Mark Masselli: Welcome to Conversations on Health Care. I am Mark Masselli.

Margaret Flinter: And I am Margaret Flinter.

Mark Masselli: Well, Margaret, contention continues to be felt around the President's initiative in the Affordable Care Act, especially where it pertains to women's health issues. The bill introduced by Republican Senator Roy Blunt was nearly defeated in the senate last week. The bill called Respect for Rights of Conscience Act.

Margaret Flinter: Mark, I can't believe that was only last week. It seems like at least a month that this has been front and center of the news. This bill would have allowed employers to opt out of providing coverage of birth control or any other services based on their own moral grounds, which could have opened up the way for arbitrary challenges to insurance coverage for employees. Had the bill gone through, it was estimated that millions of women stood to lose birth control coverage or other services. And while it was defeated 51 to 48, it was pretty close call though.

Mark Masselli: It was. And in this current political climate, Margaret, it seems there will be more of these ideological threats to health care coverage. Even though a poll showed Americans across all phase are largely in support of the President's public health objectives for birth control, family planning, and women's health.

Margaret Flinter: And it was interesting to know, Mark, though I don't think we were surprised, that veteran Republican Senator Olympia Snowe of Maine voted against the Blunt amendment. Not only was she breaking with party lines on the Blunt **measure**, she cited that current climate of contentious partisan politics as a deciding factor in her decision not to seek reelection after almost 30 years in Congress.

Mark Masselli: Tough to loose a voice of reason in the political process, Margaret.

Margaret Flinter: And some sobering news on persistent health disparities in our country, a study just released by UCLA concludes that on average, life expectancy for African-Americans is eight years lower in some parts of the United States than their Caucasian counterparts with the biggest gap in the southern states.

Mark Masselli: The study does note that gapes are wider in the more rural and poor neighborhoods. One of the studies author is saying that it is much an economic problem as it is a racial one but still a statistic that should be factored into public health initiatives around the country.

Margaret Flinter: And our guest today is quite knowledgeable on the subject of public health, Dr. Robert Wallace, Chair of the Institute of Medicine Committee on Living Well with Chronic Disease. The committee has just released their report with their recommendations, and we will be talking to him today. No matter what the story, Google us at Chcradio.com, we would love to hear from you.

Mark Masselli: And as always, if you have feedback, email us at Chcradio.com. Coming up, our conversation with Dr. Robert Wallace from the Institute of Medicine. But first, here is our producer Marianne O'Hare with this week's Headline News.

Marianne O'Hare: I am Marianne O'Hare with this Headline News. It's the day after Super Tuesday, a good day for Mitt Romney who carried several states Newt Gingrich picking up his home state of Georgia. The battle continues for the GOP nomination, and the race for the GOP Presidential Nomination is really more talk about restrictions on welfare recipients and other public health initiatives. Nearly two dozen states, mostly conservative, are considering measures that would require drug testing for those receiving public assistance, and the measure is gaining attraction on the national level.

The driving force, states seeking to counter the effects of down economy want to deny benefits to those who test positive for drugs. Presidential hopeful Mitt Romney is saying he thinks it's a very good idea. Opponents say it's assuming people in need are somehow more likely to be using drugs, a stance that has been countered by numerous studies.

President Obama Monday appealed the decision that found unconstitutional, a new FDA regulation requiring tobacco companies to put large graphic health warnings on cigarette packs and in advertising. A U.S. district judge last week ruled that requiring tobacco companies to use their packaging space to post graphic images of diseased lungs and rotting teeth proved an undue hardship on the cigarette companies, and that it add constituted restrictions on Freedom of Speech. FDA rules requiring new warnings on cigarette labels are due to be in place by September of this year. Cigarette packs in Canada already carry those graphic images on their packaging, and the numbers of smokers have come down significantly.

There is a dental crisis happening here now in America. The conclusion of a report on dental care or the lack thereof among a large sector of the American population, tooth decay is not a cosmetic issue, it's a public health issue. Senate Subcommittee on Primary Health and Aging released a report last week citing some sobering statistics of full 25% of Americans over 65 have lost all of their teeth, and a growing number of Americans are seeking dental attention in the emergency room For conditions that could have easily been treated with preventive care. The report recommends a national health initiative to bridge the

gap between those who regular access to dental care, which is largely about 90% private practice. I am Marianne O'Hare with this Headline News.

Mark Masselli: Today, Margaret and I are speaking with Dr. Robert Wallace of the Institute of Medicine, Chair of the Committee on Living Well with Chronic Disease Which just released a report on the need for Public Health Policy Directives to combat this growing problem. Dr. Wallace, welcome to Conversations on Health Care.

Dr. Robert Wallace: Good afternoon.

Mark Masselli: Your committee was charged by the Center for Disease Control to undertake an interesting public health investigation to look at the total chronic illness is exacting on individuals, on their families and communities and ultimately on the health and well-being of the nation. But you noted in the report that you talk about how the population over 65 will reach 70 million by 2030 and 37 million will be managing more than one chronic disease. Your group identified nine so-called exemplar traditions that posed the greatest threat to the long-term public health. Talk to me about this.

Dr. Robert Wallace: The burden of chronic illness is well known and well described and while we did document some of this. In fact, goal of this report was actually to try to point directions where public health can have a greater impact on persons who already have chronic illness. Public health has spent much of his time, as it should, trying to prevent diseases from happening in the first place, whether they would be acute infectious diseases or chronic illnesses such as cancer, heart disease, stroke and so on.

So because public health had many effective triumphs and still lots of challenges as well for the primary prevention of disease, the fact that the population is aging in not merely persons over 65 but it's an older population, and people are living longer with a variety of chronic illnesses; many of them are doing well with them but many are not. And there are really a diverse number of chronic illnesses. So the underlying purpose of the report was to try to see how public health can reach further to help persons who have chronic illness.

Now much of the burden of chronic illness actually begins with the health care system, and nobody really 7:05 _____ with that. But the primary health care system certainly has not been able to meet all of the challenges either for a variety of reasons. CDC wanted us to look at the public side of this and see what health departments could do to help people with chronic illness, not to substitute for what the health care system does but to try to make its contribution to either preventing the complications of disease or mitigating them in whatever ways are possible.

Margaret Flinter : Dr. Wallace, I agree that the public has gotten a handle in recent years on the cost of the health care system of chronic illness and chronic diseases. I think it's only a little more recently that people are beginning to understand the toll it takes on individuals themselves and on the society, and certainly I think fairly recently out of health affairs and some other publications, there has been more attention devoted to cost in terms of lifetime educational achievement, lifetime financial achievement, lifetime family achievement based on the presence of a chronic illness and trying to as you so eloquently say live well with it. Maybe you could talk with our listeners a little more about this social cost of trying to live with chronic illness in our country.

Dr. Robert Wallace: There are a lot of social costs of illness other than the actual economic costs. When somebody in a family is ill, it has an impact on other members of the family. And we spend a lot of time looking at illnesses of different kinds, of different patterns and so forth because each of them behaves differently. An example of a social cost might be somebody who has had a cancer of one sort or another, and then as far as one can tell clinically is cured. But that person will become a cancer survivor, and that will take a psychological cost; that will take a social cost; that may have an impact on employment or future plans.

And so these social costs can run in any direction. Somebody is living with the chronic illness that may impair the ability to get a job or to get insurance and all of these weigh on individuals on families and on communities.

Mark Masselli: Dr. Wallace, as the title of the report suggests, you didn't just look at the need for managing these chronic illnesses, there should be public policies initiated from the top down, from the Centers for Disease Control and Health and Human Service right down to the local community directives for living well with chronic diseases. Could you elaborate a little more on that for us?

Dr. Robert Wallace: So illnesses take a toll of one sort or another, and we wish we could make them all go away. But given that we can't do that, it's important to really have optimal health and optimal function as best we can for everyone with chronic illness. The way the communities and policies can help with that is to ease the burdens of living and functioning with chronic illness.

I mean the great example of an existing policy is the Americans with Disabilities Act so not all chronic illnesses are physically disabling. But for those that are, it's great for persons with those illnesses to be able to get into buildings and navigate the world in a much better way. So I think that's a really great example of policy.

Margaret Flinter: Dr. Wallace, there are other recommendations that you were making as a committee about reducing the health disparities and the outcome of chronic illness.

Dr. Robert Wallace: Well, with respect to help disparities, we certainly spend a lot of time highlighting that this is still an important issue that these disparities by age, by ethnic status and so forth are not going away and need special attention. And because we are a set of diverse cultures in this country, programs need to be tailored to these two different cultures. And I think everyone appreciates that we also paid some attention to mental illness which is so important to this. And when one thinks of chronic illness, perhaps mental illness doesn't jump to the top, but we wanted to be certain that we looked at disparities and other issues with respect to that as well.

In fact, we commissioned a chapter in our report that actually looks at the effect of physical chronic illnesses on depression, on the genesis of depression which is a really important problem across a wide range of illnesses. One of the things that you also said that I want to highlight at this moment is that I am not responsible for all of this. I had a great committee and a great staff working with me at the Institute of Medicine, and they are all responsible for this. And yes, many of them are very experienced and have made many contributions in their own right, and it was pleasure to work with all of them.

Mark Masselli: We are speaking with Dr. Robert Wallace, Chair of the Institute of Medicine Committee of Living Well with Chronic Disease which just released its report Calling for Public Health Action on Chronic Disease in this Country. Dr. Wallace, your report suggests that there need to be far reaching policy directives to attack the problem of chronic illness which you warned is already reaching crisis levels. Describe some of the programs you would like to see that would have a positive impact on the prevention of illness as well as improving the quality of life for chronically ill. Can you discuss with us what it will take to get some of these programs in place?

Dr. Robert Wallace: We think the Affordable Care Act may be one vehicle. But in fact, as the health care industry consolidates, it very much needs to find ways to develop services and education and self-management tools for its patient. On the other hand, there are lots of things that could be done in the community that, in fact, should be done that aren't necessarily connected to the health care system. And in fact, there is an argument that once a patient is given guidance and repeated guidance when he or she needs that, self-management is really an individual in a family trying to figure out how best to live with that illness for themselves and to find the mechanisms that work for them. So there is always individual and family.

In terms of policies, one of the directions that we recommended for the Department of Health and Human Services and CDC was to take a more active stance with respect to health in all policies. So that's a catch phrase. And fundamentally, what that means is that government agencies and other larger organizations make policies that are not directly related to health or health care

and yet have an impact on health. There may be important decisions being made in other public sectors that have an impact on persons with chronic illness, and that needs to be attended and as best as possible anticipated.

Margaret Flinter: Dr. Wallace, I am curious either geographically, whether there were communities or organizations that you thought really represented some tremendous advances in how we are approaching this issue of living well or even **whole** states. And maybe Part B of that question, we recently had the opportunity to talk with the founder of people like me who made the point very clearly, as we all know, patients may come and see us four times a year but they live with their chronic illness every day of the year, and therefore social media and some of the online programs that have developed around support for living well with chronic illness have become more common. What did your committee think of along those lines or look at?

Dr. Robert Wallace: We talked to an awful lot of people representing not only certain conditions but also organizations approaching the social side of this, such as supporting caregivers. So we didn't really try to identify individual programs that do things best. We certainly came across many programs that do a very good job at what they do, and one of the jobs of public health is to be certain that people who have chronic illness have access to these programs because for various reasons, not everybody does. So that's one of the challenges that comes with public health.

With respect to online social communities and other approaches to this, most of them are not sponsored by government agencies, and we think, in general, they are a good thing. There are self help and group help being around for a long time. The Internet has, of course, raised this to a new level and has enabled a kind of communication that otherwise people won't have. At some point, they need to be evaluated. We didn't look at those programs specifically, but we welcome any reasonable approach to trying to give people information and communication.

Mark Masselli: Dr. Wallace, your report suggests that the current health care has not pursued in any comprehensive way incentives aligned to community-based organizations and public health and developing structures for prevention and management of chronic diseases. The currently approach is fragmented and costly. How could we do a better job at changing the health care system approaches? And maybe some specific patient-centered medical homes or accountable care organizations or maybe community health workers might be some good examples.

Dr. Robert Wallace: Well, those are all examples. And basically, in the end, in the last chapter of the report, we made a plea for alignment of the health care system and the public health system. You used the word 'fragmented', and I think that's probably correct. We need to bring everybody to the table. We

suggested that one of the roles of CDC and the State Health Department is to catalyze the community organizations working with the health care system. It's a very difficult and sometimes even painful process as to who is going to do what and who needs what. But in the end, it's a case of strategic planning and alignment between health care systems and where public health can make contributions.

Margaret Flinter: We are emphasizing public health and prevention quite a bit in our conversation, Dr. Wallace. What's your sense of how we are going to fund these efforts? Is there adequate funding under the Affordable Care Act? Do you predict that we will need a new type of funding or a new source of funding?

Dr. Robert Wallace: The fate of the prevention funds that are in the Affordable Care Act is up in the air, and people are looking at that. And that's a political process that we didn't address. We can only hope that these funds will go where they are intended by the Congress because we think, in fact, they are really needed. In the end, health care system will have to make contributions through its usual funding stream so will public health and so will all of voluntary agencies that have a role in all of this.

First of all, you have the usual sorts of primary prevention that public health does well in the community, teaching anti-tobacco practices in the schools, the quit lines and that sort of thing. Then, once chronic illness supervenes, one needs to have several kinds of prevention. First of all, you need all of the preventives for everything other than the condition that you have. So if you have chronic inflammation, you still might need cancer prevention and cholesterol levels and all of the other things that we do that we know that works. And then, on top of that, you have preventives to try the best that one can to mitigate and prevent the progression of the illness and sometimes even cure it.

And then, for those individuals where their chronic illness advances, there are all kinds of tertiary problems that occur, that cut across individual illnesses. It will fall. They get drug reactions; they get depressed. And working on preventing those kinds of long-term distal problems that people with chronic illness have is also a challenge. And so there really is a great need for prevention at all kinds of levels. And again, I can only hope that those funds will stay where they belong.

Mark Masselli: You say public health surveillance is an important element managing chronic illness across broad spectrums, and yet, there is still lack of a unified platform for sharing medical data. We seem to be progressing in that direction but some of that at snail's pace. Tell us why the need for broad base data sharing is so important here. And are there any modes of population data collection that look promising?

Dr. Robert Wallace: The Electronic Medical Record and the ability to transfer those records around the country and follow individuals when they go to different

health care systems seems to be a ways off. But I think it represents a set of technologies that can be done. It's a question of working through, first of all, cost. Second of all you want to make certain that the information in Electronic Medical Records is right. But I think we are moving in the right direction, and it's just going to take some time to make it work.

But once good interoperative universal medical record is available on everybody and certainly that individuals, patients have access to their own records, which I think is really important to all of this, then I think it will be easier to understand where the needs are in chronic illness, and we will make for better strategies and better outcomes.

Margaret Flinter: Dr. Wallace, about maybe 15 months or so ago, there was a different Institute of Medicine Committee and they issued the report on the Future of Nursing, and I remember there was a very kind of clear dynamic follow-up to that, coalitions organized in states across the country by region. What would you expect to see or hope to see happening as this now moves to the level of state commissioners of health, district health directors, local communities? What do you think will happen then?

Dr. Robert Wallace: Chronic disease control programs are basically in place in almost all states. They are there; they are in place; they don't have enough resources to do everything. And so one of our recommendations was to ask them to do strategic planning that can certainly include, and must include, other health professionals beside physicians. Nurses are very, very important part of all of this so are social workers so are community health workers. And again, I think communities will pick their priorities and do their programs in different ways. But I think this is happening at all levels. It's partly a grassroots movement; it's partly a voluntary movement; it's partly a health professional movement and certainly a public health movement.

And then on top of all of this, we made several recommendations on how to better do surveillance of chronic illness, that is how to monitor communities in terms of how many people really have illness, what's wrong with them, what are the trajectories of those illnesses. And we hope by doing that, looking at acute infectious diseases, that this will now turn in a fuller way to surveying the communities for chronic illness occurrence and outcomes. And that will help each community plan its activities in a better way.

Mark Masselli: Dr. Wallace, we like to ask all of our guests this final question. When you look around the country and the world, what else do you see in terms of innovations and who should our listeners at Conversations be keeping an eye on?

Dr. Robert Wallace: I think there are a number of things that are happening. We think that doing surveillance with medical records, and so we don't have to do

telephone surveys and that sort of thing, will be important. I am also hoping that health care systems will do more planning for prevention. And I think in many ways, personalized medicine that is using biomarkers and metabolic markers and genetics and all of the tools that are emerging now will also be important because it will enable us to target individuals for various kinds of prevention and mitigation more fully than we have ever been able to do that before.

Margaret Flinter: Today, we have been speaking with Dr. Robert Wallace, Chair of the Institute of Medicine Committee on Living Well with Chronic Disease. Dr. Wallace, thank you so much for joining us on Conversations today.

Each week, Conversations highlights a bright idea about how to make wellness a part of our communities into everyday lives. Each year, 6.3 million pregnant women and newborns die from pregnancy and complications of childhood, and 99% of these deaths occur in developing countries where women receive little or no prenatal care. Engineering students at Johns Hopkins University have developed an inexpensive solution that can cheaply and easily save lives. The problem facing expecting mothers in the Third World, even a 50-cent dipstick to test for certain conditions is too expensive.

The students responding to a challenge from the U.S. Agency for International Development developed what they call a Magic Marker that when run over a tiny urine sample on a piece of paper can simply and easily detect a variety of potential conditions. To simplify it further, the markers are color coded for testing for specific problems. And the best part, anyone can be told how to use the markers which cost about a third of a penny for use, a dramatic cost savings for those using the system.

An international aid organization is so excited about the new devices being tested on the group of expecting mothers in Nepal. They say, “This invention is poised to make a big impact on maternal and infant health around the globe.” A simple Magic Marker that can cheaply test for prenatal problems to reduce maternal and infant mortality, 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.

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