(Music)

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

Margaret Flinter: I am Margaret Flinter.

Mark Masselli: Margaret, members of Congress are back in their home states for a week long President's Day, happy President's Day to everyone.

Margaret Flinter: To you, yeah.

Mark Masselli: Thank you so much. After a week long, very drawn-out floor debate, very intense but the House managed to pass a spending bill very much on party lines to fund the government through the rest of the fiscal year and as expected, and as we discussed, it had very severe cuts.

Margaret Flinter: Well as the cold winter ends and we begin to look forward to spring I am reminded we are coming up on that one year anniversary of the historic passage of the Patient Protection and Affordable Care Act. And there is no doubt about it some of those cuts that are being voted on would prevent government agencies from carrying out some of the most essential elements of the Affordable Care Act although the President and senate leaders have made it clear that they won't stand for dismantling it altogether. But we do have to wait and see what happens next week when the senate passes its version of the continuing resolution and they are all working under very tight timelines.

Mark Masselli: They are, and we will see if they can get this done by March 04. But in this week's time, it's a good opportunity for everybody who is listening out there, take the time and give your congressman or your senator a call and have that conversation hopefully less heated than it was before but really articulating out the value that people see in the services that are provided in your local community. We took the opportunity Margaret the other day to sit down with our good friend Joe Courtney who is in the 2nd Congressional District and really talk about the impact Community Health Centers have on the underserved and special populations. He was down visiting us in New London and we look forward to continuing that conversation with other people across the State of Connecticut.

Margaret Flinter: Well Congressman Courtney is a great listener and we are always glad to welcome him to the health center. But you know I think that across the country, elected officials at the national, the state or the local level have gotten a big reminder that all politics are local and we have certainly seen this in the example around the world over the past couple of weeks as well. But engaging on the local level is really important for both Republican and Democratic lawmakers who are seeking to see that bigger picture, one that

maybe is not so black and white. And at one place we have been following closely is Wisconsin, very fascinating right now to look at what's happening there with health care and in their legislature beyond the public reaction to Governor Scott Walker's proposals which are making national news headlines across the country.

Mark Masselli: Wisconsin clearly is, and before Governor Walker was elected in the fall Wisconsin was recognized as a leader in health care reform having set an ambitious goal for near universal coverage. The prior administration in Wisconsin supported the health care overhaul and applied for one of the grants from the Department of Health to help them develop an online insurance exchange that will help consumers shop for insurance in 2014. Wisconsin along with six other states was recently announced as a winner, the money was appropriated by the law last year and this is somewhat insulated from the current budget battle and we will keep an eye on what Wisconsin does with this money.

Margaret Flinter: Well that grant may be insulated from the current budget battle but nobody is insulated from change. Governor Walker strongly opposes the Affordable Care Act. He even supported the challenge to its constitutionality in federal court so again what a difference a year makes.

Mark Masselli: It certainly does. And speaking of Wisconsin, our guest today is from the State of Wisconsin but we are not going to be talking to him about politics, we are really going to be focusing in on his research. He has been making great strides with population health research not just to make Wisconsin the healthiest state but for other states and communities to strive for the same. Dr. David Kindig is with us today from the Department of Population Health Sciences at the University of Wisconsin, School of Medicine and Public Health and its Population Health Institute. We are happy he can join us today.

Margaret Flinter: And, no matter what the story, you can hear all of our shows on our website www.chcradio.com, subscribe to iTunes and get the show regularly downloaded or if you like to hang on to our every word and read a transcript of a show, come visit us at www.chcradio.com. And don't forget, you can become a fan of Conversations on Health Care on Facebook and also follow us on Twitter.

Mark Masselli: And as always, if you have feedback, email us www.chcradio.com, we would love to hear from you. Before we speak with Dr. David Kindig let's check in with our producer Loren Bonner with Headline News.

(Music)

Loren Bonner: I am Loren Bonner with this week's Headline News. The spending bill for the remaining months of fiscal year 2011 passed the House of Representatives with provisions attached that would block money to implement President Obama's Healthcare Law. One provision in a series of defunding

measures presented by Republican lawmakers to shrink the federal government's power would prohibit the Department of Health and Human Services from using any federal money to implement the health care law. Congressman Denny Rehberg from Montana who offered up the amendment said the health care law is a classic case of government overreaching.

Denny Rehberg: It's a law designed by those who wish to control every health care decision made by health care providers and patients, by every employer and employee, by every family and individual, it will control every aspect of 1/6th of our economy.

Margaret Flinter: Besides broader measures to deny implementation funds for the law, the House approved an amendment to block federal funding for the internal revenue service to enforce the individual mandate the requirement that says all Americans must obtain health coverage starting in 2014. The House approved spending bill also cuts funding for the Title X Family Planning Program which provides information and contraceptives to low income individuals and families, the bill also eliminates federal support for Planned Parenthood, a major provider of reproductive health care in the US. The spending bill now goes to the democratic controlled senate where it's not likely to be approved.

A third judge has ruled in favor of the new health care law's requirement that individuals maintain health coverage or pay a penalty. Judge Gladys Kessler of federal district court for the District of Columbia, a democratic appointee of President Bill Clinton rejected a constitutional challenge to President Obama's health care overhaul. She reasons that Congress has the constitutional authority to regulate interstate commerce when it chooses to penalize people who forego health insurance. Two other federal district judges one in Florida and one in Virginia both appointed by Republican presidents have struck down the individual mandate requirement. US District Judge Roger Vinson in Florida went further and voided the entire law. Courts in Richmond Virginia and Cincinnati Ohio are preparing to consider the constitutionality of the law late this spring; the Justice Department is expected to appeal Judge Vinson's ruling in Florida soon to an appeals court in Atlanta. The issue however will ultimately be determined by the Supreme Court.

(Music)

This week on Conversations we are discussing ways to improve the health of our communities. We wanted to highlight one program in the State of Wisconsin that's addressing a specific health problem for Wisconsinites. Beside high rates of obesity and smoking, the State of Wisconsin also deals with a high rate of alcohol and substance abuse in its population. According to the Centers for Disease Control and Prevention, Wisconsin regularly lands at or near the top of national rankings for high risk and heavy drinking and diseases and injuries related to alcohol and drug abuse make it the fourth leading cause of death in the

state. To address the high rates of substance abuse among its residents, the State of Wisconsin began participating in a program several years ago called the Wisconsin Screening, Brief Intervention, and Referral to Treatment Program also known as the Wisconsin Initiative to Promote Healthy Lifestyles. The program is integrated into routine primary care visits. It calls for patients to be asked four simple questions about their alcohol use during the appointment. If the patient pops up positive on the screen, they refer to a health educator on the spot for further consultation. Wisconsin was one of the few states to adopt the program. Results have been positive in improving health as well as saving money. Karen Timberlake who was Secretary of Health under former Wisconsin Governor Jim Doyle says it's an early intervention that works.

Karen Timberlake: The data nationally not just in Wisconsin but nationally is that about 57% of people change their alcohol use as a result of that intervention alone and in Medicaid program where this has been implemented including in ours, Medicaid programs are saving hundreds and thousands of dollars per year in medical costs that are avoided.

Loren Bonner: Many studies have been done and all point to positive results. Early detection of at-risk or harmful drinking or drug use in an individual can go a long way in improving the overall health of one state. Let's turn now to our interview with Dr. David Kindig from the University of Wisconsin School of Medicine and Public Health. He will tell us more about the factors that influence health outcomes for a community and what new avenues population health studies can lead us down.

(Music)

Mark Masselli: This is Conversations on Health Care. Today, we are speaking with Dr. David Kindig, emeritus professor of Population Health Sciences and emeritus Vice Chancellor for Health Sciences at the University of Wisconsin Medicine, School of Medicine. Dr. Kindig also serves as senior advisor to the University of Wisconsin's Population Health Institute, welcome.

Dr. David Kindig: Hello, good to be with you.

Mark Masselli: Yeah, we are glad you are with us today. You have taught Population Health Sciences at the University of Wisconsin School of Medicine and Public Health for over two decades and can you describe Population Health Sciences, why it's so important and fascinating and how does it fit into health improvement and why should it be more widely acknowledged, studied, and adopted?

Dr. David Kindig: Happy to do that. It's a term that wasn't used so much two decades ago but is more and more. And what we really mean about population health is sort of the overall level of length and quality of our lives in groups,

populations whatever they be you know states or HMOs or neighborhoods, and also the variations or the disparities in those kinds of health outcomes across those groups. So I mean that's kind of how it's defined. Another really important part of the field of population health, the way we think about things, is that those outcomes are produced by multiple determinants of health, it's just not a health care matter, it's a balancing act across health care behaviors, genetics and increasingly the social and physical environment and how all of those things sort of work together to sort of produce those outcomes. So, if we are more and more interested in outcomes and accountability and getting value for our investments, it's an important way of thinking and studying.

Margaret Flinter: Dr. Kindig, in collaboration with the Robert Wood Johnson Foundation the University of Wisconsin Population Health Institute developed the first ever county health rankings annually ranking the overall health of every county in the United States. I would like to hear your thoughts on why county level rankings are so important and can they really bring about better health outcomes by driving policy and practice and do you have any examples of innovations that followed your rankings to share with us? I think Americans finally got used to the idea of rankings when we started seeing all the obesity rankings year after year and you could see the states turning blue and red and kind of pretty ominous but that's statewide so maybe tell us how this really gets used to drive change.

Dr. David Kindig: Sure. Well, we actually started this 7 or 8 years ago here in Wisconsin. We have been ranking the health of every county in Wisconsin for those years and then as you said last year Robert Wood Johnson asked us to take that national. It was a huge success in terms of the amount of media attention and web attention. The fact that it's based on the population health model such as I described earlier where actually every county get its rank both on its outcomes which we kind of call the current health and on the determinants, this balancing set of factors that I mentioned before, and that's sort of your future health. And it's a way to think about where are you ranking, say if you are ranking low on some of the determinants, areas in comparison to others where you might go to work on it. We totally are interested in this being something that stimulates policy. We don't want to just do measurement for its own sake. I mean we are gathering more and more of those examples on our website and actually will have a lot more when the next version of the rankings come out on March 30th. But I mean, we are getting stories about communities forming intersectoral partnerships, between health care, between United Way, between the schools boards, between businesses and getting together, looking at their determinants, looking at where we can do better, putting in grant applications, working with local and state governments. So I wouldn't say here on this program or in print that just having a ranking is a motivation to get change for sure but it's a guide post and a stimulus. And we are going to continue to be working more now with those counties as is Robert Wood Johnson and other organizations around the country particularly those that are at the bottom or

towards the bottom that have the greatest improvement to go in technical assistance or ways to try to move those forward.

Mark Masselli: Just sort of little bit of the history, it sounds like the American Health Rankings AHR has been around doing individual states since 1990 and was instrumental in helping you develop your ranking measurement--

Dr. David Kindig: It was.

Mark Masselli: For county health ranks. So we are curious about those metrics and how they are using the rankings but probably more importantly some examples about outcome measures that have been helpful in guiding population health policy. Pull the thread a little on that for us.

Dr. David Kindig: Yeah. America's Health Rankings, Dr. Remington and I, we co-direct this project, we are both on the advisory board for America's Health Rankings and we have lot of respect for what they have done over the years. When we kind of modified it a bit, I mean we did two things. Obviously we took it down to the county level and actually you asked before why counties, you know there is nothing magic about counties, we use it because lot of data elements are available with counties, we just use existing data. But it's a convenience unit in that way but it's getting down towards the community level where things can really happen so that's different. And as I mentioned before, America's Health Rankings has a single ranking for states. Now there is components in it that you can dissect out but we have really featured the fact what I said before that there is an outcome measure which balances both mortality and quality of those life years factors like unhealthy days and unhealthy mental health days and low birth-weight babies, combines those things along with our determinants ranking which talks about how are you doing on health behaviors, on health care access, on obesity rates, on smoking, on the social environment, on income and education and on the built environment. In a way population health is everything but we have found that with breaking it down like this, we are beginning to give guidance to people who want to figure it out where to get started and where to begin to work. And lots of places are under-weighing ways that they weren't before and we are going to be finding new ways to help with technical assistance as well.

Margaret Flinter: Well that is very exciting work. And let me if I can make the bridge between evidence-based practice at the individual level and evidence-based practice at the population level if you would and I understand this is something you have given a lot of thought to. So in practice, certainly in clinical practice, we are all deeply committed to using an evidence-based whether it's the US Preventive Services Task Force or how we deliver pre-natal care just to use an example right, there is an evidence-based practice for good prenatal care but when we look at what's the evidence-based population practice to reduce teen pregnancy or to reduce obesity. I am not so sure that sciences has really been

developed in that area as much around that kind of population approach. Could you talk to us a little bit about that, is there an evidence-based?

Dr. David Kindig: Yeah, you are truly right, and I don't know if this question is keyed off of the commentary that we had in JAMA last August but we wrote a commentary about, it is really off of the comparative effectiveness research thrust that is being pushed these days and so much of that is being framed very much within the medical care domain. Much of that work, almost all that work compares a drug to a drug or a procedure to a procedure or even maybe a health care system to a health care system and that's fine and that's important, that needs to be done but that's only one small cell of the population health model. And we were arguing that many more resources need to be put into the effectiveness of all of these other determinants and how they interact with each other, the social determinants, the physical environment, the behaviors. So we kind of know what's the right balance and in our rankings we actually have a weighting scheme where we weigh the different determinant factors, different amounts and there is some evidence in the literature that we give medical care at 20% and behavior is 40%, etc. But that's nowhere near as a robust as it needs to be and particularly as you drill down so we are hopeful that some part of the new comparative effectiveness research and other research by individuals and foundations will actually address those questions as well as opposed to just the narrow questions of which drug is better.

Mark Masselli: Today, we are speaking with Dr. David Kindig, emeritus professor of Population Health Sciences and emeritus Vice Chancellor for Health Sciences at the University of Wisconsin Madison School of Medicine. Dr. Kindig, you have a good grasp on the importance of child health and well being in your work as a former practicing pediatrician, and I am sure this is of great interest to you from a population health perspective. What do we need to change about how we approach early childhood development and health and where does the evidence stand there?

Dr. David Kindig: I think many, many people in the field are appreciating more and more that we have to push back these investments earlier and earlier to get the kinds of population health outcomes over the life course that we aspire to. And frankly I mean, I think that it's shocking frankly the safety net that we have for our children and when these things take so long to sort of play out their outcomes over a lifespan, all the uninsured children now are the children living in poverty, we have got in place results that they are going to play out over a long period of time. And so Medicare and Social Security are 20:11_____so we have sort of got that built in through the other end of the spectrum but we are not doing so well on the front-end. And I think now the science is coming along, I mean it's not fully mature yet but serious science is being done on the real importance of the prenatal period and the early childhood period not just with medical care but with social support and maternal education and those kinds of things that really have serious implications down the road.

Margaret Flinter: Dr. Kindig, we know that President Obama is committed to improving America's education system and certainly for years we have preached the higher levels of educational attainment are associated with better health status for the whole family and the President's budget certainly reflected a call for increased support for education. But what does the population health data actually show? For our listeners, can you tell them a little bit about the link between educational attainment and overall health status?

Dr. David Kindig: Yeah. The strongest evidence in social science that there is this relationship between years of schooling and quality of those years of schooling on health outcomes independently controlling for all other factors, that's about as strong of a causal relationship you can get in social science. But there is also a lot of evidence that the stress pathways that are produced through lower educational levels and lower income levels, they have their independent effects through neuroendocrine and neuroimmunologic pathways that produce damaging outcome. For me, the next marginal dollar for population health improvement would be in education and early childhood education and that doesn't mean that we don't invest in other kinds of things, we have to cover the uninsured and we have to work on still keeping smoking rates down and we have to keep our air clean but the evidence is pretty clear that those social determinants are really important. Education is also one that we don't have such a political divide around. I think all Americans of both parties and different political persuasions I mean therefore equality of opportunity and actually education funding has other effect over productive workforce and all of that. So that's a big one for me.

Mark Masselli: Speaking of another big one from a population health perspective I suspect we would agree that childhood obesity might be the single greatest threat to child's health and their future adult health. What lessons do you bring today to bear from your population health studies to tackle this one?

Dr. David Kindig: I am delighted with all the attention that it's getting from the First Lady on down. Again, it's a multi-determinant sort of a condition. Yeah it's obviously a critical challenge for us and again that spreads out over the life course and to unborn children as well.

Margaret Flinter: Dr. Kindig, we like to ask all of our guests this question. 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?

Dr. David Kindig: I think the work of Elliott Fisher and Jack Wennberg and the people at the Dartmouth Group, it's particularly in the medical care domain but they have been showing us where the areas of medical care spending are in the country and by procedure where we are not getting any return on health for those expenditures. And so I mean the reason that's important is that not only do we

need to bend the health care cost curve for its own right but to the degree that some of those resources could be freed up for public health and prevention and early childhood, that's critical.

Mark Masselli: Today, we have been speaking with Dr. David Kindig, emeritus professor of Population Health Sciences and emeritus Vice Chancellor for Health Sciences at the University of Wisconsin Madison School of Medicine. Thank you so much for joining today.

Dr. David Kindig: Thanks. It was nice being with you.

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 focuses on a health clinic that's calling on individuals and communities to take action to improve the health of their surroundings in their environment. The Environmental Health Clinic at New York University is similar to a traditional health clinic in that a person makes an appointment to talks about a particular health concern but what's different is the discussion has to do with an ailment related to environmental health and instead of receiving a prescription for medication or a treatment, the person leaves with a prescription for change. Now that's different. Many of the conditions primary care providers encounter on a daily basis, asthma, obesity are caused or exacerbated by their external environment. But health care professionals are often not trained to address outside forces that contribute to poor health outcomes. The environmental health clinic seeks to improve a person's health by giving them advice they can use to remedy local environmental issues as well as address specific immediate issues like household problems. These prescriptions range from elaborate green designs for neighborhoods that need cleaner recreational areas to simply incorporating a few house plans to improve indoor air quality. Community organizations have consulted with clinic staff to get help designing projects that they can use as legitimate forms of participation to promote social change, an approach to health care that's drawing individuals and communities to work towards building a more sustainable healthier environment. Now that's a bright idea.

(Music)

Margaret Flinter: This is Conversations on Health Care. I am Margaret Flinter.

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

Conversations on Health Care broadcast from the campus of Wesleyan University at WESU streaming live at www.wesufm.org and brought to you by the Community Health Center.