The "How Do They Do That?" Conference – Summary remarks
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I want to tell you the story of a friend I lost to lung cancer this year. Jerry Sternin was a professor of nutrition at Tufts University, and with his wife Monique, he'd spent much of his career trying to reduce starvation in the world. He was for awhile the director of a Save the Children program to reduce malnutrition in poor Vietnamese villages. The usual methods involved bringing in outside experts to analyze the situation followed by food and agriculture techniques from elsewhere.

The program, however, had itself become starved—of money. It couldn't afford the usual approach. The Sternins had to find different solutions with the resources at hand.

So this is what they did. They went to villages in trouble and got the villagers to help them identify who among them had the best-nourished children—who among them had demonstrated what Jerry Sternin termed a "positive deviance" from the norm. The villagers then visited those mothers at home to see exactly what they were doing.

Just that was revolutionary. The villagers discovered that there were well-nourished children among them, despite the poverty, and that those children's mothers were breaking with the locally accepted wisdom in all sorts of ways—feeding their children even when they had diarrhea; giving them several small feedings each day rather than one or two big ones; adding sweet potato greens to the children's rice despite its being considered a low-

class food. The ideas spread and took hold. The program measured the results and posted them in the villages for all to see. In two years, malnutrition dropped 65 to 85 percent in every village the Sternins had been to. Their program proved in fact *more* effective than outside experts were.

I tell you this story because we are now that village. Our country is in trouble. We are in the midst of an economic meltdown like nothing we've seen in more than half a century. The unemployment rate is approaching ten percent. Our auto industry has filed for bankruptcy. Our housing sector is a shadow of its former self. Our state and local governments are laying off teachers and municipal workers.

And health care has not escaped. Job losses and cutbacks have produced an unprecedented increase in the uninsured. Meanwhile, states are cutting back on health coverage.

Moreover, we in medicine have partly contributed to these troubles. Our country's health care is by far the most expensive in the world. It now consumes more than one of every six dollars we earn. The financial burden has damaged the global competitiveness of American businesses and bankrupted millions of families, even those with insurance. It's also devouring our government at every level—squeezing out investments in education, our infrastructure, energy development, our future.

As President Obama recently said, "The greatest threat to America's fiscal health is not Social Security, though that's a significant challenge. It's not the investments that we've made to rescue our economy during this crisis. By a

wide margin, the biggest threat to our nation's balance sheet is the skyrocketing cost of health care. It's not even close."

Like the malnourished villagers, we are in trouble. But the public doesn't know what do about it. The government doesn't know. The insurance companies don't know. They brought in experts who explained that the vast majority of extra spending is for the additional tests, procedures, specialist visits, and treatments we order for our patients. More than anything, we simply do more expensive stuff for patients than any other country in the world.

So the country is now coming to us who do this work in medicine. And they are asking us, how do they get these costs under control?

It is tempting to shrug our shoulders. It is tempting to say this is just the way good medicine is. But we'd be ignoring the evidence otherwise. For as we've learned today in great detail, health care is not practiced the same way across the country. Annual Medicare spending varies by more than double, for instance, from less than $6000 per person in some cities to more than $12000 per person in others. I visited a place recently where Medicare spends more on health care than the average person earns.

You would expect some variation based on labor and living costs and the health of the population. But as you look between cities of similar circumstances, between places like McAllen and El Paso, Texas, just a few hundred miles apart, you will still find up to two-fold cost differences. A recent study of New York and Los Angeles hospitals found that even *within*

cities, Medicare's costs for patients of identical life expectancy differ by as much as double depending on which hospital and physicians they go to.

Yet studies find that in high-cost places—where doctors order more frequent tests and procedures, more specialist visits, more hospital admissions than the average—the patients do no better, whether measured in terms of survival, ability to function, or satisfaction with care. If anything, they seemed to do worse.

Nothing in medicine is without risks, it turns out. Complications can arise from hospital stays, drugs, procedures, and tests, and when they are of marginal value the harm can outweigh the benefit. To make matters worse, high-cost communities appear to do the low-cost, low-profit stuff—like providing preventive care measures, hospice for the dying, and ready access to a primary care doctor—LESS consistently for their patients. The patients get more stuff, but not necessarily more of what they need.

Fixing this problem has felt dishearteningly complex. Across the country, we have to change skewed incentives that reward quantity over quality, and that reward narrowly specialized individuals, instead of teams that make sure nothing falls between the cracks for patients and resources are not misused. But how do we do it?

Well, today we sought to look at this problem the way Jerry Sternin looked at that starving village in Vietnam. We looked for the positive deviants—the places that are already doing better than the rest—for their lessons. We've looked at ten communities ranging from Portland, Maine to Sacramento,

California; from Tyler, Texas to Lacrosse, Wisconsin. About half of them have had health care that has been lower cost and higher quality than average for a long time. About half actually started out high cost and bent their cost curve to become lower cost along the way.

And after an entire day of hearing their stories of how they are doing it, we've gotten the glimmers of a possible pattern for what needs to be done. They have worked on several attributes that have made them successful.

More than anything, we learned that these communities have worked to build a culture of collaboration for restraint against the tendencies to make business and revenues the goal—to keep the needs of patients first. It's hard. We heard today about the fierce economic competition in many of these cities. In Lacrosse, Wisconsin, for example, there are two health systems that battle for patients and revenues; Richmond, Virginia, there are three; Sacramento, there are four.

But as a colleague from Consumers Union commented after listening to them explain what they do, they've kept it more like a golf competition, not all out war. They are playing within the rules. They are not battling to destroy each other.

They have also had physician-leaders who took their communities' needs for improvement of patient results and control of costs to be a serious concern. They have seen financial reimbursement as a constraint, not as the goal. Portland, Maine, described a population-wide collaboration by physicians to track sixty measures of quality for their patients and to meet voluntary cost

reduction goals—and they have done it for at least two years already. A Tallahasee, Florida, health system told of "value analysis teams" reviewing high-cost technologies for whether they provide genuinely adequate value for patients to justify investment. Others here told similar stories of work across the entire continuum of care to reduce both overtreatment and undertreatment.

This is remarkable. But it raises the question of what can really be done to change the culture of medical practice elsewhere. The answer, I think, was in how these communities have sought to protect the cultures they have built. And that was by building *forces for restraint* against the damaging tendencies of our health system. They specifically reported building four different kinds of forces.

First was leadership. These communities actively sought and engaged physician-champions who shared the goals and had experience delivering on them.

Second was altering financial incentives. The communities reported multiple ways they have found to blunt the perverse financial incentives of our system. Many here have had a significant proportion of salary-based physicians—such as Sacramento, California, and Tyler, Texas. Others have kept fee-for-service payment but with significant incentives for quality or disincentives for overtreatment.

Third, virtually every community here reported using measurement to provide a force for restraint. The physicians from Scott and White Memorial

Hospital in Tyler, Texas, and from the Guthrie Clinic in Sayre, Pennsylvania, told of providing physicians with quarterly feedback using detailed data on quality metrics and on levels of overtreatment or undertreatment. One other community leader told of finding that he and his fellow physicians had provided 52,000 CT scans for a population of about 300,000 in one year. This was embarrassing, he said, and the data helped them recognize they could reduce cost and improve quality by formulating clearer ordering criteria.

Fourth, all described the importance of engaging with their communities to help them see how much high costs and poor quality were harmer the greater good. It was painful sometimes. They engaged with employers and government in active collaborations. Everett, Washington, had Boeing; Cedar Rapids, Iowa, had Rockwell Collins; Portland had the Maine Health Management Coalition with multiple employers and the state governor's office. And all of them pushed for greater data transparency, for LEAN management to reduce waste, cost and quality targets, and other key steps.

I took a critical lesson from these experiences. And that was: It Can Be Done. In this moment of doubt about our abilities to achieve true health reform, this is important to remind ourselves. It Can Be Done.

What is more, reform must be done. For these communities also described threats to their successes. And if health reform can do anything besides assure universal coverage, it must protect and spread what these communities are accomplishing to control costs. They had concerns about being unable to sustain these gains in this economy without a change in our

mainly fee-for-service system. They had concerns about anti-trust laws preventing the collaborations necessary to improve care and reduce costs. They had concerns that the pressure from the severe necessity to control costs could cause a rupture of relations between doctors and hospitals in their communities—or between doctors and doctors. They had concerns that they would not have the workforce to build more effective primary care.

Nonetheless, what they told was a story of extraordinary lessons and possibilities. We should understand what we have witnessed. These are American medical communities that are actually working to insure they actual serve the needs of their patients—working to insure that both overtreatment and undertreatment are avoided.

In doing so, they are learning how we can save both patients and costs. And in doing this, they are helping save our country. They are our hope. We thank them.