

**LET'S GET HEALTHY CALIFORNIA (LGHC)
TASK FORCE AND EXPERT ADVISOR GROUP MEETING**

September 28, 2012

**The Sidney R. Garfield Health Care Innovation Center, Kaiser Permanente California
San Leandro, California**

Summary Meeting Notes

10:00 am - 3:00 pm

Task Force Attendees:

Don Berwick, MD, Bruce Bodaken, America Bracho, MD, Diana Dooley, George Halvorson, James Hay, MD, Mitch Katz, MD, Pam Kehaly, Ken Kizer, MD, Richard "Dick" Levy, Ph.D., Bob Margolis, MD, Joy Melnikow, MD, Ed Moreno, MD, Steven Packer, MD, Dave Regan, Joe Silva, Anne Stausboll, JD, Kelly Traver, MD, Kerry Tucker

Expert Advisory Group Member Attendees:

Ann Boynton, Nadine Burke Harris, MD, Sophia Chang, MD, Patricia "Pat" Crawford, DrPH, RD, Steve Fields, Deborah "Debbie" Freund, PhD., Jane Garcia, Neal Halfon, MD, Jim Mangia, Elizabeth "Beth" McGlynn, PhD, Mary Pittman, Dr.PH, Wells Shoemaker, MD, Steve Shortell, PhD, Anthony Wright, and Ellen Wu

Absent:

Molly Coye, MD, Lloyd Dean, Susan Desmond-Hellman, MD, Alan Glaseroff, MD, Ed Hernandez, OD, Lenny Mendonca, Arnold Milstein, MD, Bill Monning, Richard "Dick" Jackson, MD, Robert "Bob" Ross, MD, Antronette "Toni" Yancey, MD

Presenting Staff:

Ron Chapman, MD, Patricia "Pat" Powers

Welcome and Opening Remarks

George Halvorson, Chairman and CEO of Kaiser Permanente, welcomed everyone to Kaiser's Garfield Innovation Center. He discussed the fact that as an ACO receiving capitated payments Kaiser can innovate in ways that are not possible with payments tied to a fee schedule. Kaiser predicts four sites of care for the future: the hospital, the clinic, the home, and the internet. Each of these will be substantially different than what we see today. Kaiser employees have generated more than 400 innovations; about 80 are being tested and several dozen are now standard practice. Innovations are no longer being patented, rather, Kaiser wants to share and spread great ideas for improving the quality of care.

Secretary Dooley thanked Mr. Halvorson and welcomed the Task Force and Expert Advisors, and especially Co-Chair Dr. Don Berwick for his active participation throughout the Task Force process. Dr. Berwick expressed his interest in the process and appreciation to Secretary Dooley and staff.

Member Six-Word Story Sharing

Members were asked to create a six-word story for the meeting that would communicate a vision for health in California ten years from now. Select stories will be woven into the Task Force report to illuminate goals and priority areas.

First Name	Last Name	Six Word Stories
Co-Chairs		
Don	Berwick	The best place to be alive.
Diana	Dooley	Living well. Dying well. Sharing. Caring
Task Force		
Bruce	Bodaken	Healthy Californians; Courageous leadership. Stands Up. (Shared Responsibility, shared goals, shared sacrifice - leaders lead the way)
America	Bracho	Healthy beginnings: Equity, proactive, collective wellness
George	Halvorson	Continuously improving care - optimal health
James	Hay	Healthy California means invest in yourself
Mitch	Katz	Healing healthcare, affordable to all
Pam	Kehaly	California Gold. Wealth through your health
Richard	Levy	Transformative quality, cost, and convenient access
Bob	Margolis	(1) Communication among caregivers, informed active patients (2) Continuously stealing best practices from George (and others)
Joy	Melnikow	Educated, active children moving California forward
Bill	Monning	Let us get healthy California, walk
Ed	Moreno	Creating conditions to live healthy lives
Steven	Packer	Optimize Wellness Provide Cost-Effectively To Everyone (Haiku)
Dave	Regan	Cataclysm imminent. Renew. Remake. Relapse? Choose!
Joe	Silva	All kids helping each other improve
Ann	Stausboll	Get up and enjoy the coast!
Kelly	Traver	(1) California Health: Both a Right and Responsibility. (2) California Health: Bold, Compassionate, Inclusive
Kerry	Tucker	Engaged. Individualized. Energized. Thriving. Delicious. Tennis at age 85
Expert Advisors		
Ann	Boynton	Business. Opportunity. Free. Anything. Everything. Greatest.
Nadine	Burke-Harris	(1) Bold Action for a Healthy California (stolen from Service Employees International Union (SEIU)) (2) Everyone trying to reproduce California's results
Sophia	Chang	(1) Californians strive for better health together (2) Collectively creating a culture of health
Patricia	Crawford	Prevention equals fewer healthcare visits
Steve	Fields	Understanding root causes leads to results
Deborah	Freund	Join together; the race for better health
Jane	Garcia	Health Caring for All! Investing in California
Neal	Halfon	(1) For lifelong health accelerate prevention now (2) Curb future illness, optimize health now (3) Health Development, community development, economic development
Jim	Mangia	California Gets Healthy Through Engaging Social Determinants
Elizabeth	McGlynn	(1) 55% not good enough (2) We could. We can. We will!

Mary	Pittman	Prevention works, invest in your community
Wells	Shoemaker	(1) California: energetic pacesetter for national reform (2) Californians set pace for national reform
Steve	Shortell	(1) Number one in health is fun! (2) One mind, body connecting in health
Anthony	Wright	Everybody in; improving our health together
Ellen	Wu	Equity and Social Responsibility are fundamental
State Staff		
Ron	Chapman	Happiness and wellness in healthy communities
Neal	Kohatsu	Engaging all, we can achieve health
Pat	Powers	Mind. Body. Spirit. Integrated achieves unfathomable
Ron	Spingarn	Healthy purposeful thoughts, intentions and actions
Miscellaneous		
Paul	Esparza	Together we WILL succeed. No question (In-Home Supportive Services Sonoma County)

Presentation and Discussion on: Task Force Goals, Indicators, Targets

Task Force director Pat Powers presented the [Draft Framework and Dashboard](#) that had been presented publicly during the September 12th webinar and mailed to members in advance of the meeting, as well as posted on the agency's website. This most recent version includes targets and data sources for each indicator, which are set to the current best outcome score by race/ethnicity (R/E) group. The dashboard also reveals the worst outcome scores by indicator. Staff recommended that the key equity goal for the Task Force would be to close the gap between the two groups. This sets a very ambitious stretch target for all.

Members discussed the pros and cons of setting such targets. While people liked the notion of having ambitious goals for health equity by setting the 2022 target to the best possible outcome in 2012, concerns were expressed about whether this is realistic. Also, there is a need for sensitivity around how to communicate disparities - this does not mean, for example, that all resources for improvement would shift to one R/E group.

Other global comments from members included the desire to see fewer goals and more ambitious goal statement language (this was not included in the slide deck, but is in previously disseminated materials); and to include more information related to communities and the social determinants of health.

Presentation: Starter Interventions

Dr. Ron Chapman, Director of the California Department of Public Health and State Health Officer, presented [Sample Task Force Interventions](#) put together by staff to stimulate discussion on evidence-based broad interventions that cut across multiple priority areas. There are numerous resources to draw upon – entire books are written about how to reduce obesity, for example. Examples in the presentation were drawn from Centers for Disease Control recommendations, as well as the Institute of Medicine.

Driver Diagrams: Identify Cross-Cutting Interventions

Members of the Task Force talked about what their respective organizations were currently doing in the way of interventions that relate to the LGHC work. In addition, expansion of existing efforts and new ideas, some of which may involve collaborations with other organizations, were suggested. These included:

Speaker	Intervention
Design, Evaluation, Convening	
Steve Shortell	There are many things that the academic world can do: (1) summarize the evidence base; (2) commit to helping to design some of the interventions; (3) design and conduct evaluations; and (4) serve as relatively neutral conveners.
Adverse Childhood Experiences	
Nadine Burke-Harris	In my capacity as the founder and CEO of the Center for Youth Wellness in Bay View Hunters Point in San Francisco I can help to provide a community-based family-centered model. In addition to providing clinical care, I am committed to educating others on the impact of trauma on our youth. For example, we partner with the school system, the police department and others about the impact of trauma on our youth. I encourage everyone in this room to pick up the book by author Paul Tough called <u>How Children Succeed</u> .
Culture of Health	
Joe Silva	Every October we have a communitywide fitness challenge. Our newspaper and others actively participate.
Dave Regan	We would like to recruit 25,000 healthcare worker union members as volunteers to be the evangelists, if you will, for a statewide culture of health campaign. Two promising vehicles for reaching significant numbers of people are: (1) churches and (2) schools. If we could develop an agreed upon simple curriculum related to a culture of health we could deploy thousands of healthcare workers as leaders in our organization, along with our counterparts in other organizations, to engage millions and millions of people
George Halvorson	What we really need to do is to have California have a culture of health that has healthy behaviors, healthy eating, and active living as a framework, or philosophy for going forward. And if we could transform California into believing that and doing that, we could leave a legacy that's far greater than anything else we could do. We need it in the schools, we need it in the workplaces, we need it in the unions, we need it in every setting. We should involve the Governor to embrace this, along with celebrities.
Mary Pittman	We are working in partnership with the state and small and rural counties, as well as some others, on CDC-funded community transformation grants. We can assist with messaging around a culture of health as most of the counties are already working to reduce tobacco use and obesity, and achieve good blood pressure and hemoglobin A1C scores for their populations. We can highlight the work of the Task Force, as well as bring back best practices. For example, we have research from the Supplemental Nutrition Assistance Program (SNAP) education in low-income communities that can be shared.
America Bracho	The sector that is missing here are the families that actually are struggling - that do not have access to care, are going hungry, do not have jobs and/or do not have housing. We need to address these socio-economic factors so that in ten years we can say that we had a systemic impact.
Ed Moreno	For those of us in public health field, we have been serving as facilitators, conveners and messengers of importance, of promoting public health and healthcare, and quality health among agencies and departments within our local health jurisdictions. In Fresno, the schools, businesses, transportation, all collaborate. We also see a role for ourselves under immunizations, infant mortality and tobacco control.

Speaker	Intervention
Disparities	
Bob Margolis	We're all in here talking about our employee programs and so on, but it's the uninsured, it's the people not tied to the health system, it's the people with poorer socioeconomic issues that we're not going to get to through the bully pulpit. If we want to be bold we need to look at how to tie true incentives to improvement.
Mary Pittman	We can put all of the indicators into our database for easy Geographic Information System (GIS) mapping. Counties can have access to this information and we can readily see visually how we are progressing.
Jim Hay	I know our county (San Diego) Department of Health is working on an outreach program, a Hot Spot Program.
Domestic Violence	
Bruce Bodaken	A priority of our foundation is violence prevention, predominantly domestic violence. We'll be willing to expand that work which not only has the effect of getting the woman or the man out of an unsafe situation; it also has a real impact on healthcare costs.
Food/Nutrition	
Kerry Tucker	We have a state board-driven program right now, which I chair, that's attempting to double farmer contributions to food banks from 100 million pounds to 200 million pounds. That is, as somebody noted, "low hanging fruit"! Also, there are individual commodity groups that spend significant monies on nutrition education initiatives already. The Dairy Council of California has got good group education initiatives, where they're reaching 2.2 million kids a year at every grade level.
Learning, Innovation, and Integration	
Neal Halfon	We might think about creating some kind of center or network for innovation in California that would focus on community innovations. We need some type of learning system so that we are not continually reinventing the wheel and just running helter-skelter, doing a whole variety of different things.
Mary Pittman	We'll collaborate with anyone else who is working on this across the state, academics and other organizations. We also do a lot of neutral convening to try to bring groups together to share what they're learning.
Steve Shortell	The Berkeley Forum is one example of a convener. Also, there used to be an Advisory Group to the California Department of Public Health that cut across sectors. The Superintendent of Education attended some of the meetings. It is important to remember that when we engage with other sectors we need to be mindful of their reward and incentive systems. How can we get on educators' agenda and get them on ours?
America Bracho	It's very complex how to integrate systems and how to affect the different sectors that have decision making points. Well maybe as we integrate and we should try to identify long term and short term impacts. We all have a role at all levels, from the bottom to the top.
Steve Fields	Behavioral health is particularly a balkanized county-by-county service system in spite of having state departments for mental health. There has not been a leadership model that has taken the role of disseminating best practices and a mechanism, whether it's financial, political or otherwise, to ensure that counties learn from one another and adopt different ways of doing anything. We are heading for disaster on severely mentally ill issues around hospitalizations, readmission rates, and then ultimately around reimbursement for these counties. How do we learn about the behavioral health models that have worked in various counties, how do we get that information in one place through foundation and academic support, and then how do we find a delivery mechanism to counties?

Speaker	Intervention
Palliative Care	
Bob Margolis	We're a relatively progressive state, a very democratic state, and there's tremendous dysfunction and opportunity around end of life care, and around palliative care and around appropriate care. Forty percent of Medicare people are dying in the hospital in California, while states like Oregon that have had a statewide discussion about this are at half of that level. I think we can make significant progress if the state would take on this challenge. We should have a community discussion about compassionate, appropriate end of life care that includes death and dying and grief and spiritual help.
Steve Packer	We can reallocate the resources that we are in fact wasting at the end of life and shift them to early childhood programs. We need to engage in a dialog that involves people in faith based communities, schools, and retirement communities. I would endorse Bob's concept of the thought that this is a cultural and societal discussion that we absolutely need to have ~ we talk about it a lot but we're not very good at it.
Payment Reform	
Ann Boynton	We are looking intently at what we've learned from our pilot programs in Sacramento and Humboldt county with our partners in realigning payments to reward the right kinds of outcomes from the delivery system. We are looking at how to incent greater integration in a fee-for-service environment. We are focused on outcomes and are demonstrating our commitment to that in our upcoming re-procurement processes, along with strategies of virtual integration in a non-Kaiser world. (Of course we have a significant commitment with Kaiser as well.)
Ed Moreno	I also serve on the commission for the local plan in Fresno County. I would like to see more engagement with local health plans on how to shift reimbursement to reward quality and outcomes versus focus on services.
Bob Margolis	Incentives create change and behavior follows incentives. For example, the mental health system in San Francisco County is significantly more cost efficient and better than the mental health system across the bay. Benchmarking opportunities vary county by county; we need a mechanism at the state to incentivize improvement ~ not necessarily best practice, but improvement. Using payments to drive improvement would really create a business case; otherwise it is just speaking from the bully pulpit. It is the uninsured, it's the people not tied to the health system, it's the people with poorer socioeconomic issues that we're not going to get to through that the bully pulpit. If we want to be bold, let's look at how you can really tie true incentives to improvement.
Quality Improvement, Doctor Training	
Jim Hay	The California Medical Association, together with the Medical Board, has access to the doctors, so therefore one of the things we can certainly do is supply information to doctors. We can help to promote and educate as much as we can. For example, there is a statewide colon cancer screening program, as well as one we have locally in San Diego.
George Halvorson	Medicare is now getting much more aggressive on quality. If we had National Committee for Quality Assurance (NCQA) reports from <i>all</i> providers in California, we extended what we have now from two-thirds to all, we would not need to create a separate agenda on quality. We could essentially defer to that agenda, which is robust. Further, we could defer an agenda related to medical homes, given all of the good work going on by NCQA.
Schools	
Debbie Freund	I think we could mobilize college presidents at campuses to adopt the communities around us and take responsibility for their health and working with them on health improvement. We like to get undergraduate and graduate students engaged in the community and can get them to volunteer in hot spots.
Kelly Traver	I'd love to see at every school a room where kids can go, the parents can go, the siblings can go ~ essentially a clinic that is accessible and affordable. It can include telemedicine where you can see the patient on a screen, you can listen to their heart, you can look in their ears, etc. Another idea is to give kids pedometers, or a similar device. Then every month or so there's a competition or rather a personal challenge people can actually win. If he/she gets to a certain level, they get to leave school an hour early, or maybe get to be able to do some event that the school sponsors. Through positive peer pressure the kids will all want to achieve that goal.

Speaker	Intervention
Schools cont.	
Joe Silva	We should have common goals, but we do not want any legislated mandates. If we want California to get healthy we can do that through the schools that educate more than six million kids. Each is different, however, and we approach each separately to understand their goals. Our office is working with every single district, fifth and seventh grade. We have a partnership with our county health department, with our local hospital, with Blue Cross. As Dave suggested, we would like to see the counties work with the unions in their particular county, because Alameda differs from Shasta County, which differs from San Diego County. Kelly mentioned telemedicine. We can easily find ten schools to participate in the kind of project she mentioned.
Workplace Wellness Employee Incentives	
Bruce Bodaken	One of the things that we do within our company is offer a sliding scale for anyone who is under \$50,000 for their health insurance. We also provide incentives to reduce their cost of healthcare coverage by things they do like biometric screening, bioactivity, etc. We also sponsor challenges that go on during the year over a variety of things. People enjoy contests and the most successful reward is to receive a health day off.
Dave Regan	When we bargained our Kaiser national agreements earlier this year we actually put into the union contract the goal of making the Kaiser workforce the healthiest workforce in the healthcare industry. We set a goal of reducing by five percent over three years levels of Body Mass Index (BMI), cholesterol, smoking and blood pressure. And to the extent that we can then document actual healthcare savings, there's an agreement that we split it 50/50 with the employer, and employees get bonuses. We avoided individual penalties at Kaiser; rather, if the group reduces in the aggregate these measure by five percent, the whole group benefits.
Dick Levy	We give discounts—we give \$100 to every employee in our company--\$100 discount on their medical insurance, if they have a Health Risk Assessment (HRA). If they meet certain guidelines for obesity and cholesterol and glucose, etc., we give them another \$400 off their premium. Before we started doing this our healthcare costs in the company were going up five percent a year—or much more than five percent a year; three years ago they went up 28%. Now they're actually going down. So these things work, and they're very simple. This is low hanging fruit. We also put in a fitness center, and people use it, and we give them time off, extra time at lunch if they want to use the fitness center. We have a nutritional cafeteria, where everything is labeled. And people are told and taught how to read those labels, and what it means to them. We have incentives for people to use public transportation, and to walk from the bus stop. If they don't drive, we give them an incentive, a financial incentive. These things really work, and they're small amounts of money. The business community is doing these things, health employers should do so as well.
Mary Pittman	As an employer of 650 employees inside our own organization, we've been doing a lot of wellness programming and we found a huge increase in people walking and taking brief bouts of physical activity during the work day, which has had an impact on our workers' comp - our rates actually went down. It can have a return on investment.
Pam Kehaly	At Blue Cross we have an annual fitness challenge, and it's a 60 day period of time. It's competition, where we all compete for points, and points are given based on your physical activity for the day, such as walking. They also get points for nutrition. If you eat a certain number of vegetables per day, you get points for that. It really engages people; they get very excited. Why 60 days? Sixty days, according to behavioral health specialists, is the amount of time you need to do something and it becomes a habit. I can engage the employer community in California to participate in a state-wide competition, using that vehicle that we have.
Ann Boynton	All of our plans participate with us in employer wellness programs for our employer sites, and over the next year we will be drafting a new baseline for employer wellness program that we will be taking out to our employers to really drive home to them, a continuous improvement in employee wellness, where the incentives are aligned correctly for everybody.

Wrap-Up and Next Steps

Staff will take into consideration all comments made at the meeting to revise the Goals, Indicators, and Targets, as well as ideas related to interventions. The third and final in-person meeting is scheduled for Tuesday, November 13th in Sacramento. Dr. Don Berwick will be attending in person; details regarding logistics are forthcoming. Task Force and Expert Advisor members were asked to send any additional comments to staff within the next week.

NOTE: Subsequent to the November 13th meeting, members and the public were notified that staff would be collecting intervention vignettes from members in lieu of the October webinars that were scheduled as placeholders last summer.