Lauren Gilchrist, Special Advisor to the Governor for Health Reform

An Interview with The Civic Caucus

2104 Girard Avenue South, Minneapolis, MN 55405

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Notes of the Discussion

Present : Dave Broden, Janis Clay, Rick Dornfeld, Lauren Gilchrist, Paul Gilje (coordinator), Curt Johnson, Randy Johnson, Verne Johnson (chair), Sallie Kemper, Ted Kolderie, Dan Loritz (vice chair), Walt McClure, Wayne Popham, Dana Schroeder, Clarence Shallbetter.

Summary of Discussion: Lauren Gilchrist, Special Advisor to the Governor for Health Reform, distinguishes between three main healthcare issues: access to health care, quality of health care, and management of health factors external to the health care system. She cites the difficult challenges of increasing numbers of uninsured, variation in quality of care, and rising costs. The administration advocates a "triple aim" of better care, better health and lower costs. That goal will be advanced, she believes, both through the continued development of the state's health exchange and with enactment of several key recommendations of the Governor's health reform task force. Those recommendations include measures to increase access, support accountable care organizations and prevention efforts, broaden the use of electronic healthcare records, make more effective use of all levels of health care professionals and increase the ranks of primary care providers.

Introduction of the Speaker. Lauren Gilchrist is Special Advisor to the Governor for Health Reform. In this role, Gilchrist works with governor Dayton, state agencies and other public and private stakeholders to implement health reform statewide.

Gilchrist previously served as health policy advisor to US Senator Al Franken and received the Congressional Staff of the Year award from the American Diabetes Association for her work on the Affordable Care Act. She also served on the US Senate Health, Education, Labor & Pensions committee as a public health policy fellow for Chairman Edward Kennedy and contributed to the framing of the Affordable Care Act.

Prior to her work in Washington DC, Gilchrist was Outreach Director for the U of M Powell Center for Women's Health and worked in direct service with women and at-risk youth. She holds a Master's degree in Public Health in Maternal Child Health and Epidemiology from the University of Minnesota.

The problem.

Lauren Gilchrist asserts that the broad term "health care" is best understood as a continuum of health-related issues. The problems encountered in "health care" are best defined if we separately consider the issues unique to three different parts of that continuum:

- There is the process of getting the care that people need. That's the access and insurance coverage part of the problem: **How do people get to the care they need?**

- There is the quality of the care itself once people have accessed the health care system: **How do we make sure people get the best care possible?**

- There are health matters that arise outside of the health care system. Up to 70 percent or more of our health is determined by factors outside of health care: how much education we have; where we live; what kind of work we do. We can't ignore that 70 percent, she said. The problem becomes: **How do we support health outside of the health care system?**

Gilchrist said Minnesota is currently sixth in the nation in overall health indicators, a drop from first place in 2005.Some of that decline, she said, is attributable to trends in the wrong direction:

- **Increase in number of uninsured.** In 2001, about six percent of Minnesotans were uninsured; we're now at nine percent and have been holding steady there. We need to be sure we're getting people access to the care they need.

- **Large variation in the quality of health care.** Gilchrist said Minnesota is unique in having a very strong health measurement infrastructure, so we know where the variation is. Most states don't have this type of information.
  She gave the example of best practices for optimal diabetes care. "We have pockets of the state where the majority of people with diabetes are getting the ideal care for diabetes," she said. "We have other parts of the state, such as northeastern Minnesota, where maybe 10 or 15 percent of people are getting optimal diabetes care. We have a really broad range in quality of care. Overall, Minnesota has 20 percent of people getting optimal care for diabetes."

- **Rising health costs** . Gilchrist said health care costs per capita are on an unsustainable trajectory, with seven to eight percent cost growth each year in Minnesota.

Fourteen percent of the state economy is health care and that's just at the beginning of the baby boomers retiring. She noted that by 2030, there will be 165,000 Minnesotans over 85 and health care spending increases with age.
"It's sobering to look at those numbers," Gilchrist said. "This is really a potential crisis."

The goals.

Minnesota must look at the triple aim: better care, better health and lower cost. Gilchrist said Minnesota Governor Mark Dayton put forth a vision of health care reform based on achieving better care, better health and lower cost all together. Those three goals together are called the "triple aim."

The Minnesota Health Care Reform Task Force, appointed last November by Gov. Dayton, is charged with providing leadership and advice on how Minnesota should move forward on the triple aim. The task force will develop recommendations to the governor and the legislature by Nov. 30, 2012.

The task force, which has 17 members, includes legislators, commissioners and representatives across the spectrum of health care-public health and prevention all the way to long-term care. "We need to be talking about these things all at the same table," Gilchrist said. "We've been able to create a forum where there has been substantive and civil discussion around some really tough issues."

The task force has developed the following principles to guide its work:

- The outcome of health reform should be to maximize health and functioning for all Minnesotans at a cost that is sustainable for our economy.
- All Minnesotans should have affordable and portable health care coverage and accessible, high-quality services at predictable costs.
- We must create and restructure health delivery services and payment approaches to support high-value care that centers on the needs of all Minnesotans.
- Minnesotans should be engaged in their own health and health care, including awareness of the costs, risks and benefits of health services and health behaviors.
- Health reform should take into consideration that other areas, such as education, economic development, housing and transportation, have powerful influences on health outcomes.
- Prevention of avoidable health problems and complications should be central to health reform efforts. For example, it would be better if we prevented diabetes, rather than having optimal care for those who have it, Gilchrist said. "We need to look at primary prevention-preventing disease before it occurs."
- We must reduce health disparities and increase health equity through all efforts. One of Minnesota's weaker points, she said, is variability in health care quality. We are one of the healthiest states overall, but if we compare the healthiest Minnesotans to the least healthy Minnesotans, we have one of largest gaps in the country. We need to close the gap by bringing up the lowest people.
- Minnesotans need to prepare for decisions and needs they will face as they age. We must ensure that our systems of care and financing-acute and long-term care, health care and community-based services-are prepared to meet these needs. Gilchrist said we must have discussions and education, through programs like Honoring Choices, so people understand what decisions and choices individuals and families will face.
- We must make the best use of existing resources and build on what's working in the current system. We have to be thinking about how to provide better care at lower costs.

The strategies.

Recommendations of working groups. The Health Care Reform Task Force has four work groups, which began meeting last year: access; care integration/payment reform; prevention/public health; and health workforce. Each of the groups has presented its recommendations to the full task force over the past few months and the task force now has draft recommendations. Final recommendations are due to the governor and the legislature by the end of the year. Gilchrist discussed some proposals of the various work groups under consideration by the full task force and the Exchange Advisory Task Force.

Exchange Advisory Task Force.

- **Move forward on a Minnesota-made health exchange.**

The Exchange Advisory Task Force is a separate group that is considering options for how to best build a Minnesota-made exchange. Gilchrist said the health exchange continues to be controversial. One perspective is that we shouldn't create the exchange, because that's meddling and is creating unnecessary infrastructure. That view says we should just let the market be, let private insurance run as is and create more competition within the existing market.

However, finding good, affordable health insurance is very challenging for many individuals, families and small businesses. The exchange presents the opportunity for consumers to access health insurance in a more organized, user-friendly way, and receive tax credits or Medicaid, if they are eligible.

Even among those who want to have an exchange, there is controversy over what the exchange should look like, who should run it and what the role of the state should be. Gilchrist said some states are creating exchanges within their high-risk pools; some are creating them as new state agencies; some as private entities; and some as public-private partnerships.

The Minnesota Exchange Advisory Task Force has provided preliminary recommendations regarding a state-based exchange, including support for operating the exchange as a public-private partnership.

Governor's Health Reform Task Force.

1. Access Work Group:

- **Make health insurance affordable for low-income Minnesotans by eliminating premiums and co-pays for individuals and families with incomes up to 150 percent of poverty.** This would include many people currently in MinnesotaCare.

Nine percent of Minnesotans are uninsured. Sixty percent of the uninsured are eligible for public programs like Medical Assistance or MinnesotaCare, but they're not enrolled. Barriers to enrollment include complexity and cost of enrolling in programs. Gilchrist said even MinnesotaCare premiums are currently enough of a barrier for the lowest-income people that they may choose not to have insurance.

2. Care Integration and Payment Reform Work Group:

- **Organize the care delivery and payment systems around the patient, not administrative systems that do not improve health.**

While Minnesota has one of the best health care systems in the world, Gilchrist said we still have fragmentation and division in how we fund health care, which drives fragmentation at the patient level and the care level. We end up with redundancies and inefficiencies that don't serve the patient. About 50 percent of health care is paid for through public programs (Medicaid/Medicare) and about 50 percent through commercial insurance and employers. Initiatives such as health care homes help address these issues across public and private payers in Minnesota.

- **Support accountable-care organizations as a new way of paying for health care services.**

Accountable-care organizations provide incentives for providers to meet certain outcomes and then share savings with providers if health outcome and cost targets are met. These shared-savings models are evolving to "shared-risk" models that hold providers financially accountable if they do not meet agreed-upon outcomes. These models focus on improving health while also monitoring costs.

- **Support Minnesota providers' use of electronic health records.**

In 2007/2008, Minnesota made it a goal to have all hospitals and health care providers using electronic health records by 2015. Federal stimulus funds were available to help build electronic records for many health care providers and Gilchrist said most larger health care systems now have such records. However, many smaller providers, long-term care providers and mental health providers haven't received the resources to make the change.

3. Prevention and Public Health Work Group:

- **Invest public health funds upstream in prevention.**

An example of upstream prevention that Gilchrist mentioned is a diabetes prevention program that focuses on people who are pre-diabetic. It offers information about nutrition and exercise in a group setting over 13 to 16 weeks. The program has decreased the risk of participants developing diabetes by 60 percent.

4. Health Workforce Work Group:

- **Look at student loan forgiveness for primary care providers.**

Primary care providers who focus upstream and on prevention are really an important area of emphasis, Gilchrist said. We want to make sure we have specialists, but our primary care workforce has been weakening over the years, since their salaries and reimbursements are lower. This has occurred while demand for their services is increasing and will continue to increase.

- **Create an interprofessional health care team that allows everyone to work at the top of their license, including investment in health care providers who provide the most value for the dollar.**

Having an adequate health workforce requires us to be making some investments in the pipeline now, which is hard to do in this budget environment, Gilchrist said. In Minnesota we have some unique models of new professions that are developing, such as community health workers, community paramedics and dental therapists.

We also need to be using nurses, nurse practitioners and physician's assistants to the top of their license. Then we can use community health workers and dental therapists for services like education and help navigating the health care system. " It's not just about having more people in our workforce," she said. "It's about using the people we have more effectively."

Health Care Reform Task Force must prioritize. In response to a question, Gilchrist said the task force will have to prioritize its proposals. The goal of the group is to have some level of consensus on the recommendations. But, she said, "It's unlikely that every recommendation currently under consideration will move forward."

The governor and the legislature will decide which ideas to move forward. Many of the recommendations do require legislation and funding, but some can be done administratively, she said.

Citizen Solutions: Look beyond the triple aim. From April to July 2012, Citizen Solutions-a project of the Bush Foundation and the Citizens League-held 40 community meetings across the state with 1,100 Minnesotans to discuss how to make our state healthier and our health care system work better. According to the Citizens Solution report, participants agreed that the health care system's triple aim of better health, better care and lower cost does not go far enough. They believe that those objectives are essential, but not sufficient, to truly achieve health.

Citizens Solutions determined three principles for action:

- Empower Minnesotans to be co-creators and co-managers of their health.
- Equip Minnesotans to make healthy choices within the health care system.
- Encourage the redesign of institutions and the creation of environments that help reinforce health daily choices.

These principles are intended to help guide future health and health care policies in Minnesota, including proposals of the Health Care Reform Task Force.

Updating Medicaid and MinnesotaCare systems is a major part of the cost of developing the health insurance exchange. In response to a question about the cost of developing the health insurance exchange, Gilchrist said the reason we need significant investment in Minnesota is that we are now running our Medicaid and MinnesotaCare systems on "legacy systems-really, really outdated eligibility and enrollment programs." Part of the reason it's so difficult for people to navigate these programs is because we have such arcane infrastructure, she said. Just modernizing those public programs requires a fair amount of investment and provides a high return on investment. We're getting federal money to do that.

She noted that Minnesota is not spending more on the exchange than other states and is, in fact, spending quite a bit less than some states.

People must take a greater role in their own health care. A questioner asked how people can be encouraged to take a greater role in their own health care. Gilchrist said some employers are now making greater investments in employee wellness programs to make sure the work environment supports better health. Target and Best Buy have been leaders in providing health incentives to encourage their employees to be healthier. We also need to support community health with programs like the Statewide Health Improvement Program, including what kind of food and how much physical activity kids are getting at school.

We also need to be looking at how to bring that focus on prevention to our public programs, such as the diabetes prevention program being run with the Medicaid population. She said the state has a role as payer to encourage prevention in schools, housing and transportation by making the "healthy choice, the easy choice" and building physical activity and better nutrition into our communities.

People need a better understanding of the cost and quality of health care. Gilchrist said some national physician groups are outlining the top overused procedures in various fields, such as cardiology. This information is available at www.choosingwisely.org. "Physicians should be discussing the full range of options with patients and patients should be asking about these procedures to make sure they're not getting unnecessary care," she said.

"We need to give patients those types of tools. We often don't know which questions to ask or what the cost is. We have to be increasing the transparency in order to make consumers capable of having more responsibility in the system."

In response to a comment that some insurers and providers seem to think they've made a lot of progress on cost and quality, Gilchrist said Minnesota is a national leader in these areas and also has the foundation to be doing a much better job on the triple aim. We have a measurement infrastructure, nonprofit health care systems and nonprofit health insurers. Also, we have a culture of collaboration, she said. "In most other states, health care providers and insurers won't sit at the same table. In Minnesota they sit at the same table all the time."

"It's the task force's role to say that Minnesota has the foundation to be the healthiest state, but if we look at the trajectory we're on, we can still do more to lower cost and improve quality," Gilchrist continued. "We have to be doing more. We've done a lot and we've got a lot of tools, but if you look at the numbers, we're not doing enough."