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

Margaret Flinter: And I am Margaret Flinter.

Mark Masselli: Well Margaret, we are inching ever closer to October 1st, the day that the online insurance exchanges in the Affordable Care kicks off.

Margaret Flinter: Well, it's a day we have waited for, for a long time. And a lot of states are still scrambling to get online for the first customers who will be wanting to purchase insurance in the new online marketplace.

Mark Masselli: New York State is ready for business with its exchanges. They even have a catchy marketing campaign with a little help from Billy Joel. We are in New York state of health, has a nice ring to it.

Margaret Flinter: I wish we could find a song like that in our state. And of course, they have also made their insurance rates available for review as have all the states, and it appears that there will be some bargains for New Yorkers shopping for insurance under the Affordable Care Act.

Mark Masselli: Indeed, several states are boasting insurance rates that are far lower in some cases than the going commercial rates.

Margaret Flinter: And speaking of insurance rates, Mark, for the second year in a row, the growth in insurance rates has slowed considerably on a national level. We were seeing almost double digit increases in recent years; in fact, health insurance premiums were up 196% since 1999. But last year, the increase was a modest 4% and I am hearing we are going to see that again this year.

Mark Masselli: Margaret, you are absolutely right. Insurance premiums for job-based family coverage rose a relatively modest 4% reflecting slowed health spending, but that's not necessarily the rosiest of pictures. For the first time, average health insurance cost for a family plan has topped $16,000. That's a lot of money for health coverage.

Margaret Flinter: It is. And of course, there is huge concerns about the out-of-pocket expenses not just the premium. So still so much work to do to contain health care costs. That's going to require transformation in how we deliver care, how we make it more efficient and more effective in terms of the outcomes for everybody.

Mark Masselli: That's something our guest today is working hard to do. Dr. Rishi Manchanda is the Founder and President of HealthBegins, a startup using innovative technologies to improve care for patients with social as well as medical needs.

Margaret Flinter: He has written a really interesting book, The Upstream Doctors, in which he promotes the growth of an upstreamist movement treating the social determinants of health that are so associated with poor health outcomes.

Mark Masselli: We have got another visit from Lori Robertson, managing editor of FactCheck.org.

Margaret Flinter: And no matter what the topic, you can hear all of our shows by Googling CHC Radio.

Mark Masselli: And as always, if you have comments, email us at www.chcradio.com or find us on Facebook or Twitter; we would love to hear from you.

Margaret Flinter: We will get to our interview with Dr. Rishi Manchanda in just a moment.

Mark Masselli: But first, here is our producer Marianne O'Hare with this week's Headline News.

(Music)

Marianne O'Hare: I am Marianne O'Hare with these Healthcare Headlines. Doctors and Medicare patients, the numbers are up. According to our report from the Department of Health and Human Services, the number of physicians accepting new Medicare patients rose by 1/3rd between 2007 and 2011. It's now higher than the number of physicians accepting new private insurance patients. It's partly reflection of the aging population. We are only weeks away from the October 1st start date when Americans will be able to purchase health insurance online in those insurance exchanges setup by the Affordable Care Act. And California is one of the states who got into the act early. But a poll out shows the average Californian knows little to nothing about the state exchanges. The field poll found only 25% of Californians had heard anything about the state's exchange called Covered California, and only 18% of the uninsured population, those who are most likely to be users of this system, had any knowledge if all of how it works. The poll's findings suggest much more needs to be done to educate consumers in California.

And what about the National Health Insurance scene which will be covering the needs of more than 30 states across the country? A couple of national surveys are making some predictions. The average health care costs across the board are expected to rise a little over 5% in the next few years. And most analysts are predicting an increase in high deductible plans being offered to employees as well as incentive programs for wellness activities like increasing exercise and losing weight. But workers don't have much to cheer as the increases are still

double the rate of wage increases and four times the rate of inflation. I am Marianne O'Hare with these Healthcare Headlines.

(Music)

Mark Masselli: We are speaking today with Dr. Rishi Manchanda, a physician, public health entrepreneur, and founder and president of HealthBegins, a startup implementing innovative technologies to improve care for patients with social as well as medical needs. Dr. Manchanda is also Founder of Rx Democracy, a national nonpartisan coalition to promote health equity through civic and voter participation. He is a board member of the National Physicians Alliance, and Dr. Manchanda is also author of the Upstream Doctors in which he calls for the upstreamist movement to transform health care by addressing the social determinants of health care. Dr. Manchanda, welcome to Conversations on Health Care.

Dr. Rishi Manchanda: Thank you for having me.

Mark Masselli: You have been a long time activist, seeking better health outcomes for tackling social determinants of health. In your recently released book, you coined the phrase upstreamists. Tell us about this upstreamist movement you are trying to generate in health care and who are the upstreamists in the health care system.

Dr. Rishi Manchanda: In the book, The Upstream Doctors, I argue that the future of health care depends quite simply on growing and supporting more upstreamists. And these upstreamists are the rare innovators who are on the frontlines of health care. They are the ones that see that health like sickness is more than a chemical equation. They are the ones that see rather that our health begins in our everyday lives, in the places where we live, where we work, eat and play, what the experts call the social determinants of health. They can be doctors, nurses or other clinicians. They are the ones who know that asthma for instance can start in the air around us. They understand that obesity and heart disease originate partly in the way that we have constructed our busy modern schedules, in the way that our neighborhoods are designed. Now the last point about the upstreamists is that the upstreamists move beyond just having this understanding of health where it begins but really translate that knowledge to meaningful action and they do so not just as advocates in the community but as really transformers of their clinical care delivery.

Margaret Flinter: Dr. Manchanda, you had an early introduction into the upstream concept of health care. You were a student at Tufts, working with the underserved population in Boston and you have worked in rural communities in Africa, South America and India. And I am really curious to ask you, in so many ways the touch points are similar to the development of the Community Health Center Movement in the United States with Tufts and the work of Dr. Geiger and

others. I know you have been involved in Community Health Centers in your career, and so tell me where does the upstreamist movement take off from those concepts of community-oriented primary care and being of and in the community and responding to the social determinants of health.

Dr. Rishi Manchanda: I think it's a great point and in fact in the book I talk about the lineage of upstreamists that dates back to even further back beyond Jack Geiger, to the (07:09 inaudible) of course in South Africa where Geiger himself received his own inspiration, and then even further back to Rudolph Virchow, the father of modern pathology as well as the father of social medicine. So the upstreamist movement has been part of medicine from the get-go in terms of modern medicine. And I think COPC, the Community-Oriented Primary Care movement here in the U.S., the Community Health Center Movement, certainly the upstreamists who are out there on the front-lines of health care today are all part of the same lineage. There is a lot to be learned I think from the lessons of upstreamists, pioneers. It's vital for us to think about the ways in which we orient the health care system to treat health where it begins.

Mark Masselli: And I want to pull the thread a little on the concept of upstreamists. In your book, The Upstream Doctors, you give a very illustrative example of why health care industry is failing so many. And you talk about a patient Veronica who had been suffering for over a year with progressively worsening headaches and other debilitating ailments and the use of specialist and numerous tests didn't really have any effect on her situation. So tell us about the upstreamist approach you took to focusing on her disease causality and how things were turned around.

Dr. Rishi Manchanda: This was a patient who came into a clinic I was working in, in South Central Los Angeles and when I first met her, she had her head in her hands in the exam room and she had been suffering from headaches that had come and gone for a number of years. She had gone to three different emergency rooms trying to get relief or care. In months and years prior, she had tried to get relief in going to the fragmented primary care system in that community and was still unable to kind of get a diagnosis. Prior months before I had seen here, she had received a dozen blood tests, a spinal tap or a lumbar puncture, and it's the whole host of interventions that represent in some ways the best of modern medicine.

But for Veronica, each visit to the emergency room ended the same way. She was told that her test results were "normal." One of the hospital visits led to a $1200 bill, her own rent was about $850 a month so already she was experiencing stress financially. She was fighting back tears as she described the toll this situation was taking on her family. But I do think there is something in Veronica's story that's also more illustrative of the upstreamists scenario, and we did things slightly differently. And the difference was that our medical assistant not only recorded vital signs as part of the normal operating procedure in a clinic

but she also asked her some simple questions about her housing. Veronica indicated that she had problems with mold and water leaks. That data helped to tailor my care; that social data was critical. It allowed me within 15 minutes to feel pretty confident in my diagnosis after talking with her and doing a targeted physical exam. Veronica in fact had migraines related to chronic nasal allergies and sinus congestion and these conditions are often made worse by dampness and the very things that were markers of such housing in her home.

So I ended up giving her some treatment but then I also referred her as part of my treatment plan to a program run by our clinic in partnership with some local organizations to help make her housing healthier. And so one of our partner organizations sent a community health worker to her home and assessed her situation, provided her with new techniques for controlling some of the dampness in her home, and even connected her to resources so that she could advocate more clearly with her landlord. Veronica followed this advice. A few months later, she came back in the clinic and she hadn't been to the emergency room anymore, her home was healthier, her headaches were gone and she and her family had gotten better. That's a glimpse as I call it in the book of a slightly better standard of care and I think that's illustrative of what we can all strive for with the upstreamist approach.

Margaret Flinter: I think you have a stated goal of promoting the development of a national task force of at least 24,000 upstreamists in the American health care system by the year 2020 and you have said that we don't just need to cultivate the upstreamists but the comprehensivists and the partialists and the integrated medicine also plays a vital role. So tell us how you are going to develop, cultivate, inspire this national task force.

Dr. Rishi Manchanda: The upstreamist really comes from that simple story that many of us know in public health which is the story of friends who approach a river and see a child pleading for help and the three friends jump in to try to help that child to safety, only to find that there are more children in the water, and eventually overtime those friends start to take care of those children. One of them focuses on the children who are at most risk of drowning right away. Those are what I would call the partialists or the specialists in our system today. They are the ones who are trained and are vital parts of our system. The other person becomes the comprehensivist, the one who can coordinate a raft so that they can avoid falling over the waterfall. But that's the era that we are in right now, the era of the comprehensivist. As we have seen with the Affordable Care Act, we have a moment right now where the Patient-Centered Medical Home is on the rise, the idea that everybody deserves a personal physician and a team of providers.

The story though, that parable also includes a third person and that is that person who starts to swim upstream and she shouts back I am going to find out who or what is throwing those children in the water. By the year 2020, many expert organizations estimate we will need about 460,000 partialists. Experts estimate

that we will require certainly more comprehensivists and we will need around 250,000 primary care comprehensivists by the year 2020. That's about 45,000 more than we have currently as well. While we strive for that goal that we also again get 24,000 upstreamists in the system and these are people specifically tasked with the opportunity to redesign their health care system to build bridges to other sectors to improve the quality of care and the social determinants of health.

Mark Masselli: We are speaking today with Dr. Rishi Manchanda, a physician, public health entrepreneur, and founder and president of HealthBegins, a startup implementing innovative technologies to improve care for patients with social as well as medical needs. And Dr. Manchanda is also author of The Upstream Doctors, in which he calls for the upstreamist movement to transform health care by addressing the social determinants of health. So there is a lot of providers coming into the practice who are going to end up being upstreamists and so it doesn't seem that there is currently an infrastructure in place to support the outreach that you envision. So let's look at your new startup HealthBegins and I understand it's a portal for upstreamists in health care to connect and share solutions to address patient and social and community needs. So what are the new innovative technologies you are deploying with HealthBegins?

Dr. Rishi Manchanda: So the work of HealthBegins is to use to try to work in both addressing some of those specific problems head-on and find partners to address the ones that we are not able to address head-on. So, for instance, the first thing we did in terms of our work with HealthBegins, we decided to take on the first challenge of the lack of a network. There simply isn't at this point a space for upstreamists to come together as there is for the comprehensivists and the partialists. And we decided to create that both in the real world as well as online several months ago. We started an online platform and now it's invite-only platform; people can visit the site at HealthBegins.org and sign up.

But the other work that we are doing is around training and across the country not only are we giving presentations to residents and practicing clinicians but we are also taking that content, give specific information about how we can connect the dots within health care to the social determinants. We are moving our content into online modules, moving content into a format that's accessible by learners at all levels. And so by deconstructing the infrastructure problem into addressable pain points, we can really make a dent in this movement.

Margaret Flinter: Dr. Manchanda, I know from what you have said and what you have written that you are interested in data, big data sets that really help you understand populations. At our home state here, the health directors have worked very hard over the past several years to develop a health equity index, which looked at every single city and town and the state, of the social determinants of health, really able to create an index down to the block level. Are there any points of light around the country where that level of availability of

data on the social determinants of health likely to be affecting that individual or that family are incorporated into the primary care system?

Dr. Rishi Manchanda: Yeah. The great news is you are talking about Connecticut and around the country that there are some glimpses of better care on the horizon and of specifically the applications of Big Data, of Health Information Technology, and bridging this divide between clinical care and the social determinants. So I think of examples in the State of Vermont where the blue print for health that has been adopted there as part of their statewide implementation of the Affordable Care Act has not only called for a medical home and the formation of Affordable Care Organizations but really the inclusion of community health workers and there is going to have to be a data infrastructure in place in that state. There is examples of organizations out in as far as Hawaii that I profile in the book about a clinic called KKV for short and what they do is collect information about their patients' food habits and access to food, and based on that data, we are able to not only provide better care in the clinic walls but then advocate for the institution of a community farm.

The Institute of Medicine released a report outlining opportunities to improve the integration of primary care in public health. And as that report indicated, widespread adoption of electronic medical records represents a major opportunity. Many clinics are well-positioned to collect data from their patients on the social determinants of health. We are going to have the ICD-10 that updated classification list developed by the WHO that's in the next few years going to come online and require clinicians in the US to code for diseases and signs and symptoms of course but also for social circumstances to a level of specificity that's been unprecedented.

Mark Masselli: You know, I want to talk a little bit about the tech side because health care industry has been very slow to adapt and adopt into new technologies. You say you have been looking at the (16:52 inaudible) like roadmap for health care and you say it's been done in other industries and obviously it's not been done in health care and it should be a way finding tool. Tell us about your idea for a six-step roadmap that can help us better map out the social determinants that are impacting population health.

Dr. Rishi Manchanda: Yeah. I think it's important because there is a rise of technology solutionism and for us not to fall into a trap that many technology enthusiasts sometimes report which is that there is an app for everything. In some ways, technology can only make us better and more efficient but it enables the real work of the upstreamists which is to leverage that technology and data to move the needle on the social drivers and that means the work of face-to-face organizing. While there is an app for a lot of things, there is not an app for the important work of reorganizing our health care system. So the six-step roadmap within HealthBegins is designed to help the people who might be listening to this

right now and thinking well if I want to be an upstreamist, that sounds great but how do I do this.

So we walk people through those six steps and make it attainable. The first step is of course to define the population and then to move on to define the social determinants of that community and to use technology to do so to then develop a very specific intervention and then to use the best knowledge of quality improvement to think about moving the needle on that social determinant, not only taking the data from that pilot but then of course celebrating that spread and using specific tools that come from the social movement and business community to spread that knowledge.

So the specific example of where the tool of the (18:22 inaudible) comes in is we started working on the education side with high school students and over the past year, so many high school students have participated in the educational curriculum where they learn about the social determinants of health. Every week, as they learn about housing or nutrition or whatnot, they also map the resources that can address those drivers. And when I say map it, they literally are going online and looking for the resources that can address the needs of their parents and their neighbors. And that mapping exercise results in a resource listing database that we then turn over to the clinical partners to say now use this resource listing database, this (18:54 inaudible) service to now more easily connect a patient with a social need to the resource that these students have mapped. We called this model Community Health Detailing 2.0, the idea of taking exercise of detailing that the pharmaceutical industry has used for so long and bringing it to using the expertise and the power of community mapping to help detail the prescribing behaviors and the practices within a clinic. So the community itself is saying here are the resources doctor that exist outside your clinic walls and here are the ways in which you can help a patient that walks in your door to find them through a simple, easily accessible online tool. That's our vision, we have built the prototype of it and are proud to be in the midst of a beta right now with some clinic partners here in Los Angeles to make that app.

And right now, doctors and case managers and others in the health care system are looking at when they find a patient coming in with a social need, they are still looking at binders full of tattered papers to find that number for the housing agency or the (19:53 inaudible) provider or the food stamp or the legal aid foundation. So it's incredible that we are still using 12th Century tools to tackle 21st Century problems.

Margaret Flinter: We have been speaking today with Dr. Rishi Manchanda, a physician, public health entrepreneur, founder and president of HealthBegins, and author of the Upstream Doctors: Medical Innovator Track Sickness to its Source. You can learn more about his work by going to www.healthbegins.org or follow him on Twitter by going to Rishi Manchanda. Dr. Manchanda, thank you so much for joining us on Conversations on Health Care today.

Dr. Rishi Manchanda: Thank you for having me here.

(Music)

Mark Masselli: At Conversations on Healthcare, 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 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: President Obama recently made a sweeping claim about the Affordable Care Act, saying that all of the uninsured would be able to get insurance on the exchanges "at a significantly cheaper rate than what they can get now on individual market even, without federal tax credits." But experts including Health and Human Services Secretary Kathleen Sebelius have said that younger Americans would likely pay more on the exchanges while those who are older would likely pay less. Much will depend on the individual. If you have a medical condition, you will likely pay less on the exchanges than what you would have paid on the individual market, and perhaps you weren't even able to get coverage at all. But not everyone will pay lower rates.

The law requires a minimum set of benefits which will make some plans more generous and more extensive. The law also changes how insurers can calculate rates, and experts have long predicted that will cause a shifting in premiums. Right now, insurers can charge more based on health status or gender. They won't be allowed to do that in 2014. They will also be limited to varying premiums based on age to a 3:1 ratio, meaning older folks can't be charged more than three times the rate for the young. This change from medically underwritten policies to community rating, which limits premium variation, will bring better deals to some and worse deals to others. About 90% of the uninsured will qualify for Medicaid or subsidies to help them buy insurance, but Obama said they would pay less even without accounting for subsidies. 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.

(Music)

Mark Masselli: Each week, Conversations highlights a bright idea about how to make wellness a part of our communities and everyday lives. Low literacy rates

have been linked to poor health outcomes around the globe so Nicholas Negroponte decided he should do something about that. The Chairman Emeritus of the MIT Media Lab has been on a mission since 2005, the year he launched One Laptop per Child whose mission is exactly that. Negroponte figured his organization could meaningfully change the lives of about a 100 million children living in world without access to education. He felt that this sturdy child-friendly laptop relying on solar power could change that statistic.

Nicholas Negroponte: What if we go to these parts of the world where there are no schools. We can try and experiment where the kids teach themselves.

Mark Masselli: Negroponte was so inspired that he tried an experiment in an Ethiopian village, no schools, no literacy, that brought boxes of computers to the village, left them there with no one to instruct the children in any way.

Nicholas Negroponte: Within five days, they were using 47 apps per child per day. Within two weeks, they were singing ABC songs and within five months, they had hacked Android.

Mark Masselli: Negroponte says this could enable a whole new way of teaching around the globe that effectively has the power to eliminate illiteracy, and one hopes, improve the economic and health figures of these children as well. The One Laptop per Child organization now has deployed three million computers in 40 countries and 25 languages. Distributing a simple, durable laptop into the lives of children who would have otherwise been left illiterate, and offering a promise of brighter future, 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 Center.