(Music)

Mark Masselli: This is Conversations on Healthcare; I am Mark Masselli.

Margaret Flinter: And I am Margaret Flinter.

Mark Masselli: Margaret, we spoke about the launch of our National Childhood Obesity campaign Recess Rocks last week. It was a huge success with Connecticut Governor Jodi Rell and California Governor Arnold Schwarzenegger declaring September 8th, Recess Rocks Day. And now the program is available for children in schools all across the country participate and you know they can find out about both our contest and our program at www.recessrocks.com.

Margaret Flinter: Well, it's a coast to coast phenomena and we were very excited to launch it last Wednesday and on the same day, First Lady Michelle Obama outlined the next phase of her Let's Move campaign. That's her initiative to solve the problem of childhood obesity within a generation. And as children across the country began a new school year, this year the First Lady is focusing the campaign on School Lunches, a subject that all of us parents who are very familiar with. She is encouraging more schools to participate in the HealthierUS Schools Challenge, that's a program that requires schools to meet higher standards for school foods for nutrition information and for physical education and the improvements will lead to monetary rewards for schools which could be used to fund health initiatives down the road. Mark, I read they are even crafting a new online tool for expert chefs on how they can work with schools and do their part to provide support for these changes.

Mark Masselli: That's very exciting and with Congress back in session this week, the First Lady is pressing the house to pass the childhood nutrition reauthorization bill which will make it easier for children from low income families to qualify for free or reduced cost lunches. Many of the priorities of the First Lady's campaign to fight childhood obesity were included in the bill's reauthorization like the adoption of National Food Nutrition Standards at all schools and a funding increase that would result in healthier food options in school cafeterias.

Margaret Flinter: Well Mark, I don't know about you but this is one bill I am willing to bet by money on, will pass easily. It's passed in the Senate, it's received support from both the republicans and the democrats. The Institute of Medicines recommendations call for a decrease in the amount of sugar and fat and salt in school meals in five years and to increase whole grains and to double the amount of fresh produce they serve within 10 years. So that's a very ambitious goal. Now speaking of the Institute of Medicine, our guest today is Dr. Michael McGinnis, a senior scholar at the institute. Dr. McGinnis is a Health Policy Expert who has served as the Deputy Assistant Secretary for Health as

Assistant Surgeon General and is Director of the Office of Disease Prevention. That was a position in which he began the Healthy People initiative in the late 1970s that continues right on today setting a series of health goals for our nation every decade. We are delighted Dr. McGinnis is going to join us today.

Mark Masselli: But no matter what the story, you can hear all of our shows on our website www.chcradio.com. You can subscribe to iTunes to get our show regularly download or if you would like to hang onto our every word and read a transcript of one of our shows, come visit us at www.chcradio.com and now you can find us on Facebook. You will find the button on our website or you can search Conversations on Healthcare Radio Show.

Margaret Flinter: And as always, if you have feedback, email us at www.chcradio.com, we would love to hear from you. Now before we speak with Dr. McGinnis, let's check in with our producer Loren Bonner for the headline news.

Loren Bonner: I am Loren Bonner with this week's headline news. President Obama attempted to defend the new healthcare law last week after Medicare's Office of the Actuary found that the nation's healthcare tab will go slightly up instead of down to 2019 as a result of the healthcare overhaul. The president who has insisted for months that reform with lower health costs said that the finding spell out what is the consequence of ensuring an additional 30 million more Americans.

President Barack Obama: At the margin that's going to increase our cost we knew that, we didn't think that we were going to cover 30 million people for free. But that the long-term trend in terms of how much the average family is going to be paying for health insurance is going to be improved as consequence of healthcare.

Loren Bonner: And president also took the opportunity speaking to a room full of reporters to applaud the first phase of implementation. September 23rd marks the six-month anniversary at the healthcare overhaul and several key provisions take effect next week. Health Secretary Kathleen Sebellius has stuck by her word to keep insurance companies accountable. She told the health insurance lobby group America's insurance plans that there will be zero tolerance for insurers falsely blaming premium increases for 2011 on the patient protections in the Affordable Care Act. She says the Government Urban Institute and Mercer have estimated that the law should only impact premiums by 1 to 2.3%. Appearing on Fox News AHIP President Karen Ignagni said that it's a basic law of economics that additional benefits incur additional costs.

Karen Ignagni: Number of different interpretations about what's on the horizon based on what are our underlying costs. So if you have an underlying cost

problem that we haven't got in our hands around, number one, and you add new benefits that's going to require new cost.

Loren Bonner: And speaking of AHIP the groups Medicare and Medicaid conferences underway in Washington this week, Don Berwick the newly appointed head of CMS laid out some expected changes from Medicare under healthcare reform including better care for patients at a lower price and better health for the US population as a whole. Berwick also stressed the importance of working in coordination with the insurance industry saying, my job at CMS is to build relationships and partnerships where we can make healthcare better trust will resurface.

Margaret Flinter: This week Conversations on Healthcare focuses on some of the current issues facing clinical care. The human genome project has given rise to clinicians' ability to individualize healthcare through genetic testing. Test to identify susceptibilities to common disease like cancer and diabetes may provide a guide to preventive care or the use of genetic test to identify likely responses to drugs may help to achieve safer and more effective drug therapy. This along with engaging individuals and shared decision making captures the goal of personalized medicine. The institute of medicine established its roundtable on translating genomic based research for health in 2007. Although new genetic testing technologies haven't been widely adopted into the clinical setting and research is still ongoing, the Institute of Medicine seeks to understand how these advances are valued in the healthcare setting. The roundtable has brought to the surface many of the diverse perspectives about genetic testing in the healthcare setting and has tried to answer some of the fundamental questions like how do stakeholders prioritize various aspects of genetic test when determining value. And how do people access the relative value of genetic test when making personal healthcare decisions. Next step on the roundtable's agenda may be a discussion about implementing genetic testing. Last week The National Institutes of Health said it will expand its research network that's been focusing on how an individual's genes affect responses to different medications and treatment options. The NIH will invest a $161 million over the next 5 years in its Pharmacogenetics Research Network. NIH director Dr. Francis Collins says through these studies we are moving closer to the goal of using genetic information to help prescribe the safest most effective medicine for each patient. Let's turn now to our interview with Dr. Michael McGinnis Senior Scholar at the Institute of Medicine and Executive Director of it's round table on value and science driven healthcare.

Mark Masselli: This is Conversations on Healthcare. Today we are speaking with Dr. Michael McGinnis the health policy leader who has served through the Carter, Reagan, Bush and Clinton Administrations as Deputy Assistant Secretary for Health, Assistant Surgeon General and Director of the Office of Disease Prevention. Currently Dr. McGinnis is Senior Scholar at the Institute of Medicine, welcome Dr. McGinnis.

Dr. Michael McGinnis: Thank you Mark and Margaret, pleasure to chat with you.

Mark Masselli: Yeah and congratulations on your many years of public service. I am sure we will read in your memoirs how you survived such significant political transitions from Carter to Reagan and Bush to Clinton. But today let's start talking about your work at the Institute of Medicine. You are a pioneer of evidence based medicine and you joined the institute in 2005 as they became interested in looking at how evidences developed and used in healthcare. Could you tell us about the roundtable on value in science driven healthcare that you directed the institute and what are the goals of the project and why does the Institute of Medicine support research in this area?

Dr. Michael McGinnis: Well thank you for that question. It's actually critically at this stage. The roundtable value science drive healthcare began as your ramp up indicated as the roundtable of evidence based medicine and the reason for getting under where the outset was simply the fact that there is a huge gap and a growing gap between what we know what's proven to work under which circumstances in clinical care and what we need to know. The reason I say it's a growing gap despite the fact that there is a fair amount of research in it is that everyday we have new interventions, both diagnostic and treatment that are developed that hold important prospects for treating disease. And everyday we also learn more about people's individual variation and responses to those diagnoses and treatments. And so we clearly need to ramp up substantially the pace in which we develop evidence about what works best for whom under what circumstances. So the Institute of Medicine took on the special focus of attention on trying to develop people's awareness about this evidence gap and building the momentum for action.

Margaret Flinter: Dr. McGinnis you have influenced health policy in so many ways during your career and I would like to highlight just one of them. Dr. Julius Richman the Surgeon General and Assistant Secretary for Health in the late 70s and early 80s appointed you to head the Office of Disease Prevention and Health Promotion where you jumpstarted what Dr. Richman called the Second Public Health Revolution with the healthy people series, a series of health goals for the nation every decade. Now when you embarked on this project in the late 70s you were tackling then very contemporary health issues like smoking, diet, sedentary living and safety practices which are still pretty contemporary in 2010. And we have certainly made progress on some of them particularly smoking but in other areas like obesity things just have gotten worse. Just that Healthy People initiative go far enough in laying out a blueprint for what our goals and actions ought to be or is it time for revision to that process?

Dr. Michael McGinnis: Well any process needs to be revised constantly. The initial healthy people process which set goals to be achieved between 1980 and 1990, I think did a pretty good job for two of its aims. One was to draw people's

attention to the importance of prevention essentially prevention is the absence of a problem. And since we are as a society mostly focused on the squeaky wheel, we had to find a way to celebrate things that don't occur. So setting these goals in effect help people understand what might be possible if we could apply ourselves effectively over decades. But as you say the nature of the problems change and the importance of reaching out to engage players outside the health sector has become ever more a prominent mandate. So we need to tailor our efforts along the way and there is a long way of saying that yes the healthy people process has been helpful both for 1990, for 2000, 2010, 2020 will be but it needs to improve every single year.

Mark Masselli: Dr. McGinnis speaking of prevention, you led the creation of the US preventive task force in 1984 to assess clinical preventive services, now the backbone of much of the screening, immunization and testing and clinical practices in primary care. How has the taskforce recommendations faired under the federal health reform bill? Do you think we will see widespread adoption of the guidelines under any new health plan developed for the health insurance exchanges for instances and do you think there is the public welfare mandates in the area of prevention?

Dr. Michael McGinnis: I think the direct answer to your question will the public support the focus on prevention I think that there is a much greater appreciation and the importance of prevention and hence the public will support it, is supporting it and is in fact likely to demand it. And the law, the Affordable Care Act passed earlier this year actually enhanced it substantially the prospects for the recommendations of the US preventive services taskforce to be implemented by virtue of formally establishing that body in statute as the official body that determines what will we provided in the way preventive services under Medicare and Medicaid. We have come a long way in that respect. The reason that I formed the taskforce in the first place back in the 80s was despite the fact that there was a substantial body of evidence developing at that, even at that time on the effectiveness of preventive services, immunization, screening, counseling so forth. There was relatively little reimbursement for those services in private plans or by the government, in fact Medicare was prohibited from providing preventive services except by individual in effect the active congress. And so when we would ask why preventive services couldn't be reimbursed under any of these various insurance plans we get back to the question or the answer where is the proof? And of course there was lots of proof, the preventive services taskforce used this rigorous standards of evidence to deliver that proof. I think it's been effective in growing the acceptance and delivery of preventive services but it's far from as effective as it should have been because we have a big gap between what needs to be provided in the way of proven preventive services and what actually is provided. I think that the Heath Reform Act will be very helpful in that respect.

Margaret Flinter: Well I can tell you that in our organization we rely on the preventive service taskforce recommendations as a fundamental element of our model of care so we thank you very much for your work in that area Dr McGinnis. And you also in addition to the taskforce and the screening initiatives you initiated at the National Coordinating Committee on Worksite Health Promotion from 1979 to 1987 and also the National Coordinating Committee on School Health emphasizing throughout that it's not just about what goes on in the clinical exam rooms but it's also about workers on in our schools and in our workplace. Would you like to point to any significant progress that you have seen in innovations in either school place or workplace health that contributes to healthier communities and individuals?

Michael McGinnis: In both cases there have been substantial gains, the credit to what we see in the way of developments in school health for example, the emphasis finally on better childhood nutrition in school food services. And finally on the kinds of foods that are included in vending machines is a tribute unfortunately to the recognition that childhood obesity is threatening a generation in fact perhaps multiple generations. And the issue of health promotion and preventive services that are emphasized through the workplace and through employer polices, we do see a substantial focus on that now recognition of the possibility of really changing workforce health profiles but that's driven substantially by the exploding healthcare costs and the drain on our national competitiveness regardless of what the reason is. I think there is attention and again back to the Affordable Care Act, there are now incentives that are possible if appropriately implemented to help shift the focus more toward health outcomes as opposed to individual services and that should provide another boost to the, strengthening the length between payment for services in medical care and what goes on in the community.

Mark Masselli: Today we are speaking with Dr Michael McGinnis Health Policy Leader and Senior Scholar at the Institute of Medicine. Dr McGinnis back in 2008 you have worked with Kaiser Permanente to develop an action plan to guide the use of evidence in decision making about obesity prevention policies and programs, tell us about that evidence, and I remember that it's not too long ago since counseling for obesity wasn't even a covered service under most Medicaid or private health plans. How has the evidence been incorporated in the Kaiser plan and beyond that do we have good comparative effectiveness research in the area of childhood obesity?

Michael McGinnis: Actually we have relatively little evidence in a range of pediatric interventions. There is now a rather substantial boost and interest in that arena. It's very complicated because much of the childhood obesity epidemic can only be addressed by factors outside the clinical arena. Progress is dominantly going to come from what happens outside those clinic doors.

Margaret Flinter: Dr McGinnis I would like to talk about one other area of health and healthcare that often doesn't get as much attention as it should, and really didn't get as much attention in the federal health reform process as I hoped it would and that's the state of rural healthcare and rural health services in America. We know that adequate dental care doesn't reach enough people particularly low income and people living in rural areas. Can you tell us what the Institute of Medicine is thinking about in this area and will we see some recommendations coming forth from the institute in the future?

Michael McGinnis: If you look across the boards in terms of national health status and step back a little bit and say what single issue is the most prominent challenge for the nation in the health arena, it would have to be the disparities in health status and health challenges. And the issue of rural health is what might be viewed as a central indicator in that respect. Because it is far more prominently a problem and a serious problem in lower income populations and isn't given the recognition that is needed.

Mark Masselli: Dr. McGinnis when you look around the country and the world what do you see in terms of innovation and who should our listeners at Conversations be keeping an eye on?

Michael McGinnis: Actually I think that the listeners should be keeping an eye on themselves because assuming ownership of their health status and healthcare is probably the innovation that is most actively in progress. The major and driving dynamic here is just what's going on in the scientific arena. When we look at the tremendous pace of growth of information and insight about the generic variation, individual variation, the patient and clinician as a shared set of partners in understanding, bringing all of the evidence to the fore and in working together to make the decisions is just going to be absolutely inevitable and necessary. So that's why I say as you look at scientific progress most of that progress I think is ultimately going to drive the patient who have to take more control over their own health prospects and decisions about their healthcare.

Margaret Flinter: Well that's a tremendous message to our listeners and to the country. Today, we have been speaking with Dr. Michael McGinnis, Health Policy Leader and Senior Scholar at the Institute of Medicine. Dr. McGinnis thank you so much for being with us today.

Michael McGinnis: Well thank you Margaret and Mark.

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

Margaret Flinter: This week's bright idea comes to us from Africa where following the summer's World Cup tournament in South Africa soccer fans are still as active as ever but on a somewhat different project, The Football For Hope

Community Centers. In 2007, FIFA the International Soccer Association teamed up with the Street Football World Network with the goal of using soccer to promote social development, peace, and social change. The founders of the Football for Hope Movement hoped to use what they see as the universal appeal of soccer to bridge cultural gaps and bring people together to solve critical issues. This year FIFA and Street Football World launched a new 20 centers in 2010 campaign with the aim of raising $10 millions to fund 20 Football for Hope Centers across the continent. Six centers are already nearing completion in South Africa which will serve as models for the remaining 14 in the years to come. Although all the centers share Football for Hope's broad mission of positive social change with a particular focus on health and education. Their individual programs will be tailored to specific local needs identified with and by local partner organizations. All of the centers will also contain renewable energy systems such as wind and solar and will be built from a cycle bulk of materials. The basic design of each center, a mid-sized Astroturf soccer field, classrooms, and healthcare clinics so to conserve as an open and gathering space for local youth as well as a school and health clinic for the whole community. The first Football for Hope Center opened its doors late in 2009 in South Africa with the mission of using the power of soccer to fight AIDS and provide youth with the skills and support to live HIV free. The center's local partner, Grassroots Soccer runs classes for 12 to 18 year olds in which they are trained as peer educators. These young people are becoming health ambassadors in their community sharing what they have learnt in creative ways with their families and friends. By using the unifying power of soccer to create vibrant health and education centers the Football for Hope Movement is helping provide people with the resources and the knowledge they need to promote wellness in their own communities. Now that's a bright idea.

Margaret Flinter: This is Conversations on Healthcare; I am Margaret Flinter.

Mark Masselli: And I am Mark Masselli, peace and health.

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