# Creating a Population Health System:

## INNOVATION OPPORTUNITIES

A national health policy conference to identify economic incentives and new models to promote health, minimize costs, and improve quality.

## Conference Summary

The University of Iowa

**Institute for Public Health Research and Policy**

The Concord Coalition

This conference was sponsored by University of Iowa Health Care; UnityPoint Health; RUPRI Center for Rural Health Policy Analysis – Rural Health Value Program; The Leona M. and Harry B. Helmsley Charitable Trust; Iowa Healthcare Collaborative; and McCrossen Consulting.

# INTRODUCTION

Health care in the United States is in the midst of one of the most significant transformations in 50 years. Changes taking place in the U.S. health care system – many initiated or encouraged under the Patient Protection and Affordable Care Act – are restructuring reimbursement models, driving innovation in health information technology, and expanding coverage to large numbers of previously uninsured populations. These changes – and many others – are intended to transform America's current "sick care" system into a true "health care" system that supports population health.

Clinical providers, payers, policymakers, and patient advocates are working to plan and execute the myriad and profound changes required to convert the current care model that derives from a fee-for-service business model to a model focused on creating and supporting a "well" population. Sensing the significance of this moment, The Concord Coalition and the University of Iowa College of Public Health partnered to convene a national health policy conference to create a vision and national dialogue about a shift to a truly healthy population. Specifically, the conference included discussions focused on economic incentives and new models to promote health, minimize costs, and improve quality at all levels: federal, state, and institutional or system-based.

On April 22, 2015, over 175 participants gathered at the University of Iowa for a one-day conference exploring various strategies and tactics that would support development of a population health system. Distinguished keynote speakers, including Alice Rivlin, director of the Brookings Institution's Center for Health Policy, and Jim Weinstein, chief executive officer and president of Dartmouth-Hitchcock Health System, provided critical national perspectives. Thought leaders representing Iowa health systems and payers joined with colleagues from state and national organizations to delve into critical reform issues that are being addressed in health systems and communities across the country.

The conference also was the inaugural event convened by the new Iowa Institute for Public Health Research and Policy, based in the UI College of Public Health. This gathering of visionary leaders reflects the aspirations of this new endeavor to help shape policy through multidisciplinary engagement and to serve as a catalyst bringing together the best of what we know to create better population health in Iowa and across the United States.

Additional information, including a complete conference program and participant biographies, is available on the conference website at **www.public-health.uiowa.edu/pophealth/**.

It is our intention that this conference serve as a catalyst for on-going dialogue with health system executives and providers, insurers, businesses, policymakers, community and public health leaders, and association representatives until we've created a sustainable network that achieves population "health" for all.

Sue Curry
Dean and Distinguished Professor
University of Iowa College of Public Health

Sara Imhof
Director, Education and Grassroots Advocacy
The Concord Coalition

# FIRST KEYNOTE

## Map to the Future: Economic and Other Incentives for Achieving Population Health


### Alice Rivlin

*Director, Center for Health Policy, Brookings Institution*


### The Benefits of Good Health

In her keynote, Rivlin acknowledged that there are many definitions of population health. In her view, "Health is an existential value. It's something we all want." Although there are many complicated definitions of what health means, a person knows when he or she is healthy, feels good, and is able to complete the tasks of the day. Health is fundamental. From an economic perspective, the benefits of good health include people's ability to work or study longer, harder, and better.

### The Intersection of Health and Health Care in the U.S.

American health care is very expensive, Rivlin noted. Nearly 18 percent of the total U.S. gross domestic product (GDP) is devoted to health care, and that number may rise with an aging population. By comparison, countries in Northern Europe have arguably better outcomes and spend only 12 percent of their GDP on health care.

There is evidence of waste and duplication in the U.S. health care system. Additionally, not everyone is covered by health insurance, although that is in the process of changing. And, simply put, the U.S. is not a very healthy nation. In terms of longevity, infant mortality, and other health care measures, we rate quite low when compared internationally.

This leads to two interrelated questions:

1. How can we have a more effective health care system that provides higher value for the resources we spend and better outcomes, including less waste, fewer errors, and higher patient satisfaction?
2. How can we have better health?

### Shifting the Focus to Health

Although a more efficient system would clearly have positive effects on our health, we miss the point when we emphasize the health care system over health. Good health is about what happens *before* a person enters into the health care system. It is tied to genetics, diet, exercise, air and water quality, and exposure to violence—to name a few contributing factors.

When comparing the American system to that of better performing countries, we have to consider these factors. Adopting the same practices of Sweden's hospitals and physicians would not have the desired effect, for example, unless we also adopted their diet, exercise, transportation, and gun laws.

### Payment Models

As the federal government continues to focus on improving the efficiency of the U.S. health care system, one item under the microscope is how health care providers are paid. The fee-for-service approach dominates our system. It incentivizes the number of procedures performed as opposed to providing better care.

How do we make the shift? One answer is in the form of Accountable Care Organizations (ACOs) – groups of physicians, hospitals, and other health care providers who coordinate care and who are rewarded on the basis of outcomes.

### Roadblocks to Successful ACOs

ACOs are an attractive idea, but there are definite roadblocks to their success. Rivlin shared a few:

- *Measurement* - There needs to be agreement on what is being measured, e.g., What do you mean by "health"? How do you know when health care is being effectively delivered?
- *Risk Adjustment* - If rewards are given on the basis of keeping people healthier, then there is an incentive to exclude sick people. How can payment be adjusted based on the healthiness of the overall population, as opposed to a selected group of healthier individuals?
- *Patient Engagement* - Patients do not choose to be part of an ACO; rather they are attributed to one if they happen to be seeing a doctor who is a member of one.
- *Specialists* - ACOs are focused on primary care physicians to the exclusion of specialists.

### From Health Care to Health

Making a shift from health care to health exposes other shortcomings. Often, the kinds of positions needed to help ensure better health in a particular community are not ones covered by the current payment system.

Rivlin noted a recent study of pediatric asthma emergency room visits. When followed up with a home visit from an educator, future ER trips decreased dramatically. Simple and cost effective, but, observed Rivlin, educator positions are not covered by health insurance.

### Looking Ahead, Cautiously

Despite the obstacles, Rivlin ended with a vision for the future in which all members of a community take health as a serious challenge and in which the majority of people are part of an integrated health system. Such a scenario would promote better health, but Rivlin cautioned that it likely would not cost substantially less than our current system. "The hope is that we can have a population that is healthier," she concluded, "but don't count on it being cheaper."

## Panel 1

## Perspectives on Incentives for a Population Health System

**Moderator:** Gerd Clabaugh, Director, Iowa Department of Public Health

**Tim Gutshall**, Vice President and Chief Medical Officer, Wellmark Blue Cross and Blue Shield, talked about the need for shared accountability. He provided data on how few Wellmark users are so-called "triple-chronics," and yet these are the people who use the most resources. How do we do a better job of keeping people healthy so that they remain in the lower, less costly segments? Health literacy is key to helping people understand costs—what they mean and how to control them.

**Bob Schlueter,** Bureau Chief, Adult and Children's Medical Programs, Iowa Medicaid Enterprise, spoke about the Iowa Health and Wellness Plan, which was enacted through bipartisan legislation to provide comprehensive health care coverage to low-income adults. Thirty percent of members participated in a wellness exam, which greatly reduced later emergency room visits. The health risk assessment also helped administrators decide how to distribute funds.

**Christine Miller**, Assistant Vice President of Integrated Strategic Planning and Business Development, University of Iowa Health Care, described the formation of the University of Iowa Health Alliance with the goal of aligning multiple organizations to work collaboratively while each maintains its separate plans. The focus is on clinical integration within a statewide coverage network that includes non-traditional access points, such as telemedicine. The weak link to date has been incorporating specialists into the system. She also stressed the need to involve patients in decision making so that they best understand a procedure and its potential risks.

**Amber Lenhardt**, Executive Director, Finance, UnityPoint Health Partners, described areas in which her group made deliberate changes and improvements, including data collection and information technology, reimbursements, analytics, capturing risk, and physician education team-based care.

# SECOND KEYNOTE

## Executing on Population Management

### James Weinstein

*Chief Executive Officer and President, Dartmouth-Hitchcock*

### Changing a Broken System

In his keynote, Weinstein drew from his experiences at Dartmouth-Hitchcock (D-H), a health system that serves 1.5 million people throughout New Hampshire and Vermont. He premised that our current system must change because health care is currently convoluted, overly expensive, and resistant to change.

As Rivlin noted earlier in the day, the health care system is increasingly compelled to address problems that originate in other areas such as the family, education, housing, and the environment. Although we know that all of these areas are crucial to our future, the money spent on health care completely dwarfs that spent elsewhere.

### How Do We Get There?

As the head of D-H, Weinstein has had the opportunity to create a vision for a sustainable health system. The five tenets of his ideal system are:

1. Focus on health, not just health care.
2. Care based on value, not just volume.
3. Population-based strategy as the foundation, not market share.
4. Reward quality, not quantity.
5. Patients are informed and receive only the care they want and need.

A concept called the Triple Aim is an important goal in achieving Weinstein's sustainable health system. Developed by the Institute for Healthcare Improvement, the triad includes health of a population, experience of care, and per capita cost.

### What Is Population Health Management?

Weinstein offered a definition of population health management:

1. Applying systematic quality and process improvement approaches in order to achieve the Triple Aim,
2. An active management approach, and
3. An Accountable Care Organization (ACO) that manages populations' health.

### Levers to Success

Weinstein named several "levers" that contribute to success:

- *Community* – It is crucial to include community in all levels of decision making and to continually ask whether programs align with the community's needs. Instead of offering what is available, offer what is needed.
- *Benefit Design* – Benefits should reflect a population health approach, as opposed to being complicated and costly.
- *System Level Management* - We cannot blindly believe that one size fits all. Forming alliances must be to the benefit of the entire community.

## Model of Care

A pyramid-shaped model provides an alternative to the traditional physician/medical assistant, cookie-cutter paradigm. In the D-H system, physicians are at the top of the pyramid because there are the fewest of them and their services are only utilized as absolutely necessary. Below them, in ever-expanding roles, come nurses, care coordinators—including behavioral specialists and social workers— and finally, at the base, health coaches (similar to those in the asthma study Rivlin cited) and medical assistants.

Delegate responsibility among players to make the most use of each person's skills, Weinstein emphasized. Physicians, for example, should not be doing hours of data entry; it is not an appropriate or effective use of their skills.

## Key Areas for Success

In addition to having a leader who believes in the long-term importance of reinventing the system, successful sustainable health systems have the following qualities:

- *Actionable Information* - This includes registries; admission, discharge, and transfer summaries; variation data; clinical operations; and data that is usable by everyone, including patients.
- *Primary Care Practice* - Population health teams using the pyramid model and working with standardized practices; inclusion of community members who are involved in all aspects from hiring to building design.
- *Communication and Processes* - Clear leadership and communication from the top; processes that support workflow; practice that fits with the ACO's goals.
- *Aligned Funding* - Successful and sustainable payment models; incentives that are aligned with an organization's goals and include specialists.

## Community Is Key

Return to the community for answers and guidance, counseled Weinstein, who gave examples of several programs that promote health in D-H communities. These include a healthy school lunch program and improved everyday services for people with mental illness. These are not complicated programs, says Weinstein; rather they are low cost and ultimately benefit everyone by decreasing health issues.

## Connecting Nationally

In addition to his work with D-H, Weinstein helped start the High Value Healthcare Collaborative, a consortium of 17 health care delivery systems that serve more than 70 million people each year. In approaching other leaders to form the consortium, Weinstein said, "Why don't we come together and walk the talk together?" He believes that if this group of already recognized leaders can share data and best practices, others will join. The Collaborative is a national, large-scale attempt to execute the principles of population management Weinstein has developed at D-H.

## Panel 2

### Innovative Thinkers: Perspectives and Programs for Achieving Health and Reducing Societal Costs

**Moderator:** Jeff Maire, Past-President, Iowa Medical Society and Board Chair, Iowa Healthcare Collaborative

**Trish Riley**, Executive Director, National Academy of State Health Policy, spoke about the different definitions and models of ACOs that exist around the country. There are examples of states providing community mental health support, assistance for the recently incarcerated, and dental care. There is no dearth of creative ideas, but there is a lack of consistency. Riley also warned that we are replicating programs before we evaluate them.

**Sally Kraft**, Medical Director, High Value Healthcare Collaborative, said that as we talk about transforming the delivery of care, we must "walk in partnership with patients, caregivers, and communities." Patients can be engaged at all levels of redesign: they may serve on design committees when new buildings are conceived, review educational pamphlets, and provide input to hiring. She advocates for simple yet meaningful measures and urges that we need to find ways to incentivize population health so that doctors will want to go into this area.

**Karen Borgstrom**, Director, Partners for Community Wellness, Dartmouth-Hitchcock, discussed how "health ambassadors" reach across a community connecting with friends, co-workers, and neighbors. Each community has its own culture and unique barriers to health, which ambassadors better understand and can help overcome. She advocated undertaking service inventories and needs assessments; do not make assumptions or replicate work.

## Panel 3

### Make It Happen: Creating or Reforming Policies to Support Health-based Economic Incentives

**Moderator:** Sue Curry, Dean, University of Iowa College of Public Health

**Alice Rivlin** cautioned that change will not happen via the federal government, but rather at the community and state level. "Washington can change the reward system and do a lot of good, but most of what we're talking about is not going to be top-down."

**Paul Jarris**, Executive Director, Association of State and Territorial Health Officials, warned that health spending is not growing very quickly. Since 2010, health spending has grown at the same rate as the economy, which is remarkably slow compared to past years. We've seen a period since 2002 when health spending dropped, but now it's starting to slowly increase. He spoke about the role of health spending in the national debt and also about how the federal system was created prior to the concept of population health. He spoke about quality and measurement, especially the so-called "doc fix" legislation.

**Joe Antos**, Wilson H. Taylor Scholar in Health Care and Retirement Policy, American Enterprise Institute, said that the experience of care for most people is still poor. "We have yet to really improve the population's health," he said. He cautioned that during the day of the symposium, speakers had mainly talked about health care and not health, and yet the vast majority of people are not actively involved with a health care provider. We need to be willing to branch out and work, for example, with architects to create healthier spaces or find ways to include the arts and humanities in discussions about improving health care at our nation's universities.

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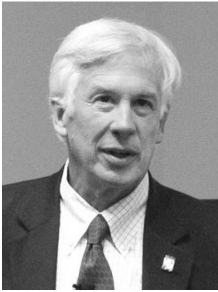

*Dr. Jim Weinstein, CEO and President of Dartmouth-Hitchcock, addressed challenges and opportunities in population management.*

*Alice Rivlin, Director of the Brookings Institution Center for Health Policy, spoke on economic and other incentives for achieving population health.*

*Above: Conference participants gather in the College of Public Health atrium prior to the opening session.*

*Sara Imhof, Concord Coalition Director of Education and Grassroots Advocacy, welcomed conference participants.*

*College of Public Health Dean Sue Curry moderated a panel discussion about economic incentives.*

*Iowa Department of Public Health Director Gerd Clabaugh was a conference participant and panel moderator.*

*Wellmark Medical Director Anshul Dixit talks with Wellmark Vice President and panel participant Dr. Timothy Gutshall.*

**Acknowledgments:** Conference summary text by Jennifer New. Photos by Johnathan Choate.