Viewpoint

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Sometimes, regardless of training and experience, a rare person appears with "chief executive" written in her heart. Penny Wheeler, MD, fits the description. She swapped her physician's lab coat for a suit seemingly overnight when she was appointed president and CEO of Minneapolis-based Allina Health, a $3.8-billion, 13-hospital integrated health system serving Minnesota and western Wisconsin. Well, she *was* chief clinical officer in between. "I went from full-time practice to chief clinical officer, from coping with a complex hysterectomy to not knowing how to run my email program. There was no ladder," she recalls. Prior to being chief clinical officer, she served patients at Women's Health Consultants in Minneapolis as a board-certified obstetrician/gynecologist and was president of Abbott Northwestern Hospital's medical staff, chaired the Allina Health Quality Committee and served on the Allina Health Board of Directors. In addition to her current role, Dr. Wheeler chaired the Minnesota Community Measurement board, a regional health quality collaborative, and is on the board of Portico Healthnet, an organization dedicated to helping uninsured Minnesotans receive affordable health coverage and care. She has been recognized as an outstanding healthcare executive for her work forming internal and external care collaboratives with an impact on community health. Dr. Wheeler has an undergraduate degree with honors from the University of Minnesota and a medical degree from the University of Minnesota Medical School. Oh, yes, she's also an avid in-line skater and bicyclist.

You have been a leader in creating internal and external care collaboratives to improve community health. How do these collaboratives work and what impact have they had on community health?

I follow the philosophy shared by Don Berwick to avoid the tragedy of the commons, where everybody self-optimizes to the detriment of the overall good. We've avoided that pitfall through smart collaborations. For example, Children's Hospital of Minnesota is a wonderful children's hospital. Together we created a contractual joint venture to build a mother/baby center using our expertise in obstetrics and theirs in neonatal. We have now added three mother-baby centers starting with the first at Abbott Northwestern. We pool all the revenue, dividing it on the basis of the valuation of our services. Our volumes are up 23 percent and we avoided building a duplicative center in our community.

PENNY WHEELER, MD, PRESIDENT & CEO, ALLINA

I feel the most engaged with partnerships that further the communities' health. For example, Allina has created an accountable care community collaborative in our northwest metro area with HealthPartners, a health system that many would see as a competitive threat to Allina. By partnering together, we have improved the quality of care for the community and lowered the cost of care, as opposed to competing across the street from each other. It's the best thing for the community. For example, we aligned our goals of access to mental health and high-tech imaging use.

What have you learned from these collaboratives—especially the external ones—in terms of data sharing?

The data sharing has been great. We can better understand utilization measures from HealthPartners insurance information and pair it with clinical outcomes to understand the best areas upon which to focus. If we didn't have their claims information, I can't tell you if someone hasn't filled a prescription. So, we can determine the total cost from price and utilization data. How can we do better? In another collaborative, Health Catalyst, a firm we've partnered with, is going at risk with us for patient outcomes, by integrating the clinical and financial data to enable improved performance.

Allina received an equity interest in Health Catalyst, a data-analytics firm, for some of the predictive tools you had developed, as you said. What are your goals in this partnership?

While all our clinics and hospitals are on Epic, we have lots of databases with demographic, patient experience and cost data that did not come from the EHR. That makes it difficult to calculate what the real quality and experience per dollar spent is. We turned to two guys from Intermountain Healthcare who in 18 months developed an enterprise data

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warehouse that produced actionable data to improve care. Our team then was able to do things like build a predictive model for readmission risk which showed us how to target care-management resources.

We knew we couldn't cut staff in data analytics, fall behind on quality tool development and continue to improve care as desired, so we outsourced that team to Health Catalyst. Those employees who were previously Allina employees became Health Catalyst employees. Health Catalyst had $200 million to invest in new tools when we did not have those funds to spend, nor the wealth of experts to develop new big-data tools for care. We partnered with them so we wouldn't lose that great talent and could still have the best data tools for care improvement. Twenty percent of what we pay for is in outcomes-based risk.

> *"We follow a fair process: one, engage people who know the work most deeply; two, explain why you took their advice or not; three, give people expectations and clarity."*

Quality and cost of care are two sides of the same coin. The most effective way to make care more affordable is by making it better. We're still 95 percent fee-for-service, but committed to be a leading organization driving toward outcome-based risk. We're a pioneer ACO. It's the right thing to do. We're trying to use our organizational muscle to develop closer relationships with a payer partner so we can further value-based payments.

How would you characterize the Minnesota market in terms of its amenability to collaboratives, partnerships and data sharing?

We're highly collaborative. Our Northwest Alliance is an example. Minnesota Community Measurement was established to align our goals so we don't, for example, have one diabetes measure here and another there. We're one of the most collaborative areas of the country. Minnesota is one of the most generous states per capita in philanthropic giving, with a real sense of social commitment.

What has Allina achieved in terms of analytics?

The need for integrated data is why we built our enterprise data warehouse. We designed it to make it accessible to physicians and others providing care. We use it to aggregate more than 50 data sources. Epic is the biggest but hardly the only source. Our clinical program committees use data from the EDW to set goals and drive our clinical-services-line quality performance. In cardiovascular, for example, we've been able to improve care and reduce mortality rates and save $10 million. We're in the top decile largely as a result of our advanced data integration. In sepsis prevention, the data helped us save 240 people from premature death in the past two years.

Allina was recognized last year as a top-five large U.S. health system in terms of care quality, patient satisfaction, coordination of care, cost of care and operational efficiency. What were the key factors in achieving this level of success?

Allina has a culture that is low on ego and high on collaboration and performance, and we're one of the more aligned organizations in what we do. We have a commitment to quality, measurement and analytics, a commitment to improve and an infrastructure to support those goals. As CEO I encourage a lot of inputs from those who know the work the best. It's about asking good questions rather than having the answers. We follow a fair process: one, engage people who know the work most deeply; two, explain why you took their advice or not; three, give people expectations and clarity. We practice a collaborative leadership style. The top-down, slam-your-fist approach doesn't work in transforming an environment.

How do you maintain that level of performance as healthcare moves into a value-based care model characterized by taking on risk for population health, patient and consumer engagement and virtual care and telehealth?

Harder and harder choices must be made. That's where novel and innovative thinking comes in. There's no better time to be in healthcare than right now. We have a great opportunity to move healthcare in a positive direction for all those serve. We're still on a fee-for-service chassis that incentivizes us to do more things to more people. We have an opportunity to move to value-based rewards which aligns far better with our mission of optimizing health for those we serve. I believe my mentor, Don Berwick, had it right when he said, "Healthcare is more about love than anything else, because if one person trying to relieve the suffering of another is not love, I don't know what is." We have a great opportunity to change lives for the better with increasing moves to enhance quality and value. Let's take it!

~ Chuck Appleby
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