(Music)

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

Margaret Flinter: And I am Margaret Flinter.

Mark Masselli: Well Margaret, here we are, first days of August. The traditional dog days of summer are behind us.

Margaret Flinter: And we have had plenty of those already this year Mark, which I have to say I love. Also, maybe a good time to slow the pace down a little, take some time to relax away from the daily stresses and recharge your creative batteries.

Mark Masselli: Absolutely. Stress, as we know, can take over, and we know that one negative impact it can have is on your health. So take a little vacation time, if you can get it, and take care of yourself.

Margaret Flinter: Well I hope you take your own advice. But a recent study out there shows that these days people aren't taking much opportunity to leave the office behind, the majority people who do go on vacation remain in continued contact with their work worlds via their electronic devices.

Mark Masselli: That they do. They have become a valuable tool in the modern world. But it's a good idea to just disconnect for little time if you can get it.

Margaret Flinter: Well I will tell you one thing that I am going to stay connected to Mark and that's the Olympics, so much exciting competition and prowess to watch.

Mark Masselli: It is. It's inspiring stories too. I think what makes the Olympics so magical for people, so many of those athletes have stories of perseverance and overcoming adversity to get where they are. It's a great microcosm of the best of the human experience.

Margaret Flinter: That it is, Mark. And our guest today is somebody who has devoted his career to finding ways to improve the health care experience and improve health outcomes. Dr. Elliott Fisher is the Director of Population Health and Policy at the Dartmouth Institute and he has been examining how Accountable Care Organizations have a chance at improving both access to care but also yielding better health outcomes.

Mark Masselli: He will be talking about how health care reform is going to improve care for those with chronic illness.

Margaret Flinter: And indeed, for all Americans Mark, as we move through this incredibly exciting era of health care reform, and FactCheck.org's Lori Robertson will have another campaign claim to try and dig out the truth.

Mark Masselli: But no matter what the topic, you can hear all of our shows by Googling CHC Radio.

Margaret Flinter: And don't forget, please email us at www.chcradio.com; we love to hear from you. We will get to Dr. Elliott Fisher in just a moment.

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

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Marianne O'Hare: I am Marianne O'Hare with this Headline News. Massachusetts continues to lead the nation in the arena of state-based health reform. The Bay State which passed the most sweeping health care reform in the nation back in 2006 under then Governor Romney led to near universal coverage for most residents of Massachusetts. But that bill was not intended initially to contain cost. This past week the legislature in Massachusetts passed a new health care reform measure aimed at containing cost. The bill which could be a model for other states seeks to save $200 billion in health care expenditures and costs over the next 15 years by linking health care cost increases, those annual surges in health care costs we have seen add up to 8% to 10% per year to the actual growth rate of the state's economy or GDP.

Meanwhile, some states are not only saying no to Medicaid expansion, they are cutting back on their current Medicaid expenses. According to a 50-state survey by the Kaiser Health News, states like Illinois are now limiting enrollees to 4% prescriptions per month; Alabama is cutting Medicaid reimbursement 10%; Florida is cutting funding to hospitals who treat Medicaid patients, and other states have limited their Medicaid funding. Not all is on the downswing; Arizona is increasing its Medicaid reimbursement formula and some other states are seeking to restore Medicaid funding to pre-recession rates. All of this in the wake of the Affordable Care Act which is seeking to expand Medicaid across the country to cover more of America's uninsured.

And finally, watching all that Olympic athleticism is impressive, but what about the collection of awe-inspiring six pack abs? University of Southern California (03:50 inaudible) Todd Schroeder says, how you get them, well my friend, the old adage really is true, no pain, no muscle gain. Putting muscle through the constant strain is where those six pack abs come in. You want to look like Michael Phelps or Abby Wambach, you are going to have to take their lead and work for it. I am Marianne O'Hare with this Headline News.

(Music)

Mark Masselli: We are speaking today with Dr. Elliott Fisher, Director of Population Health and Policy at the Dartmouth Institute for Health Policy and Clinical Practice. He is the James W. Squires Professor of Community and Family Medicine at Dartmouth Medical School, and is co-chair of a research initiative to study the effectiveness of the Accountable Care Organization in improving access to health care, yielding better outcomes and reducing cost. Dr. Fisher, welcome to Conversations on Health Care.

Dr. Elliott Fisher: Oh it's great to be here. Thank you very much for having me.

Mark Masselli: Well now, we have the Supreme Court decision upholding the Affordable Care Act behind us now but the real work of implementing the law lies ahead. And at the Dartmouth Institute, you have been advocating for universal access to health care for some time now. What are the key areas in which we are now likely to see the most rapid acceleration of progress and fundamental change?

Dr. Elliott Fisher: Well the prediction is really tough especially about the future as Niels Bohr said. So it's very hard to predict what the future will hold. But I think there are some things we can say with confidence. The coverage reforms are absolutely critical. We all want all to live, I certainly want to live in a country that covers every resident, every American, and make sure they have access to great health care. And the law makes major steps forward in that direction. And I think the principles underlying it, universal coverage, having everybody purchase insurance so that it's affordable for everybody and helping pay the cost for those who are too poor to afford it, those principles were adopted by Massachusetts, our underlying reforms in Vermont. And even if we have a change in the party leading the Presidency and the House or Senate, I think we will see the same direction toward coverage needing to be pushed forward. Where I am confident that reform is coming is on the changes in the delivery system that will lead to better care and more affordable care that will lower the cost of care.

There has been a strong consensus on both sides of the aisle starting three to five years ago that the underlying problems in U.S. health care that are driving up costs and leaving quality remarkably uneven and care poorly coordinated, that those underlying problems are recognized, understood and we will need to see the changes, changes in payment, changes in delivery, many of which are embedded in the Affordable Care Act but are also being strongly supported by those outside Congress from right and from the left.

Margaret Flinter: So Dr. Fisher, let’s focus on that payment system issue for a moment. You and your colleagues at the institute have long advocated for revamped payment system, and I think most health care leaders will say fee-for-service is outdated, it promotes waste. So you have been studying this potential

transformative impact of the Accountable Care Organizations or ACOs, groups of providers and hospitals working together to cohesively manage care of patients. Tell us about your research at Dartmouth on ACOs, what are you hoping to learn, and maybe a little bit about why the Affordable Care Act called for their specific creation as a vital aspect of the nation's health care reform model?

Dr. Elliott Fisher: Sure. Well if we look back a few years, there was this emerging consensus that the underlying cause of a lot of our problems was a fragmented delivery system, which is reinforced by fee-for-service practice. And some of the research we did demonstrated almost all physicians practice in natural referral networks around one or a couple of hospitals. There are a group of physicians that refer to each other, usually admit to a common hospital. So there are these natural networks that are operating under fee-for-service medicine, not held together by anything more than the informal relationships among the physicians. And we, working with Mark McClellan, former Administrator of the Center for Medicare and Medicaid Services, the Medicare Payment Advisory Commission, which is an agency that advices Congress about health care reform, we started to realize that one could figure out who the patients were associated with each of these natural networks and then figure out how much it was costing right now to take care of them, even under fee-for-service create some incentives for the physicians who are working together informally, to work together more coherently and more formally. And if they reduce costs and improve care, they would get a share of the savings and care would be improved for patients.

This concept, this notion of Accountable Care Organizations, was embedded in the Affordable Care Act as it passed and we are now seeing over a 150 or so federal Accountable Care Organizations already launched. But very interestingly, we are seeing just as many in the private sector, that is private health plans like Aetna, Cigna, many of the Blue Cross plans, have adopted this model of encouraging docs and hospitals to come together to work toward a common aim, improved care for patients, and then being able to get paid in the same way largely through fee-for-service, but if they reduce unnecessary utilization and achieve savings by improving care, they are financially rewarded.

So it's a transitional payment model, it can be adopted in almost every community in the country, and we are seeing that it's adopted in diverse communities across the country. What we are doing now is trying to study how well it's being implemented, learn a lot from early implementation. We have some early results and those are quite promising.

Mark Masselli: Well you recently had thought leaders from across the board come together for the National Accountable Care Summit and you mentioned Dr. McClellan, who was the former CMS and FDA administrator who co-chairs this initiative with you. So tell us about the meeting and as you look back, it's sort of a seminal gathering with all stars aligned now that the Supreme Court has ruled

and the bill is moving forward. And talk to us a little bit about your partnership with Dr. McClellan as well.

Dr. Elliott Fisher: The difference at this meeting from prior summits was prior years, people were talking about it, they were saying what is an Accountable Care Organization? This year, people were saying, well we have already launched ours, here is what we are doing, we are finding this is working for our patients. It was much more about we are now learning on the ground how to do this and sharing our insights with each other. The partnership with Dr. McClellan has been absolutely critical to our success. He is a brilliant both administrator and thinker about how Washington works. He is a PhD in economics so he knows how incentives work. He is also a physician by the way. But the partnership has been very good. He is focused largely on how do we get these things implemented through the policy circles in Washington and get people to buy into them. My focus on research and design and understanding the incentives that physicians operate under from our research about how health care works across the country, it's been a great partnership.

Margaret Flinter: Well, so often people say to us, you know that sounds an awful lot like the HMO and managed care approach of the '90s. So we would like to ask you, what's different this time around, one question; a second question, are the ACOs primarily just focused on the Medicare population or are they relevant to the more general, younger and healthier patient populations, and if I could squeeze in a third piece to that, I am so struck by your comment that they build upon the natural network of physicians and hospitals that exist already and the natural relationship there and I am curious about your thoughts on, are you sure those natural networks still exist as strongly as they once did?

Dr. Elliott Fisher: First, the difference between then and now, there are some very important differences. In the old days, health plans, insurers, were largely trying to shift risk to physicians, who were not prepared to manage risk. The new model is really about shared risk between insurers whether it's the federal government, on the part of Medicare or private payers such as United, Aetna, Cigna, sound actuarial models, where the physician groups and hospitals that have formed an ACO are only held responsible for those costs that they can reasonably be expected to be responsible for.

Second huge difference between the old days and the new days is in the old days there were no measures of quality. We did not expect HMOs to improve quality; quality wasn't even measured. The major thrust with ACOs is transparent quality measurement and you don't get any share of the savings unless you demonstrate that you are improving the quality of care for the patients you serve. You are making care more accessible, you are making it easier for patients to get into the office after hours, you are improving their blood pressure, you are improving their diabetes if they have those conditions.

The third big difference is in the old days, we tended to lock patients into their HMOs. The new model is complete freedom of choice but the ACO has pretty strong incentives to help coordinate your care. It goes back to an old Buddhist concept, “The best fence is a good pasture”. So it's a very different model. The new model is about the providers, hospitals and physicians, plans and patients, who are quite engaged in the design of many of these new models, all three of those collaborating to improve care.

The second, does it have any relevance to the younger population? Well Massachusetts, Blue Cross Blue Shield and now other health plans in Massachusetts have already adopted the program for their under 65 populations. The early evidence from that experience is that patients are getting better care, quality is improved dramatically in the under 65 population. Secretary Leavitt, speaking at our conference said, accountable care is coming and it's coming in the private sector even more strongly than it's being advanced in the public sector. And finally, this question about natural networks; I think what physicians and hospitals are recognizing is that there is so much opportunity to improve care and lower cost by much more effective coordination to improve care rather dramatically.

Mark Masselli: We are speaking today with Dr. Elliott Fisher, Director of Population Health and Policy at Dartmouth Institute for Health Policy and Clinical Practice. The Dartmouth Institute is a preeminent research and education institution devoted to the ongoing reform of US health care system. I wanted to talk a little bit about the debate around health care reform. Opponents argue that we can’t afford to carry the tens of millions of additional uninsured Americans in an already bloated health care system, and they claim the measures in the health reform law are going to crush small businesses and cost jobs. And you as a researcher, when will this Buddhist enlightenment come to the population so that we can get back to the center and try to get all sides working together to reform health care system in America?

Dr. Elliott Fisher: I would say 10 years ago, anyone talking about cost containment was going to be accused of rationing, of denying beneficial treatments. Some of that talk is still being heard but there has been a strong consensus in the research community. Our own work at Dartmouth, other investigators from McKinsey, the Institute of Medicine, all have agreed that there is about 30% of US health care spending that is simply wasted. It's wasted on avoidable unnecessary care; it's wasted on high administrative cost. The place where we are seeing agreement, bipartisan agreement is on the mechanisms that will allow us to achieve better care and lower costs, moving toward payment systems that reward value over volume. And that sweet spot is what will make health care affordable in the longer run. Unless we figure out how to take out that 30% of waste, we will not have affordable care for small businesses or large businesses.

The argument right now about expanding coverage under the Affordable Care Act, and that it will lead to higher cost for businesses, is largely around the cost of insurance in a market where health care costs have been rising at 10% per year. And requiring everybody to buy into a system where costs have been rising at 10% a year does seem a little scary. But I don't think we will fix health care unless we both cover everybody and do the delivery system reforms we need. Without universal coverage, the easiest way for health plans or businesses to reduce cost is just simply not take care of sick people and that's not acceptable in my vision of what the United States should be.

Margaret Flinter: Dr. Fisher, let me focus on those patients once again. One of the pillars of your research goals at the Dartmouth Institute I believe is on empowering patients and helping to facilitate patients and making informed decisions about their own health care. Tell us how the Accountable Care Organizations work to empower patients to be better informed stewards of their own care?

Dr. Elliott Fisher: Well there are number of initiatives in the Affordable Care Act, and ACOs are one, that are really trying to promote patient engagement in managing their care, their own health more effectively, and in making wiser choices about the major treatment decisions they face. So, ACOs have incentives to keep people healthy. Once you have high blood pressure or diabetes or you are overweight, the person who needs to take care of you is yourself and your family members because chronic illness is a daily problem of being engaged in your own care. And ACO have a strong incentive to help individuals improve their health.

The second really important area of the Affordable Care Act that we have been involved with to implement programs around the country on what we call shared decision making. Many patients, faced with an important clinical decision, such an elective angioplasty for coronary artery disease that is if you have chest pain caused by a blockage of your artery, there are some choices that you face. If you don't have an acute heart attack, it's an elective procedure to have a little tube put in, the clot pushed out of the way but that's an elective choice. Most Americans looking at that choice think that their life is being saved by the procedure, it's not. It doesn't reduce their risk of death, it doesn't even reduce their risk of heart attack; it slightly improves their symptoms.

If you care about improving your function and not having any chest pain, maybe you want a stent but you should understand that there is a lifetime of medication that you have to take after having that stent. When we adopt these programs of informed patient decision making what we see is patients make decisions that are much more aligned with their own preferences. And what we end up avoiding is wrong patient surgery. If you received a procedure that you, if well informed, would not have wanted, that's just as bad as wrong side surgery, that's a wrong patient surgery. Those are really important decisions that patients need

to make. And some of the reforms in the Affordable Care Act and in many of states are going to help patients make those decisions and become much more engaged in their care.

Mark Masselli: Dr. Fisher, you have talked a lot about the importance of the collection of data, its importance in the model of care delivery that we have. Tell us a little bit about how technology and data systems are going to help us achieve that goal.

Dr. Elliott Fisher: There are probably two important ways that they will help us. First is these tools, whether they are on smartphones or web applications, are going to allow patients to become engaged in their own care in very important new ways. Some of the more innovative health systems have adopted patient portals that allow patient to complete a health risk appraisal, understand what behaviors they have and what they are doing and what they can do to improve their health. So I think the tools will become much more patient friendly. Similar tools will enable patients to work with their physicians or with a health coach by email, by Skype, without having to take a half day off and go sit in a waiting room.

The second use of the data systems, and we are finding this to be very important, is that they will help us better understand how our own health care systems are doing and what can be done within that health care system to improve care. We will find opportunities because one practice is doing a better job at keeping people healthy than another, we can learn from those differences that the other physicians in their community can learn from.

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

Dr. Elliott Fisher: One of the most exciting things I am seeing is the emergence of a community engagement in managing the future of their health care system. An initiative of the Fannie E Rippel Foundation called ReThink Health has in five communities around the country at least started to bring diverse stakeholders together from community members to hospital leaders to business leaders to start to have a conversation about what is it going to take in our community to improve the health of all of our residents and to lower costs for all of us. Those conversations are starting to lead to promising insights. Can we use community organizing as a way of engaging patients in taking back their own health and their health care system?

If you look at the early success of Grand Junction in Colorado, what they achieved in one of the lowest cost communities in the country, this was a community-wide initiative led by the physicians, hospitals quickly joined,

businesses became involved. One thing we learned at Dartmouth from our studies of variations is that health and health care are both produced locally. What that means is that we as community members are going to have to engage in leading the change within our health care systems and we see promising signs that that is starting to happen.

Mark Masselli: We have been speaking today with Dr. Elliott Fisher, Director of Population Health and Policy at the Dartmouth Institute for Health Policy and Clinical Practice. Dr. Fisher, thank you so much for joining us today at Conversations on Health Care.

Dr. Elliott Fisher: Thank you very much for having me.

(Music)

Mark Masselli: 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 US politics. Lori, what have you got for us this week?

Lori Robertson: Well, Mark and Margaret, one of our readers sent us some misleading mailers that a conservative group is sending out in Kansas. And these mailers claim that a failed effort to amend the state constitution would have given residents the ability to opt out of the federal health care law. But the truth is that no state law can do that. The US Constitution says in its Supremacy Clause that federal law is the "Supreme Law of the land". The group behind the mailers is Americans for Prosperity which was founded by David Koch. David and his brother Charles are the owners of Koch Industries, which is in Wichita. Some of these mailers are attacking moderate Republican state senators who voted against this amendment and other fliers are supporting Conservative Republican lawmakers who supported that amendment. Now, this proposed amendment is like other state proposals and laws. It declared that no law could compel Kansans to buy health insurance or require them to pay a fine for not having it. The legislation failed in the Kansas Senate by one vote so it won't be on the November ballot for voters this fall. But law professors and the Congressional Research Service have said that a law like this would have had no effect on the federal law. 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)

Margaret Flinter: Each week, Conversations highlights a bright idea about how to make wellness a part of our communities and everyday lives. Childhood obesity is a growing problem in this country and in industrialized nations around the world. And in spite of the burgeoning health crisis related to childhood obesity, advertising sugary cereals and fast food to children continues unabated. While cereal companies have promised to self police the content of their products as well as their advertising, the average child cereal still packs a full teaspoon of sugar for every three teaspoons of cereal, and fast food consumption in general, still increasing. Now a study out of the University of British Columbia has impressive findings on the impact of a long term ban on fast food advertising for children. Such a ban has been in effect in the province of Quebec, Canada for over 30 years and results are pretty clear. Childhood obesity rates in Quebec have steadily declined over that time while they have rocketed up elsewhere. It's estimated that the ban on fast food and junk food advertising to kids in Quebec Province has led to a 13% reduction in fast food spending and an estimated reduction of the consumption of 4 billion calories among the province's youth during that time. When the health hazards of drinking and smoking among the youth population were identified, advertising bans were put into place and that's had a positive impact on youth consumption. A ban on advertising junk food to kids, to curtail the burgeoning consumption of unhealthy foods, now that's a bright idea.

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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.