



# Dr. Sanne Magnan, Commissioner, MN

## Dept. of Health

Civic Caucus, 8301 Creekside Circle #920, Bloomington, MN 55437

*October 1, 2010*

**Present:** Verne Johnson (Chair, phone); David Broden, Janis Clay, Marianne Curry, Bill Frenzel, Paul Gilje, Jim Hetland (phone), Jan Hively, Sallie Kemper, Dan Loritz, Joe Mansky, Tim McDonald, Wayne Popham (phone), Clarence Shallbetter, Bob White

**Summary of Magnan's comments:** When Dr. Magnan became Commissioner of Health, Governor Pawlenty listed three goals for the build a public health infrastructure; and work for health reform. In her three years in the position Magnan has made progress on all three-particularly health reform.

The United States has a poor health care value equation, spending too much to achieve too little in terms of health outcomes. Growing costs in health care for Minnesotans is putting a strain on the state budget, and will crowd out all other spending priorities unless addressed.

In 2008 the Minnesota Legislature passed and Governor Pawlenty signed into law a series of health reforms that will help improve prevention of chronic illness, encourage innovation in care, reform payment methods and implement a quality and value measurement system. These last two components will enable consumers and insurers to make choices of care providers based upon quality and cost, allowing transparency for better health care results for less money. This structural reform will facilitate care redesign and begin redesign of payment and spur innovation for better health outcomes.

**A. Context of the meeting** -As Minnesota faces a structural imbalance in the state budget, the growing cost of health care is seen as the biggest source of rising state expenditures. It will be essential to find ways both to slow the growth of inflation in costs, help people be healthy and to help people get better care, not just more care that is uncoordinated, inefficient and not patient-centered. Commissioner Sanne Magnan will speak about efforts the state is making on these fronts.

**B. Welcome and introductions** - Dr. Sanne Magnan, a physician and PhD, was appointed Commissioner of Health by Governor Pawlenty in 2007. She heads the Minnesota Department of Health, the state's lead public health agency.

Prior to being appointed commissioner, Dr. Magnan served as president of the Institute for Clinical Systems Improvement (ICSI) in Bloomington. A board-certified general internist, she serves as a staff physician at the Tuberculosis Clinic at St. Paul-Ramsey County Department of Public Health and as

clinical assistant professor of medicine at the University of Minnesota. She has also been vice president and medical director of consumer health at Blue Cross and Blue Shield of Minnesota and a physician at Lino Lakes Correctional Facility. She has served on several boards, including that of Minnesota Community Measurement. In 2004 and 2008 Minnesota Physician named her one of 100 Influential Health Care Leaders in Minnesota.

Magnan holds a medical degree and a doctorate in medicinal chemistry from the University of Minnesota. She earned her bachelor's degree in pharmacy from the University of North Carolina. She is married and has two daughters.

**C. Comments and discussion** -During Magnan's visit with the Civic Caucus, the following points were raised:

"I think this is great," the commissioner opened, about the conversational format of the Civic Caucus.  
"What I would propose is making this more a dialogue than a presentation."

### **Goals of Magnan's tenure as commissioner**

Magnan opened by telling the group of the conversation she had with Governor Pawlenty prior to her taking on the job of commissioner. She had asked him what success would look like. He told her:

1. Minnesotans would be protected against any public health threats
2. The department would build public health infrastructure
3. The commissioner would advocate for health reform

Magnan is pleased with her department's results but acknowledges that there is more work to be done. Preventative measures and plans have been put in place. Strategies for improving the public's health have been developed. And, in 2008 Minnesota passed comprehensive health reform, which was titled *Minnesota's Vision: A Better State of Health*. (See: <http://tinyurl.com/3vf7kl>.) "Minnesota has done things that were later included in the federal health reform legislation," she said, such as administrative simplification and health care homes (medical homes). "We have been working on reforms that seek to achieve many common goals, and we continue to share our experience and expertise with national experts. We believe that answers to the redesign of our health system will be found in innovative states such as Minnesota."

Legislation usually does not articulate goals per se, but goals can develop from the law. "In our state, stakeholders adopted the Triple Aim of improving population health, improving the consumer/patient experience, and improving affordability." Magnan said that working on the three aims or goals simultaneously is a challenge, but necessary if we want to achieve the health reform we desire.

### **The United States has a poor value equation in health care**

Magnan cited the words of Marmor, Oberlander and White from the April 7, 2009, issue of Annals of Internal Medicine: "We spend too much for what we get." If you look at an international comparison of health care systems among Australia, Canada, Germany, the Netherlands, New Zealand, the UK, and the US...the United States spends the most-by far-and gets the least in positive outcomes.

She described a visit to Germany, where health care spending per GDP is 10 percent (the US spending as a share of GDP is 17 percent). Yet, Germany's outcomes are better. The Germans have a payroll deduction that goes into a centralized pool, and the government distributes those monies among 154 statutory health insurance funds. The funds compete over how to deliver care for the money distributed. If the funds are unable to meet healthcare needs with the allocated Euros they can go to members to get more money-but there is an incentive not to do that.

This concept goes back into the 1800s, and builds upon their idea of solidarity-amongst all ages, genders, and class. They also have a strong primary care sector, which helps with preventative care. Prevention, including a healthy lifestyle, is a huge factor in their success. For example, they have very walkable and bikeable cities with significant mass transit, and they have more access to fresh fruits and vegetables - environments that help to fight obesity.

### **Challenges ahead**

Health care costs are rising in Minnesota-faster than any other large sector of the economy. It is projected that by 2018, if left unchecked, the state will double what is spent now on health care. The pressure is building on both ends. Costs are inflating faster than economic growth, and there is an upward trend in the number of people uninsured and the number reliant on state programs.

Meanwhile the population is aging. Magnan shared information from the state's economist Tom Stinson and the state's demographer Tom Gillaspy. "We are entering a watershed period for an aging population, trending toward more than half of population growth being seniors aged 65 and up." By 2015 'empty nesters' will outnumber married couples with children. By 2020 older singles aged 55 and up will be 57 percent of all singles living alone, and the labor force will be growing at a record-low rate. The state's economist Stinson and Gillaspy like to ask: So when did we know that the people born before 1946 would be turning age 62? Have we been planning enough for the age wave? "No," Magnan said.

### **Effect on other areas of state budget**

If state health care costs continue to grow at the projected annual rate of 8.5 percent, in contrast to projected growth in revenue of 3.9 percent, there will not be money available to fund growth in costs of education or other areas of the state budget. See the Budget Trends Study Committee report from 2009: <http://tinyurl.com/2fpntdu> .

Only about 20 percent of what constitutes a population's overall health comes from health care itself. The other 80 percent are what people often call the "social determinants" of health that are much more influential than, for example, going to see a doctor for checkups. The things that are more predictive of population health are behaviors (tobacco, physical activity, nutrition, alcohol, etc.), socioeconomic factors (education level, job status, affordable housing, etc.) and the environment.

"We forget that this 80 percent is what's most important-what I call 'upstream.' So we end up focusing on emergency or 'sick' care, which will consume more resources."

Minnesota still ranks among the top in health outcomes, Magnan said, but the determinants are changing-bringing the state's overall rank among the states from third to sixth. "While we're doing well

in outcomes, those things upstream-children in poverty, educational achievement or failure, personal behaviors-that so strongly determine outcomes are changing. We need to invest in our children," in order to improve conditions that impact long-term outcomes for generations to come as well as current populations. We also need to address disparities, e.g., among populations of color, American Indians and people in poverty.

### **Minnesota's 2008 health care reform law**

In 2008 the Legislature passed and Governor Pawlenty signed into law significant health care reforms. The legislation built on the work of a Health Care Transformation Task Force convened by the Governor and Legislature, and a Health Care Access Commission convened by the legislature.

A summary of the reforms may be found on the State's website at: <http://tinyurl.com/3vf7kl> . Briefly, components of the reform package include:

#### **Statewide Health Improvement Program (SHIP)**

SHIP is prevention-oriented, seeking to decrease the number of people that are obese or overweight, or who use or are exposed to tobacco. The program targets four settings - schools, worksites, communities and health care - to provide a comprehensive approach. The program is not implemented directly by the state, but by local communities and tribal nations. For example, in schools, SHIP interventions work to change the meals provided by schools and vending machine offerings, as well as to encourage safe ways to walk or bike to school—"getting down to the nitty-gritty about what students are eating in school, about their physical activities."

More broadly, "this is about changing the environment in which we live," Magnan told the group. Changes in behavior take time to grow, she emphasized, and SHIP needs to continue to invest in changing policies, systems and environments over the next 10 years to fully realize its impact. But change has happened already. For example, 28 college campuses are already working on smoke-free policies, and over 180 schools are creating safe ways for kids to walk to school.

#### **Health care homes**

Certification has begun for "health care homes." A health care home is not a place, but an approach to primary care, allowing providers, patients and families to work in partnership to improve the health and quality of life. Certified health care homes strive to better coordinate primary care for people with complex or chronic conditions. Health care homes support primary care, which in turn can improve health outcomes and work to contain or reduce health care costs.

#### **Payment reform and quality measurement**

The legislation supports measurements of the quality and total costs of health care by providers, so that they may be compared to those of other providers. The provider peer grouping system will group providers based on value - both risk-adjusted quality and cost - and will make it possible for consumers, providers, purchasers and policymakers to make more informed decisions about health care.

Measurements of performance by providers will allow for payments based on quality and cost. "We will be the first state in the nation to do that systematically across an entire state, and to incentivize

this." Minnesota will be able to show who is doing better, for less. This information will become available in the coming months.

### **Minnesota has to redesign care and payment**

"Let me expand a little bit more on the provider peer grouping. We need to change the conversation, and the provider peer grouping (PPG) will do that. Based on other data, we believe that PPG will show that there is not a direct relationship between cost and quality. In health care it is not necessarily true that more service is better, or more cost is better. PPG will be a tool allowing us to show, with hard data, where outcomes are better, and who is better at producing those better outcomes for less. It will spur quality improvement and models to reward patients for using higher value, lower cost providers. The law requires that one year after PPG is released, the state's employee health plan, local units of government and private health plans develop products that incent consumers to use higher-value care.

Understanding the way health care providers are paid is key to understanding why costs have increased so rapidly. The way we reward providers today is by paying for patient visits, tests, hospitalizations, procedures, etc. But we don't reward providers for keeping people healthy and out of the hospital or for coordinating care. Furthermore, our system is not necessarily attuned to the needs and desires of patients. For example, when you ask, the majority of people say that at the end of life they want to die at home, but 75 percent die in a hospital or institution.

We have a specialty-oriented reimbursement system. It is not rewarding primary care, Magnan said. "We need to set up an incentive so it's not that 'more is better,' or 'more expensive is better.'" The emphasis should be on quality outcomes and encouraging a strong primary care base. Purchasers are working to change this. For example, the Legislature instructed the Department of Human Services to decrease payments to specialists by 13 percent, but held primary-care physicians' reimbursements unchanged.

Care needs to be redesigned from a patient's viewpoint. For one primary care office's redesign, when a patient calls the front appointment desk, the receptionist asks not what appointment does the patient want, but what the patient needs. Often patients' needs may be met without an appointment. And we need to pay providers differently. Instead of only paying a provider for patient visits, tests, procedures, and hospitalizations, new models are being explored, e.g., global payments for certain diagnoses or for total care, and we will hold the provider accountable for outcomes and cost.

This is one approach towards bolstering primary care in Minnesota, which is an important goal. Fewer doctors are going into primary care since the payments for primary care have been so much lower than payments to specialists. But research shows that where primary care is more prominent in the overall scheme of health care, costs are lower and patients are very satisfied with their care. So it is abundantly clear that primary care providers are a high value and should be rewarded.

A participant asked Magnan how the state would gather "outcomes" data? The state is fortunate to have Minnesota Community Measurement, she replied, and they have been gathering data that has been reported on a voluntary basis. Now with the 2008 legislation, this data must be reported, so there will be data on all primary care providers and hospitals in Minnesota, Magnan said.

"Right now we reward sick care, we don't reward health. We need to redesign care and redesign payment so that keeping people healthy and out of hospitals is not only the right thing to do but is also what is rewarded." That is a major lever to induce reform for structuring clinics and hospitals and making appropriate investments in costly equipment.

In response to questions about what one specific thing would address rising health care costs, Magnan said, "It would be nice if there were one simple answer to fixing health care costs. There is not just one answer-there are priorities for how we move forward however." The redesign of care, the alignment of payment incentives, prevention efforts and getting improvements "upstream" are going to be very important. Other issues such as long term care will need to be addressed as well.

### **Electronic health records**

Sixty-six percent of Minnesota clinics have electronic health records installed and either some or all of the clinic staff and providers are using it. Electronic health records will not necessarily save costs by themselves as simply a documentation tool, Magnan emphasized-but they must be used to provide better information to improve care, to increase coordination of care and reduce complications of care, which should decrease health care costs.

### **Federal legislation**

Magnan said that the state is seeking guidance from the Federal government on implementation of the health care reform law enacted in Washington earlier this year. The Minnesota Legislative Commission on Health Care Access has developed work groups on health insurance exchanges, payment reform, small group insurance markets, and work force shortages.

### **"Minnesota and the New Normal"**

With changing demographics and changing economics, there are significant challenges in health care. "Tom Stinson talks about needing to change the social compact-we need to change what people give, and get. This will be a fundamental change in how people live and act." Stinson and Gillaspy talk about "Minnesota and the New Normal." We will need to discover what that "new normal" is in health and health care.

### **D. Closing**

Minnesota's Vision for a Better State of Health includes better care, better health for a population and lower costs. Minnesota prides itself on being a model for the nation, and this package of our state health care reforms is significant because it addresses the structure of our health system itself.

Magnan closed by saying that the state will continue to focus on a few key areas, including prevention (the leading preventable causes of death of tobacco, obesity, and alcohol) and the redesign of care and payment systems that use competitive peer grouping and reward primary care providers.

**Thank you, Commissioner Magnan** , for taking time today to discuss this important issue.