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

Margaret Flinter: And I am Margaret Flinter.

Mark Masselli: Well Margaret, some interesting numbers have come in. A study just released by Robert Wood Johnson Foundation in Athena Research Division of Athena Health shows that dire warnings of long delays at primary care facilities due to the millions of newly insured Americans simply have not happened under the Affordable Care Act.

Margaret Flinter: It is an interesting data set Mark and part of an ongoing partnership to check the true impact of the Affordable Care Act., it's called the ACA view and the aim is to provide a non-person analysis of the actual effect of the Healthcare Law.

Mark Masselli: Its advocating real time patient and provider experience data from Athena Health large patient database. They provide a health IT system for 52000 practitioners. They are measuring some 35 metrics overtime are able to rely on real time data for research and analysis.

Margaret Flinter: It's sure there is no significant wait time added to the patient experience for those seeking primary care or other ambulatory services. That was the direct prediction that came from the (inaudible 1:06) of the Healthcare Law and certainly there were some experience of that in Massachusetts years ago. So other interesting findings in the report as well should be of interest to anybody in the care delivery or health policy if you look at it.

Mark Masselli: And there is another interesting matter to note that is the direct results of the Healthcare Law, insurer seem pretty happy with the outcomes so far since the nation's uninsured rate dropped from 18% last year to 13.4% this year. That means millions more customers for insurance companies and there will be another wave of newly insured during the next open (inaudible 1:38), we are not too far – it's around the corner Margaret.

Margaret Flinter: Very interesting to see just how many opportunities the Healthcare Law is providing for gathering real metrics on Healthcare System hopefully on outcomes too. And that's bound to have an impact on the actual delivery of care.

Mark Masselli: That's something our guest knows quite a bit about today, Margaret. Peter Speyer is the Chief Data and Technology Officer at the Institute of Health Metrics Evaluation at the University of Washington.

Margaret Flinter: They have developed a ground breaking report on the collective health of over 200 countries around the globe. It's called the global burden of disease. It's the most detailed report to date on the causes of poor health and death by country. Let me talk in about some of the fascinating health transit, their report is real.

Mark Masselli: We also have our weekly visit with Lori Robertson, managing editor of Factcheck.org.

Margaret Flinter: And no matter what the topic, you can hear all of our shows by going to chcradio.com.

Mark Masselli: And as always, if you have comments, please email us at info@chcradio.com or find us on Facebook or Twitter, we love hearing from you.

Margaret Flinter: We will get to our interview with Peter Speyer 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 these Healthcare Headlines. The Healthcare Law by the numbers. A 10.6 million people, that's the number of Americans, who sort some kind of assistance signing up for insurance under the Affordable Care Act. Some 28000 assisters help to guide those 10 million plus Americans through insurance exchanges. Those online portals set up by the ACA to provide insurance at market place. Eight million folks signed up for the insurance ultimately and another five million included in coverage through expanded Medicaid. Folks living in states that created their own exchanges were most likely to find assistance as well. And insurers did pretty well too. The Nation's uninsured rate peaked at 18% last year after the roll down of the first open at the moment that percentage dropped down to 13.4% meaning millions of new customers for the insurance industry. Hepatitis C finally has a vanquisher but the regimen is cost prohibitive in most cases. The State of Oregon appears to be nearing what could be a first in the nation's stats limiting availability to Medicaid patients of new hepatitis C treatments that offer great promise that at a very high price, \$84000 for three month's treatment. On July 31, the state committee will consider guidelines intended to limit treatment only to patients who face serious liver damage without the drug. And women in Detroit have a worse chance of surviving maternity than women in Libya, Uruguay, or Vietnam. The maternal death rate in Detroit is 3 times the national average and is going up according to recent data. Those working on the front lines of maternal health are helping initiatives in the Affordable Care Act will get high-risk women into more prenatal care sooner. Better news in the stroke front. According to a study looking at 20 years data, the incidence of stroke is down about 50% over two

decades and death by stroke reduced by 40%. The decline being attributed to better control to high blood pressure reduced smoking rates and better care protocols. The rise in diabetes however made negatively impact that trend overtime. I am Marianne O'Hare with these Healthcare Headlines.

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Mark Masselli: We are speaking today with Peter Speyer, Chief Data and Technology Officer at the Institute for Health Metrics Evaluation at the University of Washington where he oversees the infrastructure for global and public health data gathering from Governments around the world that lead to the ground breaking report global burden of disease. Before that Mr. Speyer was director of global marketing strategies for **Corbus [PH]** at digital imaging managing company which oversees the rights to over a 100 million images. In his native Germany, peter worked as a senior consultant at (inaudible 5:36). Peter holds MBA from Temple University and a masters of business engineering from the University of (inaudible 5:43), Germany. Peter welcome to conversations on Healthcare.

Peter Speyer: Hi Mark. Thanks and hello Margaret. It's great to be here.

Mark Masselli: You have been at the forefront of this new era of big data analytics which is really transforming global health and at The Institute of Health Metrics Evaluation you are responsible for managing vast screens of data from around the globe which measures disease and causes of death and over a 180 countries and we were fortunate to have the director Dr. Murray on the show. We are talking about the initial report of (inaudible 6:12). Tell our listeners how you help create the secure infrastructure that allowed the report to come into be.

Peter Speyer: So the global burden of disease study is a really large and complex study, incorporating lot of data from very many different sources, what we are trying to do in this study is to analyze to what extent our health is impacted by different disease and injuries and so we are trying to express in life year equivalent how many years we are loosing to these diseases both from premature mortalities about 55 million people die every given the year around the world and so we are summing up for every death how many life years we are loosing from those as well as how diseases that ail us but don't kill us impact our lives or how much our health is impacted by those. And so we are creating a metrics called feasibility adjusted life which is our current (inaudible 7:02) for measuring overall health loss. We have knowledge which to model where we are annually updating these numbers, so the analytic work is done here at the institute and then we are working with about a 1000 experts in 100 countries that help us looks at the data. So we run the analysis for about 300 diseases, 69 risk factors that impact these diseases, and we are looking at 188 countries. So we have really tried to incorporate everything. I need dataset that has information on health outcomes around the world. We are working with Census Data, survey

sort of collected, diseases registries for example cancer registry exist in so many countries and collect information about cancer, health record data from hospitals, and claims data from insurances. So we are incorporating about 30000 different data sources in this most current update of GBD. So we are comprehensively looking through the websites of ministries of health and the statistical organizations, NGOs and others. In many cases we have to directly contact folks at those organizations and negotiate access to data because as you can imagine health data especially if it's very deep, health and has information on individual, it is very sensitive and so it is a constant balance of trying to get access to these data and make them available for research.

Margaret Flintner: Peter certainly gathering the data was just one of the number of very daunting tasks required to complete the project in addition you had to come up with some new tools in ways of using them to assisting the data, analysis and maybe you could share with us what kinds of innovations in big data analytics made it possible for you approach all this information and useful ways that maybe couldn't have been done in the past and did some of the new analysis revealed surprises about the state of global health and crises of mortality around the globe?

Peter Speyer: We are starting with measuring all cause mortality around the world. That means is for every age group (inaudible 8:42) around the world and what that means is for every age group in every country we are trying to identify exactly how many people died in that given year from a given cause and then we are analyzing which causes are responsible for these deaths. So once we have analyzed causes of death, we go on to analyze how diseases that ail but don't kill us and we are looking at the prevalence of different diseases and then we look at risk factors and then putting it all together and as you can imagine with the number of datasets we are to apply various statistical methods and given the number of datasets and the complexity of the analysis we have actually built that our own computer class there was about 10000 nodes so 10000 computers stuck together and still it takes 4 to 5 days to run the analysis beginning to end. So with this current duration of GBD we really innovated on each one of these steps and developed new methods and I would say given that in more recent times much more data became available and the methods that we are deploying have much more sophisticated that we have impacted a lot of change in terms of how we can do these analysis. Let it be fine. We over the past 20 years made a huge progress in terms of reducing mortality in children. There were about 10 million deaths in children 1990 and we reduced it to about 7 million in 2010, which shows how we reduced infectious and childhood diseases. So the second big finding is that we are living longer, and getting older but we are living those additional years, not in complete health. And then the third big inside is we are looking at risk factors besides disease burden and in 1990 leading risk factor was childhood malnutrition. So most burden in the world was still caused by malnutrition and in 2010 that changed to diet as leading risk factor. So we went from having two little food to eating too much and the wrong things. In the west

diet is actually responsible for what 14% of total burden now, followed by smoking and overweight. And we just recently unreleased the study on obesity and overweight and shows that about 30% of the world population is overweight or obese and in the US this number is actually 50%. So lots of these insights are really instinct both on the disease side and the risk factor side.

Mark Masselli: Peter brings us the interesting intersection still daunting to be in the Healthcare Industry. We have these rims of data, vast bodies of knowledge and health information, but how do we access all the data? What do you plan for disseminating all this complex health data that would make it user friendly to improve health policy and practice?

Peter Speyer: So the GBD result is an extremely and complex and large data set. We have about a billion data points just in terms of results. And then we are trying to make these results available to very different audiences, right. We want other researchers to pick up our work and improve on it. We have often addressed policy maker and decision makers, you know, the see suit at NGOs and companies to use the aid for decision making. But then we also want to reach you know, the casual user or general audiences that can use this information to understand better how health is impacted around the world. So what we are trying to do is tailor kind of presentation of these results to the different audiences and using very different mechanisms. So for one as I said all the message that we are using for GBD are published in pre-reviewed papers so reaching journalists through papers like the (inaudible 12:04) health analyst. Then we are writing detailed reports both on how we did the analysis and in some of the key insides and findings that we have from the study. We are going to conferences to present our findings as well as policy workshops to help policy makers interpret and use these results correctly. The game change and the biggest innovation in terms of outreach are these interactive data of visualizations that are now available on our website, which is at [health data .org](http://healthdata.org). Because those really make all the data available from a very high level of view to a very elastic view of details and it basically allows our audiences to dwell into the level of detail that they are comfortable with and so, what we are trying to do is make these into it is enough that people can explore our data set, look at patterns, look at trans across, you know, across country as well as in a given country and our flex of visualization GBD compare uses very many different visuals that you can then use in combination to re-dive into the data sets and its typically, people spend, you know, minutes on websites at best and use it for GBD compare rages between 30 minutes and an hour on average. So, people are really getting into the data and into interacting with these data and exploring them and then last but not least, we have launched a platform called the global data exchange and here we are cataloging all the input data as well as the result data sets, to make it easy for others that want to is similar analysis and then basically obtain and work with these data themselves.

Margaret Flinter: I have a feeling that some one out there is taking your research and now marrying it up to what we think of the social determinants of health. The poverty in a country or the educational level of attainment in a country, and I am curious if you have seen and used in that way to drive policy change within the ministries of health with countries around the globe and if there are any examples you might share whether report is being used to drive policy change.

Peter Speyer: So we are looking at social determinants as information in terms of estimating health so we have a large database of things like to access to water and sanitation, educational status, income per capita and so on. In terms of usage, we get a lot of interest from around the world. So we see on the website that we have users from 200 plus countries and we have specific examples like the Government in the UK that saw the results of our study and wanted to dive deeper and look up nationally how different populations within the UK are affected and so we have launched a project with them to go into more detail there or the minister of health in **Rhondda [PH]** contacted us and saying that these visualizations are so useful that they are having recurring meetings where they go through these and use the evidence that we have put together for them and those are just 2 examples, I mean there are so many more where we directly engage with folks at ministries or nonprofit foundations across the UN and so on, that we know, use our data, and interact with our tools and interact with our tools and really use them in their day-to-day work to make decisions.

Mark Masselli: We are speaking to Peter Speyer chief data and technology officer at the institute for health metrics evaluation at the university of Washington where he oversees the infrastructure for global and public health data gathering from governments around the world, which lead to ground ranking report, global burden of disease and here we have entered this era of quantified staff where patients are increasingly seeking information on whether it is on their genu or tracking vital signs or wearing fit beds, what is your advice to practices as they think about how to manage this generated information by individuals that might help facilitate the two way flow of information, obviously the mobile phone being able to bring people to new realizations about their own health?

Peter Speyer: This is a phenomenal trend and it is really interesting to see how it is catching on really across the world. I myself I am tracking you know, activity level, food intake, workouts and so on. And as people doing this more and more, I think, this is really useful information at many levels. Actually physicians should be using this. I mean, I should be able to with this to my doctor and let him or her know about this data and they should use it for helping manage my health. I think the problem we are still seeing is that physicians come back to that with answers that range from all that is so interesting, let's have a look all the way to I have where to put this in my system, so I think there is still this divide where now we, have all these tools to collect all these data, but there is really no good streamlined way of getting that into the day-to-day Healthcare System. I think for now there is a lot of the burden on the individual, it's kind of try and use these

data, obviously it is very useful to track your activity. I myself, I am motivated to move more and workout more because now I have a track record of how well I actually did this. And that's very useful tool for individuals to bring together all the health data in one place like to have mixed of health law that has been around for years that allows you to pull in your health record information and then now increasingly data from these devices. But on the flip side, I think we will need to be careful to look at, where do these resides and how can we really move across the health system as well as then make them available for analysis right? And then maybe to take one step back, obviously these data are also very important for analysis at the population level like we do GBD. So statistical activity is one of the risk factors we are tracking and getting more information about individuals and how active they are and getting these information is somewhat streamlined way would obviously be hugely beneficial and make our life easier, but we are not quite there yet.

Margaret Flinter: Well Peter I think it so important that in addition to looking to mortality and causes of death, it is the project brought into really look at the chronic conditions have such a profound impact, I understand that you have launched a price to improve public health by turning evidence in the global burden of disease into successful programs that impact the public health challenges which are so associated with these, which really are global epidemic of chronic illness tells about that pricing what you are hoping to accomplish.

Peter Speyer: We launched a price last year and it is called the root price on tuning evidence into health impact. So this price was initiated and funded by day(inaudible 18:17) with is a board member at the institute for (inaudible 18:22) and it is basically promises a price of 100 thousand dollars for an organization or an individual that use data from the GBD to impact health for a population. The importance of this goes much beyond this, where we are trying to get all these entries and examples of how people are using health data and we plan on spreading information about these to inspire others to begin to collect all these examples of how people are turning evidence into impact and really making a life better for people around the world and then spreading examples and hoping that others will use it as an example to also use more health data, use more evidence to base their decisions on.

Mark Masselli: We are speaking today with Peter Speyer Chief Data and Technology Officer at the Institute for Health Metrics Evaluation at the University of Washington. You can learn more about of his work by going to healthdata.org. Peter thank you so much for joining us on conversation on Healthcare today.

Peter Speyer: It was my pleasure. Thank you very much.

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Mark Masselli: At Conversations on Healthcare, we want our audience to be truly in the know when it comes to the facts about healthcare 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 politicians from both parties are continuing to make false claims about Medicare in an effort to scare seniors. In the Kentucky Senate and add from democratic candidate Allison (inaudible 19:57) features the retired co-miner who asks how senator of Mitch McConnell could have voted to raise its Medicare cost by 6000\$ but McConnell did no such thing and neither did any other republican law maker. The claim is an old one about the 2011 budget plan proposed by Representative Paul Ryan. It called for phasing out traditional Medicare and gradually replacing it with a premium support system of government subsidized private insurance. A non participating conventional budget office did estimate at the time that anyone enrolled in this private plans would pay about 6000\$ more in 20-20 and they would have under the client system, but the retired co-miner in the add would have been affected by the plan. He and anyone else aged 55 and older would have stayed on traditional Medicare. More important Ryan has made scheduled changes to his proposal over the years and the model that he now supports, could produce savings for seniors according to another CBO analysis. In addition, CBO says that its 2011 estimate was based on assumption about healthcare standing that turned to be incorrect and it's modeling of seniors and ensures behavior has improved. McConnell responded to Ryan's add with a misleading one his own, claiming that the Affordable Care Act "touched \$700 billion from seniors Medicare." The bill doesn't slash 700 billion from the current budget if it cuts in the future growth of spending over a decade and the reduction of the price payments of hospitals and other non-transition providers. Also that same 700 billion dollar in cuts is part of the Ryan Budget Plan that McConnell voted to consider. And that's my fact check for this week. I am Lori Robertson managing editor managing editor of Factcheck.org.

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Margaret Flinter: Factcheck.org is committed to factual accuracy from the countries 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 chcradio.com. We will have FactCheck.org's Lori Robertson check it out for you here on Conversations on Healthcare.

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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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Margaret Flinter: Each week conversations highlight a bright idea about how to make wellness a part of our communities into everyday lives. It is a known fact that the current generation of American children is more obese than any previous generation. And at Washington DC Community Health Center, Unity Healthcare, a pediatrician was in a quandary over how to tackle this growing health serge. He began with the unique solution targeted to a teen patient whose body mass index or BMI had already landed her in the obese category, what he did was write a prescription for getting off the bus one stop earlier on her way to school, which made her walk the equivalent of one mile a day. Dr. Roberts Zaire of Unity Community Health Center understood without motivation to more, kids just might not do it. The patient complied with the prescription and has moved from the obese down to the overweight category, certainly an improvement. He then decided to expand this program by working with the DC parks department, mapping out all the potential walks and play areas kids have within the cities' parks mapping 380 of them are.

Dr. Roberts Zaire: How to get there? Parking? Is parking available if someone is going to drive? Bike racks, there is a section pets, park safety. Dr. Zaire rates park prescriptions on special prescription pads in English and Spanish with the words Rx for outdoor activity and schedules like this. When and where will you play outside this week? I like to listen and find out what it is my patient's like to do and then engage the parks that I prescribe based on their interests, based on their schedule, based on their things they are willing to do. Ultimately Dr. Zaire says with some 40% of his patient population grappling with overweight or obesity, he wants to make the prescription for outdoor activity adaptable for all of his patients and adaptable for pediatricians around the country. He plans to create an App for his parks database where providers and patients alike can use it and one day he would like to be able to track his patient's activities in the parks. Rx for outdoor activity pertinent clinicians, park administrators, patients and the families, to move more yielding, fitter and healthier young people. Now that's a bright idea.

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