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

Margaret Flinter: And I am Margaret Flinter.

Mark Masselli: Margaret, last week we talked about the Supreme Court not listening an expedited hearing about the Affordable Care Act. This week they came out and said they won't consider an earlier challenge to the law instead opting to allow the case to proceed through the normal channels.

Margaret Flinter: And that doesn't mean that they won't be hearing the case, it just means they won't be hearing it soon. This has been quite a season for long delays on almost everything that we expect to see coming out of Washington. So we will have to watch closely as the case moves through the appellate courts.

Mark Masselli: Hurry, hurry wait, wait and we are often though you are with that and meanwhile the Supreme Court is hearing another case. That could have an interesting effect on healthcare and beyond. Vermont passed a law that would prohibit pharmacies from selling information about which drug doctors prescribe most to pharmaceutical companies, business implications beyond how pharmaceutical companies market to doctors since any decision could impact how other forms of data are gathered and sold.

Margaret Flinter: Well, the pharmaceutical company had its hits over the last month or so with their progesterone drug to prevent Preterm Labor and now this. Another topic we have been following closely this made some news reactions to the proposed restructuring of Medicare in the republican budget proposal. We were wondering when we would see that reaction.

Mark Masselli: That's right Margaret, a few weeks ago we were wondering we are all the town hall meetings with seniors telling their representatives to keep their hands off of Medicare were and in light to the recent budget proposals put forth by representative Paul Ryan, which includes privatizing Medicare, well over the Easter recess. We started hearing the beginning to some rumbling republican law markers have been back in their home districts and some of them have really been feeling the heat from their constituents.

Margaret Flinter: And of course I don't think anybody is surprised by that certainly entitlement reform especially of Medicare has always been very politically sensitive and a recent poll from the Washington Post-ABC news found that hasn't changed much. The majority of Americans 2/3rd still say they want Medicare to stay the way it is. So convincing the public that the republican proposal for referring Medicare is a good idea is going to be quite the uphill battle.

Mark Masselli: And although the republican plan is supposed to privatize Medicare for the next generation of seniors. It seems like many of the outspoken seniors of these recent town hall events were skeptical of the republicans' promise that they would remain protected. This is a big turnaround from the town hall debates two years ago when President Obama's healthcare plan was on the table.

Margaret Flinter: And in these early months of the next presidential campaign – I think we can now call this the early month of the next presidential campaign – the president was on the road last week. He was criticizing the republican plan and the democrats have launched immediate campaign accusing republican house members of doing away with Medicare and putting retirees in danger.

Mark Masselli: Well healthcare will remain in the bull's-eye for the campaign last season and we will keep an eye on it here at Conversations on Healthcare.

Margaret Flinter: And anyway you can cut it what we do know is everybody all politicians have to be figuring out the best way to reign in healthcare cause and really that's on the national agenda for all of us.

Mark Masselli: That leads us to today's guest. We are happy that Dr. John Wennberg is here to help us today. Dr. Wennberg is the Peggy Y. Thomson Professor for the Evaluative Clinical Sciences at Dartmouth College and founder of the Dartmouth Institute for Health Policy and Clinical Practice which houses the well known Dartmouth Atlas Project. We look forward to speaking with Dr. Wennberg about his research, which for the past 40 years is focused on variations in healthcare around the country. And what we can learn from him about making the healthcare delivery system more equitable and efficient.

Margaret Flinter: We are very glad to have Dr. Wennberg with us today and no matter what the story you can hear all of our shows on our website chcradio.com. Subscribe to iTunes and get the show downloaded or if you want to hang on to our every word and read a transcript of our show, visit us at chcradio.com. And if you are a social media aficionado, you can become a fan of Conservations on Healthcare on Facebook, and don't forget to follow us on Twitter.

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

Loren Bonner: I am Loren Bonner with this week's Headline News. The First Family made sure that health and wellness was central in this year's Annual Easter Egg Roll.

In addition to listening to some great music and dancing a little bit you can roll you eggs, you can do some yoga, you can play with some, do some obstacle courses, play basketball and tennis.

Loren Bonner: Under the theme “Get Up and Go” the festivities on the South Lawn we are part of First Lady Michele Obama's "Let's Move!” initiative to bring awareness to health eating and activities for children. The Supreme Court said they won't consider an early challenge to the healthcare law. Virginia’s request to expedite the review of the law was turned down by the Supreme Court. It offered no reasoning and there were no noted descending votes. The Supreme Court’s usual practice is to consider cases only after an appeals court has ruled. The court of appeals for the fourth circuit in Richmond, Virginia will hear arguments in the Virginia Case on May 10th. The Department of Health and Human Services has decided to award quality bonuses to hundreds of Medicare Advantage Plans rated with the average 3 or 3½ stars. Roughly 1/4th of Medicare beneficiaries are enrolled in Medicare Advantage Plans. They are for lower out of pocket costs and more comprehensive benefits than the traditional program. President Obama’s healthcare low gradually cuts $145 billion over 10 years from Medicare Advantage starting in 2012 mostly to correct a problem with overpayments to the plans. Medicare has classified the bonuses as a demonstration program, relying on broad legal authority congress gave to the agency to experiment with quality improvements. The money will come from the Medicare Trust Fund.

Mark Masselli: This is Conversations on Healthcare. Today, we are speaking with Dr. John Wennberg, the Peggy Y. Thomson Professor for the Evaluative Clinical Sciences at Dartmouth and Founder and Director Emeritus of the Dartmouth Institute for Health Policy and Clinical Practice, as well as the Founding Editor of the Dartmouth Atlas. His latest book Tracking Medicine: A Researcher’s Quest to Understand Health Care is published by Oxford Press. Welcome Dr. Wennberg. In your career for the last 40 years which is chronicled in your book is focused on the variations and healthcare across the country and its affects on the health of individual patients. What exactly is the study of practice variation which you also called the science of healthcare and why have you found it so important through the years and tell me does my zip code really matter in the type of in quality of healthcare that I received.

Dr. John Wennberg: Well let me start with the basic observation is that if you compare the healthcare in one community with another and you take the trouble to adjust for the different factors that might explain it on the basis of illness for a patient preferences, you end up with huge differences between the amount of healthcare received by population A and population B and they can be right neighboring communities. We first ran across this in Vermont where we looked at a whole bunch of different attributes of healthcare system, the one that sticks out in most people’s mind is the incredible variation that we saw in _____ 7:43 rates where literally by going 5 miles up the road and entering a new hospital service area, you could jump from about a 20% risk of having a _____7.52 by

age 15 to well over 60%. So, that gives you an idea of what you know the basic variability was, and this variation simply could not be explained on the basis of differences in the incidence of sore throats, tonsillitis or anything like that and it was traced pretty much directly back to the medical opinion of the physician within a different community.

Margaret Flinter: Dr. Wennberg, I think that certainly gives us a hook on looking at these variations and certainly you have made the point that illness doesn't explain it all and nor does anyone factor not genetics or environment or age or anything else I guess but when you try and understand these variations across the country so that we can build some effective health policy and practice procedures, it seems that you are left always looking at the Medicare data because that's what we have got on a national basis, and yet you use the example of tonsillectomy and I know hysterectomy was another one you know in certainly less than Medicare age people often, how do you get at the data on the rest of the country? I know there are special populations like Medicaid and the commercial populations so that we have a complete sense of what is going on with variation.

Dr. John Wennberg: The earlier studies that we did in Vermont, Maine, Rhode Island, Iowa and some actually in California, were all based on 100% hospital discharge data. So we were looking at both 65 and under 65 and certainly we found them and there are still plenty of evidence that this is true is that the experience of older people above 65 and older when it comes to surgical variations pretty much mimics that as under 65 or vice versa.

Mark Masselli: Dr. Wennberg we are having a déjà vu moment again in our country when we are fixated on the federal budget deficit in rapidly increasing healthcare expenditures and obviously in the cross areas of Medicare, what can the politicians learn from your research about the most beneficial ways to restructure Medicare and how to contain cost while providing the best outcomes that are possible.

Dr. John Wennberg: Politicians will have to understand that not all healthcare is the same. Some things that vary and do so because they are essentially measures done to improve the quality of life and patients have different preferences for those treatments. But all the policy way I know of getting at to which rate is right question is to actively involve the patient in decision process because after all it's the patient's preferences that need to be driving the decision not medical opinion, opinion of local physicians. And at this time in our history we can certainly see in the patterns of variation that it's medical opinion, not patient's opinion or preferences that are driving these. Now that's just one of the categories and I would say in terms of Medicare that makes up about 25% may be 30% of cost, those kinds of procedures. Most of it basically going for managing chronic illness, for managing patients who ultimately are going to succumb from their diseases so it's a long term management of chronic illness

that is where most of the money in Medicare goes I would say about 60% would be a pretty good answer to it. And here the variation that we see around the country is driven primarily by the differences in frequency with which chronically ill patients visit their physicians are referred to specialists or hospitalized or put in intensive care units, receive MRIs or other forms of imaging and other laboratory tests. So it's the intensity of care which differs so much from one community to another which also is the driver of cost. So if we want to deal with cost and Medicare and the trends upwards we got to somehow figure out how to deal with supply sensitive care to bring now chaotically we manage chronic illness over time under some form of organized systems. The organized systems such as the Mayo Clinic and Intermountain Health Care, Geisinger Clinic do much better in terms of continuity of care over time. They use fewer resources and spend less money and I don't think it's not just an accident. It's the organized system that's there that permits the timely tradeoff between primary care and specialist and the judicious use of hospitals and results in lower overall cost.

Mark Masselli: Well that seems like the mountain to climb if we only have four organizations that you can site and we have a 100,000 people providing healthcare out there multiple of that, you know what's the crosswalk over for the system that will get us to develop world class organization who are focused in on patient outcomes and not always about volume and bottom line.

Dr. John Wennberg: Right that is the bottom line question, isn't it? Now the Health Reform Act does have the so-called accountable care organizations which could be viewed as a, and I think should be viewed as a bridge to the future and the sense that it provides opportunities for Chief of Service Medicine to become more organized to begin to move towards a budgeted approach and to develop the infrastructures necessary to really manage chronic illness over time. And I might add also the infrastructure to make certain concept of shared decision making and informed patient's choice gets implemented for surgical procedures and other conditions or treatments that are definitely preference sensitive.

Margaret Flinter: This is Conversations on Healthcare. Today we are speaking with Dr. John Wennberg the Peggy Thompson professor for the Evaluative Clinical Sciences at Dartmouth, Founder and Director Emeritus of the Dartmouth Institute for Health Policy and Clinical Practice. Dr. Wennberg you mentioned the Affordable Care Act and certainly it gives our nation an opportunity to reform the delivery of healthcare but I would tell you that one of the most remarkable outcomes of the work of the Dartmouth Atlas and I think it was brought to the public consciousness probably through Dr. Gawande's New Yorker article looking at McAllen, Texas is that it was the first time I saw this issue of variation and price variation in utilization make sense to the person in the street if you will. Our own local Chamber of Commerce sponsored a workshop certainly thereafter with the business community to talk about the Atlas about these variations and looked at our own local communities in the State of Connecticut to try and make sense of why these variations happen. Is this a sea change that you are now seeing

where business people Chambers of Commerce consumers are finally engaged in this discussion and get that variations may not be so good for your health either?

Dr. John Wennberg: I think that's really incredible sea change and let's keep the sea moving. The Dartmouth Atlas was started in the early 90s when we were assuming that the Clinton Health Plan would come true and we got support in order to show what the regional differences were because it was so organized around regions. When it failed basically we had a data, we had an atlas but we didn't have a customer base and what we hoped it would be that if we could begin to publish this information and do it consistently over time that ultimately it would surface as a major issue and it would probably be time to the next health reform cycle, which in fact, that's pretty much what's happened. So yes I really think these conversations are happening, we see it in the press coverage to the Atlas. We are getting reports of all sorts of feedback and discussions going on. I think we have gotten beyond the death panel kind of problem that we saw a couple of years so, people begin to take it very seriously at the end of life variations, the cancer treatment intensity varying so much as it does from place to place. We are getting debates over End-of-Life Care, we are getting debates over efficiency in Chronic Disease Management. And I think that's the essential start to some strong consensus I believe it's going to have to come out of this.

Mark Masselli: Dr. Wennberg certainly in terms of cultural changes we have, here on the show we would like to talk about the next generation healthcare providers and how they are being trained and so talk to us a little bit about is the science of variation being taught at these institutions and what can we do on the side of training that next generation to help address some of the structural problems that you have identified?

Dr. John Wennberg: I think that's probably one of the most disappointing features of the trip so far is that medical education is so hide down to the traditions in the 19th century in terms of what's taught, who teaches, what's important and there is basically very little room for the science of healthcare delivery in the modern medical school curriculum. And this is a shame because this is where we got it somehow the cultural change is going to happen ultimately when the providers themselves change.

Mark Masselli: Yeah, hold the thread a little, the issue of how we inform, how we have an informed consumer out there. And I don't know if there is an app out there or if we start with sort of assessment level education drive in our country to make consumers more discerning in their selection of providers, in the selection of procedures that are done. What are your thoughts about, what do you see as models out there that we should be looking at?

Dr. John Wennberg: We have spent a lot of time figuring out how decision aides are properly designed and properly structured into every day practice, could in

fact change the dynamic, essentially change the culture at the doctor-patient's level. And there is a large number of clinical trials now showing the decision needs properly implemented really do change the dynamic and lead the decisions that are higher quality. High quality decision being one in which the patient was truly informed about the treatments options and the risks and benefits and also where the patient was invited into the decision process so that his or her preferences for one outcome or the other, a lumpectomy or a mastectomy or a knee replacement or some more conservative treatment their preferences for those kinds of treatment outcomes drill the decision process. And there is a plenty of evidence that this works and it could be implemented broadly but to do that it's going to take both push and I hear again I think the business community has a lot to say about it, but also push from CMS and also push from provider leaders for which there are some emerging.

Margaret Flinter: Dr. Wennberg I was struck by your reference to the organized systems certainly Geisinger, Kaiser Group Health, the Mayo Clinic and as Mark noted people often tend to speak of those in the same sequence but when we look at other large systems of care around the health center, our perspective would certainly be the country's community health centers represent another, somewhat different but somewhat organized system with a thousand health centers caring for 20 million people. Certainly the VA represents another large organized system and I want to tie this back to the education and training issue because certainly medicine is not alone among the health professions in the hideboundedness if that's a word of how things are taught but it seems to us that it's the residency is where people get trained to a model of care and we have certainly been active proponents of we train these practitioner residents in our organization certainly many health centers have medicine residencies. But that's where you get to train people to a model of care. I am curious as to whether you and your colleagues are working with residency directors around the country to make these changes at that level around things like shared decision making for instance which certainly seems to be a core competency for anybody doing the primary care residency training.

Dr. John Wennberg: The only thing that we can notice that so many of our residency programs are held in hospitals that do not practice shared decision-making. And even perhaps more problematic they are practicing a brand of medicine and managing chronic illness that basically is unsustainable in terms of the resources they use and that's not true of all teaching hospitals. You receive Washington, you receive Oregon are all on the low side of the chronic disease management spectrum. Residents there are presumably are getting a different brand of medicine and people who are trained at NYU, New York University Hospital or other teaching hospitals in New York, or Miami, or Philadelphia. The concern about that issue particularly concerned about the mix between primary care and specialist does need to become a public policy issue and we should not continue to fund postgraduate medical education without reference to the content

and the environment in the context in which their care is being given. So at least that's my opinion.

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

Dr. John Wennberg: Some of the best systems I have seen for example would be, some of them would be in New Zealand where they have solved the problem at least they have satisfied some of the problems of financial incentives. They have got good IT systems. They are organizing chronic disease management on a continuum involving both primary physicians and medical specialists. So there I think you see some systems that are doing things in a very promising way.

Margaret Flinter: Today we have been speaking with Dr. John Wennberg the Peggy Y. Thomson Professor for the Evaluative Clinical Sciences at Dartmouth and the founding editor of the Dartmouth Atlas. Dr. Wennberg, thank you so much for joining us on Conversations today.

Dr. John Wennberg: You are welcome.

Mark Masselli: Each week, Conversations highlights a bright idea about how to make wellness a part of our communities into everyday lives. This week's bright idea puts the community front in center in an effort to fight childhood obesity. Although adults in Colorado are the leanest in the nation, obesity among children in that state is rising at an alarming rate. Today 22% of Colorado's 10-14 year olds are overweight or obese. A non-profit group called 2040 Partners for Health is bringing several communities in Colorado together to confront this issue. The group has decided to start working in five Denver neighborhoods where the childhood obesity rate is 30%. With the help of researchers from the University of Colorado the team is using an approach known as Community-Based Participatory Research which puts residence in charge of defining their own problems and finding solutions. Researchers started out surveying families in the five neighborhoods who had children between the ages of 10 and 14. They charted height, weight and asked questions about neighborhood safety and physical activity. They went into neighborhood schools and did the same. Next they asked adults and children for their input on how to make neighborhoods healthier. The children requested that school playgrounds be open after hours and many parents suggested healthier school lunches and neighborhood recreation center. In the community the message is been well received and meaningful action is starting to build. More than 60 community members have signed up to participate in healthy advocacy in their neighborhood. It may take years for many of these ideas to be fully implemented but policymakers in Colorado are beginning to understand what these neighborhoods need to be healthier – an approach to health that's transforming neighborhoods by engaging residents. 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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