Moderator: Welcome to Conversations on Healthcare, with Mark Masselli and Margaret Flinter. A show where we speak to the top thought leaders in health innovation, health policy, care delivery and the great minds who are shaping, the healthcare of the future. This week Mark and Margaret speak with Iyah Romm, Founder and CEO of Cityblock Health, a venture of Sidewalk Labs, a division of Google's parent company Alphabet. They are creating a new system of tech-enabled care delivery that's addressing care gaps in underserved urban areas.

Lori Robertson also checks in, the Managing Editor of FactCheck.org. She looks at misstatements spoken about health policy in the public domain, separating the fake from the facts. And we end with a bright idea that's improving health and wellbeing in everyday life. If you have comments please email us at www.chcradio@chc1.com or find us on Facebook or Twitter, iTunes or wherever you listen to podcast. And you can also hear us by asking Alexa to play the program, Conversations on Healthcare. Now stay tuned for our interview with Iyah Romm, the CEO of Cityblock Health, on Conversations on Healthcare.

Mark Masselli: We are speaking today with Iyah Romm, Founder and CEO of Cityblock Health, an innovative tech-enabled care delivery company focusing on underserved patients in urban settings. A venture that was incubated with Alphabets, Sidewalk Labs, prior to that he was Chief Transformation Officer at the Commonwealth Care Alliance, driving efforts to improve care delivery in health plan operations. He was Founding Policy Director at the Healthy Policy Commission and before that he served in the Massachusetts Department of Public Health working on the state's healthcare reform efforts. Mr. Romm served as an adjunct faculty at Atul Gawande's, Ariadne Labs and was named to Modern Healthcare list of Up & Comers. He earned his Bachelors in Biology at Brandeis, studied medicine at Boston University. Iyah, welcome to Conversations on Healthcare.

Iyah Romm: Thank you for having me Mark and Margaret. It's great to be with you this morning.

Mark Masselli: You have been a healthcare activist since you sought to enter the medical profession and you founded Cityblock because you see health is the issue of our lifetime and that health disparity is the rise of chronic disease and unsustainable cost have increased poor health around the country. He decided that health should be addressed at the granular level which is in your name, right down to the block where someone lives. What is the tech-enabled approach you have deployed at Cityblock and how does it address some of these upstream challenges?

Iyah Romm: I think its important Mark and Margaret first of all let me say about Cityblock is. We are about 18 months into the best journey of my life

certainly professionally, learning about approaches that community health transformation, technology spread, grassroots organizing public health and venture capital all alike towards the question of how do you build a system that's [inaudible 00:02:50] from all of these disciplines, to improve health and communities all across the country. Fundamentally, we are a social justice company because we recognize that [inaudible 00:02:58] of our health system including many of those that you have just described, especially for those most vulnerable among us are unacceptable.

We saw it at Cityblock to build a personalized health system that serves lower income, individual living in certain neighborhoods, as they grow as to good health. We believe that health happens locally and so we put each individual we care for, and importantly the community is the desire of what we do, the care that we deliver is care that's designed for who our members are without judgment, wherever they are. Our approaches we did in the organization that personalized care can't be about to one care model or to one toolset, I heard one of my friend and colleague, Dr. Sachin Jain from CareMore on your program recently and he similarly described a philosophy and approach, the idea that we have to build a wide array of tools within our proverbial took box and the trick to doing this work well is figuring out in which order to pullout this, and use those tools, to understand quickly if they are not working. And then define the right balance across engagement health outcomes and cost efficacy to ensure that that algorithm to how you apply different approaches, teach individual or community works more effectively, recognizing that any of these tools, food, transportation, social connection, child and elder care, are largely unknown to the healthcare system.

So what we do is build relationships with our members, we provide value based and it is wholly capitated care to long-term urban populations, predominantly those on Medicaid, Medicare and those who are really eligible for both. We also later focused on the fact that this week has disproportionally poor quality outcomes, and poor experience of care despite the fact that there is disproportionally high spending. We forge long-term relationships and bring services to meet them where they are, be it in our neighborhood hubs, at home, at work it all has to be local.

The three pillars of our model are community health partners, hire from the communities in which we serve, where we hire from empathy, the cost domain for relational skills, these are really the quarterbacks of our care team. And then around them we layer and integrated care team, RN, care managers, social workers, behavioral health specialist, both primary care and psychiatric advanced practitioners and physicians employed and partnered across the community, to build that integrated environment. Our neighborhood

hub serves a primary care clinic, and, in the future, we envision a variety of ways that each of these hubs is customized to the local community.

For example, our first [inaudible 00:05:13] has a child playing room where we can have a visit with one of members at the same time as that number of children are playing in that room. And then we have a digital platform that bind it altogether, really help partners and educated care team that deliver primary care, behavioral health, palliative care, alongside services that addressed the social determinants of health.

Margaret Flinter: Well I want to share with our listeners this very powerful infographic you have on your Cityblock website that sort of guess at this issue of how much things cost, do you use the example of if there was a hospitalization that cost $10,000. And the comparison to how many other services could have been provided for that same amount that would have potentially kept the person out of the hospital. 120 behavioral health visits or 500 hours with a community care worker. Share with our listeners how shifting some of the spending to the prevention model and to addressing the social determinants of health, might just lead to better and less costly outcomes.

Iyah Romm: Sure, when you stop and think about it for a moment, an average hospitalization which is going to shift a little bit market-by-market, accounts for those per fours of the community care worker, but also accounts for significant transportation or one of my favorite statistics, two and half years at food stamps for family. And we think about the opportunity for meaning to investment of those factors that underline health of a population, I think it's very clear that we have opportunity to reinvest.

So many model vendor in this space has demonstrated and you can reduce total utilization. Emergency department spending, and inpatient hospital spending find in the order of 35% to 40%, even though with model like ours that can support them out in the community that can provide wraparound services to help them be healthy, when you show then the emergency department, hospitals are very good to getting you into their beds. And in the pharmacy side they have variety of pragmatic factors here that I think are really important to consider. We had a member recently who had the current emergency department utilization, who made really smart choices, to access the emergency department at the end with every month, to get a 30-day based [inaudible 00:07:20] because they knew that the emergency department was lashing that out in the end of every month. And the reason for that is because they had a $350 copay on that insulin medication.

And so being able to find ways to intervene around the cost of

pharmacy services, slides of current and preventable emergency department spending I think is really powerful. The reasons that people go to emergency departments are largely again fairly rationale, the people are going for familiarity, it's a place in care where they are treated equally with all others because the guiding principle that drives how people are prioritized in the emergency department is not insurance status typically, it is sick or not sick. That's virtually the only place in the healthcare system outside of some of the exceptional community health centers among us, where people are not judged for the insurance part that they carry or for the ways that they addressed or where they live. One of my favorite recent anecdotes from my members is that she goes for the Wi-Fi and the air-conditioning in the emergency department. And so for all of those things there are preventable ways for us to build, trusting safe spaces that are available after hours. And even so doing make relatively incremental investment that drives very significant savings in the overall total cost of care.

Mark Masselli: So you have adopted this varied approach to improving access. I wonder if you could talk to our listeners about how you are leveraging technology and what it looks like in your toolbox that you find affective.

Iyah Romm: The journey for me of realizing that a common theme of those frustrated in family healthcare workers and the lack of meaningful tools to engage and communicate with those that we serve [inaudible 00:08:55]. So when I had an opportunity to partner with Sidewalk Labs, to think about what Cityblock could become with a core infusion of technology from the outset, I got very excited about the possibilities. So the core of our technology asset common is appropriate platform for those consumers who tend to be able to look to be not who they are at low-income, Medicaid recipients, some of those on Medicare. And very specifically as we came to pull together capabilities that I think are fundamentally fairly practical, their capabilities around communication, cost management. Our community health partners [inaudible 00:09:27] and can hold them accountable.

And then very specifically we hired on for our team the folks who think about product expertise that really fundamentally focus on beautiful user-friendly design. When I put in front of the senior Alphabet leadership, screenshots from some of the leading electronic health records that are charging 100 and millions of populating the dollars in the market today, they laughed and thought I was joking. And so the opportunity to build simple, easy-to-use tools with those foremost goal of maximizing the value team and interactions anywhere between our care team members, those that we care for. And some of these stuff just isn't that effective to be frank, figuring

out staff deployment models, figuring out workflow management, how do you communicate across teams in seamless ways. And importantly how do you capture all of this, for example the ability to ask family members or caregivers of our members that we are caring for, directly in to [inaudible 00:10:18] full budget of the care team.

And what we heard from our members, was a real desire to be able to provide [inaudible 00:10:24] to each of the, father, mother, brother, sister and caregiver, whoever that was. The other thing that we have gotten is text messaging, one of the tools that we have built is the way to pull all of our text messaging content, which is a primary form, I think the compliant communication between our members and their care teams into a common database that directly feeds the record so that we can escalate chronically where somebody is expecting to be sick, to a clinician member of the care team is providing oversight. And then underneath it all, we have built you know Integrated Telehealth and a variety of really interesting clinical decision support tools, very specifically built it [inaudible 00:11:02]. The work on technology here is about asking very simple questions and building very simple solutions.

Margaret Flinter: When I think about what you are doing, in essence you have what I would call in some ways a select population of universal insured people. In fact we think about the challenges that are out there right now, preexisting conditions could fall, essential benefits could fall, then the story that you told of the patients who had the $350 copay, they lived by the millions. Are you looking at a strategy to make your model work to embrace those individuals as well, talk with us a minute about that?

Iyah Romm: Fundamentally I believe that if you build the system that is oriented towards Medicare or those who are commercially insured, you are going to not force yourself to build systems that address factors that are fairly unique to the lowest income populations among us. And so it is easy to build and to not deeply engage in the comprehensive needs of social factors in populations that are not a Medicaid. For us that was an important one from the outset. What enforced us to do was build a toolkit that was fully inclusive of all of the needs with those populations. And then importantly also I believe that it's itself an opportunity for conversations about how you start to serve other populations --.

So I should note that our first partnerships in New York with EmblemHealth, stretches across virtually all of their lines of business. But also when you are working for example on Crown Heights, Brooklyn which is where our first site is, there are variety of folks who are living on the bubble of eligibility for those programs, who are struggling with the same challenges of poverty. And in many ways,

some of the social practice challenges around those populations are even more challenging to wrestle with, the individual that you referenced with the copay is a great example of this, so that is not a challenge that a Medicaid beneficiary would face in the same way, but it is a unique challenge to a certain type and kind of insurance.

Another example of where this manifests is on some of the social factor, so you know access to Food support may not be there in the same way for folks who are on individual markets, for example. And importantly part of our model is focused on trying to care for whole household. And so on a given Cityblock, there maybe household living side-by-side that stretch across lines of business as we think about them in insurance [inaudible 00:13:28]. But frankly in a given household there are also individuals that stretch across those lines. So we are built around the notion that we can care for whole family units and whole households. Medicaid is an important core component to this and it's an important identity, but fundamentally as you say, this is about caring for people actual population.

Mark Masselli: We are speaking today with Iyah Romm, Founder and CEO of Cityblock Health, an innovative tech-enabled care delivery company focused on underserved patients in urban setting a venture of Alphabets, Sidewalk Labs. Iyah, I think you may be in the vanguard of this trend of nontraditional companies leveraging their market power to create new pathways in the last couple of months at Amazon, Berkshire Hathaway and JPMorgan Chase also launched the innovation, but I wonder if you could pull the thread for us on how close you are to scaling this model, maybe also just paint this picture of what a national model of what you are contemplating might look like?

Iyah Romm: Sure, for us we are pretty open and pretty humble about where we are stage wise. We are an early company that is humbled it got the attention that we have gotten, because then we are trying to tackle fundamentally a very hard set of problems, in a way that is both methodical about how we learn and iterate and improve, but also there is tremendous [inaudible 00:14:50] across the country. One of the things that motivated me in coming to do this work, was the fact that many of the models that we could all articulate on this conversation, fundamentally have not scaled at the level that a large technology company would for example [inaudible 00:15:07] scale. If you add up all of the lines under management of companies that look like us and are variations on the team and the space, it still numbers in the hundreds of --. And when we think about that compared with the profound opportunity and also this question of how you crack them at the being able to do this on much larger scale, I think it's very important.

When we think about growth on models like this, I don't know yet to be totally honest, what it looks like in terms of release some play books or care models or how you think about productizing from value technology as we think about large growth. But what I do know is that the answer can't be buildings 3000 clinics across the country. We all know healthcare has plenty of books in order as it is, what it has to be is finding ways for the model to scale across the chassis of existing infrastructure all across the country. And thinking about ways that we can build models that flex and hyperlocate in a way that it is heavily rigorous.

We focus a lot of our time [inaudible 00:16:04] we spend a lot of our time in technology thinking about, how do you build a system that using Advanced Analytics capabilities and using the technology infrastructure that we have fundamentally rebuilt and how you manage a practice like this. We talk all the time for example about clinical guidelines, but there has never been a randomized control trial of how do we think about administering meds for somebody who has diabetes, who is also streak homeless and [inaudible 00:16:30] and eats out of the trashcan. That is not how we think about clinical evidence, it's not how we think about care model evidence.

So part of our foundational bet is that by building insight driven capabilities that allow us to learn very quickly, allows us to understand how we even ask these questions of our members very quickly and [inaudible 00:16:48] them to local context that we can think about real opportunities to scale. Our model in Brooklyn I think is a pretty interesting one as a first outset, this is something that I think is not largely known about us, but our practices in Brooklyn are actually collocated inside of an existing primary care of practice group and managed care physicians of New York. It has been very interesting partner for us, because fundamentally where patients have a meaningful trusted relationship with the provider, we have no interest in breaking that. I think it's the wrong conversation to say, in order to get access to a new model of care you marginalize vulnerable person, have to make a different choice about what you actually care. Instead we have to build systems that wrap these models inclusion around folks whoever they are, by meaningful chunk of the population that we care for in New York, our members actually have a primary care provider that belongs to a different medical group. We have a very close partnership with those medical groups to ensure that we are collaborating effectively and managing care together.

Margaret Flinter: We have been speaking today with Iyah Romm, Founder and CEO of Cityblock Health, an innovative tech-enabled care delivery company that's focused on underserved patients in urban settings. It's a venture of Alphabet, Sidewalk Labs and you can learn more about their work by going to www.cityblock.com or follow them on Twitter

@cityblockhealth or at @iyahromm, that's I-Y-A-H R-O-M-M on Twitter. Iyah, thank you so much for your dedication to innovation in healthcare, to your focus on underserved populations and for joining us on Conversations on Healthcare, today.

Iyah Romm: Thank you for the conversations, I enjoyed it very much.

[Music]

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 non-partisan, 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: The Democratic Senators have repeatedly claimed that Supreme Court nominee Brett Kavanaugh's history shows he would be a danger on the court to the Affordable Care Act. For instance, Senate Minority Leader Chuck Schumer said in late August that Kavanaugh "has written opinions skeptical of our healthcare laws." The Democrats point primarily to a case called Seven-Sky v. Holder which came before the U.S. Court of Appeals for the District of Columbia Circuit for Kavanaugh as a Judge in 2011. The Appeals Court rejected this challenge to the ACAs individual mandate which requires most people to have insurance or pay a penalty. Kavanaugh dissented but his objection concerned the jurisdiction of the court, not the constitutionality of the healthcare laws.

Kavanaugh wrote that the court shouldn't have heard the case because the Anti-Injunction Act said, "A tax must be assessed and collected before a suite against it could be decided. And the individual mandate didn't go into effect until the 2014 tax year." The Federalist, a conservative publication published opposing views on it, one commentator said Kavanaugh's dissent was a "roadmap to save Obamacare" while another said that was "nonsense".

A law professor and expert on healthcare, also wrote that Kavanaugh didn't show a strong opposition to the healthcare law in that case or a second case that Democrats have also cited. That case Sissel v. HHS in 2015, questioned whether the Affordable Care Act was unconstitutional because it violated the Origination Clause of the constitution which says that legislation that raises revenue must originate in the House of Representative. The Appeals Court rejected a request that the full court hear the case, saying "The purpose of the ACA was to overhaul the National Healthcare System, not to raise revenue." Kavanaugh dissented saying the ACA was indeed a revenue raising bill, but he said it complied with the Origination Clause, he said, he would grant a rehearing of the case, but he went on to argue

that the court should rule for the government. And that's my factcheck for this week, I am Lori Robertson, Managing Editor of FactChecks.org.

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

[Music]

Margaret Flinter: Each week Conversations highlights a bright idea about how to make wellness a part of our communities and everyday lives. Tens of millions of people around the world have conditions that make it impossible for them to speak on their own, requiring them to adapt to a computerized voice box for communicating. Perhaps the most well-known of these folks is the physicist Stephen Hawking.

Stephen Hawking: I would have thought it was fairly obvious what I meant.

Margaret Flinter: The problem is that sound of Hawking's speaking through his voice box is the same voice sound say that a 10-year-old girl with a neurologic disorder might be forced to use as well, because there just haven't been many voice options on the market.

Rupal Patel: In the U.S. alone there are 2.5 million Americans who are unable to speak and many of whom, use computerized devices to communicate.

Margaret Flinter: At a recent TED Talks, speech researcher and innovator Dr. Rupal Patel shared a program she has launched that can change that reality, VocalID.

Rupal Patel: I thought there had to be a way to reverse engineer a voice from whatever little is left over. So we decided to do exactly that. We set out to create custom crafted voices that captured their unique vocal identities.

Margaret Flinter: Creating a voice bank of donor voices that will allow voices to be individualized for each unique patient, seeking to communicate through an electronic voicebox.

Rupal Patel: Why don't we take the source from the person we want the voice to sound like and borrow the filter from someone about the same age and size, because they can articulate speech and then mix them, because when we mix them, we can get a voice that as clear as our surrogate talker and is as similar in identity to our target talker, it's that simple.

Margaret Flinter: Since this popular TED Talk, 16,000 people have signed up to be voice

donors at the Human Voicebank Initiative. So volunteers like this little girl will read a series of simple phrases over a several hour period.

Female: Things happened in Paris. I love to sleep. The sky is blue without cloud.

Margaret Flinter: And then those phrases are matched with the voice footprint of the patient being provided for.

Female: This voice is only for me. I can't wait to use my new voice with my friend.

Margaret Flinter: Such speech synthesis will give that person the dignity of a speaking voice that is as closely match to their own identity as possible. To take that dream from the lab into the real world, Dr. Patel who is a Professor of Computer Engineering at Northeastern University has launched the website www.vocalid.com.

Rupal Patel: I imagine a whole world of surrogate donors from all walks of life, different ages coming together to give people voices that are as colorful as their personalities.

Margaret Flinter: And with the bank of voice donors now building around the world, Dr. Patel expects that patients with conditions ranging from Muscular Dystrophy to Lou Gehrig's disease or stroke will one day be given the chance to communicate in a voice made just for them. The Human Voicebank Initiative matching vocal donors with millions of people who seek to authentically communicate with friends and family and a voice that most closely matches what would be their own, now that's a bright idea.

Mark Masselli: You have been listening to Conversations on Healthcare, I am Mark Masselli.

Margaret Flinter: I am Margaret Flinter.

Mark Masselli: Peace and health.

Moderator: Conversations on Healthcare is recorded at WESU at Wesleyan University, streaming live at www.chcradio.com, iTunes or wherever you listen to podcast. If you have comments, please email us at www.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.