THE BROOKINGS INSTITUTION

ACCELERATING HEALTH CARE INNOVATION TO ACHIEVE SYSTEM-WIDE IMPACT

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Keynote Speaker:

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P R O C E E D I N G S

MR. MCCLELLAN: All right. While our panelists are getting back to their seats, and please, if you're able to stay, I know some people have other obligations, if you're able to stay, we have some seats here in the front row for you.

I will introduce our next speaker, and that is an old friend and colleague of mine, Don Berwick. And now that we've talked some about what's needed for evaluating and implementing pilots and then moving down this path towards actual effective dissemination, we're going to talk more specifically about not just where CMI fits in, but about where all of the initiatives that CMS and the rest of the health care system fit in, as well.

And to help us launch this discussion, we're honored to have Don Berwick with us today. Don, as all of you know, is the Administrator for CMS, he comes to CMS from the Institute for Health Care Improvement, and prior to that, worked as Chair of the National Advisory Council for the Agency for Health Care Research and Quality, and also has worked extensively with the IOM and with many, many health care organizations around the country to try to close these gaps in quality and efficiency, so please join me in welcoming Doctor Berwick. Don.

MR. BERWICK: Thank you so much, Mark. It's a pleasure to be here and always a pleasure to visit Brookings. And I want to begin by thanking Mark personally. I don't know a friend I have around the country who's been a better mentor or a guide to me as I've tried to get into my position, and, in fact, through many years of thinking together about health care policy and the future of health care in our country, I am deeply indebted to Mark and to the Engelberg Center for its leadership.

The intellectual energy and creativity that's coming out of this institution is second to none and helps me all the time as I try to think through the challenges that my colleagues and I in CMS are facing.

I have read the materials that have been prepared for this meeting and sat in on part of the panel we just heard, and I'm less and less sure that I have anything to offer you that you haven't already gotten. You've got the best thinkers that I know together to try to come to some better understanding of how this wonderful new venture, the Center for Medicare and

Medicaid Innovation, can be the kind of engine for change and support to leaders around the country that I fully believe it was created to become, and I fully intend to try to birth it properly.

I thought what I would do is just take a few minutes to give you a setting in a larger context in CMS as I now have come to know it. I'm three months into the job, I think my three month anniversary just passed, so I'm not quite a veteran, but a little bit more oriented to where the bathrooms are, and I'm learning a lot.

I continue to find the job absolutely thrilling. It's an incredible organization, an amazing time in history, and a wonderful set of opportunities that we face, and I'm blessed by colleagues, top to front line in that organization who inspire me every day of getting out to every region that I possibly can, I plan to visit them all in the next few months, and I spend time just in the presence of people who couldn't be more committed to making health care in this country have the opportunity to become everything we want it to be, it's terrific.

It's sort of three places right now if you want to get a scene of what CMS is like. Place number one is the insurance company. It, as you know, pays out over $800 billion a year in support of health care delivery for 100 million people, and it has hundreds, thousands of contracts of various sorts, it's quite a large enterprise of that type, very experienced, very skilled.

And the staff that I meet and get to work with I'm in awe of as I watch them manage the processes of that large and important American asset.

The second thing it is now is, the agency with the lion's share of the duty to implement the Affordable Care Act. I think about 70 percent of the elements of the Affordable Care Act get implemented through rulemaking and other processes within CMS.

I arrived when that was already well up and running. It's hit every major deadline. Again, I stand back in awe of a staff that can add that important assignment to their previously full-time jobs. They're doing an amazing job.

The whole process of rulemaking with the Affordable Care Act I must say is absolutely fascinating. It's rich in opportunities and texture, and as we think through the details of how to make it move into reality, it's a thrilling role. But the third job is the one that I'm here to

talk about really, and it's most pertinent to CMMI, as we're now trying to call it, and it's the job of helping American health care get better.

I have proposed to the staff all through the agency a kind of vision statement that I'd like to pursue in my time there, it's that CMS is a major force and a trustworthy partner for the continual improvement of health care and health for all Americans.

I'm actually building without any shame at all on Mark's leadership when he was there as he tried to understand CMS as a public health agency, and this is really just a more detailed vision, a major force and a trustworthy partner for the continual improvement of health and health care for all Americans.

I say for all Americans not because we will take our eye off the ball for beneficiaries, we will not, they're our major charge, but as you all know, when CMS acts well, it can be a leader and can cut a pathway for others in the country who have other populations that they're stewards of for better and better care.

The core definitions of better health and health care that I carry around tattooed on my body you've heard from Rick, and that's the Triple Aim. Triple Aim, I want to give it its true providence, it was a term that I believe was originally proposed to me by John Whittington, a physician in Peoria, Illinois, who worked in the organization that I previously was associated with, the Institute for Health Care Improvement.

It is equally credible to Tom Nolan, one of the great thinkers in our country, a colleague of mine also from IHI. So John and Tom originally proposed this concept of organizing system development thinking around the Triple Aim.

Rick talked to you about the Triple Aim, and let me bore you by revisiting it for a moment and just try to be clear about how I conceive of it, because it's the centerpiece for the self image, the definition of success for CMS as the – during my leadership.

Triple Aim refers, as you've seen, to three goals. The first is better care for individuals, patients and people who could become patients tomorrow. Better care has very strong definitions. Now, thanks to the leadership work of these two to medicine at the turn of the century, in 1999, with a report, To Err is Human, and in 2001, with a report, Crossing the Quality

Chasm, a committee on which I served, the Committee on Quality Care in America, and indeed, chaired the Subcommittee on Aims, on system redesign and change, laid out six dimensions, which, to me, provide the vector of possibility and directionality for our improvements. They were, as you know, safety, that means not harming people when they're in our hands and care.

Effectiveness, which is essentially aligning care with the best known knowledge, the best science, so that we guarantee to patients the benefit of the care that can help them and do not subject them at their own risk to care that cannot help them, that's what effectiveness means.

It's in the old days, in the Institute of Medicine, it was called avoiding overuse and under use, because it referred to finding of care with knowledge.

The third aim is patient centeredness, a topic on which I wrote about in Health Affairs before I had this job at some length. The patient centeredness refers really to control, it has to do with offering people in care and their loved ones a chance to really control what happens to them, to make the choices that they care about, to have respect for the diversity and individuality in care, to give them the knowledge through which to heal themselves as much as they wish to and can, to make wise choices, but it's mainly control. Patient centeredness is care in which we, the deliverers of care, are servant to the people we serve.

I have said it in the past that it is configuring our role as guests in patients' lives instead of hosts in our institutions. The fourth is timeliness. It's the – one of the most modern attributes of excellence around the world; is that we don't waste time. We deliver what is needed when and how it's needed because delay itself is waste and in the case of healthcare delay, unwanted delay is, in fact, risk and hazard. So the ability to make care flow smoothly over time and space is a core quality process, a quality attribute.

The fifth is efficiency. And that's the reduction of waste, in all of its forms, wasted supplies, wasted material, wasted time, waste of ideas, waste of spirit and moral. It's viewing the world as a place of abundance but, in which we're not privileged to fail to make sure that we do matches need.

The avoidance of waste is now been represented in modern leadership and management as lean production, lean thinking. It's the ability to bring a sense of flow and evenness and responsiveness into all kinds of systems. And we now know in the global basis if one wants to be successful in almost any industry, you better think lean; so most healthcare.

And finally, equity, which were I going to write the report again, I might have put that number one. It's the closing of racial and socioeconomic gaps in health status in our country so that it becomes no longer true that once race or wealth predicts ones' health, which is now, of course, a major predictor of health.

The Institute of Medicine laid out those six aims for improvement in the Crossing the Quality Chasm Report; safety effectiveness, patient centeredness, timeliness, efficiency, and equity. And that defines one corner of the Triple Aim, one of three; care -- it's better when you need care.

The second corner is better health. Better health for populations from the population perspective, often achieved through interventions with individuals and clinical preventive services, but otherwise achieved also by making our communities and environments more conducive to what we want, health robustness, longevity, the ability to maximize the use of our time and talents.

We know from the work of Evans and Stoddart, and David Kindig, and so many other leaders' understandings of epidemiology and public health in the past, how little leverage healthcare has on health. The figure is about 10 percent.

If you look at the variance in health status within any population and attribute that variance to cause, about 10 percent of the variance will be attributable to variations in healthcare. The rest is attributable to variations in genetics, environment, risk behavioral choices, much of which we can do something about.

And so if we are serious about a healthcare system, which is in fact partnered in producing the end result we want which is to be healthy, then I don't think we have the privilege of saying we won't work conscientiously as at least a good partner, and maybe even a leader with

respect to the generators of ill health. We have to take that seriously. And the enterprise of healthy populations is a more expansive one than the enterprise of good individual healthcare.

And the third part of the Triple Aims is lower cost, reduction of cost, measured as you wish, per capita or otherwise. And I want to make it very clear. It's reduction of cost without harming a hair on anyone's head. No one gets harmed; no patient, no community, no loved one.

It is about the reduction of cost through improvement and that's the modern view of – approach to that aim. Why do it? Because medicine is a shareholder in public goods. It's a shareholder of opportunity in which other opportunities exist as well in other sectors; education, the environment, and infrastructure, and other things we care about, museums, roads, and fun in life. Viewing ourselves as a shareholder makes us less entitled to any share we can get and should make us more interested in prudent approaches to the reduction of cost through improvement itself.

When the Triple Aim was first brought to my attention, better care, better health, and lower cost through improvement, the other thing brought to my attention is that to be able to execute change, leadership, on such a complex collection of aims requires stewardship. That is, it would be unlikely that the Triple Aim would be achieved unless someone is there to achieve it. And the question is who. Who has the Triple Aim on their screen?

The challenge we face is that in a system as we built it, it's hard to find a steward of all three. We can find stewards of any one, which indeed produces conflict as debate and controversy emerges around whose aim is the more important.

Only through stewardship of the three aims as a system, all together, with organizations and leaders and communities who understand that all three count and that achievement of all three with appropriate weightings on them is socially desirable. Only through leadership of that type would one predict that the Triple Aim is – can be placed within our grasp.

I believe and hope that CMS can be one among the parties in our nation that can assume some level of stewardship of the Triple Aim, all of it together. It can't be done alone though.

There's no agency and government, CMS or other, in fact probably no single organization in society that can alone achieve that result: better care, better health, and lower cost. There has to be some sense, in my view, of a strong partnership; a strong shared view of the Triple Aim as our compass.

In my learning to lead at CMS, probably no word is more important to me than partnership or cooperation. It's reaching across; it's creating a common table at which we all can get done for society what we need to.

The Affordable Care Act in this context is certainly an answer to some people. It's an answer to 32 million people who have insurance who otherwise would be in the – with laws implemented, don't have insurance, would wake up in the morning worrying that they'd become bankrupt, now they won't. They'll have insurance.

It's an answer to people with chronic illness because it offers opportunities for integrated and seamless care. It's an answer for young people who now can be covered under their parents' insurance policies, an answer to people who fear that they can't afford drugs as we close the donut hole; lots of answers.

But it's a sort of bigger idea to me that the Affordable Care Act is a trampoline; it's a – it provides the nation an opportunity, through many of its mechanisms, to do what we need to do which is to change healthcare together, all together, not anyone doing it to someone else but – but to reinvent the care in the direction that we or our loved ones as patients, and families, and stewards of the Triple Aim care about.

That change process, that finding the better way, is at the heart of what the Affordable Care Act makes possible. It makes it possible in many, many different ways; through new payment mechanisms, demonstration authorities, very rational changes in the way we are providing incentives and payment.

But one of the – the jewel in the crown, the biggest opportunity perhaps in the entire new law for invention and discovery together of the care system that can achieve the Triple Aim, is the Center for Medicare and Medicaid Innovation.

In the seven pages that describe it, in Section 3021 of that law, an extraordinary opportunity is created under extraordinarily exciting circumstances. The purpose of this institute is to test innovative payment and service delivery models to reduce program expenditures, lower costs, while preserving or enhancing the quality of care through improvement. It's exactly what I feel excited to have been able to take on as the Head of this agency.

It suspends the budget neutrality requirement in important ways for this to be explored and discovered. It provides a lot of funding; $10 billion of funding over the first 10 years. And it will, if properly carried out, become an American trampoline for better care, better health, and lower cost.

I was absolutely thrilled when Rick Gilfillan, whom you've met now, agreed to take on the job of setting up this Center. Rick was already working closely with the CMS Deputy Administrators. He had a range of very important responsibilities which he was fully engaged in when I arrived.

He's someone I've known for a long time because of his work prior to this with Geisinger where I came to know him. I know his quality, I know his thinking, and I know his mastery of a lot of the principles of change, and design, and improvement that underlie proper discovery.

At Geisinger he helped design bundled payment, the episode of care reimbursement plan, and this amazing thing at Geisinger, proven care, which is probably one of the most important achievements in the country with respect to reliability of healthcare producing better results for patients with highly reliable processes and very complex forms of care. I could not have had the opportunity to find a better colleague than Rick to set this up.

What it will do now is with the questions on the table for you, Rick and I both look forward to your advice. We're working very hard on this. It's taking more time, more of my time, to think through CMMI with Rick than almost anything else I'm doing right now. It's really exciting.

I don't know where we'll end up and I don't want to trump any better ideas you have here. The way I'm thinking about it right now though, briefly, is that we want innovation, we

want better models, we want healthcare that can achieve more than it can in its current configuration.

We'll have to stratify the redesigned challenge I believe and that's what Rick and I are talking about. For starters, I am thinking about three kinds of stratification. The first, I would call is entity level improvement. We know virtually how to eliminate pressure ulcers in this country. There are scourage; if you've ever had a relative or a loved one with one you know the pain, and the cost, and the disability.

We have organizations in this country, Extension Health for example, the hospital system Midwest that has reduced pressure ulcers by 80 or 85 percent, even more. We know how to eliminate many important kinds of infections. We know how to eliminate hazards in medication administration. We know a ton.

What we don't know is how to make the best the standard. How to move excellence of the type we really understand at the level of delivery of care, be it a nursing home, a hospital, or a clinical office, to become the norm.

That itself is innovation; to be able to think about how the best becomes the norm is one example of entity level improvement that I think we can discover our way toward with appropriate support; not against anybody, but with lots of people, in fact with everyone if we can.

Rick and his panel comments talked about the excitement of thinking about the processes of diffusion and spread themselves as the object of innovation and that's a good case. It's not that all entity level solutions are in hand; they're not. We don't – we haven't anywhere near explored the full impact of lean thinking, and lean production in – in healthcare systems and we can do that.

And there are many forms of complication, and disability, and hazard, and imperfection that – into the healthcare system that can be dealt with through proper design and redesign, change, under clinical leadership and with the full participation of patients, and families, and entities.

The second level is probably the most charismatic right now and that's seamless coordinated care, integrated care. It's being able to construct journeys for patients through their

illnesses and lives because so many of us now live in this country with conditions that we'll live with for the rest of our lives. The chronically ill, 10 percent or 15 percent among us right now, will absorb 70 percent of the costs and their journeys are fragmented right now. Their journeys that make less sense than the patients and families wish they did and less sense on the caregivers wish they could.

When we talk about accountable care organizations, or bundled payment, or medical homes, or health homes, what we're using are words that encode a dream, which is to have care that's seamless and coordinated at every level so that we can live full lives in the least possible pain with the least possible dysfunction and that can't be done within entities. That can be done across entities and among components of care and communities to craft journeys.

We don't know how to do that, not as well as we wish. We have great prototypes around; we have enormous successes around the country, which I have seen many of in my prior life before I arrived at CMS. And I believe that we can build on a great foundation of progress but only if we think very, very hard and are able to support creativity throughout the country to adapt healthcare and community systems to produce this seamless coordinated care.

The one thing we know about integration is one size won't fit all. I don't know how many sizes we'd need in this country but it's probably more like a dozen because the integrated care that will function in inner city Manhattan, won't work in suburban Chevy Chase, and that won't work in rural Montana.

We're going to have to figure out what integration looks like, customized to section, to – customized to segment, customized to context, and under the control of local context because the best innovations will surface from communities that solve the coordination problems themselves instead of from the top down solutions. The CMMI, if it does the kind of work I think it will, will be a font of support and encouragement for local way finding toward the kind of seamlessness that we want for ourselves, which will have associated with it better care, better health, and lower cost through improvement.

The third arenas, in some ways the most difficult, and it's innovation and prevention, innovation and population based health. I think to some extent, our would be

investment, our intended grappling with the generators of ill health, obesity, behavioral choices, risky behaviors, violence in society, disparity, nutritional challenges, and so on, that these – these agents of ill health we know to be the enemy. We know them to be the appropriate targets of true innovation toward health in our country.

I'm not sure we grapple them seriously enough though. I think if you look at the level of investment and the degree of inventiveness, one looks rather far before discovering the future that we really want to discover in pursuit of population based health.

I would like to see CMMI, in some important respect, have as part of its portfolio energizing and making more serious and more successful investments in the population level and what we really ought to mean by population health, and community health, and that will take us far and wide. Perhaps, far out of healthcare but still will (inaudible) to pursuit of the Triple Aim; better care, better health, and lower cost through improvement.

I just say in closing it cannot be done alone. It cannot be done alone. There's no – there is no possibility that CMS alone, even with leadership as fine as Rick's, will get this job done.

We're going to have to find a platform for partnership that leverages the commitment and the resources of all of the components that care about healthcare; the patients, and families, and communities, the payer community insurers, those who deliver care no matter in what kind of institution or with what degree after their name. The private sector widely writ including employers, government, to whatever extent it can. All of us who care about the future will better do this together than separately.

I'll close with a little thing. This is probably – probably less useful – the least useful thing I'll say but I can't help sharing it. So I've been trying to articulate this to the staff at CMS and will be doing more of that. They're ready, I mean everyone is just gangbusters to try to make care better together. And – but it's a little scary because we're into new terrain here; a little bit different self image, and rethinking investments, and even measures of success.

Sister Mary Jean Ryan, the former CEO of SSM Health System and a friend of mine, some a couple of years ago sent me a little poem that she said was her favorite poem,

which I'm using there and a little bit about what I hope is somewhere on the – the threshold to the Center for Medicare and Medicaid Innovation. The poem goes like this. "Leap, he said. The people said we are afraid. So he pushed them and they flew." Thanks.

MR. MCCLELLAN: Don, thanks very much. It covered a lot of ground in your remarks. That's the first time I've heard the ACA analogy to a trampoline. I'm sure it feels like that in more ways than one.

But I think the main context in which you're talking about that analogy was in doing things together; that you can create more momentum, most boost, more lift, more of a – more of that successful jump, flying that you were talking about at the end if you're able to leverage partners.

And you talked a lot about partnership in your remarks. I wonder if you might say a little bit more about your sense of how that's going so far. Where have been the bright spots? Where you think more – more really needs to happen?

MR. BERWICK: It's – it's all bright. The, you know, people have asked me what has been the biggest surprises taking over your job. The biggest is probably the staff. I mean an incredible group of people are in that agency, as you know, Mark, the spirit and the commitment is just stunning and I'm so privileged to go to work in the morning and meet those people.

But the other is the conversations of the people coming to see me from any sector. I'm talking about the insurance sector, the private industry, the deliverers of care, the Trade Associations, the professional societies, patients' groups.

Everyone has the same first question when they come in the office which is how can I help you or how can I help. The – the – I believe we're at a – there's a national sense of possibility and need that are converging in – in a moment of unfreezing that I think is extraordinary.

The possibility of partnership is enormous. The platforms are hard to construct. Even something as simple as measurement, where I know you and I are talking all of the time about rationalizing the way we actually assess our progress. If we're serious about the Triple

Aim, if we're serious about patient safety; why would we approach it with 20 different portfolios of measurement? Why wouldn't we align?

Well, the mechanics of setting up public private relationships which allow us to finally come together and agree on – in a sensible direction, that's very tough. Aligning payment, you know, making sure that we're talking to each other enough is – is difficult. But I'm completely optimistic about it and the will seems enormous right now.

MR. MCCLELLAN: Great; thanks. And Don has been gracious enough to stay for a few questions. So if we have some – and I see a couple here in the audience; go ahead.

MS. POPLIN: Hi, I'm Doctor Caroline Poplin. I'm a Primary Care Physician. One thing that hasn't been mentioned so far is what we used to call the Arms Race. As a driver of over utilization and excess cost, you know, one cardiology practice gets a 64-slice scanner and then everybody else has to have one and once those scanners are in place they have to be used if they're to be paid for.

Now, in addition, we have specialty hospitals specializing in cardiology procedures and orthopedic procedures and once they're built, they have to be used. So is CMS thinking of doing anything about that?

MR. BERWICK: If you pay for fragments you get fragments and each sub element, proud of its work and trying to do well, perfects its local work. The idea and systems thinking is you don't necessarily get excellent entireties, excellent wholes from excellent parts.

We'll need to navigate our way as a country into more thinking about systematic cooperation and it's kind of like weaving a net underneath the patients and families. So we're holding them all together instead of separately and I think that's the agenda.

Yes, I'm concerned about anything that's done to or for patients that doesn't help them, which in fact, subjects them to risks, and exposures, and radiation, and side effects that they don't need or want and we have to take a very careful look at that.

The more we move toward attempting to define and purchase on behalf of patients and families what they want, which is health, function, comfort, the relief of confusion, and are orienting payment and purchase toward results than the more sense will the pieces make

that come together to produce those results. And a lot about the Affordable Care Act, a lot about the policy directions in CMS and in the private sector are more and more trying to find our way to results, value, and outcomes instead of simply event after event after event.

MR. MCCLELLAN: All right; one more up here.

MR. WEST: Doctor Berwick, thank you very much for joining us. My name is John West and I'm the Health Policy Director with the Jewish Federations of North America. We have networks of nursing homes, hospitals, family and children's agencies.

I wanted to discuss an upcoming report with you of the Fiscal Commission and get your ideas on – your thoughts regarding what they are going to do. We hosted Alice Rivlin several weeks ago who said that the biggest point of concern for the Commission right now is Medicare and how we're going to finance Medicare in the next years and as well as decades. Can you offer some insight into how this innovation might be effected or pampered by the Fiscal Commission Report?

MR. BERWICK: Well like you I'll wait for the report. I think we have to see what – what's said and it'll be enormously important help to thinking about policy directions in the country. I think the best I can do is to state my – my confidence that if we stay focused on the wellbeing of patients and families and if we really support the interactions between patients and families and the good people caring for them or want to do the right thing, if we stay focused on values to make sure that every step taken is a step of helping, we will find our way to a healthcare system that is both of high quality and capable of producing the results wanted, oriented, I hope toward help, and sustainable, affordable, and it should be – Commission asked me, I would say focus on quality and we will find our way to proper stewardship and social resources as well.

MR. MCCLELLAN: Don, thanks very much for joining us today; really appreciate it. All right; so while Don's exiting I'd like to call up our next panelists. You know, you heard from Don a pretty broad vision for goals for improving care and how CMS and HHS can fit into that but that it's really about broader partnerships as well.