

**Oregon's Coordinated Care Model Summit:  
Inspiring Health System Innovation  
December 3-4, 2014  
Portland, Oregon**

**Don Berwick - The Leadership We Need**

Thank you Governor. Thank you all for the chance to spend time with you. I don't live close to Oregon. I am 3,000 miles away. I feel very close to this place. As Governor Kitzhaber said, I have had the chance to be here many times. I always take inspiration and excitement from being here. And especially, I must say from the friendship that your Governor has shown to me through the years. He has been a friend, an advisor, a mentor to me. It is an honor to get to join him in encouraging you on this extremely important work.

Bravo. You are doing something amazing. The more I learn and I learn all the time about what you are doing. The more I truly believe then in a country whose direction, not just with respect to health care, but to health and indeed investments in social justice. A country that's having a little trouble finding its way right now. There is a very bright light here. What you can do here in the state of Oregon could be an example for the whole nation. That places a burden on you, the burden of leadership. You are so far ahead of most others right now that you are inevitably going to be the pioneers who experience uncertainties, the obstacles that others haven't yet found. You are going to solve problems no one else has yet solved. That is going to require continuing will, continuing confidence, continuing leadership, and a sense of importance about what you're doing. I just want to say a few words about that before we get to the really exciting stuff. Which is listening to what some of these CCOs have done recently.

I would say to start, I can already see some of the barriers that you are trying to climb here, the mountains ahead of you. You have to find a way to maintain cooperation, which is the biggest problem in improvement. You have to find a way to navigate your way to unprecedented levels of cooperation, which means everybody's willing to give up something so the entirety gets better. You are going to have to understand what the country has not understood with health care. Which is as important as finance is, as important it is to get insurance right, and coverage right, it does not solve the problem.

The problem of American health and health care is solved only by changing the actual systems of delivery and the social determinants of health the Governor was referring to. We have to shift our view in American health care reform from finance reform, which is on the critical path, to delivery reform and care reform. Which is what I think the CCOs are struggling with now and will for a few years ahead. We have to understand how to make the voice of patients and families and communities authentic and powerful. You have got the structures do that in the CCO world. These are just three examples of the kinds of obstacles you're facing at a level I haven't seen in other settings because you are so far ahead.

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Let me give you a few thoughts about how I might think about this. I continue to believe that the Triple Aim framework is the right one. The American health care system has been focused for years on making care better, which we have to continue to do. Now the broadening of focus to the two other parts of the IHI Triple Aim are crucial. You adopted this years ago here in this state. Not just better care, but better health and lower costs. Lower costs not by rationing. Not by holding anything back. Lower costs through the improvement of the system of delivery. I wish I could tattoo the Triple Aim on some part of your body for everyone in the room and keep your focus on this as a system of achievements that you are going to show us the way to. I did that when I was at CMS. Nobody at CMS didn't have a tattoo by the time I left.

Let me show you why. Most of you've seen everything I'm about to show you but let's just recite it quickly. Costs are severely impairing our ability to be the nation we want to be. This is the international comparative data showing the rate of rise of American per capita cost expenditures and percent of GDP. There isn't any country within shooting distance of us. The next most expensive country is thirty or forty percent lower per capita than we are and that includes Oregon. The differences adjusted for cost-of-living are persistent. They have been there for years. Despite all the talk of health care reform and change in America, we continue to ignore in some fundamental way the distance between us and other high performing health care system with respect to per capita costs.

I did run for governor in Massachusetts and had an amazing experience. Unfortunately I didn't win the election but I certainly won a lot of learning. I want to show you the window of this problem from the viewpoint of a state just like Oregon. This is the Massachusetts window. Between 2001 and 2015, every single line item in the Massachusetts state budget is down. Parks and Recreation down twenty-five percent. Local aid's down forty percent. Higher Ed's down thirty percent in constant dollars. There is only one item in the state budget that has gone up in that fifteen-year period. That's health care expenditures by the state; it's gone up seventy-two percent. This is a different version of it showing you exactly the same result. Health care is confiscating opportunity from the viewpoint of public finance.

I learned as a candidate or was reminded about the faces behind this. This is a guy I've come to know named Gorge Sanchez. He's twenty years old. He ran away from home at twelve. His mother is an alcoholic. His father is unable to take care of him. He never went back, dropped out of school, got his first gun at age twelve, stole a car at fourteen. By sixteen he had committed armed robbery and was in jail. He is out now six months ago. A bullet is headed for Gorge Sanchez. This young man is at a cusp in his life. I can tell by meeting him. You'd fall in love with him if you met him. He's a charming, gracious guy. He's headed one way or the other. Luckily, Gorge is in a program called SSYI. Safe and Successful Youth Initiative in Massachusetts. Funded initially at ten million dollars for eleven centers, now cut to five million. Under some versions of the state budget we are feeling zeroed out. What Gorge gets from SSYI is what he needs: GED training, vocational services, mental health care, substance abuse care. He is on a tight rope. With the support system we could offer Gorge, he might get back into the mainstream as he wishes to be. If that support system goes away, Gorge is in deep, deep trouble. I want you to keep his face in mind through the rest of the slides.

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That is what the public side looks like. It is exactly the same in the private sector. Every analysis that I do about the confiscation of resources by health care from other sectors in the public finance side appears on the private sector side. It comes in the form of premiums rising much faster than inflation for wages do. Remember there is only one source of finance for health care in Oregon, in America, anywhere, in Massachusetts. That is the wages of laborers. No other source of funding exists. It may go through federal taxation, state taxation, out of pocket costs. It may come from employer contributions to premium or employee contributions to premium. Every single nickel you spend on health care is coming from the wages of laborers. Every single nickel that is confiscated by health care, that could be used elsewhere, is coming out of the pockets of the people who pay.

Therefore as we continue to see the rate of rise of costs, we see the shift of burden more and more on the backs of people who do work. Serious problems paying medical bills exceed in the United States any other country's level of serious problems as reported by the public by a factor of two. More and more people are seeing the opportunities they have to use their funds for other reasons (just like the government can) taken over by health care. This is the proportion of states in which the public is spending more than twenty percent of its income on premiums from the under age 65 population from 2003 to 2011. The whole country is turning into the highest level of confiscation.

This is continuing in most states. I don't know the patterns in Oregon right now. One of the adjustments that the private sector is making to this takeover of resources by health care, is to shift more and more of the burden directly to individuals under some guise that somehow skimming the gain or comes out of people's pockets the system improved. Untrue. What it means for laborers is that more and more is going out of their pockets into health care. Now that would be just fine, it would be okay. I can't think of an aim more important for our communities or our states than to be healthy to thrive. If this constant shifting of resources into health care were purchasing what we want, vitality for ourselves. The chance to see my grandchildren for as long as possible with as much health as possible. It is worth it to me. I can't think of a better way to spend the money. That is where the defect is. It is not true. A tremendous amount of the resource that health care is taken over is not adding value to people's lives. It comes in the form of tremendous amounts of administrative waste. Which in a rationalized health care payment system could be recovered for other resources, other use.

This is the analysis that I did and published in the *Journal of the American Medical Association* just before your launch. In which a colleague at Rand Corporation and I (Andy Hackbarth) looked at non value-added activities in the American health care scene. What we determine is that if we just took six forms of things that don't add value to people's lives: doing too much overtreatment, failure to coordinate care (the mainstay of the CCO idea), failures in care delivery (like errors in care), excess administrative costs (as I just showed you), excessive pricing (because there's no transparency about pricing) and fraud. It leads at the median to an estimated thirty-four percent of American health care expenditures being pure waste. One out of three dollars buying nothing at all. As part of that distance between us and those other nations that are achieving more with less. We are getting less for that. This is the WHO graph of life expectancy versus health expenditures per capita and there's only one real outlier in this curve, the U.S. way, way high in expenditure and way below the theoretic potential for achievement of health status.

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A very interesting figure appeared last year from the Commonwealth Fund. David Blumenthal and David Squires produced this remarkable chart, which I think makes the point even better. They asked a really interesting question. What if American health care expenditures, instead of being the most costly in the world, were the second most costly? What if the trajectory over the past thirty years of health expenditure had not followed the American trajectory but had followed the trajectory in Switzerland which happens over that three-year period to be the second most expensive country.

Here is the answer. If the United States had not been number one but number two in health care expenditures, the total amount the country would have spent on health care in that thirty-year period would have been fifteen and a half trillion dollars less. I have done the math for Massachusetts. It blows away any other concern you might have about state budget or private sector expenditures. It is an enormous amount of money. At the fifteen and a half trillion dollar figure, Blumenthal and Squire say that we could have chosen instead to send 175 million people to college free. Or we could (this is in their reports so I did not make this up) they said we could cover the state of South Carolina in solar panels. Which I don't think they are proposing but it's a metaphor which would generate more than double the electricity needs of the entire nation forever.

This is a lot. It is worth it right because between us and Switzerland, we get more. Fifteen and a half trillion dollars more of results. No. In the WHO ratings of health systems performance, Switzerland is number two. We are number forty-seven. Our life expectancy in this country is fortieth in the world. Switzerland is number two. There isn't any evidence that this massive over-investment in the architectural of care is yielding what we need. That is the problem we face. It is the gorilla in the room. It is the biggest possibility we've got. If that were true, then all the fretting we're doing about how to get daycare and GED training and vocational services and mental health care for Gorge goes away. We have the money. It's right there if we want it. Every concern that the laboring public has about its ability to send its kids to college and go to a movie tonight and eat out for dinner more often than they can. Every concern they have about the use of resources goes away. There is enough money in the waste of the health care system to restore justice to our governments and vitality to our communities, plenty.

I showed this when I was here two years ago. I showed you this so if you saw it, pretend you didn't. This is a bridge in Honduras. It is the Choluteca River Bridge. The Choluteca Bridge is near Tegucigalpa, Honduras. It was built in 1938. The Honduran government brought in the American Bridge Company which builds fabulous bridges. They built the Bronx Whitestone Bridge. To build a great bridge in Honduras because the Honduran weather is really assaultive to bridges. It was tested over and over this bridge. The worst test was in 1995 when a big hurricane called Hurricane Mitch (no offense Mitch). Hurricane Mitch hit Honduras. It destroyed one hundred and fifty bridges. It was a killer hurricane. It killed many people. It did not take down the Choluteca River Bridge. The Choluteca River Bridge stayed. The problem was the river moved. If you visit Tegucigalpa today, near it you will find the bridge in the wrong place. This is American health care. I always feel a little unfair; it's a low shot because it's not really true. There's a river under the first bridge.

When I was the training in pediatrics, every kid I saw with leukemia died. Now they all live. I had dinner with a friend last night, a high school classmate of mine who lives in Portland. His life has been

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saved by very audacious treatment of a chronic kidney disease. It's successful. He is going to live another twenty years. That is the first river, the first bridge.

Let's not for a minute believe, that we have to sacrifice or give up the miracles of audacious technocratic medical care when they work. Let's be judicious about it. Let's make sure that it does work. Nothing about the argument about the river in the wrong place should allow anyone to argue in my opinion that we need to withhold truly effective care from the population at the technocratic end. The point is the big river isn't there. It is the one we just been talking about this morning already: chronic disease care, care of advanced illness, preventive care, mental health care. The kinds of support we want to live long and healthy. Health care cannot create health, not the way it is invested today. That's the value add problem. Oregon is building the second bridge. If we get this right, the river will get crossed. The remarkable thing is money will be yielded by that, not consumed. Yielded for other uses.

It's a national embarrassment that we have to still struggle to make a public case for health care as a human right. I do and will and I will never stop. Health care is a human right. We need to make that so in this nation. Where we are with this Medicaid enrollment issue is enraging. I know in my heart that the only way we can actually make that commitment and deliver on it, is to build a second bridge. It is to make universality justice sustainable by giving care the right way. If we don't, the devil's to pay. The safety nets going to get hurt. Watch what's happening with Medicaid now in the nation. Workers are going to have less income. That shift to out-of-pocket expenditures is vicious. Businesses will be less competitive in the global marketplace. All the stuff we built around health care, research and teaching and other important investments, they're going to get threatened.

I chaired the Institute of Medicine Committee this year, last year on the graduate medical education reform. A lot of voices nuancing why would we take health care dollars and devote it to the training of health care people. We don't do that from lawyers or for others. What do we do. This is the task for you in this room and for your colleagues all over the state. What we have to do is to rebuild the care, not just finance. We need to change the finance, go for it, you need to. The toxicity of the finance system is serious but that doesn't get the job done. What gets the job done is care remade. What I know from thirty years of work with the Institute for Health care Improvement, with colleagues in this room. Mark Pearson, we worked together twenty years ago. We know, you know, we can find out what the new delivery system looks like. What the second bridge is. It just isn't the same as the first one. If we cling too tightly to technocratic hospital-centric work, it isn't going to work. You can't get there from here.

Two quick examples I'll show you that thrill me. The NUKA System which I talked about here before. I will talk about it every place I go. It's the Alaska Native System in Anchorage. Sixty thousand Alaskan natives being cared for by a system they own. They own it. It is the Alaska Native Corporation, their South Central Foundation. Dramatic results when care becomes team based, prevention focused, spiritually oriented, home based. These were the NUKA results between 2004-2009. By the way, this is the NUKA office. The doctor's office but there's not just a doctor in it. There is a doctor, a nurse, a nutritionist, behaviorist, a physical therapist, a social worker. They always are working in teams. I can give you the NUKA model. I am sure you've heard about it here many times. Doug Eby is a close friend of yours. These are the results over a five-year period: a fifty percent decline in ED utilization; a

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fifty-three percent decline in hospital admissions; sixty-five percent down in special utilizations, twenty percent down in primary care utilization and enviable quality scores, employee satisfaction and patient satisfaction.

This is another example. This is the ECHO Project, which I believe you know about in Oregon now. It's been developed by Doctor Sanjeev Arora. The guy in the tie at the end of the table here. He's a hepatologist. His main interest was in Hepatitis C management for which in New Mexico where he lived, you had to come to Albuquerque to the tertiary medical center to get your Hepatitis C virus cleared. Which can be done two out of three times with proper medication. He didn't think it was necessary to come to Albuquerque. He thought he could develop an electronic system of supporting education throughout the entire state of New Mexico and he did it. He now can achieve for Hepatitis C viral eradication better results in a small nurse run clinic in a rural town in New Mexico, than he could if the same patient came to Albuquerque for quaternary care. He's done it now across the spectrum with the state, all over the state. Now he's generalized the Echo Project to a whole range of chronic care conditions.

What I am telling you is that in Oregon, you could have a single center of support for all the primary care systems of Oregon to deal with very high-tech challenges, at very low cost with better outcomes than you get by referral to tertiary centers. He has done this in prisons by the way. He's taking prisoners and training them to deliver very high tech care for Hepatitis C and other conditions.

Here is the point. We know what a new care system looks like. I have shown you NUKA: team-based, spiritually oriented, home-centered care, owned by the community. We know what proper telemedicine looks like: the ECHO Project or the AFHCAN card which is a telemetric system in rural Alaska. The telehealth project in the UK that's put nurse specialty care into homes with a forty-five percent reduction in mortality rate in severely chronically ill people. Published in the *British Medical Journal*.

We've seen vast expansions of ideas about how to use the workforce properly. Instead of having dentists take care of rural Alaskans, now dental health aide therapists do. We have seen totally new views of the patient and the role of patient and families in their care. My colleague who now runs the Institute for Health Care Improvement, Maureen Bisognano, is fond of saying that we have to move health care from a system that says what's the matter with you, to a system that says, what matters to you. When the community gets a strong voice of that type, when they begin to shape the care that they receive, you begin to get wiser and less expensive results. We know what the new care looks like. It is not on the first bridge.

Governor Kitzhaber has shown this slide a lot of times I know. I have to and you have probably seen it before. It is what to keep in mind. It is where you are right now in the CCO arena. The future state is better. Build the second bridge and Oregon will be healthier, costs will fall, and your Gorge Sanchez's will be able to get the services they want. Your laborers will have more to take home. The problem is the fixed structures in place. It's burrowing through a status quo over-invested in bricks and mortar - that is the first bridge. Over-invested in a labor force distribution that doesn't reflect the actual needs of a community and way under-invested in the generation of health from the community-based activities that

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do that.

What we're experiencing nationally now is a very strong and I must say frighteningly effective pushback from the status quo. Hospitals trying to maintain their revenue. Top-line business strategies. Consolidating increasing prices at a time when prices should fall. Insurers turning where they can to the least powerless, the covered beneficiary in saying sorry you got to pay more out of pocket now. We are seeing a public that is frightened to death that this means rationing. In some since it does when you shift cost to the individual. Professionals and suppliers defending prices and becoming more and more frightened. Everything on this slide fights against what I told you is the single most important principle in improvement and that is cooperation. Everything in the slide causes subsystems to ring-fence to draw their wagons into a circle and say not here, not now, stay out. That won't work for Oregon, it won't work for America.

I know this place. You got a chance to do something pretty remarkable. This slide. I made it up on an airplane after a couple of scotch and ginger ales. It means this. It means, Oregon, you got a choice. You got a choice. I drew it as green or yellow. Yellow is fight for today. Fight for the status quo. Keep the revenue. Hospitals try to stay full and top-line business strategies should work. Every individual defend what you get. You might win: that is, the health care system might win. that's a loss for George Sanchez. You might lose: that's a loss for health care because if you don't change care, there's less money to go around. Guess what's going to happen if people can get the care. There is only one right direction on this terrible slide. It is the Triple Aim. Better care, better health, lower costs and that means redesign.

I think the way I think about it is this. I would say to a hospital audience what would you do if an empty bed became more profitable than a full bed. The second bridge became more attractive than the first. Here's the deal. It has to become what will you do when an empty bed becomes more profitable than full. That's what you're trying to do in Oregon. You're trying to make hospitals interested in being empty. Shift the attention toward the building of health and wellness toward the Triple Aim. It is a very very big problem. Once you put health on the screen as you are here, you've got to start to think in systems terms at a level like you never thought before. This comes from Sweden but it's a slide you have seen many forms of. This is what makes you healthy or well.

This was my earlier point. Find health care on the slide. It is there but it is teeny. The Oregon of the future, able to generate the resources from health care to devote to other areas of endeavor, able to stay healthy is going to be a different delivery system. It matters a ton. I am scared about this guy. There is no Oregon Health Authority in Massachusetts. There is no CCO movement. I'm telling you in this year's budget, the SSYI program that can save George's life, I think is at serious risk of being zeroed out instead of being quadrupled the way it should be. That's what we're fighting for.

I will close where I started. I know the challenge isn't going to be easy. The disruptions are going to be major. I got three quick suggestions for you. Suggestion number one is get very, very self-conscious about the level of cooperation you're exhibiting. No matter what argument you can make for holding back your cards, or keeping to yourself what you've already got, whatever you can make it isn't right. Not if the systemic need, the public need, the justice need is for you to work together. It's everything. So every CCO, every community, let's understand cooperation and index it and make it accountable for it.

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Second, I am speaking directly to the CEOs of the CCOs. I know no other place to pin this responsibility. I know you're interested in the money. I know you're interested in the deal. I know you're interested in the form of the contract. It isn't enough. The leader of a CCO today is going to have to be a leader of the actual change of the delivery of care itself. If you're not interested in the substance of that and you can't support the transformational efforts that are underway through the Transformation Center and the good doctors and nurses who are with you, who want to make care different. If you aren't an expert in care, get expert in it. If in your board meetings and in strategic planning and your accountabilities to your own reports you are not holding each other responsible for the change of the delivery of care, not just the finance of care, then you aren't yet doing the job. You can do it and I will help you. I will help you learn anything you want to know about what the new care delivery system needs.

And the last point, so you have done something wonderful in the law which is require that in the CCO world the patients speak – patient advisory councils. Great. Nice start. When you want to navigate towards the second bridge and build a new system, your best architect is the patient, it is the family, it is the community. It is not a matter of tokenism. It is not even about representation. It is about the distribution of power. I think the CCOs that are going to thrive are going to turn power over to the communities and the patients at a level that will feel very uncomfortable but will yield benefits that are inestimable. It's the people who have the need that know how that need should be met.

Congratulations! The country needs you. I am so glad to be able to be part of your work.

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