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Acknowledgements

- Thank you, Karen. It's a pleasure to be here. I appreciate your friendship and your constant willingness to dialogue.

Other CMS Speakers

- I'd like recognize two of my colleague CMS leaders who are providing you today with more detailed updates on Medicare and the Affordable Care Act*:*

- Dr. Barry Straube – CMS Chief Medical Officer and Director of the Office of Clinical Standards and Quality, who spoke to you earlier this morning; and

- Jon Blum -- CMS Deputy Administrator and Director for the Center for Medicare, who I understand wraps up your session here later today.

Opening

- As you may know, I am coming to the end of my second month at CMS… still quite new on the job, and learning fast every day.

- I am finding the job thrilling – constantly interesting, and extraordinarily exciting at this time of productive change in our health care world. It is an enormous privilege to serve in this way.

- I am a pediatrician and my main field is health care quality. But I would like to tell you why I decided to take on this new challenging role at CMS.

  - The actual answer somehow traces back to my own childhood. I grew up in a tiny Connecticut town, Moodus, Connecticut. My father was one of the two GP's in that town, where he practiced for over 40 years. He

was the old style GP – he did it all – delivered babies, assisted in surgery, took care of people all the way along –infants to elderly. He took his own X-rays and looked at his own blood smears. He made house calls, and among my earliest memories is the sound of his car starting outside my bedroom window in the middle of the night. Some worried mother had called; or someone in pain; or the constable at the scene of an accident. And he went there. Always. He knew all the names, and all the stories, and many of the secrets. He helped people all the way through – beginning to end.

- He would have laughed if anyone had called his practice "a medical home" or said he practiced "patient-centered care." I suspect he would have asked, "What other care is there?" It was just his work to him, embedded in his community. But that's what it was – that's what he was – home base for the people who needed him. And that is the image etched in my mind permanently as what health care is. The "medical home" in that sense for me is not a program or a component – it is the essence. It is my father's wood-paneled consulting room on Town Street in Moodus, across from the library. And "patient-centered care" is my father's car starting in the middle of the night.

- Today, of course, the context for all of that would be barely recognizable to my father. There were no computers. Heart attack patients went to bed for three weeks. Advanced practice nurses did not exist. Public accountability was non-existent; professions regulated professions, end of story. Generations X and Y and the millennials were not conceived, and their iPods and iPads were only in science fiction books. For half my father's career, there were no Medicare and Medicaid.

- Actually, my father would probably be quite angry today. He would want just to be left alone to do his work. But, he would also know that, in fact, wouldn't be possible anymore. Complexity, interdependency, technology, accountability, the imperatives of the economy would all now be too interwoven into his world and his patients' lives. But, he and

I would both know that there was something precious – essential - in what he did for our people and our town, and how he did it. I would want to help assure that – to rediscover that. To make his work once again possible. Can we recover Town Street, Moodus, or it is long and irretrievably gone?

- The world of commitment and caring that my father represents to me is not gone. It is far too important to lose. And I took this job to do whatever I can to make sure that it thrives.

- Let tell you another story. It's about what happened to me on the day I was sworn in – July 12th. I was in Boston – my home – at the time, and went to the Federal Building there for my swearing-in ceremony. I went through the Security inspection at the entrance, and, as I passed through the metal detector a rather burly security guard on the other side beckoned me. "Can I talk with you?" he said. "Of course you can," I answered, "you have a gun."

- He said, "You're Don Berwick, aren't you?" "How do you know?" I asked. "Because I study your website at the Institute for Healthcare Improvement."

- I was puzzled. He explained. "My name is John McCormick," he said, "like the tenor. My daughter, Taylor McCormick, died. She was 17 months old when she died because of a medical error. I want to spend the rest of my life trying to keep that from happening to any other child. And, I want to help you in your new job any way I can. Thank you."

- That's why I took the job. I want to make the care in America as good as we have every right to expect it should be. I see in CMS, and in the new law we now have in our hands, a chance to do that. I took it in honor of Taylor McCormick… even though I did not know her name until the day I was sworn in. I took it honor of my father.

- I want you to help me do that. I invite you to help me do that.

- CMS is a large organization, full of dedicated, capable staff, and with a superb leadership group. It is a very busy place. My mental model is coming to view CMS as carrying out three important assignments at once:

    - Running a large, effective health care insurance system – with $850 billion per year of payments, hundreds of contracts, and millions of relationships. The staff are superb – dedicated, expert, and hard-working.

    - Implementing the new Affordable Care Act. This task is also formidable. And… CMS has not missed one single deadline. I am in awe.

    - We have an important third job, as well – and it's personal, because it's so much the job I came here to do. It's my main focus: helping to change health care in America to realize its full potential. And that's what I'm going to talk most about with you this morning.

- Please keep in mind that these are early thoughts. None of this is set in stone. I am sharing my initial impressions and my preliminary plans, only.

- I'll start where I will end: We need your help. Our nation needs your help. You have and will have a profound influence on the direction our country will take in the crucial next few years. The folks gathered here today --the company CEOs and the COOs, the Medicare and Medicaid contractors, the Medical Directors, Long-term Care Professionals, Drug Benefit managers, and the regulators, legal counsel, and the quality assurance professionals – you are – or you can be – keys to success.

- AHIP - with its 1,300 members -- providing insurance to more than 200 million Americans – can be an essential partner in navigating American health care to the destination our country needs. I think we should work together on that.

The Affordable Care Act

- By any stretch, the Affordable Care Act is a landmark. It promises to be a turning point in access, coverage, quality, and cost of health care in our nation.

- The Affordable Care Act is the most significant health care legislation since Medicare and Medicaid were created. It is an answer.

- It is an answer to the worries of the 32 million Americans who lack the peace of mind and access that come with health care insurance.

- It closes -- over time -- the Medicare prescription drug “donut hole” for tens of millions of beneficiaries who without might have to forego their medicines. We mailed our 1 millionth $250 rebate check two weeks ago.

- It offers coverage to young adults under age 26 through their parents’ policies.

- And it answers the needs of many people with chronic illnesses and pre-existing conditions who, without this new law, are excluded from the health insurance market.

- It helps small businesses make health care insurance available through subsidies.

- And it helps millions of people at the margins of low income to find and afford insurance with the health insurance exchanges and meaningful assistance.

- The new law is an answer to those who want health care in America to be, not just more available, but better – higher quality – for patients and families.

- It uses innovative and constructive forms of payment – payment on the basis of quality of care, payment for preventive care, and payment for new and bold demonstration projects.

- It fosters creativity by establishing a new Center for Innovation to encourage and support new ways to fund and deliver care.

- It invests heavily in modern versions of integrated care – Accountable Care Organizations (ACO's) and medical homes.

The Affordable Care Act – The Question

- But, make no mistake, the Affordable Care Act is not just an answer; it is also a question. It is a question to every single one of us, both inside government and, more importantly, outside government. The question is this: "Will we redesign health care in America?" Will we reshape it together so that every single American can count on getting exactly the care they need and want exactly when and how they need and want it, every single time, at a cost we can afford?

- That is my intent in CMS on my watch. It is to help CMS become a major force for the continual improvement of health and health care for all Americans.

- But getting this right – that third task – creating the health and health care we need – is not a task that CMS, alone, could hope to achieve. It will take us all. You, too.

- We need badly a common aim for what we want American health care to accomplish, and a common vision of the health care system that can do that.

The Affordable Care Act - The Problems

- That vision is embedded in the Affordable Care Act, and we need to make it a reality – a vision of a responsive and continually improving health care system available to Americans at a sustainable cost.

- Progress can only start by facing the reality – all together – the stark and clear fact that our care delivery system in its current form is not up to the job. We cannot with our current system of care give Americans the care they want, need, and deserve.

- The problems do not lie in any failure of good will, benign intentions, or skills of our doctors, nurses, health care managers, or staffs. With rare exceptions, they are doing their best.

- The problems lie in the design of the care systems in which they work, systems never built for the levels of reliability, safety, patient-centeredness, efficiency, or equity that we owe to ourselves and our neighbors.

- This is the conclusion reached by the Institute of Medicine in its landmark 2001 report called, *Crossing the Quality Chasm*, which declared, based on a massive review of data and evidence, that: "Between the health care we have and the care we could have lies not just a gap, but a chasm."

- The Institute of Medicine labeled the six aims for improvement as: safety, effectiveness, patient-centeredness, timeliness, efficiency, and equity.

- The care we *could* have is care with no needless deaths, no needless pain or suffering, no helplessness for those served or those serving, no

unwanted delays, and no waste; it is care that leaves no one behind – that leaves no one out.

- This is possible. All over America, there are today hospitals, clinics, and office practices that are moving steadily toward dramatically better care. They are our pioneers.

- I am thinking of examples like Dr. Anthony DiGioia, an orthopedic surgeon at the University of Pittsburgh Medical Center, whose program of patient-centered care now gets patients with total hip and total knee replacement surgery out of the hospital and safely back home, walking, in less than three days -- on average -- with nearly zero complications and nearly 100% patient and family satisfaction.

- I am thinking of community health centers, like Clinica Campesina in Denver, whose care of diabetics is approaching perfection.

- And, the safety-net hospitals like Denver Health, where costs have fallen by tens of millions of dollars by smoothing the flow for patients and staff with modern methods of lean production.

- In fact, I am thinking of hundreds of places and thousands of people. My career for the past 30 years has been blessed by the chance to work with thrilling, breakthrough examples of better care – safer, more effective, more patient-centered, timelier, more efficient, and more equitable. Hundreds and hundreds of examples.

- In the best of your work as companies sponsoring creative new forms of care management, you are discovering and inventing successful models, as well. You, too, have the seeds of optimism in your hands.

- And “optimism” is the crucial resource. It is crucially important for our nation to recognize the unfortunate fact that the care we want is not yet with us, but it equally – even more –important to recognize the hopeful fact

that the care we want and need is not at all out of reach. We can have what our society requires: better care and less costly care at the same time. We can close the chasm.

- With the Affordable Care Act in place, more than ever, that vision is attainable. But, to attain it, we will have to change.

- You don't get this level of improvement simply by trying harder the old way. You get it by finding a new way.

- I think it was Albert Einstein who said, "Insanity is doing the same thing over and over again, and expecting different results."

- Or, as we say in the world of quality improvement, "Every system is perfectly designed to achieve exactly the results it gets." If we want new results – and we do – we need a new system. All improvement is change.

- And so that brings me back to the question that the Affordable Care Act poses: "Will we change?" "Will we redesign health care in America?"

- That question will be answered, if at all, not primarily by government – and certainly not by government, alone.

- The job of changing care – for the benefit of our people and our society – belongs properly, first and foremost, to those of us who give care – professionals, health care organizations – encouraged and supported by those who arrange for them to give care – insurers, employers, and communities.

<u>The Triple Aim – The Answer</u>

- What should that redesign accomplish? I have written about, and I recommend, a set of goals that I call, "The Triple Aim."

- The Triple Aim refers to three goals at once:

- (a) better care for individuals – as described by all six dimensions of quality in the Institute of Medicine report: safety, effectiveness, patient-centeredness, timeliness, efficiency, and equity;

- (b) better health for populations with respect to the upstream causes of so much of our ill health – like poor nutrition, physical inactivity, substance abuse and unwise behavioral choices, violence, and economic disparities; and

- (c) reducing *per capita* costs by eliminating waste and needless hassles… and, hear me clearly, specifically *not* by withholding from us or our neighbors any care that helps then – specifically *not* by harming a hair on any patient's head.

- I invite stakeholders throughout health care to rally around the Triple Aim, and to begin, together, to make the changes that allow for it.

- I am trying to focus the attention of my CMS colleagues on three arenas of strategic priority for starters: acute care, integrated care, and community-based prevention… with specific aims for improvement in each.

<u>One</u>

- First, we need to make the quality of care in hospitals and outpatient clinical settings better – *much* better – everywhere, and for everyone. The Institute of Medicine's Six Aims provide the proper framework for action and assessment.

- Let's start with safety. That's about Taylor McCormick. The IOM's report on patient safety – To *Err Is Human* – is over ten years old now, and we still lack the firm national commitment to make the safest care the standard care everywhere – no matter where an American patient goes.

- It is time for a rededication to safe care, and I urge that we aim now for a major and immediate reduction in medical injuries to American patients in hospitals.

- Equally, we owe our patients everywhere reliable care – so that every single person can count on care that accords with the best known science.

- I am not in favor of a health care system in which patients and families roll dice on the quality of the care they get depending on where they happen to go.

- We also owe ourselves patient-centered care, in which each human being is treated with dignity and respect for their own, unique characteristics and preferences.

Two

- Second, we need to make substantial and prompt progress toward better-integrated care – care that makes sense to patients and families, so that they don't feel lost and forgotten and confused as they make their way through our complex systems.

- We owe them journeys, not fragments.

- That is the only possible way that people with chronic illness or disabilities can get what they really need.

- Too many of us know what fragmented, disorganized care looks like. You have to tell your name and address and story again and again to everyone you see. No one seems to talk to each other. Your record is forgotten or unavailable. One doctor prescribes a medicine that conflicts with a medicine another doctor prescribed. You wait endlessly on hold, and you can't get the answer to your question. It's all in fragments. And you and your loved ones are holding the bag.

- How does that happen? Fragmentation is the cause. The great systems theorist, Professor Russell Ackoff, once, tongue in check, proposed to build the best car in the world.

- He would find the best of every part –the brakes from a Jaguar, the door from a Volvo, the fuel system from a Camaro, the suspension of a BMW, and so on. Then he would assemble them, and "voila!" – The best car in the world.

- But any five-year-old can tell you what will happen. It won't work. The parts won't fit together. A car isn't just a collection of parts; it is a system of interacting parts. That's why cars need designs. And that's why health care needs design, too. "Everyone does their best" is a bad plan. The right plan is, "Everyone does their best together."

Three

- Third, we shouldn't be waiting for problems – we should be preventing them. And that means tackling the causes of illness where those causes lie – in our communities, our habits, our social supports, our choices – where we live.

- America is seriously under-invested in using what we know about preventing illness, and we therefore live with the chronic epidemics of obesity, heart disease, asthma, and depression, for example, that we don't need to live with.

- As the commercial says, "You can pay me now, or you can pay me later." And prevention, if we get serious about it, is a big, big bargain.

- I intend to guide CMS toward the Triple Aim as our highest-level goal – better care, better health, and lower *per capita* costs, and I intend to focus our energies, as much as I can, on those three levels of excellence: excellence in care (all six IOM aims), excellence in integration, and excellence in prevention at the community level.

- The glue that will allow us to work together constructively, each doing our share, will be shared goals. Today, what I have offered is mainly narrative – philosophy – and sense of direction. It will acquire meaning and promise if, and only if, we can tether the intent to specific aims – goals for our nation.

    - I urge safety – for our patients and staff. But how safe? How much less injury? By when?

    - I urge patient-centered care. But how will we know when we have truly given patients and families the dignity and control they want over their lives and care? And how much dignity? And by when?

    - I urge reliability. I think every patient in America should be guaranteed to benefit of the best science for their needs. No rolling dice. But, how much reliability? For which conditions? By when?

    - I urge working up stream on the conditions that make us ill – obesity, risks, violence, and unsafe habits. But, how much prevention? How much of a reduction in the obesity epidemic? Where? By when?

    - And I urge lower costs, without harming a hair on any patient's head. How much lower? Where? By when?

- I will be working hard with my CMS and HHS colleagues in the weeks ahead to clarify goals like those, and I will urge us as an agency to measure our own success by the yardstick of progress toward the goals we establish and share.

- What we in CMS can do, and what, on my watch, we will do, is to make it more and more feasible for stakeholders of good intent – especially when they act together – to join us in those goals, and to find and adopt their own, best approaches to the Triple Aim.

- CMS can help by adjusting payment methods to support that, by assuring sound and useful measurement of progress, by making it easier and easier for people to find best practices in their own neighborhoods and across the nation, by providing intellectual capital with our own Innovation Center, and, where we can, the venture capital so that people can take the risks they need to take to learn as fast as possible – we frankly don't have much time.

- We can host and encourage consortia of effort, so that organizations and people who are trying to do similar things can learn together from each other.

- And, when we need to, we can and we will establish and enforce accountabilities – as a purchaser of care for over 100 million Americans, we in CMS have a duty to do that.

- We will help. We will encourage. And we will carefully watch.

- And we can do that with you, too. We can make far more progress as a nation all together than if we work at cross purposes and apart. Far more progress if we work in full partnership with the clinicians and organizations that give the care, and hand in hand with the patients, families, and communities whom we serve. Far more progress if we agree on what we intend together to accomplish, for whom, by when, and where.

Conclusion

- None of this will be easy. All of us will have to change the way we do business. And there's plenty of work ahead.

- To quote Thomas Edison –"Opportunity is missed by most people because it is dressed in overalls and looks like work. "

- I cannot do this alone. CMS cannot do this alone. And government cannot do this alone.

- We will either build the new health care system for America together – professions, organizations, associations, insurers, employers, and communities – together – or we will not build it at all.

- This will not require – it will not yield to – a massive, top-down, national project. That's not the way to do it. The successful redesign of health care is a community-by-community task. That's technically and morally correct, because, in the end, each local community, and only each local community has the knowledge and skills to define and deliver what is locally right.

- The solutions for Albuquerque will not be the same as for Augusta, and the solutions for inner-city New York will be different from those for rural Montana.

- What they will have in common will be the promises they make: better care, better health, and lower cost – for all.

- What I ask for is partnership. I would like to help forge an unprecedented level of shared aim, shared vision, and synergy in action among the public and private stewards and leaders of health care.

- My door is wide open to the associations, delivery systems, professions, and other leaders who will join, authentically, in pursuit of the Triple Aim for America.

- Let me be clear, in closing, about one final, serious matter: *authenticity.* Authenticity matters. Those who wish only to preserve the *status quo* are not going to be constructive contributors to our nation's future. They cannot be effective partners, and we simply do not have time to pretend that they are. We just do not have time for games anymore.

- But those who agree that now is the historic opportunity – perhaps the last in my lifetime – to navigate our nation to better care, better health, and lower *per capita* cost – to navigate us to the care we can be proud and confident to hand to our children – those who welcome change and will agree to lead it will find a friend in me, levers in the new law, and gratitude in communities they serve.

- Thank you for this opportunity to give a glimpse of my vision for CMS and an outline of our agency priorities in the years ahead.

- Now, I look forward to hearing from you, Karen – if you'd like to open this up for a few questions.

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