gaps in access to specialty care that patient's facing, you certainly talked about the rural issues where distance is the problem. But certainly even in urban areas we see people without insurance or with the wrong kind of insurance with just a lack of numbers of specialists in the field to treat. But Project ECHO goes beyond just access to A specialist and I have sighted on several of your sessions and you can see it's really giving the primary care providers access to an entire team of specialists to help them manage their patient. I've seen you with us, you're a gastroenterologist, hepatologist, but I've seen you with psychiatry, with the nurse care coordinator and addiction medicine specialist, also around the table to weigh in on the problem. So, tell us about this team consult approach and how did that come up about?

Dr. Sanjeev Arora: So Project ECHO is based on four key ideas. The first is, as you saw in our clinic is the interactive video conferencing technology where many, many primary care clinicians join simultaneously. They not only learn from us at the university but they learn from each other. The second idea there is best practices and that relates to the question. Best practice for a disease involves knowledge from variety of different sources. So, we said, we would bring this team-based best practice approach to the primary care clinicians. So, the training and the expertise is developing is along multiple domains as opposed to just one expert's opinion. And the third key idea in Project ECHO is case-based learning. That these primary care clinicians we've shown in our research over time become absolute experts and they need that less and less, I hope you got the idea when you were listening how these doctors had become quite expert in this disease. This is not a disease typically that primary care treats, in fact when we started Project ECHO in New Mexico not a single primary care doctor was ever treating -- had ever treated Hepatitis C. And the fourth is we measure outcome, so it's a combination of all these three things. And in order to do these well having a multidisciplinary team at the University is essential.

Mark Masselli: Dr. Arora, assured goal in healthcare today is to increase quality while reducing cost and I think we first became aware of your work through our relationship with the Dartmouth Institute and I know you're paying close attention to the two outcomes. You've talked about having good understanding of its effectiveness in terms of quality, what would you say about cost and if it is

effective in both of these areas doesn't it make sense to have this as a fundamental approach to linking primary care and specialist versus just its current application in rural and underserved areas.

Dr. Sanjeev Arora: So certainly that's I hope and thank you for articulating it so well. We think our Project ECHO saves cost in multiple different ways. So first, it's an obvious and simple way it saves cost in rural area that saves travel costs. So when I used to treat Hepatitis C before I started Project ECHO, patients would have to travel 200 miles each way. And if I was treating Genotype 1 infection which accounts for two thirds of all patients in the United States, they would have to make about 18 trips of 250 miles each way to see me and you could imagine the amount of economic loss that resulted in, there is of course the gas mileage but the time off work, and then they were feeling sick so they often had to bring relatives with them, that was one aspect of cost saving, the travel cost. The second is that when you bring best practice care you reduce errors in the healthcare system because you bring coordinated care in our healthcare system typically one party is not often aware, one physician is not aware or what the other persons are doing. But when you all are in a room conversing together you reduce errors and improve quality. And error reduction is a very important component of cost reduction. Third key way Project ECHO saves costs is if you treat disease early then you prevent downstream cost of emergency room visits, of hospitalizations, also of end-stage liver disease, liver cancers in the future, liver transplants, Hepatitis C is the number one reason why people get liver transplants in the United States right now. So, there is this preventable cost of disease that happens. The fourth is that there is a desegregation in our health care system between the prevention arm of our health care system and the therapeutic arm. So the Departments of Health do something different from others from the doctors who treat patients whereas from a patient's perspective this care needs to be integrated. So what we do in Project ECHO is we bring this together and we essentially rebalance because right now the therapeutic arm or our health care system is very heavy, where as we don't do enough prevention etcetera. So you can have a rebalancing of this system when you bring public health principles back into a knowledge network. And lastly, I think that doctors typically have to travel large distances to get continuing medical education credits that they need to keep their licenses. And, in our case, we don't really need to do that because they can sit in their offices as you've seen on the video conferences. And they can get their educational credits while taking better care of their patients at the same time. And we certainly hope that we can integrate some of these ideas into the health care system of the United States for more cost effective again.

Margaret Flinter: Dr. Arora, you've spoken to so many compelling outcomes that we're seeing and I would add to that list may be we haven't expressed it specifically, the increased satisfaction with their primary care practice that the physicians and nurse practitioners who are sitting in on your sessions have from being able to manage these conditions for their patients with their patients and

their own practice. But, of course, there is one problem which is our payment system hasn't really caught up with this at all, and neither at the time the primary care providers spend on their video conferences with Project ECHO nor the extended time it may take to treat patients with these complex issues is readily reimbursed. Are you engaged in policy efforts to try and remedy this disconnecting? And have you been able to accomplish any of that in your home State of New Mexico?

Dr. Sanjeev Arora: So I think that -- I think you hit on the absolute soft spot of Project ECHO, which is really the issue of our payment when you said when you sat in the Connecticut Community Health Center Clinic those people who are volunteering their time to learn and treat and better have to help their patients -- the patients better. And so the reason why Project ECHO works is because doctors are extraordinarily interested in doing that. But I think for a long term sustainable solution we have to start thinking differently about what we reimbursed in healthcare. And I think that this kind of team work gaining knowledge producing a more efficient health care system should be reimbursed in some way. And we are in policy discussions with the state government here and we are initiating some policy discussions with the federal government to try and understand what would be the mechanism for a primary care clinician to be reimbursed for this kind of work that they do, which is very meaningful. It improves the health care system and it helps patient reduce his cost. But currently in a fee-for-service system, the major value accrues only when a doctor sees a patient in person and also there isn't adequate compensation for complexity. This remains a challenge for Project ECHO that we are trying to overcome. But I think that we are getting relatively good reception from the payers because they understand the limitations of the current fee-for-service system as it is designed today. But I think we are hopeful that we will be able to make effective change in the future.

Mark Masselli: This is Conversations on Health Care. Today, we're speaking with Dr. Sanjeev Arora, founder of Project ECHO. I want to pull the thread on that conversation a little and it seems to me that this disruptive innovation you have will also change the role of specialist into much more of a real time consultant helping direct other healthcare providers and how best see patients. Can you talk a little bit about the emerging role of specialist in your project as well as the primary care provider?

Dr. Sanjeev Arora: Sure. The principle goal in project ECHO is what we call a force multiplier. The force multiplier is based on one simple fact that there is a worldwide shortage of specialists. It's much worse in developing countries but even in the United States in rural and underserved areas and urban underserved areas of the kind you talked about this is a shortage of those specialists. So the underlying premise is that if we can create knowledge network where primary care clinicians can do work, which is as good as a specialist then you get force multiplication that is you get a logarithmic improvement and capacity, you get a

10 times in expansion and capacity. So what does this do to the role of primary care clinician? The role of a primary care clinician changes is the traditionally primary care clinicians see themselves as generalists with an expertise and everything. And what ECHO is saying is that, yes, that's a wonderful goal but add something to it. Now you are a generalist with a special interest in Hepatitis C, and one of your colleagues is a generalist with a special interest in rheumatology, another one is a generalist with a special interest in HIV and so on and so forth, so that now you have embedded within your own primary care practice various kinds of expertise which creates self-supporting organizations in these underserved areas. So, that's the role of the primary care clinician. We see the role of a specialist changing too because traditionally the federal government funds graduate medical education. What they do is they provide large amounts of funding to academic medical centers to train residents and fellows, these are people in training. But with the knowledge explosion that is occurring in the world, we need -- these doctors need training throughout their life, but there is no mechanism right now for that. We believe that a specialist at academic medical center should have dual roles, one is, one role is to actually treat patients and train trainees that reside in academic medical centers like residents and fellows etcetera, but then also assume the responsibility for continued training of the rest of the workforce which graduated many years ago, but in order to be effective and actually deliver best practices they do need to be connected to knowledge networks. And we believe that the ECHO model could be one effective way to make that happen.

Margaret Flinter: Now, Dr. Arora, I look back in may be 15 months and I was hearing about project ECHO for the first time and since then I have to say in the last few months especially I hear it just about everywhere I go in healthcare and I probably tell everybody about it wherever I go, as well. So it seems to me and when we think about the range of issues that project ECHO has organized itself to address the behavioral health issues chronic pain which is such an enormous issue rheumatology, HIV aids all of these things, it seems to me that we really have reached a tipping point where replication and spread of the model is absolutely lined up to happen, but as we know from, you know, creating some innovations of our own, to ensure that you preserve the quality the robustness of your model, the standards of how you've done it is challenging. May be you could share with us who are your partners across the country who you're working with on the replication and spread of this well maintaining that fidelity to the things that make ECHO work so well which you've I think laid out very well for us?

Dr. Sanjeev Arora: I think that you -- I'm sort of amazed how well you understand our project and challenges. And so, currently we have replicated project ECHO at the University of Washington and we have a very effective replication going on there for chronic Hepatitis C, for chronic pain and for substance use disorder. So, we have three programs in full swing there. We have also replicated project ECHO for HIV with the University of Florida. We've replicated it for chronic pain

Hepatitis C, congestive heart failure and diabetes and the VA system of the United States, not in the entire system but in seven regions. We are in negotiation with several states, to put ECHO program there. So, essentially there is a rapid spread going on and of course as you pointed out that, you know, we've had a lot of learning occur in the last seven and a half years and we don't want everybody to have to start from scratch and then spend years to get to where we are. So we would -- we are trying to set up a system where we can be -- provide effective technical assistance to a very broad range of replicators so that they can replicate project ECHO with high fidelity, maintaining outstanding patient outcomes, ensuring that primary care clinicians have high satisfaction.

Mark Masselli: Today, Margaret and I, in speaking with Dr. Sanjeev Arora founder of Project Extension for Community Health Care Outcomes known as project ECHO, a model of care that's linking primary care providers with specialists to improve healthcare outcomes. Thank you so much for joining us today.

Dr. Sanjeev Arora: Thank you.

(Music)

Mark Masselli: Each week, Conversations highlights a bright idea about how to make wellness a part of our communities and everyday lives. This week's bright idea focuses on creative solutions to feed the hungry especially during this thanksgiving holiday season. For several years the relief group feeding America has been helping underserved communities in the United States access fresh healthy food. The concept is simple, if a community can organize a food pantry, it will come to them. Mobile food pantries are managed by local food banks or agency staff volunteers bring into action once the truck arrives on site to unload and distribute the food. And the food brought by the food bank or donated is free to those who come; no proof of need is required. Since many underserved areas lack grocery stores, the priority for many mobile food pantries has become not just access but getting quality food to these deserts. Mobile units permit food pantries to mobilize a much larger circle of players into supplying food to the needy. This not only increases the number of people who receive the service but expands food pantry distributions into communities they haven't been able to reach before according to feeding America there are over a 130 members operating mobile pantries throughout their national network supplementing the regular offering of a local food pantry while at the same time bringing fresh food to food deserts. Now, that's a bright idea.

Margaret Flinter: This is Conversations on Health Care; I am Margaret Flinter.

Mark Masselli: And I am Mark Masselli, peace and health.

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