My Work: Managing Interfaces

States

CMS Administrator

The Press

Congress

CMS Staff

CMS Leadership

Lobbyists

White House

Department

Sibling Agencies

Professions
The Context

• Economic Pressure
  – In the past decade, all wage increases have been absorbed by health care costs.

• Political Polarization

• The Loss of Authentic Dialogue

• Confusion in the Public

• Uncertainty about the Future
“The First Law of Improvement”

Every system is perfectly designed to achieve exactly the results it gets.
Preventing Central Line Infections

- Hand hygiene
- Maximal barrier precautions
- Chlorhexidine skin antisepsis
- Appropriate catheter site and administration system care
- No routine replacement
Central Line Associated Bloodstream Infections (CLABs)
(from Rick Shannon, MD, West Penn Allegheny Health System)

Infections per 1000 Line

- Traditional Care
- CVL "Bundle"

CLAB Deaths in 12 Months

- Traditional Care
- CVL "Bundle"
Types of Improvement: Noriaki Kano

• Kano I: Reducing Defects
• Kano II: Reducing Costs, while Leaving the Customer the Same or Better Off
• Kano III: Creating and Introducing a New Product or Service
High Spending Regions Have Worse Quality

Baicker and Chandra, Health Affairs, 2004
The Dartmouth Atlas

The Quality of Medical Care in the United States: A Report on the Medicare Program

The Center for the Evaluative Clinical Sciences
Dartmouth Medical School

The Dartmouth Atlas of Health Care 1999

Medicare Spending per capita 2006
- $10,250 to 17,184 (55)
- 9,500 to < 10,250 (69)
- 8,750 to < 9,500 (64)
- 8,000 to < 8,750 (53)
- 6,039 to < 8,000 (65)
- Not Populated
The Institute of Medicine
Aims for Improvement
....A Reminder

• Safety
• Effectiveness
• Patient-Centeredness
• Timeliness
• Efficiency
• Equity
The Triple Aim

Population Health

Experience of Care

Per Capita Cost
Nathaniel and Caleb
"The moral test of government is how it treats those who are in the dawn of life, the children; those who are in the twilight of life, the aged; and those in the shadows of life, the sick, the needy, and the handicapped."

November 4, 1977
Linking Justice to Improvement

• Coverage is key to improvement.
• Improvement is key to coverage.
The Consequences of Inaction

- Cutbacks in Coverage
- Weakening of the Safety Net
- More Burden on Individuals
- Research and Teaching under Siege
- All Payers Affected
- Threats to Other Social Purposes
Deficit Reduction Options for Health Care
“The Great Risk Transfer”
(from James Orlikoff)

1. From Federal Government to States
2. From Federal Government to Medicare Beneficiaries
3. From Federal Government to Taxpayers
4. From Federal Government to Providers
And the “Sustainable Growth Rate” (SGR?)….
(from James Orlikoff)

• Repeal of the SGR Medicare Physician Payment Formula would cost $358 Billion over 10 years according to the CBO.
• That amount gets added to the deficit
• MedPAC’s SGR Repeal Proposal…
  – Freeze Primary Care Pay for 10 Years
  – Reduce Specialist Pay 5.9% per Year for the Next 3 Years, then Freeze There for 7 Years
  – Take the Rest from Hospitals and Drug Companies
A Vision for CMS

“A major force and a trustworthy partner for the continual improvement of health and health care for all Americans.”
My Questions at CMS

• How will this affect quality?
• How will this affect the poor?
• How will this affect costs?
Improvement Tools in the Affordable Care Act

• Transparency

• Payment to Support Care Integration
  – ACOs, Bundled Payment, Medical Homes, Health Homes, Community-Based Care Transitions, etc.

• Attaching Payment to “Quality” Metrics

• Investments in Innovation

• “Direct” Cost Pressures
  – Productivity Adjustments
  – Medicare Advantage Reductions

• Investments in Prevention
Southcentral Foundation  
Anchorage, Alaska

- “Nuka” – Alaskan word for strong, giant structures and living things.
  - Also the name for the health care model that transformed the system from health care transactions for patients to a healthy system with the population
“NUKA” CARE SYSTEM
Southcentral Foundation
Anchorage, Alaska, USA
Components of “Nuka” System

- Caring for a defined population or list
- Barrier free team-based care
- Redefining relationship to specialists
- Shifting to deliver “health” not just “disease care”
Some Nuka Results

• Urgent Care and ER Utilization = 50%  
• Hospital Admissions = 53%  
• Specialist Utilization = 65%  
• Primary Care Utilization = 20%  
• HEDIS Outcomes and Quality = 75-90%ile  
• Employee Turnover Rate < 12% per year  
• Customer and Staff Overall Satisfaction > 90%
Nuka Per Capita Expenditures

Cumulative Per Capita Expenditures
Relative % Change with 2004 as Baseline

- SCF Cumulative Primary Care
- SCF Cumulative Hospital Services
- MGMA Cumulative Increase (Multi Specialty Cost)
DENVER HEALTH
LEAN PRODUCTION RESULTS:
$144 M SAVED
DENVER HEALTH OUTCOMES: #1 IN UHC
The AFHCAN* Cart

ROI: 10.54:1

*ALASKA FEDERAL HEALTH CARE ACCESS NETWORK
Alaska Dental Health Aide Therapists “DHAT”

DHAT PROGRAM: COULD MEET ALL DENTAL NEEDS IN ALASKA VILLAGES WITH 70 DHATS
Introducing Christian

The Old Way

• Ryhov Hospital, Jönköping, Sweden had traditional hemodialysis and peritoneal dialysis center.
• In 2005, a patient, Christian, asked about doing it himself.
Self-Dialysis

• Now 60% of Ryhov Hospital dialysis patients are on self-dialysis
• Their aim: 75% of patients
Self-Dialysis Results

- Costs now 50% of costs in other hemodialysis units
- Complications dramatically reduced and subsequent expensive care avoided
- Measuring success by “number of patients working”
Stabilization Wedges: Solving the Climate Problem for the Next 50 Years with Current Technologies
“Wedges” of Improvement: Greenhouse Gases

CO₂ Emissions - The area between the two curves represents the avoided carbon emissions required for stabilization.
“Wedges” of Improvement: Greenhouse Gases

A stabilization triangle of avoided emissions (green) and allowed emissions (blue)

B

Fossil fuel emissions (GtC/y)

Continued fossil fuel emissions

Year

2000 2010 2020 2030 2040 2050 2060

“WEDGES”
“Wedges” of Improvement: Health Care Costs
Theoretical Waste Categories

1. Overtreatment
2. Failures to Coordinate Care
3. Failures in Care Delivery
4. Excess Administrative Costs
5. Excessive Health Care Prices
6. Fraud and Abuse
Waste Category Annual Dollar Estimates

Single-year (2011) estimates based on a review of the waste literature, after resolving overlapping waste areas:

<table>
<thead>
<tr>
<th>Category</th>
<th>Cost to CMS (2011 $B)</th>
<th>Cost to US Health Care System (2011 $B)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overtreatment</td>
<td>$67 to $87</td>
<td>$158 to $226</td>
</tr>
<tr>
<td>Failures to Coordinate Care</td>
<td>$21 to $39</td>
<td>$25 to $45</td>
</tr>
<tr>
<td>Failures in Care Delivery</td>
<td>$26 to $45</td>
<td>$102 to $154</td>
</tr>
<tr>
<td>Excess Administrative Costs</td>
<td>$16 to $56</td>
<td>$107 to $389</td>
</tr>
<tr>
<td>Excessive Health Care Prices</td>
<td>$36 to $77</td>
<td>$84 to $178</td>
</tr>
<tr>
<td>Fraud and Abuse</td>
<td>$30 to $98</td>
<td>$82 to $272</td>
</tr>
<tr>
<td>2011 Total Waste</td>
<td>$197 to $402</td>
<td>$558 to $1263</td>
</tr>
<tr>
<td>As % of Total Spending</td>
<td>20% to 37%</td>
<td>21% to 47%</td>
</tr>
</tbody>
</table>
US Health Care System Theoretical Waste
(Aggregate Waste 2011 - 2019)

TOTAL US HEALTH CARE SYSTEM WASTE ≈ $11 T OVER 9 YEARS

1. Overtreatment
2. Failures to Coordinate Care
3. Failures in Care Delivery
4. Excess Administrative Costs
5. Excessive Health Care Prices
6. Fraud and Abuse

in billions

“Choosing Wisely” – An Example of Professional Leadership

NINE SPECIALTY GROUPS: 45 OVERUSED PROCEDURES

U.S. PHYSICIAN GROUPS IDENTIFY COMMONLY USED TESTS OR PROCEDURES THEY SAY ARE OFTEN NOT NECESSARY

Nine Physician Organizations Each Identify Five Tests or Procedures in their Respective Fields That May Be Overused or Unnecessary

Choosing Wisely™ Campaign Led by ABIM Foundation, with Consumer Reports, to Improve Health Care Quality and Patient Safety

Contact: Nick Ferreyros
(202) 745-5102
nferreyros@gymr.com
“CHOOSING WISELY” -- NINE SPECIALTY GROUPS: 45 OVERUSED PROCEDURES

Don’t perform stress cardiac imaging or advanced non-invasive imaging in the initial evaluation of patients without cardiac symptoms unless high-risk markers are present.
Asymptomatic, low-risk patients account for up to 45 percent of unnecessary “screening.” Testing should be performed only when the following findings are present: diabetes in patients older than 40 years old; peripheral arterial disease; or greater than 2 percent yearly risk for coronary heart disease events.

Don’t perform annual stress cardiac imaging or advanced non-invasive imaging as part of routine follow-up in asymptomatic patients.
Performing stress cardiac imaging or advanced non-invasive imaging in patients without symptoms on a serial or scheduled pattern (e.g., every one to two years or at a heart procedure anniversary) rarely results in any meaningful change in patient management. This practice may, in fact, lead to unnecessary invasive procedures and excess radiation exposure without any proven impact on patients’ outcomes. An exception to this rule would be for patients more than five years after a bypass operation.

Don’t perform stress cardiac imaging or advanced non-invasive imaging as a pre-operative assessment in patients scheduled to undergo low-risk non-cardiac surgery.
Non-invasive testing is not useful for patients undergoing low-risk non-cardiac surgery (e.g., cataract removal). These types of tests do not change the patient’s clinical management or outcomes and will result in increased costs.

Don’t perform echocardiography as routine follow-up for mild, asymptomatic native valve disease in adult patients with no change in signs or symptoms.
Patients with native valve disease usually have years without symptoms before the onset of deterioration. An echocardiogram is not recommended yearly unless there is a change in clinical status.

Don’t perform stenting of non-culprit lesions during percutaneous coronary intervention (PCI) for uncomplicated hemodynamically stable ST-segment elevation myocardial infarction (STEMI).
Stent placement in a non-infarct artery during primary PCI for STEMI in a hemodynamically stable patient may lead to increased mortality and complications. While potentially beneficial in patients with hemodynamic compromise, intervention beyond the culprit lesion during primary PCI has not demonstrated benefit in clinical trials to date.
Some Principles

• Put Patients First
• Protect the Disadvantaged
  • Start at Scale
• Return the Money
  • Act Locally