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Margaret Flinter: Welcome to Conversations on Health Care with Mark Masselli and Margaret Flinter, a weekly show where we speak to the top thought leaders in health innovation, health policy, care delivery, and the great minds who are shaping the health care of the future. This week, Mark and Margaret speak with Dr. Sachin Jain, President and CEO of CareMore, an innovative coordinated care delivery model for high use patients in Medicare and Medicaid, using team-based interventions, wide services, a program to target loneliness and inactivity to yield better outcomes and a better quality of life for patients.

Lori Robertson also checks in, the managing editor of FactCheck.org, looks at misstatements spoken about health policy in the public domain, separating the fake from the facts. We end with a bright idea that's improving health and wellbeing in everyday lives. If you have comments, please email us at chcradio@chc1.com or find us on Facebook or Twitter. We love hearing from you. You can find us on iTunes, or Stitcher, or wherever you listen to podcasts. Please feel free to leave a review there.

Now, stay tuned for our interview with Dr. Sachin Jain on Conversations on Health Care.

Mark Masselli: We're speaking today with Dr. Sachin Jain, President and CEO of CareMore Health, an integrated health care system, focusing on improving care coordination with high-risk Medicare and Medicaid patients. Previously, Dr. Jain was CareMore's Chief Medical Officer and Chief Operating Officer. He was first Deputy Director for Policy and Programs at The Center for Medicare and Medicaid Innovation under President Obama and CMS Administrator, Don Berwick. He was just named Modern Healthcare's 50 Most Influential Physician Executives. He earned his BA, MBA, and medical degree from Harvard.

Dr. Jain, welcome to Conversations on Health Care.

Dr. Sachin Jain: Thank you so much. It's great to be with you.

Mark Masselli: Yeah, and as a physician with real focus on care transformation, it seems like you've landed in the perfect spot at CareMore, which is an integrated health plan and delivery system, designed to target high-risk chronically old patients through focused care coordination. You've been getting lots of national attention for significantly reducing hospitalization and poor health outcomes. I'm wondering if you could tell our listeners about your unique approach and why it's been so effective.

Dr. Sachin Jain: Yeah, I'd say the great thing about CareMore is that it's not so much a model. It's actually multiple models. More importantly, it's an approach. I think it's a philosophy of care, the idea of that we need to

better manage chronic disease, we need to understand the social determinates of health, and really manage the disconnection that patients experience when they receive care across the care continuum. We are fundamentally organized around the problems that patients experience and work to try to solve those problems. We have multiple different operating models, but what I would say is one common culture, one common philosophy, and one common approach to actually dressing the needs of the patients that we serve.

Margaret Flinter: Dr. Jain, you've laid out this three-pronged approach that's been developed. You've got the CareMore Care Centers, the CareMore Chronic Care Management Programs. Then you've got something called the CareMore Extensivist. Talk with us about how these three entities are designed around the patient experience.

Dr. Sachin Jain: Let's start with the care centers. I think the care centers take all the things that you'd love to have in a primary care office. Most primary care offices are sub-skilled to deliver. We have Chronic Disease Management Programs for all the most common chronic diseases of the senior population. We have integrated behavioral health. We have dietitian to help with counseling. We have exercise programs that are focused on the senior population. What all of that amounts to is really risk stratification of patients, and then targeted and focused interventions to keep our patients healthy.

Extensivists are really about taking care of the patients when they are in the hospital, but then also taking care of them in post-discharge follow-up as well as in a post-discharge clinic. Ordinarily, that would be three different care teams that are actually taking care of the patients. We have one team taking care of the patient across all those sites. What it does is it creates a higher level of coordination across all of that care.

Then the third piece is really the case management infrastructure. That really, it is the glue across the system. It's our case management that actually keeps it altogether. That's in addition to the patient's primary care provider. There's this whole extra infrastructure that wraps around the traditional health care system that actually makes it work for the patients. What we feel is that we have fewer hospital admissions, shorter lengths of stay, more satisfied, more loyal patients, and delayed progression or slowed progression of chronic disease.

Mark Masselli: Well, and I think your whole model, this approach, is about a philosophy of care. Your organization was one of the first systems in the country to provide ride services for patients to keep appointments. As you were talking about, CareMore also decided to deploy your program to improve diabetes management that I'm wondering if you could describe some of those targeted

interventions?

Dr. Sachin Jain: What we do is not rocket science. I think managing chronic disease is a relational art. We focus on building really strong, durable, engage relationships with our patients, so that they know that somebody is actually concerned about their overall well being. It's old school medicine.

Margaret Flinter: Right.

Dr. Sachin Jain: As many of us know, old school medicine has gone out of stash in a lot of places. Part of our, I think, role is in promoting a system that really works. One of the key enablers of the CareMore model is the chassis on which we're built is not a fee-for-service chassis. We are built with a notion of full delegation of risk, meaning we get paid a per member, per month risk-adjusted payment. Because we have a high level of loyalty, our patients don't leave us. We are not playing the game that a lot of insurance entities play, which is not being concerned about longitudinal health care costs. Our average member stays with us for nine years.

We are investing. We are spending more money upfront with the idea that our patients will have fewer medical complications, the slower progression of disease. The average acute episode of illness lands somebody in the hospital and cost $12,000 or $15,000. If you were to take that money and actually reinvested in prevention, you get phenomenal outcomes. That's how we are able to provide transportation to our members because we noted that's one of the barriers to access to care. That's how we are able to provide post-discharge meals for patients. That's how we are able to deliver a Togetherness Program, which focuses on providing social interaction engagement for our most socially accelerated members. Those are expensive interventions. They are far less expensive than sending a patient to the hospital for an ICU admission.

Margaret Flinter: Well, Dr. Jain, obviously the burning question is, so how come this isn't available to everybody. Let me start with an earlier question that I wanted to ask. We've been carrying a lot, and we had Dr. Charles Alessi from the National Health Service in England on the show recently, really zeroing in on this question of loneliness that's faced by so many people, and just how bad it is for health outcomes among the elderly. Sounds like you've taken that to a higher level in terms of specifically targeting loneliness. Tell us a little bit about that. What dementia prevention strategies are showing promise in your work?

Dr. Sachin Jain: Loneliness is an epidemic in plain sight in American society. There's been a change in our family and social structure in this country. Seniors are living longer. They're also living lonelier. One of the things that we've recognized is that lonelier seniors oftentimes take less

good care of themselves. We talked about the burden of chronic disease. The way in which chronic disease is managed is through high levels of self care, watching your diet, taking your medicines. What we find is people who are not connected to other people, oftentimes the first thing that goes is their self care. For the loneliest patients in our health care system, we create intervention, a phone call from somebody who cares about you, can make all the difference in the world. They can be that spark of encouragement. It can be a nexus point for a connection to community resources.

We have, what we believe, is the world's largest and oldest loneliness program, we call the Togetherness Program because we want to de-stigmatize this condition. We connect people with togetherness connectors for particularly socially isolated members. We send social work interns or other individuals into the home to try to pull people out of their homes and connect them with others. We encourage them to participate in group exercise activities at our senior gym. We make sure that their medical needs are met.

What we are seeing from the early data, we just celebrated the first-year anniversary of this program, is that patients are healthier. They are participating in preventative health care measures more. They are participating in exercise more. We saw 75% greater participation rate in group exercise activity, and in intervention group as compared with the control group because people are participating in this Togetherness Program. Incredible opportunity I think for us to skill impact and make a dent in a problem of greater and greater importance in our society.

Unfortunately, dementia is one of these areas of medicine and clinical care, where we don't have a lot of good medicines or treatments. We're really going to look to the pharmaceutical industry. They come up with some solutions to this problem. Before those solutions get to market, we need to figure out ways to take better care of dementia patients. One of the worst places you can take care of a dementia patient is in the hospital. We take a demented patient. You put him in an unfamiliar setting. It's literally a recipe for delirium. Delirium is a recipe for downward spiral for a dementia patient.

A lot of what we do is teach families how to proactively intervene when they have health care, medical problems, and what to expect. Ordinarily, there's this phenomenon of sundowning in many demented patients, where they become a little bit delirious in the evening hours. That can be very scary for families. The first place that they'll take their family members is to the emergency room, which then can sometimes create this downward spiral of a hospitalization. If they know what to expect and oftentimes they can stay out of the hospital, and staying out of the hospital, they can avoid downward

spiral, which I observed so many times when I was more regularly practicing inpatient physician.

Margaret Flinter: Right, absolutely.

Dr. Sachin Jain: This is I think one of the great opportunities we have is to while we wait for these great pharmaceutical interventions to come to treat the disease of Alzheimer's and other forms of dementia, helping families learn how to use the health care system for patients who do have cognitive impairment, can be a huge opportunity, improve the quality of care and decrease health care costs.

Mark Masselli: We're speaking today with Dr. Sachin Jain, President and CEO of CareMore Health, an integrated health care system, focused on improving care coordination for Medicare and Medicaid patients, significantly improving outcomes. He was just named Modern Healthcare's 50 Most Influential Physician Leaders.

Well, I think we've all read in the news, Dr. Jain, that Atul Gawande has been appointed the CEO of the newly formed Amazon, Berkshire Hathaway, JPMorgan organization. I'm wondering as you think about this broad charge that he has, improved efficiency, save money, better job, caring for patients, do you have any other advice that you'd pass along as he takes on this enormous challenge?

Dr. Sachin Jain: Absolutely. I think that the most important thing we can do is to make sure that we have happy physicians and happy nurses, and that we support clinical models, where we're restoring the joy of practice. We need to make being a physician or nurse in America sexy again. What it used to be 20, 25 years ago, that this was considered the greatest profession of all. I think we really need to do that. Sometimes people say that we need to create a more patient-centered care to the exclusion of a physician-centered health care system. I think you need to be centered on both. You can't have a patient-centered health care system without taking care of the workforce that delivers the care.

I think there's been a devaluation of the health care workforce. We tend to treat health care workers and clinicians like they are commodities. We used word like provider to describe them, when in fact they're highly trained professionals with high values and a moral code. The thing that makes me most excited about Atul taking that position, and he's just a giant in the field, and that he's probably one of the most sophisticated thinkers on health care. I know he gets this. I know that the solutions that he's going to be thinking about are going to be holistic and thinking about patients, physicians, system-wide stewardship, care teams. These are all topics that Atul has inspired the whole industry around. I think that that's going to result in solutions that are inclusive of more holistic view of the whole thing.

Margaret Flinter: Well, Dr. Jain, I'm really excited to hear about your excitement about and focus on training both the current and the next generation of physicians, nurses, nurse practitioners, and sounds like Pas, and social workers, and may be community health workers, since much of this kind of model is not something that people are trained to in depth. This is something that we've put a lot of focus on in our work around post graduate trainee in particular, but also now with medical systems, we do with our ends in primary care to train people to clinical complexity, but also train them to a evolving high performing model of care, and just the idea of having the same care team caring for the patient as they are in the acute care setting. Maybe just talk with us a little bit about what kind of infrastructure you've built for that.

Dr. Sachin Jain: I think that at the center of the infrastructure is something we're calling the CareMore Academy. We have just recruited our first Vice President for the CareMore Academy, which is a gentleman from Connecticut, named Bob Tedeschi. Bob, he's so skilled across so many different domains. He's a college athlete. He really understands teams. He's a Pulitzer nominated journalist for The New York Times. He's got the gift of personal articulation. He's the spouse of a nurse, a mother of a nurse. He has a deep understanding of the health care system and the central role of compassion, and the need to preserve that compassion for people, who deliver care. What we're really working on with him is designing programs that are around the culture of true team-based care for the sickest of the sick. It's the central task in building the health care system of the future is actually getting these elements right.

A second part of it is having a real focus on what the product is and product definition. For that reason, we recently appointed Dr. Vivek Garg, CareMore's Chief Product Officer. It's the first time we've had that role, really recognizing the need for us to build scalable platforms and chassis onto which we can layer different components to serve different populations. CareMore is kind of known for its historical model that you're referring, the care centers and the extensivists. We are now live in Connecticut with a home-based primary care model. We have a 10-year history, providing institutional care for nursing home and homebound patients that wraps around our kind of traditional health care delivery model.

All health care is very local. For that reason, we're just getting much more rigorous about how we define our product, how we scale our product. You asked this question before about why this model hasn't scaled to more places. I would say this is at the heart of it is kind of getting really rigorous in the same way that Apple is rigorous about designing products. We in the health care delivery world have not have been that rigorous about designing products. At the same time,

the foundation of all of this is world class clinical care.

That's why we appointed Dr. Zubin Eapen, our Chief Medical Officer, last year. He's world class cardiologist. He was an associate professor at Duke University, a renowned clinical investigator, and he sets the standard for the quality of clinical care in every single interaction. That's what this takes. It takes the right culture, the right product definition, and the right clinical care to actually take care of the patients that we serve.

Mark Masselli: I was thinking as you were talking about a world class cardiologist, we just had Dr. Eric Topol on the show talking about Texas central role in advancing personalized medicine. I was thinking over your 25-year journey, the aggregation of data, and the new technologies coming into play, must have a profound influence on what you can achieve now. Talk to our listeners a little bit about actionable data and any particular digital application that you find that's been useful?

Dr. Sachin Jain: I think data is going to enable the hyper-personalization and the hyper-customization of health care. One of my big frustrations in the health care system is that no matter who you are, the system treats you exactly the same. The problem is that all of us don't have equal needs. Some of us are sicker. Some of us are more complex. The system needs to adapt in real time to meet people's needs. Your average medical office visit does not look different today than it did 30 or 40 years ago. We are on the bleeding edge of this, starting to think about how different types of data can be brought to bear on making these clinical encounters even more personalized.

Some of the types of things we're exploring are things like integrating the use of pharmacogenomics data by actually gene sequencing all of our patients to understand what kind of drugs will work for our patients. That hyper-personalization is going to unlock lots of opportunities for us to improve the quality of care, reduce costs, and really make it, so that we're not just practicing trial and error medicine. I think the average American thinks that our health care system is much more precise. I thought that before I went to medical school. Then you quickly realize that we're just beginning to scratch the surface and some of life's greatest mysteries.

40, 50 years ago, we didn't even know the structure of DNA. Today, we're inventing custom treatments based on the single base pair deletions in the genome. There's just a rapid evolution that's going to evolve, the underlying basis of which is just greater and greater amounts of information. We need systems and processes to organize that information, so that's actionable for clinicians at the point of care. That's what's needed. That's what I think we're most excited about.

Margaret Flinter: We've been speaking today with Dr. Sachin Jain, President and CEO of CareMore Health, an integrated health system, focused on improving care coordination and care for Medicare and Medicaid patients. You can learn more about their care model by going to caremore.com, or follow him on Twitter @sacjai.

Dr. Jain, thank you so much for your innovative work in transforming care delivery and for joining us on Conversations on Health Care today.

Dr. Sachin Jain: Really appreciate it.

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Margaret Flinter: At Conversations on Health Care, we want our audience to be truly in the know when it comes to the facts about health care reform and policy. Lori Robertson is an award-winning journalist and Managing Editor of FactCheck.org, a nonpartisan, nonprofit consumer advocate for voters that aim to reduce the level of deception in U.S. politics.

Lori, what have you got for us this week?

Lori Robertson: Several democrats in Congress have made preexisting health condition an issue in their fight against President Trump's nomination of Brett Kavanaugh to the Supreme Court. The issue concerns a court case filed by Texas and 19 other states, arguing that the ACA individual mandate, that's the requirement that you have insurance, is unconstitutional. Therefore the whole law must go. The Department of Justice has cited with the point and send the case, but said it doesn't think the entire health care law should be scrapped. It said only two provisions would have to be eliminated if the case were successful. Provisions guaranteeing that those with preexisting conditions won't be denied coverage or charged more based on health status.

We don't know if this case filed in a district court in Texas will even make it to the Supreme Court. If it does, it likely won't be until 2020. Several democrats have made this a main talking point. A week before Kavanaugh's nomination, a TV ad from a democratic group warned that the nominee could eliminate the ACA's preexisting condition protection, a move that "would take us back to a time when insurance companies could deny you coverage". Prior to the ACA's enactment, insurers could deny coverage based on health status, but only on the individual market, where those without employer-based plans or public coverage buy their own insurance. 7% of the population has individual market coverage.

Under HIPAA, employer plans couldn't deny insurance to workers. If a new employee had a gap in insurance coverage of more than 63 days, employer plans could exclude coverage for a particular preexisting

condition for a limited period up to a year. Pregnancy couldn't be excluded however. The ACA's preexisting condition protections mainly affect the individual market. The law also gave peace of mind to those with employer coverage or those who might want to start their own business, and therefore need to get insurance on the individual market.

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 Health Care.

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Mark Masselli: Each week Conversations highlights a bright idea about how to make wellness a part of our communities and everyday lives. One in five Americans will suffer a diagnosable mental health condition in a given year, and most often don't seek treatment. For those with serious mental health conditions, the consequences can be devastating, hospitalizations, loss of job or home, or even early death. Seeing the rise in mobile apps aimed at behavioral health entering the marketplace, the University of Washington researcher, [inaudible 00:22:51] and Zev thought a comparative effective analysis study would be a good idea.

Male: My team and I conducted a three-year comparative effectiveness trial, having a head-to-head comparison between a mobile health intervention for people with serious mental illness, called FOCUS and more traditional clinic-based group intervention called WRAP. The study really gets at some of the core differences between mobile health and clinic-based care.

Mark Masselli: More than 90% of the mobile app group engaged in the online program, both groups of patients saw roughly equal results from their completed treatment. The mobile group was more likely to engage in therapy.

Male: Probably the most important piece of the study are the clinical outcomes. 90% of the individuals, who were randomized into the mobile health arm, actually went on to meet a mobile health specialist through the use of the intervention app, that was assigned to them at least once, whereas in the clinic-based arm, we saw that only 58% of the participants assigned to that clinic-based intervention ever made it in for a single fashion. We know that the very existence

of a group can be quite helpful. For others, the interaction is anxiety provoking. When it comes to the clinical outcomes in both intervention arms, people improved both in terms of reduction in their symptoms and improvements in their recovery.

Mark Masselli: A targeted mobile app aimed at facilitating access to clinical care for those experiencing serious mental illness symptoms, improving access to intervention for behavioral health needs. Now, that's a bright idea.

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Mark Masselli: You've been listening to Conversations on Health Care. I'm Mark Masselli.

Margaret Flinter: I'm Margaret Flinter.

Mark Masselli: Peace and health.

Margaret Flinter: Conversations on Health Care is recorded at WESU at Wesleyan University, streaming live at chcradio.com, iTunes, or wherever you listen to podcasts. If you have comments, please email us at chcradio@chc1.com, or find us on Facebook or Twitter. We love hearing from you. This show is brought to you by the Community Health Center.

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