Summary of Meeting with Jan Malcolm, CEO, Courage Center

Hamline University, Minneapolis Campus, 1600 Tower, 1600 Utica Ave. S., St. Louis Park

Friday, December 4, 2009

Present: Verne Johnson (Chair, phone); David Broden, Janis Clay, Paul Gilje, Jim Hetland (phone), Dan Loritz, Tim McDonald, Wayne Popham (phone), Bob White

A. Context of the meeting - Through her work with state government, Allina, Health Partners, Robert Wood Johnson Foundation, and now with Courage Center, Jan Malcolm has been thinking ways to better serve the people of Minnesota for decades. And she has been effective. Jan has been innovative and creative, without sacrificing the quality of her work-keeping the notion of value at the forefront, always.

We can think of no better person to speak with the Caucus about redesign of services for the public good. Making this state better is about redesign of more than the public sector. It is about those private sector industries that work for the betterment of all of society.

B. Welcome and introductions - Paul introduced **Jan Malcolm, CEO Courage Center.** Malcolm has served as CEO of the Courage Center since 2005. Immediately previous to that she was senior program officer for the Robert Wood Johnson Foundation. From 1999-2003 Malcolm was Minnesota state commissioner of health. Previously she held positions with Allina Health Systems (vice president, public affairs) and with HealthPartners (senior vice president of government programs and public policy).

C. Comments and discussion -During Malcolm's comments and in discussion with the Civic Caucus, the following points were raised:

1. Quick fixes won't work —The chair opened with this statement to Malcolm, followed by a question: "You have been such a delight to watch over the years, in your different roles. You have seen the statement (Civic Caucus statement 'Different Choices,' presently out to the electronic membership for signatures)-as you read it, are we on or off target?"

"The central question about spending in any sector," Malcolm replied, setting the tone for her remarks the rest of the morning, "should be whether there is return on the investment. But we need more attention on how that return can best be measured. It may not be only within one sector or policy area, and what is the appropriate timeframe to judge results? We as a state, and other states across the country, are looking for a quick fix or easy solution to economic problems." There will not be any. "The

Civic Caucus is right to point out that since the legislature will be obsessed with the short term, the private and non-profit sectors must take leadership in looking long-term and in a more holistic or global way."

2. Health care incentives are backwards— A member asked the speaker what principles of reform she sees as required, in health care. In her opinion, Malcolm said that what is being discussed at the federal level ("too timidly," she added) is similar to what's going on at the state. "The current financial incentives for all parties-payers, providers, and consumers— are as backward as you can get." Reform needs to change the incentives fundamentally to measure and reward health outcomes, not just volumes of services. "We need value-we should drive to get the maximum *health* for the buck-not just covering more people with insurance or getting more services to people without regard for their impact."

3. Learning from other nations' health care experience?— What do you say, a member asked, to the criticism that our country can only learn so much from the health care systems of others-because we're so large and diverse?

"Sure, our population is very diverse," Malcolm responded, "but you can't just dismiss our relatively poor performance on a wide range of performance measures on that basis. Researchers have gotten very good at controlling for all kinds of variables, when they compare countries. Maybe if we were debating whether the US ranks number 10, or number 5 this would be relevant. But we're not even close to the head of the pack at number 37 *and falling*. It is just factually untrue that we have the best health system or even the best medical care system (two different ideas, actually). We have pockets of very good and technologically superior care, but we do not have the best system for delivering consistent results on an equitable and affordable basis." Value, she emphasized, is much lower in the United States than it could be, or than it must be if we are to compete successfully in a global economy.

4. Importance of links with non-health sectors— "Other countries understand better than we do that there are critical links between different policy issues and sectors that we tend to think of as totally separate. Housing and education policy, for example, both profoundly impact the health, and health care costs, of a country." Such as?

"Schools, for one. There is very little coordination between schools and the health system today. This didn't used to be the case. We used to see school as a good place to teach young people about healthy lifestyles, and even to provide health services. The pendulum has swung so far that schools are almost harmful now to student health: look at the food provided in schools as a result of budget pressures, and the fact that so few kids walk to school anymore. Minnesota is one of the only states where there are no standards for health instruction in the required curriculum.

"When I was Health Commissioner, I wanted to say to the Commissioner of Education: Let's change the way we work together. The schools do have some health responsibility, with some money in the education formula but not in a way that can easily be tracked or the results judged. And certainly schools have many other competing priorities. Principals may not want to be the ones to oversee school nurses. Perhaps this should be a local and state public health responsibility, to deliver services in the schools and to be accountable for results." Partnerships across state agencies should be the norm, not the exception.

5. Stimulating healthy life styles —A member observed that there seem to be two tracks for successful health reform that need to operate together: First the question of how to pay for expanded coverage for needed medical interventions, and second how to stop people from becoming unhealthy in the first place. The vast majority of spending (75% or more) is in care for chronic conditions-those that are long lasting and not "curable". They are however largely preventable or manageable, or their onset can be significantly delayed, such as diabetes or heart disease. Malcolm distributed an outline of a talk she made to the Citizens League in 2005, titled "Why Are We Spending So Much and Getting Relatively Little?" Highlights from that talk (data from 2005):

a. High spending; low rank —The USA spends 50 percent more per capita on health care than any other country, but the nation ranks 37th among nations in quality, 25th in life expectancy, and our ranking has fallen in infant mortality in recent decades.

b. High costs of illness in the USA —She cited the high costs of many illnesses in the USA, including heart disease ($230 billion); cancer ($202 billion); and diabetes ($132 billion).

c. Major contributors to high cost— Chronic conditions drive the great majority of health costs and are a greater threat than acute conditions. About 80 percent of health expenses go for chronic conditions. Prevention strategies must be more central. The non-medical determinants of health need much more focus. Individual behavior accounts for about 40 percent of health expenses. Leading underlying causes of the conditions that cause death annually in the USA: tobacco (400,000); diet /activity patterns (300,000); alcohol (100,000).

d. Needed strategies —Get more value out of the clinical slice of the health determinants "pie" (do what's most effective, first and don't be afraid to set priorities; demand and reward quality improvement). Put a higher priority on prevention (both clinical preventative services like immunizations and screening exams, and broader public health approaches like health risk factor reductions). Create the kinds of environmental and social forces that influence behavioral choices and protect rather than harm health-like smoke free public spaces, and walk-able and bike-able communities with affordable and nutritious foods locally available.

See more detail on Malcolm's Citizens League presentation: http://bit.ly/6NofRh

How much is our style of living contributing to health care costs-processed foods, for example? "Huge," Malcolm replied…diet and exercise is at the root of the obesity epidemic. As experts have pointed out, human biology hasn't changed in the past few decades, causing us to triple the rate of childhood obesity and to have almost half the adult population be overweight. Instead it's our individual and societal behaviors that have changed—our commuting patterns; suburban sprawl; nobody walking to school; the prevalence of fast and processed foods in our diets; screen time instead of outdoor play time, etc. We have a lot of students with signs of ill health to come. "No longer do we use the term 'adult-onset' diabetes. That's significant. 30 years from now these students will be in the medical care system with what were preventable diseases."

6. Note linkage between health and education, housing, and transportation— Who's going to take responsibility for health, a member asked? Is it all about personal responsibility? "Ultimately personal responsibility must play a larger role," Malcolm said, "that's clear from the data on the

behavioral links to health risk factors and health outcomes. But policymakers and citizens can't let ourselves off the hook for how communities are structured. Personal health choices aren't made in a vacuum, especially for some of our most challenged communities. We need to help policy makers understand the links between education, housing, transportation-and health. Where you build schools and whether students can walk to them, for example, matters. Whether public transportation serves or bypasses low income communities matters. Whether low income neighborhoods are served by supermarkets or only corner convenience stores matters."

7. Churning patients back and forth between hospitals and nursing homes —Aging? "There is not enough in the national legislation" on matters related to an aging population, or to people with disabilities. "You point to system reform progress in education (in the Caucus statement)…we haven't seen these in health care.

"We need all parts of the health care delivery continuum working together to control total costs," she emphasized, citing the tendency for nursing homes, "post acute" care facilities like Courage Center, clinics and hospitals to "churn" patients back and forth. "Pay attention to incentives," she said. What are the incentives acting on each part of the system, and do those incentives simply shift costs to some other part of the system that is under a different payment system, or a different regulatory umbrella? At Courage Center "we have ambulances coming up to the door to take people to hospitals for care that wouldn't be paid for if we provided it. And we are seeing patients discharged from hospitals earlier and earlier because of the incentives the hospitals face. Sometimes valuable steps in the rehabilitation process get skipped due to financial pressures. A myriad of incentives push one part of the system to shift the less profitable parts of care off to someone else. The acute care system is helped by pushing costs off to the long term care system, and vice versa.

8. Stop having disconnected incentives for any one entity, such as a single hospital or care center —"We need incentive structures for the entire health care system that are bigger than the incentives for any one entity," like a single hospital or care center. "In Washington right now they are finding that the first step to any serious reform (not just expanding coverage) is significantly changing the incentive structure, not just tinkering at the margins. That's tough work." We are likely to see demonstration projects authorized and pursued, which still leaves the question of whether those demonstrations will ever be fully brought to scale as they run up against the prevailing incentives in the current system.

9. Opportunity for Health Impact Assessment —The speaker suggested coming up with something like a "Health Impact Assessment," for proposed projects and policy along the lines of the sometimes required and almost always discussed environmental and economic impact studies. Health Impact Assessments are more widely used in Europe, and are beginning to be tested in the US and in Minnesota. The idea is to say, "As part of our debates about policy, or about big infrastructure or development projects, we need to talk about the health implications as much as the environment and economy."

10. System design in health care can be done by a state—" We are looking at how Minnesota can move back into a leadership role," the Chair said. "Can a state do much in health care right now, or is it too-much in the federal government?"

Malcolm expressed her opinion that we can certainly examine how we approach prevention and the management of chronic conditions, and innovate around how we deliver "health" at the state level. Because of tax laws and the ERISA pre-emption, making big changes to the insurance systems seems to require federal action, as do major changes in health care financing such as through Medicare. But system redesign in population health can be done by a state. It looks like the federal government will not be taking a "top down approach…it seems there will be broad authorization for states to experiment, perhaps with more federal support than in the past."

11. Minnesota's ranking in health care innovation— Is there a leader among states on innovating in health care? If so, where does Minnesota rank?

"We've had a history here of being a leader publicly and privately in thinking that everyone should have care. We have been a leader in collaboration across the health care sector on the best ways to measure and improve quality. Our public health departments have been leaders in the nation at disease detection and prevention. Where we have fallen back in the last 15 or 20 years is in not having a big-picture vision for where we are trying to get with health system re-design. We have pursued more incremental goals, but we haven't stuck with an over-arching strategy for any length of time. This has pushed us out of the top tier of "health reform states" in my opinion, at least until the 2008 legislative session. But now there are some pretty big questions about whether and how those reform goals will be implemented, or whether in fact we will go backwards in access and a total system perspective on costs and value."

12. Paying for someone else's care— Health care has a sense of personal entitlement to it, a member observed-people feel strongly about and protective of their own insurance and care arrangements. How much of a sticking point to reform is the sentiment that, "I don't want to lose what I have (options, tax incentives), or pay for someone else's…"?

"I think that people are becoming more educated about who the uninsured really are, or could easily be in the future. We're all more wary now about the security of our employment and the link to our medical care. We are seeing people we know lose their jobs and end up in a tight spot, and we fear for it ourselves. 80-85 percent of people agree *everyone* should have health care when they need it-the question on this is *how* we do it."

And this touches on a continual focus of the Civic Caucus, and its push of system redesign. 80-85 percent of the state agrees on a goal: health care when it's needed. Again the question in all this-the essential question, the question we too often fail to ask or consider seriously-is how.

13. Action needed by 2010 Legislature— "Imagine," a member posed, "it is June 1, 2010. The legislature has just adjourned. Have they made changes to improve our lot compared to other states? If so, what are they?"

"I'll be impressed, and grateful, if we don't go backwards in this budget environment," Malcolm said. "We need to hold the line on our recent commitment to prevention with the Statewide Health Improvement Plan that has just been launched by the Department of Health. We need to protect access to critically needed services for some of our most vulnerable populations. We need to stay focused on the true long-term costs and health consequences of our decisions. The people who lose

their health insurance aren't going to go away. Their conditions will get worse and they'll still come to hospital emergency rooms or community clinics or places like Courage Center. What are the most economical and humane ways to design the system so that it delivers what we want, but at a better value?" That's the root question. Specifically, she said that the Legislature must act in 2010 to reinstate General Assistance Medical Care or its equivalent. "Fundamental redesign is a long term proposition," she pointed out. "We need to get started, but we can't expect a perfect fix in the next session which is only a few months long."

14. Vision and leadership come from the Governor —"The governor, significantly, has the statewide responsibility, and the authority to set the agenda. Someone needs to convene a different conversation. The governor has a different perspective than the legislature. The governor needs to look and ask, ' *How are all these problems connected?'* The governor has a unique responsibility and ability to take a systemic and more long-term view. The governor needs to focus on the public outcomes we need in a macro perspective. For the most part state agencies aren't set up to do that, and the legislative committees certainly aren't set up to do that under their timelines and with their specific and usually competing charges."

15. Pioneering work in Minnesota— Some history can be illustrative here, too, for the potential of creative thinking in health care. When Verne Johnson, Civic Caucus chair, was on his way out from General Mills, he bridged a program called the National Chronic Care Consortium, funded half by that company and half by the Wilder Foundation. "What we were trying to prove was that a corporation like General Mills could partner with a foundation to do something significant and worthwhile." The partnership resulted in Elder Homestead, effectively the first assisted living program in the country. This is a bit of evidence that private organizations-for-profit and non-profit-can make significant progress in solving public problems, he said.

16. Thanks— On behalf of the Civic Caucus, the chair thanked Malcolm for meeting with us today.