

Health System Transformation Team
February 16, 2011
Transcript of comments by Governor Kitzhaber and
Donald Berwick, MD, Administrator,
Centers for Medicare and Medicaid Services¹

Governor Kitzhaber

First of all, I want to thank you. This is the third meeting and I know you have spent a lot of time at this. Hopefully, we will be spending quite a bit more here to get the product. I wish there was a secret plan. I don't think there is a secret plan. There's also not a secret roadmap. We're actually going to have to go places we haven't gone before. And I know that there's a lot of anxiety, understandably, about having to change your business plans in a new reality. But I think that we are in a new fiscal reality here, and I think it's easy in situations like this particularly when you begin to get more specific to lapse back and go back to status quo thinking. I think that would be a real mistake. I think the question you need to ask yourselves, "If not this, what?" Because the status quo is what we get if we don't figure our way through this.

I want to give you an analogy, a visual of what I think, the point I think we find ourselves at in Oregon and the country. This is an example from a book called *The Age of Paradox*² by a guy named Handy. If you bear with me, this will make sense in a minute. He talks about the growth pattern of a successful business. He points out that there is an environment in which an investment yields economic growth and an upward curve of prosperity. As the business environment of which the company operates begins to change, if the company doesn't modify its business plan to reflect the new environment the growth flattens off and then goes down.

I think in recent times General Motors is a great example of a company that didn't do that. It continued to produce big, gas guzzling cars in the face of high gasoline prices and concerns over carbon emissions. Now a successful company, when it sees that the environment is beginning to change it develops a new business plan that reflects the new circumstances, not the old circumstances, and creates a

¹ Introductory comments made by Dr. Goldberg and the Q&A session were not transcribed.

² Charles Handy, *The Age of Paradox*, Harvard Business School Press, 1995.

growth curve. And the area between the old and the new, because for a while the old system or old business model has to coexist with the new one, he calls the area of Paradox. And it's an area of high anxiety and a lot of churning. People are really nervous, they know the world is changing, they know what they're doing isn't working, but the human instinct is to hold on to what you know even though it's taking you over a waterfall.

And I think that's where we are in Oregon and in America today in health care, education, in a whole host of things. The challenge we've got is to design that new picture of the future to give people confidence to let go of the old one and move to the new one. If any of you have ever been in outdoor school there is a game called the "Ropes" game, where you stand on a post up off the ground, holding onto a rope and there is another post over here with another rope and you need move from one to another. The only way you can get there is for a minute you have to let go of one rope and grab the other rope. That's where we are. And what you're doing here is you're trying to design that new growth curve. And fortunately we're not doing it for the entire health care system here; we're doing it for a piece of it. But if we don't it I do believe that this system is going to go off the rails.

I've asked Bruce and Mike, and their staff to actually develop a picture of what the '13-15 biennium in Oregon will look like for the population we are talking about, if we don't do anything now. The budget is built, predicated, on finding several hundred million dollars of cost savings in the second year of the biennium by changing the delivery model. If we don't change the delivery model, the cut in this budget is going to get a lot bigger. Because trust me there is not a secret pot of money in Oregon that we can get our hands on and the money at the federal level increasingly is going to be focused more and more on dealing with their multi-trillion dollar national debt, which is driven almost entirely by Medicare and Medicaid. So there is a moment in time when we can shape our own future, and I think we have a very narrow, precious window of time that is closing rapidly. It won't be long before events are going to over take us and we'll lose that opportunity to shape our own future rather than simply reacting to circumstances. I think we are better than that here in Oregon and that's really what you're charge with doing and that's a remarkable opportunity. But doing nothing is essentially an endorsement in status quo and I think that you need to look that one straight in the eyes as you begin to think about this and as that

anxiety bubbles up we need to focus it toward the future. Not simply clinging to a pathway that doesn't have much possibility.

I'm very, very grateful that Dr. Berwick has agreed to join us this evening. As you know he is the head of the Centers for Medicare and Medicaid Services at HHS; that's responsible for Medicare, Medicaid and the children's health insurance program. Provides coverage for about one out of every three Americans. He is a pediatrician, Harvard trained by profession. Before he took this job in the Obama administration he was the president and CEO of the Institute for Health Care Improvement that developed the whole concept of the triple aim. I had the honor of serving as a senior fellow at IHI for a while. I think it is fair to say that there is no one more qualified to lead the health care reform effort at the federal level than Dr. Don Berwick. It's just a great honor to have you with us this evening. We've asked Dr. Berwick to talk to us a little bit about how an integrator could actually leverage the triple aim outcomes at the local and regional level. And perhaps some thoughts about the work they are doing on accountable care organizations to make sure that our work is in synch with the thinking at CMS. With that Don, I'll turn it over to you.

Dr. Berwick:

Thanks a lot Governor. I really, really appreciate the chance to join you. I wish I could be there in person, and I hope sometime that will be the case that I can join you in person. Let me begin by expressing my thanks to Governor Kitzhaber and my admiration for his work. I've had the good fortune to be Governor Kitzhaber's colleague and friend for a number of years now, and I just can't think of a leader in America today that is more likely to help us navigate towards a better health care system at a regional level and a prototype for the country than you are Governor Kitzhaber. Thank you for letting me join you.

I'm really excited by the idea of a group of leaders in a region or state that have come together to try to work on the transformation of care and care delivery of the kind of system that we need, which is a sustainable system. Governor Kitzhaber knows that for years before I joined the Centers for Medicare and Medicaid Services I had been thinking with my colleagues around the country about the nature of a better care system. The improvement always begins with goals. The framework for goals that I have been working with colleagues we use to call the triple aim, I now call the three part aim, but it's the same thing. Which

is that if you try to understand where our country needs to go, and if I can be so bold, Oregon might need to go. The definition of social need is a three part aim. The first is better care, better care for individuals when they are in care, when they need care. When they have their heart attack, break their arm, or need a check up or are depressed. On this we have tremendous amount of guidance. The Institute of Medicine, years ago, 2001, articulated the nature of quality for individuals. Well, what is it to get good care? They proposed six goals, six dimensions of potential improvement:

- Safety, not getting harmed by care, which is intended to help you. We have tremendous safety issues in the country in health care.
- Effectiveness, which means aligning care with science so that people get the best possible care for whatever condition they have. We know for diabetics quite a bit about how they should be treated but we have trouble executing care of diabetics with the degree of reliability that we ought to.
- Patient-centered, putting patients in control of their own care so they can make the choices and decisions, and have the skills to take care of themselves when they want to.
- Timeliness, avoidance of delay.
- Efficiency, which is the avoidance of waste
- Equity, closing mainly racial and socio-economic gaps in care.

Safe, effective, patient-centered, timely, efficient, equitable care. That's the first aim.

The second aim of the three has to do with health itself. It is true, we know scientifically, that the generators of ill health don't lie largely in the health care system. And that the cures for extending health—they're not accessible through health care. Only about 10 percent of the variation in health is health care. The rest has to do with the factors of society, genetics, predisposition, behaviors. So if we are really interested in healthy America, or healthy Oregon, you've actually got to expand your mind and leave the health care system a bit. Think about other things that determine health.

The third of the three aims is lower cost. Not lower cost by withholding anything whatsoever, but lower cost through improvement. Every mature industry in the world today, no matter what they're doing, are thinking about quality improvement as the root to lower cost. That's how you get lower cost; you

remove waste from processes, you focus every energy on your customer, beneficiary, patient and you get to lower cost by stripping away forms of waste that add no value to the person you are trying to help.

That's the three part aim; better care, better health, lower cost. And John Kitzhaber has picked up that idea years ago and has worked with it as well as anyone I know. As the CMS administrator I try to bring that into CMS. With my colleagues there thinking about what we can do as an agency for better care, better health and lower cost through improvement at the same time. I want to emphasize that I am not talking about lower cost by withholding any care whatsoever. That's not on the agenda. It's always lower cost by improving processes, products and services. And making sure every step adds value. Better care, better health, lower costs.

To do that we really can't accomplish that in the current system. It's going to work. If you think about what makes patients unsafe or what adds cost without value or why we don't work on health care you can trace it back to the designs of the health care systems themselves. They're just frail, they don't work. The biggest problem is probably integration, which is what Governor Kitzhaber asked me to talk with you a bit about. If you actually look at the sources of problems with better health, better care, lower costs they largely lie in fragmentation. It's largely with respect to chronically ill people.

In the case of the State of Oregon I would venture to say that the small minority of your citizens who really have most health care needs, for example, dual eligibles, Medicare and Medicaid eligible citizens. They're absorbing a tremendous amount of the resource and they're not getting value for it. Their health care is nothing like what it could be. Their condition is impeded rather than assisted by the health care system, largely because of fragmentation. So they end up coming back and forth into the hospital when they could stay at home. They get worse when they don't need to get worse with their chronic illness. They get depressed when we could have anticipated a depression and helped them in advance. And they're not given resources to control their own health. Forty percent of the Medicaid budgets for example, in most states, and I suspect the same is true in Oregon is attributed to the care of a very small number of people, the dual eligibles. The answer is we know what to do about that for the most needy of our neighbors and that has to do with integration of care. Unless

someone's taking responsibility for that three part aim (better care, better health, lower cost) for our population you don't get the kind of coordinated, integrated, seamless care—the attention to the need of the individual, the stripping away of waste, the adding of value that we know what to do and how to achieve. There are prototypes, we know, all over the country that are small examples of very successful program and projects that meet the needs of vulnerable people.

If you read Atul Gawande's remarkable article a few weeks ago in *The New Yorker*, I think it was called "[The Hot Spotters](#)", he picks out the three or four people around the country that developed prototype systems for the care of people who are in this vulnerable sector, and they produce remarkable results. We've seen hospitals and systems reduce readmission rates by 85 percent, by appropriate integrated care. We've seen problems with medication errors and hazards to patients fall by 85 or 90 percent in integrated care systems. And cost can go down too; I met today actually with an integrated care system which in the past two years has reduced cost of care by seven percent over all with a six percent improvement in outcomes for diabetic patients. The problem is they aren't systemic, they don't spread; they don't become the main, the norm. And the potential I see in the best approaches of integrated care—it's almost boundless. I think it could solve the American health care problem and we could go on to other issues if we got that straight.

This can't be done from Washington. As much as I wish I could do this as CMS administrator, I can't. I can set the stage with my colleagues there, but it's really regions and local communities that have the potential for developing real integrated systems. Again, that's what excites me about your work in Oregon. It's not easy, and the changes that are needed in design will be reflected in changes in business models. If you think about what it would be like to be in an integrated system, things look different. Hospitals for example, as bizarre as it sounds, would seek to become empty. You have to have a business environment in which it is better for hospitals to empty a bed than to fill one. Prevention has to become lucrative; the name of the game and the focus on these chronically ill people has to be intense and constant. Cooperation levels have to be extraordinarily high. But I think it can be done. I'm encouraged. Oregon has already been a leader and gone farther than most states in developing opportunities for such integrated processes. But I think you have more ahead for you in seeing the table of colleagues that John has put together excites me a lot. I think this three part aim

of better care, better health, and lower costs is achievable. I'd keep my focus on the most vulnerable people there; the people with chronic illness and many needs. I would work as hard as you possibly can on developing a nurturing integrated system that make it smart for those systems in a business sense to thrive by keeping people at home where they belong and making sure that every step adds value and health to them.

I don't think that I've said anything now Governor that your colleagues don't already know, but that sets the stage. CMS is committed to trying to help this, and I must say that the Affordable Care Act, this new context that we have in federal law, I find absolutely remarkable. I can't tell you how every day I get more impressed about what potentially the Affordable Care Act has in it to nurture this type of integrated care. It takes many forms; care organizations now are going to be possible, bundled payments, medical homes, health homes, lots of opportunities.

I know that you have ideas in Oregon about flexibility that you'd like us to state to make this possible there. I met today with the senior leaders in HHS and mentioned that I would be on the phone with you tonight. The one request I got from key leaders that was, "Please ask Governor Kitzhaber how we can help." What do you need us to do in HHS and CMS that would make it more possible for Oregon to achieve what I know you want to achieve for your people. I think I'll pause there Governor and invite any questions. I know you want me to talk a bit about ACOs you said in your email to me. But I think it might be best if I stop talking for a minute and just see if people want to probe a bit.

Governor, Dr. Berwick and Members Q & A: *Not transcribed*

Governor Kitzhaber

Thank you very, very much for your time this evening and your willingness to help us work with you as we move forward. We're very grateful for the time you've given us and I'm hoping to see you at the end of next week back at the National Governor's Association.

Dr. Berwick

Governor, I'll be there and I look forward to hoping to spend some time with you. I know how busy you'll be. And thank you for this chance. I'm sorry for the logistics of connection. Next time we do this, and I hope it will be soon, we'll find a better way to connect electronically. As I said hopefully it will be in person. Your work is phenomenally important and I just see Oregon as a beacon. If you keep at it as a community and keep in mind the three social aims, I'm sure you're going to show our whole country some solutions, and I'm very anxious to help you do that in any way I can. Governor if you have specific asks of me as a result of your work with your colleagues that you think I can do bring them to Washington, and I will work really hard to try to make possible what you'd like.

Governor Kitzhaber

Thank you very much Don.