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"For Many Years, Americans Have Been Dying at Younger Ages than People in Almost All Other High-Income Countries"

—This astounding statement is from the National Academies recent report.

An Editorial by Bob McEvoy, Managing Editor

The above National Academies statement, prepared by a panel of experts from the National Research Council and the Institute of Medicine, went on to say: "This disadvantage has been getting worse for three decades, especially among women. Not only are their lives shorter, but Americans also have a longstanding pattern of poorer health that is strikingly consistent and pervasive over the life course—at birth, during childhood and adolescence, for young and middle-aged adults, and for older adults."

Another distinguished researcher, Dr. Atul Gawande, Harvard Medical School scholar, practicing surgeon, and award-winning *New Yorker* magazine author has said that "We are in the deepest crisis of medicine's existence." He has also indicated that "Our medical systems are broken."

The recent report of the Trust for America's Health, "A Healthier America 2013: Strategies to Move from Sick Care to Health Care in the Next Four Years," verifies the poor outcomes identified by the National Academies report and Atul Gawande's call to action. The telling description below, from the Trust, is similarly astounding:

- Chronic diseases, such as type 2 diabetes and heart disease, are responsible for seven out of 10 deaths, 75% of the 2.5 trillion spent on U.S. medical care costs and billions of dollars in lost productivity each year.
- Infectious diseases, from the antibiotic-resistant Superbugs to Salmonella to the seasonal flu, disrupt lives and communities and result in more than $120 billion in direct costs and enormous indirect costs.

There are scholars and researchers working on the critical problems identified above. We have the great fortune to introduce to you an example of outstanding scholarship, which well characterizes American resilience rising to engage the profound difficulties of an evolving health care sector. International scholar and health services expert, Dr. Paul Sorum, has enlightened us in this Journal when we began our health care series, and now we bring you the work of three leading innovators who are enhancing our opportunities and abilities to move strongly forward. Their wisdom is presented for you as follows. ■

County Officials Embark on New, Collective Endeavors to ReThink Their Local Health Systems

by Bobby Milstein, Director, ReThink Health; Gary Hirsch, Modeler, ReThink Health Dynamics; and Karen Minyard, Director, Georgia Health Policy Center

A County Focus for Health System Reform

Good health and high-value health care are essential to the well-being and prosperity in every county. However, the U.S. health system is notorious for its costly, inequitable, and disappointing performance. As a result, health system reform is becoming a top priority for county officials as well as for scores of other regional stakeholders. Local action is so vital, in part, because the stakes are so high.

- Most counties deliver public health and health care services through their health departments, clinics, and hospitals, often amounting to a large portion of county spending. In addition, other county services such as public safety, transportation, housing, parks and recreation, arts, elder care, social services, and education have significant effects on people's health, their demand for care, and ultimately the cost of care.

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- Counties are also major employers that spend millions of dollars each year on health care for their own employees.
- Economic development in a region hinges on the local health system. Health care is often the single largest sector in the economy and health services are critical for maintaining productivity of the entire workforce. Also, the availability of high-quality health care, the presence of a healthy workforce, and the assurance of safe, thriving neighborhoods are themselves important attractors for recruiting new residents and new employers. On the other hand, rising health care costs and unhealthy living conditions tend to discourage families and employers from locating or remaining in a county.

Given the gravity of these issues, the question is not whether county officials ought to be involved in reforming their local health systems, but how. Here, we share stories from two counties where new, collective endeavors are under way to transform local health systems.

Our first example comes from Pueblo County, Colorado, a rural area about two hours south of Denver (population 140,000). The second comes from Fulton and Dekalb counties in Georgia, at the core of the Atlanta metropolitan area (combined population of 1.3 million). While being different in many respects, both sites are pioneers in the ReThink Health alliance, an organization committed to reimagining and reshaping health system performance across the United States—one region at a time. ReThink Health is sponsored by the Fannie E. Rippel Foundation of Morristown, NJ. (www.rippelfoundation.org)

ReThinking Health Systems

More and more, people are rethinking what it takes to achieve profoundly better results in health systems across the country. Such ambitious ventures, however, are hard to plan, unwieldy to manage, and slow to spread. ReThink Health and its allies are learning what it takes to spark and sustain system-wide improvements in different settings. These efforts usually involve three connected spheres of innovation:

- Stewardship sets the conditions for diverse stakeholders to work effectively across boundaries as they steer their common health system to fulfill shared aspirations over time.
- Organizing engages people around shared values to build power for concerted action.
- Dynamics equips leaders to see the system in which they work, play out plausible scenarios, weigh trade-offs, and learn where the leverage lies to alter future trajectories.

In practice, diverse groups of ReThinkers in a region work together to address practical, pressing questions about their health system, such as:

- How is our local health system structured?
- How and when does it change (or resist change)?
- Where is the greatest leverage to enhance performance?
- What trade-offs may be involved?
- How can diverse, often competing actors weigh those trade-offs and set priorities?
- What are we really trying to accomplish?
- Why do we care?
- Who are "we" and who ought to be involved?

Thinking through these and other issues is fraught with difficulties. As a result, most health reform initiatives tend to be short-sighted, fragmented, and unable to alter long-term trends. By contrast, those involved with ReThink Health use carefully-crafted tools, like simulation modeling, to bring greater foresight, evidence, and creativity to the process of multi-stakeholder planning and action.

Exploring Simulated Scenarios

The ReThink Health Dynamics model is a realistic, yet simplified, representation of a local health system. With a distinctive place-based and wide-angle view, it tracks changes in population health, health care delivery, health equity, workforce productivity, and

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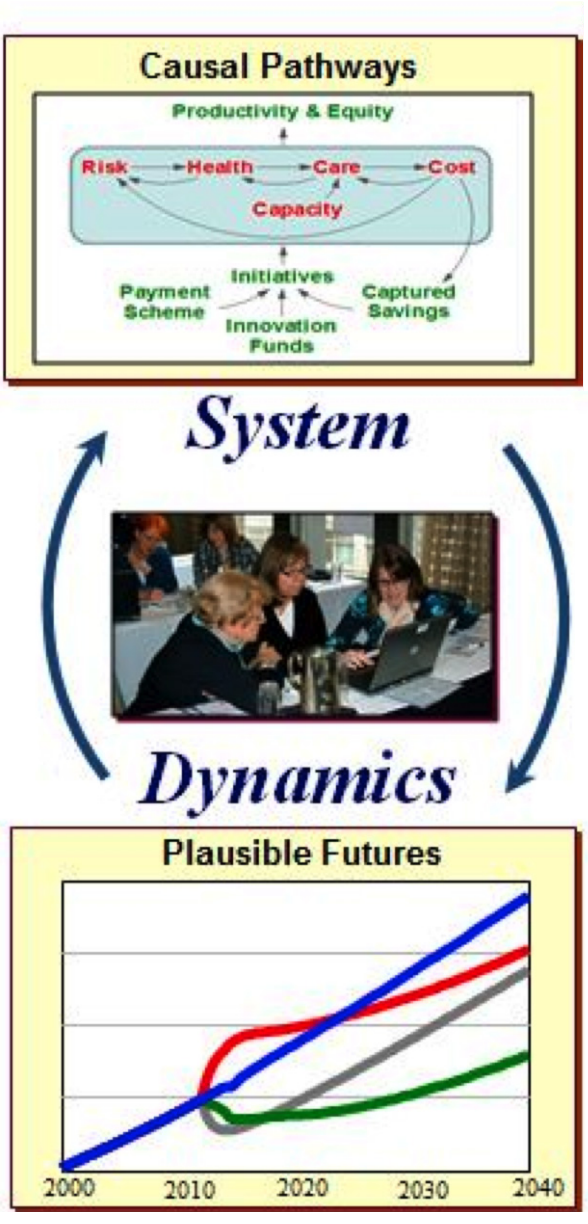

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health care costs under a variety of conditions—all within a single, testable framework tied to many sources of empirical data and open to sensitivity analysis. Information about the model and an interactive interface are available online at www.rethinkhealth.org/dynamics.

The primary purpose of this tool is to support conversations about strategy design, not to forecast specific outcomes. Planners may use the model to examine uncertainties and explore opportunities for change—as well as the stakes of inaction. Simulating scenarios also encourages greater alignment and action as innovators see and feel what their efforts could accomplish in the short-term and as they play out over decades. One potential benefit is the ability to anticipate how current investments (such as those from government, philanthropy, business, and nonprofit groups) could be leveraged for greatest impact.

Diverse teams are now using the ReThink Health model across the country, and several—like those in Pueblo and Atlanta—have incorporated local data to tailor it for their own region (other local configurations are listed online). This diagram shows the general boundary and major sectors represented in the model.

Within this general framework, planners can explore a variety of "What If … ?" questions. The model represents several dozen distinct initiative options (summarized in the table to the right). This menu includes a rich set of options, including upstream investments to reduce the risk of disease or injury, clinical initiatives to enhance the quality and capacity for care, strategies to cut costs, specific financing features, and more. Each action may be simulated individually or in combinations to study the likely consequences over time on many metrics of health, care, cost, productivity, equity, spending, savings, and return-on-investment. Additional design options let planners sequence initiatives and/or direct certain efforts only to sub-groups, as a way of concentrating limited resources among those with the most to gain.

Users may then explore the results of their scenarios by navigating through an extensive set of performance metrics. Scores of graphs like the one on page 7 show plausible paths under alternative scenarios. These graphs let users drill down beneath high-level summary statistics, yielding a deeper understanding about how the health system could change as different initiatives are enacted.

Despite its inevitable uncertainties and limitations, users have discovered many valuable insights when using the ReThink Health model. For example, local leaders have been consistently able to anticipate common pitfalls or "failure modes" that threaten to disappoint or derail regional change ventures. Some of the main failure modes stem from:

- Unsustainable program financing (i.e., attempting too much without adequate funding)
- Exacerbating bottlenecks (i.e., especially those affecting primary care)

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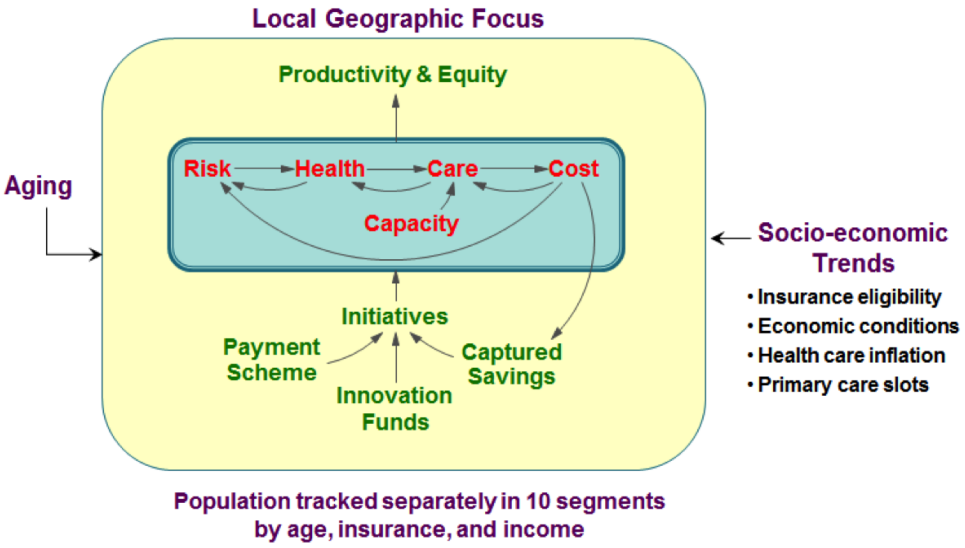
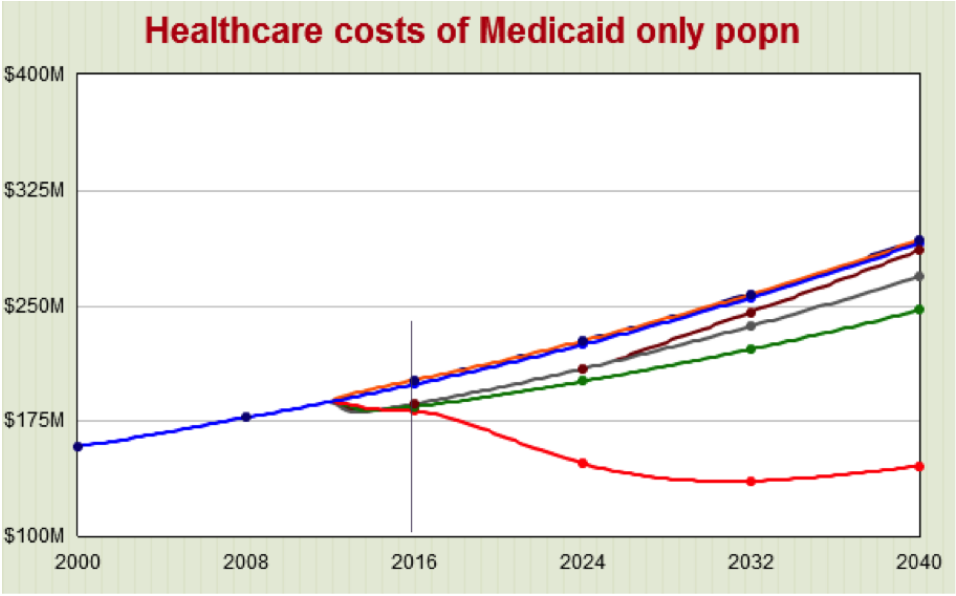


RISK	Behaviors Environ hazards	Crime	Pathways to advantage (family; student)
CARE	Prev/chronic Mental illness	Self-care	Hospital infections
CAPACITY	PCP efficiency	Recruit PCPs (general; FQHC)	Hospital efficiency
COST	Pre-visit consult Medical homes	Coordinate care Shared decisions Generic drugs	Post-discharge care Malpractice Hospice
TRENDS	Uninsurance Local economy	Primary care slots for Disadvantaged	Inflation rate
FUNDING	Innovation fund	Capture & Reinvest Share w/ Providers	Contingent Global Payment



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- Supply push responses from providers that undercut health care cost savings (i.e., increasing the intensity of care to compensate for drops in utilization and income)
- Comparing alternative strategies using only a short time horizon (ignoring longer-term benefits of different interventions)
- Improving health, care, or cost while perpetuating or exacerbating inequities (i.e., failing to alter the structural conditions that drive health inequity).

In addition, when equipped with model-based scenarios, planners are better able to address other shortcomings that may plague multi-stakeholder endeavors, such as lack of a common vocabulary, inability to interpret performance metrics, the absence of a strategic perspective, disorganization, and dysfunctional teamwork.

Pueblo Triple Aim Coalition

The health system in Pueblo County, Colorado, like many others, shows signs of stress. About 40% of the population falls under the poverty line; health care premiums are rising three times faster than wages; and health outcomes are among the worst in the state. In 2010, a small group of local leaders decided to pursue bold, comprehensive reform by declaring their commitment to the Triple Aim, an initiative led by the Institute for Healthcare Improvement that seeks to achieve the three-part goal of better health, better care, and lower cost. The initial team in Pueblo represented several of the principal health agencies: the city/county health department, the community health center, regional medical centers and hospitals, the mental health center, and Kaiser Permanente. They began by reviewing current investments in health and health care. But there were many questions about priorities and outcomes: *Are we investing our resources appropriately? Are we making enough of a difference? Is there something better we ought to be doing?*

The team sought to develop a Triple Aim strategy that would use their resources for greatest impact. They also wanted to devise a clear vision for the region and pursue a course of collective action to get there. But they recognized that their efforts were not well-coordinated; and even worse, many potential allies and stakeholders were not yet in the room. In a brief statement written to engage fellow leaders, Pueblo's Triple Aim Coalition explained that "*ever-rising healthcare spending weakens our local economy, threatens jobs, and has failed to deliver improved health.*"

Working with ReThink Health's team of modelers, they began to map the main features of their health system. *Which elements are most important? How are they connected? Where might interventions be tested? What do we know about the likely impacts and costs?* Eventually, they developed a diagram of the health system in Pueblo that helped each stakeholder find their place in the system and to see who they affect and are affected by.

They also engaged in facilitated, interactive scenario planning using the ReThink Health Dynamics model. Teams of users asked "what if" questions—and got answers instantly. They ran several hundred scenarios looking at likely results over a 28-year time horizon. Those simulated scenarios gave Pueblo's leaders an opportunity to explore what they could do through new or modified programs and policies, and just as importantly, how to pay for it, while factoring in the realities of their own region.

Over time, Pueblo's Triple Aim Coalition expanded to include more than 45 senior leaders in the region, including many who work outside the formal health sector (such as education or economic development). After wide-ranging experimentation, they converged on a set of high-leverage policies, with a durable financing strategy and critical sequencing. Their current strategy features a suite of cost-saving initiatives, like better coordinated care and post-discharge planning, combined with efforts to support self-care and new recruitment for over-burdened safety net clinics, along with focused investments to enable healthier behaviors and expand pathways to advantage.

A central element in every discussion was about the money: *How much is needed? How much could be saved? Whose was it? Where would the savings go?* Those discussions led to a remarkable stewardship strategy guided by insights from the ReThink Health model, grounded in the principles of collective impact, and governed by a new backbone organization with a commitment

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to capture and reinvest savings, share information, monitor progress over time, maintain constant communications, and assure mutual accountability.

The ability to experiment freely and to test novel strategies using a model, before attempting to enact them in the real world, stimulated their thinking and supported what might otherwise have been impossible conversations. The team determined that they could sustain a robust set of initiatives over time by reinvesting a portion of the savings back into the system. Dashboards, such as the one below, provided an overview of the results that could be achieved under their favorite scenario.

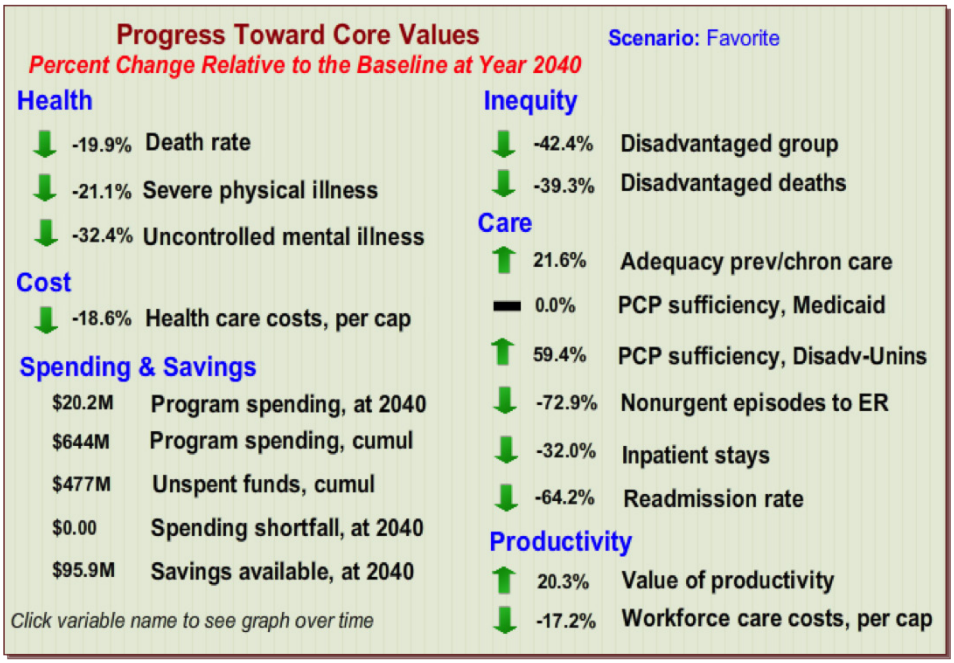
By investing just 1% of total health care spending over 5 years—or $10 million per year for a total of $50 million, this aspirational scenario suggests that by 2040 Pueblo could anticipate the following types of results: deaths decrease by about 20%, health care costs decrease by almost 19%, ER use for non-urgent events goes down by over 70%, workforce productivity increases by more than 20%, inequity is reduced, and there is money in the bank—several hundred million dollars that can be used to improve education, infrastructure, the environment, and the economy.

Leaders in Pueblo County are now creating the relationships and organizational structures that are required to implement their plan and to redesign the economic incentives that usually drive investments in health. Before moving to implementation, they are first working to create an enabling culture for this work to succeed. They are establishing a new governance structure, measurement systems, and a sustainable funding model to assure that effort will be sustained over time.

Two county officials closely associated Pueblo's Triple Aim Coalition described their insights from the ReThink Health modeling process this way.

"Gathering data and then using the model helped us to build trust and to be dedicated and committed ... The model helped us understand the importance of intervention timing, doing things in the right sequence, and identifying early wins... We can get satisfaction out of moving the dial today and knowing how it will contribute to results down the road. It gave us the impetus to stay the course because we could see the possibilities and know how successful we could be."

—Dr. Christine Nevin-Woods, Director of the Pueblo City-County Health Department



"Working with the model built consensus around common issues that will enable us to have collective impact. The work allowed us to develop a common language that made it easier to communicate. It also enabled us to see how the pieces fit together."

—Eileen Dennis, member of the Pueblo County Board of Health

They also pointed to negotiations with interested funders, promising conversations with state leaders about the prospects to reinvest savings, and the incorporation of a local backbone organization as further benefits of their disciplined, collective process.

Finally, they noted that all three of Pueblo's county commissioners were newly elected in 2012. But rather than beginning from scratch, those officials may now contribute to a transparent regional health reform process. Explicit planning tools, like the ReThink Health model, let all stakeholders see for themselves why the group's strategy is sound; and the process for collective stewardship that has been developing over the past two years remains open to contributions from everyone who is willing to work toward a healthier, more prosperous future for Pueblo County.

Atlanta Regional Collaborative for Health Improvement

The Atlanta Regional Collaborative for Health Improvement (ARCHI) is an interdisciplinary coalition working to improve health system performance through collaborative assessment and collective investment. ARCHI was created with the recognition that leaders in the Atlanta area have an opportunity to change the culture of health and health care throughout the region, and that in practice, many forces are drawing local stakeholders into a collaborative approach for health assessment and intervention. For example,

- Public health departments that seek accreditation must perform community assessments

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- Local governments are thinking seriously about their investments in health, assessing needs and setting priorities
- Foundations are increasingly choosing to invest in collaboratives rather than single agencies
- Federally Qualified Health Centers must assess the need for expansion
- Not-for-profit hospitals are pressed to assess, plan, and invest to meet new IRS regulations.

While it may be tempting to approach these challenges independently, the prospect of collaborating with others compels many leaders in the region to explore what they could accomplish together. With the potential for greater long-term efficiency and effectiveness, collaborative assessment can lay the groundwork for shared priorities and collective investments to achieve maximum impact.

Following a process similar to the one described above, a series of open meetings beginning in July 2012 prepared ARCHI members to think broadly and strategically about how their health system could change over time. Working rapidly over just four months, they compiled a rich set of both quantitative and qualitative data to develop a useful portrait of their current health system. But those data could not address some of the most critical questions: *Where is the Atlanta health system headed? How can we better direct the course of change? Where is greatest leverage? What costs and trade-offs are involved? Who decides?*

Recognizing how ReThink Health Dynamics model could support precisely these sorts of conversations, the ARCHI steering committee worked with members of the ReThink Health team to configure a model representing particular features of the health system in Fulton and Dekalb counties at the core of the Atlanta region. By November 2012, approximately 70 participants gathered for a five-hour workshop to explore simulated scenarios and consider provisional priorities. Among the participants at that event were two commissioners from Fulton and Dekalb counties and the principal health policy advisor for the chair of the Fulton County Commission.

The ARCHI modeling workshop began with a review of the baseline scenario so all participants could see what might happen if they did nothing differently. Then, working in teams of seven, they were challenged to craft their vision for Atlanta's future. Each team selected up to five initiatives plus any financing options they wanted. Nearly every group chose to capture and reinvest savings, and one group also embraced the idea of a shift from fee-for-service to per capita contingent global payments. The presence of these innovative financing schemes let the scenarios go well beyond limitations of collapsing budgets and unsustainable actions that erode over time. Despite that ability, budget constraints were still an important part of the discussion.

Eight teams submitted scenarios; however, there was only time to examine four of those in depth before voting on "*which one offers the strongest foundation for the ARCHI collaborative?*" Thanks to instant polling technology, anonymous opinions were gathered on the spot: 89% voted for the "Atlanta Transformation" scenario, which featured investments in the following policy domains: Healthier Behaviors, Family Pathways, Coordinated Care, Global Payment, Capture and Reinvest Savings, and Expand Insurance. Another half hour was spent systematically removing each major piece of that scenario to see its contribution.

Participants reported many powerful insights from the workshop, including

- The need to first assure a revenue stream before embarking on complicated policy ventures
- An appreciation for discipline to do fewer things more fully rather than many with a budget shortfall
- Observations about the relatively weaker impact of changes in insurance versus other facets of system performance
- The discovery that very different stakeholders had largely similar priorities (for example, virtually every group had Behavior, Pathways, and Coordination in their chosen set, with no prompting).

Local government leaders explained how important health is to people as individuals, to the community at large, and to the Atlanta economy. They also identified the importance of wisely investing scarce resources for health. Emil Runge, health policy advisor to Fulton County Commissioner John Eaves, indicated that formal modeling would *"help us let the people know that we are going to give them return on their tax investment. "* Dekalb County Commissioner Larry Johnson observed that, *"the county spends about $70 million a year on health and we want to achieve efficiencies and put money back into the people."*

Some additional insights from the ReThink Health modeling process were:

"The health care system can be overwhelming with its many providers and services. Working with the model enabled us to better understand what is going on. It will make it possible to have a coordinated continuum of care that functions well."

–Joan Garner, Fulton County Commissioner

"The model helped show how we could work toward the goal of a healthier community including for those who can't afford health care and healthier lifestyles.... Also, having all the people in the room who can make decisions made me want to be involved, made it worth my time."

–Larry Johnson, Dekalb County Commissioner

"The model helped us see if we will be getting the results we want. We saw how savings could yield a revenue stream down the road that would sustain the work. It showed that we can achieve the change we want by transition, we don't need to tear down everything and start over."

–Emil Runge, Health Policy Advisor to John Eaves, Chair of Fulton County Commission

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"It helped me think about the capacity to do this work as the county government and how we need to partner to fill in the gaps. The experience made it clear that you can't only have health care people in the room. You need a broad set of perspectives."

–Joan Garner, Fulton County Commissioner

As for the future, the commissioners said:

"With the information from the model, people will begin to see the pieces that they can add into what they are doing and we can gradually move toward system change."

–Larry Johnson, Dekalb County Commissioner

"The foundation has been laid. Now we need to make sure the resources are there."

–Joan Garner, Fulton County Commissioner

Conclusions

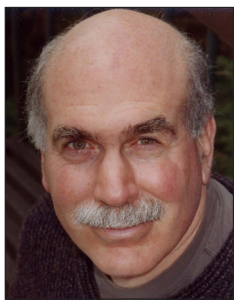
Health reform may be a national priority in the U.S., but it requires local action. Moreover, because of the sheer complexity of the health system, innovators typically require new teams, new tools, and new approaches to work effectively at this scale. For example, local leaders in Pueblo, Atlanta, and other regions are now beginning to use tools like the ReThink Health Dynamics model to support multi-stakeholder strategy design. Flexible, yet rigorous processes like ReThink Health provide an efficient way for diverse stakeholders, including county administrators, to develop their skills for true system stewardship. In particular, we have seen how innovators in Pueblo and Atlanta have used these processes to help diverse stakeholders

- See how they fit within the larger health system
- Play out alternative strategies and compare their short- and long-term effects
- Devise a sustainable funding scheme so that selected initiatives achieve their full promise over time.

Readers interested in learning more about ReThink Health can go to http://www.ReThinkHealth.org, where there are links to online simulation models, as well as many other tools and approaches designed to catalyze innovation in local health systems.

Author Biographies

Bobby Milstein, PhD, MPH, is the Director of ReThink Health's work in dynamic modeling and game-based learning. Dr. Milstein has led the creation of the ReThink Health regional model that is helping leaders across the country to develop interactive simulations that explore the likely impact of policy interventions on health outcomes and costs. He also heads the Hygeia Dynamics Policy Studio, which provides a forum for diverse actors to acquire the foresight and motivation needed to craft powerful responses to pressing priorities. Dr. Milstein is also a visiting scientist at the MIT Sloan School of Management. From 1991 to 2011, Dr. Milstein worked at the CDC where he founded the Syndemics Prevention Network, chaired the agency's Behavioral and Social Science Working Group, and was coordinator for a wide range of new initiatives.



Gary Hirsch, SM, is a system modeler for the ReThink Health data-based model and game. Mr. Hirsch specializes in applying System Dynamics and Systems Thinking. In health care, he has focused on population health and treatment of chronic illness, improving the performance of health care delivery systems, creating the capacity to respond to health emergencies, and improving oral health and delivering dental care. Mr. Hirsch is the co-developer of several simulation-based learning environments including *HealthBound,* created for the CDC to enable users to try their hand at health reform. Mr. Hirsch is the author of three books and numerous journal articles and conference presentations.

Karen Minyard, PhD, leads the evaluation team for ReThink Health. She has directed the Georgia Health Policy Center (GHPC) at Georgia State University's Andrew Young School of Policy Studies since 2001. She is also an Associate Research Professor in Public Management and Policy at GSU. Minyard connects the research, policy, and programmatic work of the center across issue areas, including community and public health, end of life care, child health, health philanthropy, public and private health coverage, and the uninsured. Prior to assuming her current role, she directed the networks for the rural health program at the GHPC. She has experience with the state Medicaid program, both with the design of a reformed Medicaid program and the external evaluation of the primary care case management program. She also has 13 years of experience in nursing and hospital administration. ■