

**Centers for Medicare & Medicaid Services**  
**National Conference on Care Transitions**  
Friday, December 3, 2010

**Linda Magno:**

And I see that we're out of time for questions. And I'm going to go ahead and welcome our next speaker to the stage, as I said I'm not going to give you bios. Dr. Berwick is here to join us today and his bio is in the back, he is the Administrator of the Centers for Medicare and Medicaid Services. I'd like to have you join me in welcoming Dr. Berwick. Thank you very much.

**Dr. Donald Berwick:**

Thank you, Linda. It's a pleasure to be here with you and I apologize for being a bit late, the traffic coming into town was just more than I anticipated, so thanks for your patience with me. I wanted not to miss the chance to welcome you all here to tell you how excited I am about the work on care transitions and take a few minutes to put that work into context then I welcome some of your questions as you – as you pursue this most important task in reforming health care.

As I was driving here, I actually was remembering an experience I had many years ago, it was probably 15 or

20 years ago when I happened to be on service teaching at a children's hospital in Boston where I was on faculty. And it was my habit in those days to look for issues in quality with the residents and the medical students that I was teaching generally to try to find out how we were doing with patients and to orient those young people toward inquiry about the experience of care.

I had a sort of turning point experience in that context that's closely related to the work you're all here engaged to study and pursue. I walked into the room of a young boy named Kevin, a 15-year old boy. I had not met him before but I introduced myself as the attending physician, and I said to him, Kevin, you've been here often and I thought you might help us understand how to make our care better.

Kevin was 15, he had a syndrome called short bowel syndrome which I believe was from birth and due to surgery he didn't have a lot of intestine and therefore had to be very careful about his nutrition and was frequently in and out of the hospital dealing with challenges. He'd been in the hospital probably 30 times in his young life.

**Centers for Medicare & Medicaid Services**  
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Friday, December 3, 2010

But he was doing well and he said to me what all patients would say right at the start, he said - no, everything's fine, you're terrific here. And I said, I know that Kevin, we're terrific but surely something could be better, could you come up with anything? He said no, no you're fine. I said no Kevin, I'm insisting.

So he said OK, and he wrote on a piece of paper three things that I've kept with me for many years - his suggestions for how to be better. He said well OK, I have three requests. So the first thing he wrote down was please tell me what you're going to do before you do it to me. It's kind of hard to deal with the surprises and if you could just make a plan with me, I can do a little better.

His second question was, he said you know there are a lot of you – doctors and nurses all around me – do you ever talk to each other? He said it would be great if you talk to each other. And then his third thing he wrote down was, he said you know, I've been here a lot, in fact, I've probably been in the hospital more than you have. He said if you ask me what I think, I can help you. Wisdom from a 15-year old. Tell me what you're going to do

before you do it – make a plan; please talk to each other – be a team and ask me what I think – I can help too. In fact, it's my life not yours.

So we can call it care transitions, or continuity, or seamless care, or coordinated care or whatever that's what the heart of this is – it has to do with creating for people who try to help, the opportunity to plan, the sense of teamwork and the possibility of strong and ongoing partnership with family and their loved ones. I see the care transitions work as completely continuous with that vision of what care ought to be. We're in a very interesting time in American health care right now, all of us together, not just CMS a time of transition itself to the future care system we want.

If we think about that for a minute, we'll rediscover that the stewardship of transition, of continuity, is at the very heart of what our country needs. In the Centers for Medicare and Medicaid Services, I proposed when I arrived five months ago that we consider ourselves as a major force and a trustworthy partner for the continual improvement of health and health care in America. That

**Centers for Medicare & Medicaid Services**  
**National Conference on Care Transitions**  
Friday, December 3, 2010

CMS shouldn't see itself just as a payer, or just as a policy maker or regulator but rather more as a partner and a force for the improvement of care.

I've been working very hard with my colleagues against no resistance at all to make that a reality. What do we mean by improvement? Well, we have to reference the social need to realize what we mean by improvement. The social need is pretty clear, it's for three things, a three-part aim. First it's to meet Kevin's needs – it's to provide better care for individuals every day. We were chartered to do so already ten years ago by the Institute of Medicine in the Crossing the Quality Chasm report which gave definition to the pursuit of better care for people like Kevin. It said that when we are sick or well but in care, there are six dimensions to our experience that need improvement.

Safety – we shouldn't be harming people in care. Effectiveness -We should be assuring that care matches science. That we do everything we can for people that can help them and we don't subject them to care that can't help them. Patient-centeredness, which is what

Kevin was talking about - that's, I'm the boss. I know a lot, let me be a full participant even the leader of my own care. Timeliness – delay is defect in health care as in any other industry. Efficiency- this refers to waste – wasting time and effort, redundancy and nonsense in care and Equity – closing racial and socio-economic gaps in health care. Safe, effective, patient-centered timely, efficient, equitable care. Society needs that. That's better care.

The second thing we need is not to be sick in the first place, and that's the pursuit of better health, and you know, as all Americans do at some level that the pursuit of health really doesn't lie in health care, that only 10 percent of the variation of health is attributed to care, most of the variation has to do with many other factors – genetic endowment but also social conditions, disparity, environmental threats, substance abuse, poor behavioral choices, obesity. These are not things that lie within the health care system. They lie outside of it but determine whether we get a heart attack and break our arm or have many of the diseases that afflict us. So we need better health.

**Centers for Medicare & Medicaid Services**  
**National Conference on Care Transitions**  
Friday, December 3, 2010

And the third thing is lower cost. That's on the screen, it has to be. We can't afford the health care system at its current level of expenditure, it's not sustainable. Just pick up the morning paper in the morning.

The modern view of improvement in which you are now part of the army- is the simultaneous pursuit of all three of those - better care, better health, and lower cost. Authentic assistance to the social needs of our country today, meaning the simultaneous pursuit of all of three of those and that's what I'm asking of CMS - better care, better health, lower cost - it defines what we want.

How do we get it? Well, one way to get it would be keep yelling at the system to do better. That violates an axiom I heard in Africa a couple of years ago working in Ghana where one of my colleagues there told me a proverb, that went roughly, weighing a pig does not make a pig fatter. The pursuit of better in any part of your life you already understand, whether it's tennis, chess, your marriage, cooking, quilting, or whatever you love to do, the pursuit of better doesn't involve yelling.

It doesn't involve weighing the pig. It involves

learning, growth, development. It involves figuring out how to hold the racquet a different way and trying that. How to add a little more paprika and see if that's better. How to sit down with your significant other and say how's it going?

Learning and change and improvement are all together in the modern view. When you're involved in the improvement of care transition you become learners and teachers and exchangers of knowledge. That's the pursuit of improvement. It's the method. If we want safe care? We'll have to give care differently to be safe.

We're not doing such a hot job of that apparently. If you read the New England Journal last week, Chris Landrigan and his colleagues produced a landmark study of progress toward safety in a state where a lots been invested in safety – North Carolina – showing that we're stalled, that patients are getting injured.

We need to end that. We need to make care safer. To do that will involve systematic, rapid, ambitious pursuit of different forms of care. Safer care so Kevin doesn't have an infection. So, he doesn't have to wait, so his dignity is

**Centers for Medicare & Medicaid Services**  
**National Conference on Care Transitions**  
Friday, December 3, 2010

respected.

So there's a whole set of changes around the pursuit of better care for individuals that would lead us to better if we are willing to change. The same goes for prevention. If we don't like the obesity characteristics in the country, I'll have to change the way we approach the problems of nutrition and the choices we make in our lives.

If we don't like the discontinuities in care, the fact that we drop the ball so often, that we don't speak to each other, that we don't ask the patient and family what they know and use that information, we're going to have to change the way we deal with people through time and space, also.

That's the hallmark of integration. It's the hallmark of proper management transition. So, all improvement is change, not all change is improvement, but all improvement is change and we – together, you and I – are after changes in the way we deal with the needs of people over time and space. And that's at the heart of the nature of transition.

Of all the changes we could make in care, probably

none are more leveraged than that. The reason is that so much of the need we're trying to meet lies among people who have chronic illness (inaudible) for a long time.

So many of the defects that have been introduced into care have to do with defects and handoffs. It happens as people move around. Kevin comes in hospitalization after hospitalization. It's the thread that knits all of that together, that keeps him healthy and safe and not the event and yet we have so long paid for events, paid for fragments and trained people within disciplines instead of working on what I know you all are working on – which is the sense of teamwork he was asking for.

Now we have the new law, the Affordable Care Act. It gives us so much leverage. As a student and advocate for improvement, what I see in that law are more tools and more opportunities than the country's ever had before for the pursuit of that reform, integration that I was talking where you want to get. It lies, of course, in coverage first. We can't get that unless we provide coverage in our country and now millions of more people will have the certainty and security that lies in having

**Centers for Medicare & Medicaid Services**  
**National Conference on Care Transitions**  
Friday, December 3, 2010

accessible and affordable insurance coverage, whether that happens through the exchanges or through expansion of Medicaid or through the ending of the use of preexisting conditions of coverage, all of which that law will put a stop to now.

So, coverage is essential, but it's not enough, because coverage of care in a system that's defective will only produce more widespread defects. And so, the changing of care is necessary in order to achieve what we want. And the law has in it all sorts of opportunities. They have incentives in the law for starters, for hospitals and caregivers. More and more over the years that that law will play out, we'll see more and more relationship between what they get paid and how well they do.

They'll be more interest in supporting them to pursuit of reliable care and continuous care, better outcomes through value-based purchasing, forms of reward, and contingencies in which hospitals that don't get safer will find themselves not rewarded for that.

But more importantly, I think, there are supports in the law, opportunities to help our country discover better and

better ways to give care. Not just weighing the pig, but taking care of it. The forms of that in the law are many. We have, for example, accountable care organizations, the reconceptualization of how we can support care on the Fee-For-Service side of Medicare to produce the kind of integrated care that Kevin was after when he said "Do you ever talk to each other?"

The accountable care organization answer is "Yes." We do and we will. We're a team. And that rule, the preliminary rule, the notice and proposed rule making will be out just after the turn of the year, I think. You'll see how we're trying to migrate payments and supports toward that form of accountability and the opportunity to integrate care.

We have the new Center for Dual Eligibles that (inaudible) is going to set up that will be announced informally shortly, but it's already in the works now. Forty percent of the cost of Medicaid in the state currently going to the care of dual eligibles. And the states are writhing in the costs right now. Well, the way out of that

**Centers for Medicare & Medicaid Services**  
**National Conference on Care Transitions**  
Friday, December 3, 2010

box is better care for dual eligibles, lower cost through improvement. We know it's possible. You know it's possible. And that center will be able to sponsor and support learning and change to help take care of dual eligibles, to integrate so we do talk to each other.

We have the new Center for Medicare and Medicaid Innovation, a tremendous, important national investment in supporting innovation all over the country, probably the most thrilling aspect of the law to me, is the way that can release the energies of the country to discover new things. And demonstration efforts, projects like the one that you are hearing about today that would allow ambitious, forward-thinking, change-oriented people who give care, organized care, to reorganize that care to better meet the needs of the people that need us the most.

Transitions, continuity, integration... Do you talk to each other? Do you ask me what I think? Will you make a plan and tell me what that's going to be in advance so we can do this together? All of that is absolutely at the heart of the kind of change and improvement in care that I think

we can achieve if we are systematic and ambitious about it.

So, thanks for your interest. You're going to learn a lot today, from each other most of all. And from scholars and others that are in the room. And I hope you'll stay closely involved with CMS and all of us as we try to navigate our country to what we need -- better care, better health, lower cost for improvement, all achieved through change. Diligent, respectful, collaborative change in the care that we offer. Thank you very much. I am happy to take questions. I'll do my best with them. There are mics on the side here.