

NATIONAL PRESS CLUB LUNCHEON WITH DR. DENIS CORTESE

SUBJECT: DR. DENIS CORTESE, PRESIDENT AND CEO OF THE MAYO CLINIC, WILL DISCUSS HEALTH CARE REFORM AT THE SEPTEMBER 18 NATIONAL PRESS CLUB SPEAKER LUNCHEON. TITLE OF HIS PREPARED REMARKS WILL BE "GREAT EXPECTATIONS: WHAT LAWMAKERS MUST DO TO REFORM U.S. HEALTH CARE." CONGRESS IS SLATED TO PICK UP THE HEALTH CARE DEBATE WHEN ITS MEMBERS RETURN FROM RECESS.

MODERATOR: DONNA LEINWAND, PRESIDENT, NATIONAL PRESS CLUB

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DONNA LEINWAND: (Sounds gavel.) Good afternoon and welcome to the National Press Club. My name is Donna Leinwand. I'm a reporter with *USA Today*, and I'm president of the National Press Club.

We're the world's leading professional organization for journalists and are committed to a future of journalism by providing informative programming and journalism education, as well as fostering a free press worldwide. For more information about the National Press Club, please visit our website at www.press.org.

On behalf of our 3,500 members worldwide, I'd like to welcome our speaker and our guests in the audience today. I'd also like to welcome those of you who are watching us on C-Span.

We're looking forward to today's speech, and afterwards, I'll ask as many questions from the audience as time permits. Please hold your applause during the speech so that we have time for as many questions as possible.

For our broadcast audience, I'd like to explain that if you hear applause, it may be from the guests and members of the general public who attend our luncheons, and not necessarily from the working press.

I'd now like to introduce our head table guests and ask them to stand briefly when their names are called. From your right, Bob Weiner, national columnist, president of Weiner Public News and former chief of staff of the House Aging Committee and Health Subcommittee; Martha Craver, associate editor, *The Kiplinger Letter*; Marilou Donahue, president and producer, *Artistically Speaking TV*; Peggy Eastman, president, Medical Publishing Enterprises; Kristen Jensen, a health reporter for Bloomberg News; Mr. Al Erato(?), a caregiver to a patient at the Mayo Clinic, and a guest of our speaker.

And skipping over the podium for just a moment, Angela Greiling-Keane, reporter for Bloomberg News and chair of the National Press Club Speakers Committee. Skipping over our speaker, Doris Margolis, president of Editorial Associates and National Press Club member who arranged today's luncheon. Thank you very much, Doris.

Mary Erato, a patient at the Mayo Clinic, and also a guest of our speaker; Simon Denyer, Washington and East Coast bureau chief for Reuters; Keith Hill, editor/writer for Bureau of National Affairs, and treasurer of the National Press Club; and finally, Eleanor Clift, contributing editor for *Newsweek*. (Applause.)

As Congress and the nation struggle to come up with a better prescription for healthcare, the National Press Club is fortunate to have at our podium one of the country's leading experts on this top, Dr. Denis Cortese. Dr. Cortese is president and CEO of the world renowned Mayo Clinic. Our guest has been a passionate advocate for changing the healthcare system from top to bottom, not just reforming health insurance, and repairing programs such as Medicare, Medicaid, and the Veterans Administration health system.

Medicare for example is expected to run a \$660 billion dollar deficit by 2023. Dr. Cortese has argued that these programs should shift from the current fee for service formula to a system that rewards doctors for delivering the best possible care at the lowest possible cost. Doctors in other words could be penalized for unnecessary tests.

Dr. Cortese, a 1970 graduate of Temple University Medical School, has been with the Mayo Clinic for most of his professional career. He did his

residency there and joined the staff full-time as a pulmonologist in 1976, after his service in the U.S. Navy. Mayo, in its mission statement, makes its values clear — to provide the best care to every patient, every day, through integrated clinical practice, education, and research. But it also notes that the Clinic should, “...operate in a manner intended, not to create wealth, but to provide a financial return sufficient for present and future needs.”

Dr. Cortese is here today to show how that formula works for the Mayo Clinic, and whether such a formula could work for the nation as it confronts soaring healthcare costs, and millions of people who lack insurance. Ladies and gentlemen, please join me in extending a warm National Press Club welcome to our speaker, Dr. Denis Cortese. (Applause).

DR. DENIS CORTESE: Donna, thank you. We should let her keep going. She was on a roll. You were covering all the key messages. That was excellent.

I’m here today to talk about the changing healthcare activity in America, and to really speak a little bit about ideas and concepts, and right at this particular time, to strongly urge our elected officials to collaborate and work together to get this important work done for all of us, all of us as people in The United States.

The framework here as we take a step back and look at it a bit, shows that healthcare in The United States is a bit in trouble. Some people might disagree with that, but frankly, we are in a bit of trouble. We’re watching Medicare having some problems funding itself in the next seven years we’re told, or sooner. We’re also realizing that from the standpoint of measurable outcomes, that we’re not necessarily getting, on average throughout the country, what we’re paying for. And we’ve heard several previous Presidents of The United States say those exact words.

This time, we’re getting close to trying to tackle that. And what we’re here to talk about today (and I’ll emphasize again) is really coming at this from the viewpoint of, what is really best for patients? What is really best for people? What is really best for each of you in the audience? Because we’re so far talking about so many different stakeholders. They’re all around the place. But none of the real discussion is focused around what is really very best for each of us, and then design a system to help us attain that as we go forward.

We’re watching what happened in the last month with all the mud and things that were going on in all of those meetings around the country, partisan bickering. There were scare tactics, et cetera. And I’m really here to say, let’s just take a step back a minute, take a deep breath. And I’m watching people actually doing that, our last visits yesterday, take a breath for a minute and say, “Let’s

refocus a bit on the fact that we want high quality affordable healthcare for all people in The United States.”

And what might that look like? Some of you might have been here the last time I spoke here. And I asked you the three questions. And I’ll ask them again. What it might look like will be depending on how you answer these questions. Who in this audience would like to be hospitalized tomorrow, even if it’s the best hospital in the world? Okay, nobody raised their hands. Who would like to be sick tomorrow? Not too many hands going up. Who would actually like to be a patient, patient being defined as somebody who long suffers or long endures? Anybody volunteer for that? So again, I see no hands going up.

So when you answer those questions as ‘no’ to each one, you begin to say, we need to redesign and rethink about what is happening in the healthcare non-system in The United States so that we turn it into a system that helps you attain the answers that you asked for. And saying that, it really changes the trend. In other words, hospitals, based on your first question, hospitals are no longer the center of the universe of healthcare delivery. They’re very important and we need them, but they’re just part of the team.

As a matter of fact, you can even make an argument that the most hospitals we have and the more beds we’re opening up, the system is failing. A symbol of success is how many beds are closed. It’s another way to perhaps look at it as an outcome that we might ask for.

So I want to talk a little bit about what you just answered, and, say, break it into two easy pieces. And the first is the piece that has to do with health insurance reform and healthcare reform. Or I call it healthcare delivery reform, two separate concepts, but equally important. Because we just said, we want everybody insured, and we want to have a different delivery system or effective delivery system.

Let’s take the easy part first. The easy part first is health insurance reform. And I hope you’re all laughing because you know how difficult it is to do this. But believe me, it’s the easy part, dealing with getting people insured.

So we’ve heard in the speech the President, who talked about safety and security and insurance for all. And we (now, ‘we’ meaning Mayo Clinic) strongly support the need for health insurance reform. And let’s talk a little bit about that. We had a story come to us from one of our patients who attended one of the meetings in Chicago recently. I thought I’d just relay it briefly to you. It’s a story about a-- she’s now a 24 year-old. She’s a graduate student from Bloomingdale, Illinois. And she had congenital heart disease. Still does, but she had it when she was young. She underwent some operations as a child, but her parents’ insurance

denied some recommended follow-up that she needed in her region, so the denial of the evaluation.

Eventually, after some hassling, got the evaluation. And then she wanted to go to a facility for an additional evaluation that was outside of the network. So you've heard that story before, for difficulty going outside of the network. She eventually was able to go outside the network, but she was treated and received advice and treatment on a charity basis. The insurance company did not cover that. So that's one concept about health insurance.

The second is, during college, she lost her parents' insurance coverage, because she passed a certain age and it wasn't covered anymore. So she was a full-time student with no insurance. Have we heard that story before as a problem for us?

And then the third lesson that she summarized, as an adult, when she had a job and she was working, she couldn't get coverage because of preexisting conditions. And we've all heard that before. So right there, there are three or four examples of a problem with keeping people insured in The United States.

And then *The New York Times* had an article, I think last weekend it was or the weekend before, about a woman who was covered by Medicare. She was a younger woman, but she was covered by Medicare because she had renal failure, kidney failure, had been on dialysis, had had two transplants, kidney transplants that had failed. But the lesson here is that she was now getting ready for her third transplant. She would need her third transplant. Why? Because the drugs that are used after the transplant were only covered for three years by the insurance company. And that's Medicare.

And it makes you wonder, gosh, you know, it's much cheaper to cover the drugs than it is to go through three transplants. So she's coming up to her third transplant. That doesn't make sense either. So when we look at examples of how to save-- Well, let's look at it from the patient's viewpoint. There are ways to solve every one of those examples I just gave you. And I'm not going to go into details how to solve it, but I'm here to say, we need to do this. We need to make sure we have the uninsured and the under-insured, having access to affordable and portable health insurance.

Now Mayo Clinic's position on this particular issue is that we would be viewing this idea of insurance as a mandate. Everybody should have it. I know there's a problem with mandates. People don't like the words. So let's change the word to anything anybody wants. But let's get everybody insured. I don't really too much want to argue about the issue of, is it required or not. But people-- Somehow in the country, we ought to get to a stable condition where people have

insurance so they don't have to go broke over it and be concerned about lack of access to good insurance.

We feel that individuals should own their own insurance. And what I mean by that is, it's their insurance. It's portable. They could take it with it (sic) wherever they need to go. So they're not locked into a job because of that insurance. We think they really should own it. So that employment status doesn't really produce then the double whammy of losing a job and losing your health insurance, or the fact that you're reluctant to change your job because you might lapse with no insurance for three or six months. We think the insurance should go with the person and be attached to the person.

We think employers should continue or-- I shouldn't say 'should'-- *could* continue by buying insurance for their employees that they like or subsidize or provide a stipend if they choose to do so. But we're not proponents of this idea of an employer mandate to provide insurance. But certainly employers could compete for employees by offering them health insurance as part of the package. It's up to them to make a decision.

We think insurers should take all comers, regardless of the health status. And that kind of goes without saying. That seems to be at the front of the line with the ideas that are being discussed here in Washington about health insurance reform. That seems to be at the front stage of it.

There is a significant role for government. And the role for government here is, frankly, as a funder, a body that helps people be able to afford the insurance, perhaps with sliding scale subsidies. And then there's another potential role for the government, and that is to regulate the insurance industry, to foster competition.

So those basically are the key components of what we're suggesting we should be looking for as we come down the road. Now, a lot of people talk about this idea of a public plan or not a public plan. I'm not here really to discuss it, because I don't know what people are talking about yet. I still had trouble understanding what a public plan means. Actually, to be very honest, from my personal viewpoint, the public plan that I hear being discussed, that is owned by the public, is a co-op of some kind, because that's real public people, living in communities, owning whatever they're doing to themselves. That's as close as I see the ...(inaudible) idea, is a co-op. That is a true public plan where individuals who live out there, the citizens own it and control it.

Now if what we mean by a public plan is a government-run plan, that's another story. If we're talking about a government-run plan, I'm not sure what people are talking about there. Are they talking about Medicare? Are we talking

about Medicaid? Are we talking about a military system? Are we talking about a VA system? Are we talking about tri-care, which is a very good insurance product that retired people in the military like? And it's a managed care insurance product. I hear nobody talking about that. Are we talking about extending SCHIP, which is another program? It's a Medicaid-like program for children. Are we talking about the Federal employees healthcare plan?

So the Federal government has a whole bunch on the shelf to pick from. I haven't heard them, anybody committing yet to, what are they really talking about. So it's hard to take a position for or against the public plan until we know exactly what it would be.

However, our advice, our suggestion (now, again, Mayo Clinic) is that we tend to favor a Federal employees-like model where there is an exchange. Patients can select from a wide range of plans where there's some grading and scaling related to quality. And drugs are covered in the Federal employees plan. And have them be able to choose that, maybe with government subsidies. And they can get a basic product or they can buy up if they'd like to, out of their own pocket.

And that, by the way, links a little closer to Wyden and Bennett, in their bill, had indicated a couple years ago, I guess it was. And that bill is still floating around out there. And the idea still exists. So I've not heard the public plan exactly addressed yet enough to really understand whether it would be good or bad for the country.

We do know that we need to move forward, though, to insurance reform. We strongly support that. We support all the efforts that are going on now to move towards insurance reform by the House, Senate and The White House. So we're right there trying to support that.

Now I want to shift to the second part, which is the hard part. And that is, once we get everybody insured, if everybody is insured in a really bad delivery system or very expensive one, then all we've done is gotten everybody insured in a really bad delivery system. Doesn't mean they're getting high quality care. Doesn't mean good care, and will probably waste a fair bit of money.

So when we look at the second component, it's the second component, the idea of high quality, affordable healthcare that we call value, high value care, better outcomes, better safety, better service over, compared to, or related to the amount of money we spend to get that. That's the value equation. And we should be looking for high value healthcare in The United States, and setting that as our goal.

I consider what I've just described what health reform is all about. What do we really mean by healthcare reform? It's the healthcare delivery reform, so we are getting, all of us as individuals, care that helps keep us out of the hospital, keeps us healthy, keeps us working, keeps us in school, and maybe helps prevent people from having-- who have chronic illnesses or chronic conditions from long suffering.

So how do we do that? How do we make that happen? This is the hardest part. And I think it's medicine's overall aim to really provide these great outcomes, safer service and lower cost.

Currently there's a significant amount of regional variation in the outcomes, the safety, and the service compared to the cost throughout The United States. We've all heard this a lot, and we hear people differing. And there's attempts to explain the variation. But when we look at that variation, it is predominantly driven, not totally, but predominantly driven by the different amounts of things that are done to us as patients. How many days are we in a hospital? How many days are we in ICU? How many tests do we actually get? It varies widely for similar conditions. And it's somewhat un-understandable at times and makes you wonder.

When we look at the regions of the country that do produce pretty high value care (and there are many of them)-- This is not about Mayo Clinic. There are many (and I'll list some of them in a little bit) but many places in the country that are getting high value care. There has been some work done to try to figure out, what are some of the common characteristics among those institutions, among those regions, among the states that get actually high quality care?

And I'll just list a few of the common characteristics, it's not a perfect match, but some characteristics that I want people to be thinking about. One, there tends to be a higher level of a cultural focus on the needs of the patient. There's more patient-centeredness thinking going on in those organizations or by those groups of providers that band together in communities, or in states that have created better environments for caring for people. They're focused more on the patient.

There tends to be a higher level of physician engagement and leadership and change in taking care of people. That's a general statement. There tends to be a much higher level of teamwork and collaboration in deciding things, medical decisions for patients. There tends to be a much higher level of coordinated care. The teams are the integration component and coordination is how they manage the patients themselves, how appointments are scheduled. Do they get follow-ups? The coordinated care is a key component of this.

There tends to be a higher rate of sharing of medical records and information from one place to another. So these galaxies of good delivery of care, high value care, there's a fair bit more connectivity about information than there is elsewhere. And when you have connectivity of information, you tend to have connectivity of knowledge. So people are able to make much better decisions for their patients.

And there is a definite higher level, particularly in organizations that get high value care, there is a much higher level of the use of what we call at Mayo Clinic, the science of healthcare delivery. In other words, we bring system engineering into the way we take care of people. We begin to systematically look at the way patients flow through. How do we eliminate waste? How do we standardize certain processes so we reduce errors, and things like this? So there are some common features that we ought to be fostering in the country so that this can happen.

Now, tell you a quick story about my mother. It's a personal story. She died in the year 2000. But about twelve years before that, she began to have problems with a fever of unknown origin, sort of aching and just didn't feel well. And that went on for maybe a year or two. So maybe it was fifteen years before she died. But then it sort of reached a head. On one Sunday morning, she called me. She was in Philadelphia and I'm in Rochester, Minnesota. And she woke up, she was blind in one eye. And we had a very clear, right then, began to think of temporal arteritis, of vasculitis that affects people. It's an inflammation of blood vessels. It can be very severe.

She saw a physician that afternoon, put her on steroids, which was the right thing to do. They did a biopsy the next day, proved the diagnosis. Usually after a year or so of steroids, you can wean the person off the steroids, and they're fine. In my mother's case, she never could get off the steroids. She ended having a generalized vasculitis throughout her body that affected her lungs, many other organs. She had significant problems, including her heart, atrial fibrillation. She had osteoporosis. She had steroid induced diabetes. She had multiple problems.

For about six years, in the Philadelphia area, she was seeing seven different doctors. And each one was not necessarily coordinating with each other. And for the last two or three years, while she was in Philadelphia, she was going into the local hospital, a fine local hospital, roughly once a month, maybe once every two months, but closer to once a month, for a day or two, going through the ER. And all those physicians would sort of trickle in and see her and do a fine-tuning, and she would leave.

But then no follow-up. It wasn't really a way to get continuity of care. And my brother-in-law is a cardiologist on the staff of the University of

Pennsylvania. And between my brother-in-law and myself, we could not get her integrated coordinated care with a responsible physician as we went forward. People tried, but they weren't able to get coordinated care.

1993, my father retires. I move to Jacksonville to work at the Mayo Clinic. I encourage them to come to Jacksonville. They did. I had them see a rheumatologist on our staff. And this rheumatologist had her see a pulmonary doctor and a cardiologist and a Coumadin nurse (because she was on blood thinners because her atrial fibrillation) and a diabetic nurse because of her diabetes problem.

For the last six years of her life down there, she was hospitalized once the month before she died. She was able to work with the nurses and call them quite frequently, get some fine-tuning done. She rarely came to our clinic. She had the one physician in the background. Our clinic was only six miles away from where she lived. It was a whole new life. She was interacting with people.

I've worked at Mayo Clinic now forty years. I was stunned to see how good her care was. I didn't believe we could do it that well. And we didn't work at it. It was just the way we did it. But the saddest part of all of this, you know how much we got paid for all that home care she was getting from us? Zero. Medicare doesn't pay unless you go in the hospital or see the doctor in the office. We couldn't design a model of care to reproduce this as a business model in the current environment.

So this has to change. This is what I mean by the science of healthcare delivery. We definitely have to do this. So we have some people sitting here at the head table who have had similar experiences about integrated, coordinated care. And that's why they're here, because they have a big interest in this kind of a problem.

Now the good news is, there are several places in the country (and they do not have to be Mayo Clinic-like)-- I'm not here to talk about Mayo Clinic. I'm here to talk about integrated, coordinated care that's focused on high value. There are places that do this — Geisinger in Pennsylvania, Intermountain in Utah, Scott & White in Texas, Marshfield Clinic in Wisconsin. And I can go on. Cleveland Clinic could be thrown in that list.

As far as cities go, there are cities that do this — and Grand Junction, San Francisco, La Cross, Wisconsin, where we have one of our Mayo Health System sites are there and another competing facility, Gunderson, is an integrated group practice. They're competing. They're providing really good care in that community.

There are states that do this, that produce really high value care — Iowa, Hawaii, Utah, New Hampshire. Yesterday you heard from the governor or Vermont. Vermont's one of those states, Wisconsin, Nebraska, Rhode Island, both Dakotas.

So when we begin to think about, what can we learn in the country, there are examples we can learn from. What's going on in those places that are producing this higher value care? That's the good news.

The bad news is, it does not pay to be good. That's the problem. It doesn't pay. The incentives are not aligned. We make more money the sicker you all are. The more time you're in the hospital, we make more money. This has to change. And our mother's example is a perfect one because it was less expense for her, higher value care. And we can't build a business model to make it work. It's a tough one in a fee-for-service environment, which is what Medicare is. Those organizations that are able to do this have their own insurance plan, their own insurance product. They're able to make that work.

But for the whole country, we need to come up with a way that all physicians can make this work as we go forward. So what we're asking people to focus on is, what is really high value care? And the idea of-- There's one example that came up — talk about fluorescent light bulbs versus incandescent light bulbs. Well, the incandescent light bulbs are much less expensive, but they might last several months, depending how long you have your lights on. Whereas a fluorescent bulb might cost five times more to begin with, but it may last ten years. Which is the higher value?

And we're saying, patients ought to be involved in making that decision. Some people may just want the one-dollar bulb, and others may really want value, long-term value. There's got to be a way to build that into the system.

So as we talk about this, we're looking at Congress. They're making some suggestions in the House and in the Senate about how to focus on value. And there are several very good suggestions on both sides in all five or six of the bills that are out there. Now what will all come out of all of this is not clear. But whatever comes out of it, it's got to have something that moves the country as a goal to pay for value.

Mayo Clinic's recommendation is that we look at Medicare as the largest insurance company that's currently run by Congress and the administration. And let's start to pay for value in Medicare. Let's begin there. Frankly, we don't need an act of Congress to do that one, I don't think. Because it is an insurance company run by the government. They can move on and start saying, "Let's pay for value in Medicare." And our specific recommendation has been, let's set a

goal that in three years, Medicare is paying for value. In those three years in the run-in, let's create a process where we define what we mean by value, we start setting up the metrics, the outcome, safety, and service compared to the cost. Let's start being transparent about where everybody is on that scorecard, and then in three years start paying for it.

Now, you might say that's an overwhelming task. But it isn't overwhelming if then Medicare says, "We're going to do that. But let's do it for the most expensive three to five medical conditions that Medicare has to deal with, just three to five." That'll be high blood pressure, stroke, a few other things that are very common, chronic obstructive lung disease, heart disease, the top five. That top five covers roughly sixty to eighty percent of all the expenditures that Medicare has right now.

And if we throw in, let's also look at three to five procedures, most expensive procedures, high volume, most expensive procedures. What are those? Hip operations, knee operations, for instance. If we just did that, focused on maybe six to ten conditions, define the outcomes-- And we can define outcomes for every one of those. Safety, easy to measure. Service, patient satisfaction, already being measured. And the outcomes, by the way, already exist. AHRQ and other groups, National Quality Forum, has these sorts of things available. The IOM has some statements in that regard. We've got Leapfrog. There are a number of groups, come to consensus on what we would measure, and begin to pay for at least those.

So what we're asking for is the vision to say, "We want to get there in a reasonable amount of time." And we think right now that we've got this big chasm to cross over. And this chasm is people insured and getting value in the health delivery system. You can't really cross a twenty-foot chasm in two ten-foot jumps. We think we have to come to grips with both. We don't have to get them all fixed the first year. But we have to say now, that in three years, we're expecting to be paying for value or in five years, we're paying for value. We've got to get there and make a commitment to that.

So to accomplish these things, we think that our lawmakers are on the right step. They're in the right direction. And we're here to support. And we continue to give our opinions about what patients might really want out of care as we look to the future. So I'll stop there and take some questions, Donna. Thank you. (Applause).

MS. LEINWAND: Okay, you didn't list Minnesota among the states providing high value care. What should the state where you're based do differently?

DR. CORTESE: We are in that list. I just didn't list it. Sorry. But, you know, we can do more, just to be very quick. We've got providers that provide excellent care in Duluth, several groups in Minneapolis and in the Rochester area. And we can do more to interconnect and distribute the knowledge that we've shared and learned together. We already do it fairly well. We have some interactions quite regularly with the other providers, but to do it in a formal way that is official, electronic, and we have a name for it. We actually have a program that we're developing to make this work. But how do we actually connect all of this?

And there's a group in the country that's taken this on from the public domain. It's led by Patrick Soon-Shiong. It's called the National Coalition for Health Information. It's just being launched-- it's been launched, but people are just beginning to hear about it, to try to foster this interconnection.

MS. LEINWAND: Mayo has pushed for higher Medicare reimbursement rates for hospitals. How do you expect healthcare reform to affect those rates?

DR. CORTESE: We haven't really pushed for higher rates. What we've pushed for is that when we look at the way payments are made, there's been a consistent pattern the last several years, that the decision would be to continually reduce the payment rates by fixing the prices in such a way that we're not keeping up with inflation. Okay?

What we're saying is, we understand that may have to happen. But let's make that reduction, not across the board, but let's link it to some measure of value, so that you end up not cutting the good ones. So we're not necessarily saying, "Pay more." We use the word 'reward'. But a reward would be, don't cut the good ones. Because the goal, the aim, the ultimate aim of everything we're talking about is to define value, seek it out, and identify it, publish it, let people know, and make sure the high value providers and states and organizations stay in business. That's the goal, is the "stay in business" component.

And frankly, anybody who's run a business realizes, to stay in business, you don't need to make a big profit, but you need to at least make a two to three percent margin to cover your replacement and keep your activities dynamic, be able to recruit people, and maybe even grow a little bit. So that's the goal that we're asking for with regard to this pay for value. And we're not saying, "Pay more," we're just saying, make sure the good providers are paid more, if you see what I'm getting at. I'm not saying pay them more, but make sure they're paid more.

Because you've got to have that lever there. Because if you've got the lever aligned with what we want, if you do the payment lever aligned with what

the delivery system wants to give to patients, they will self-organize. They'll find a way to get there. And that's the real message we're trying to bring.

MS. LEINWAND: Do you think eventually that doctors will be required to accept Medicare payments?

DR. CORTESE: I don't know if I can answer that question. When you say 'required' I wonder if what they mean is, doctors will be required to see Medicare patients, period, or all Medicare patients that want to come and see them. Because right now, we're required to take Medicare patients-- I mean, payments. We cannot not take it. I'm struggling with it, because it's a fixed price we're told we're going to be paid. When we care for the patient, we're paid what the government says we are going to be paid by them. And then they also said how much additional we can collect from the patient. So all that is set by the government. So we're already there. The only thing that some providers are doing is they make it a little more difficult for Medicare patients to get appointments. Because once you start getting more than twenty to thirty percent of your business as a provider, more than twenty to thirty percent of your business is Medicare, you begin to find you have to shift costs to everybody else to help offset the lack of the good level of reimbursement you need to care for those folks. Makes it harder for Medicare patients to get access.

So doctors do have that ability. They don't have to see the Medicare patients, as I understand it. But will we ever pass a law that says doctors have to see Medicare patients, I could see that happening. I don't see it on the horizon, but it's possible.

MS. LEINWAND: You mention that Medicare could make some of these improvements itself. Should Congress meddle at all to modify Medicare?

DR. CORTESE: Well Congress meddles with Medicare all the time. This issue I just described about the transplant patient, for Medicare to come back and say (and I understand they have said it before) that the intelligent thing to do is just cover the medications, that takes an act of-- Congress has to say that's okay. They're into the micromanagement of the operations. They're acting like a board, but they're into management decisions.

The SGR changes, the sustainable growth rate changes with regard to what we will pay doctors next year-- January first, there's a scheduled twenty-one percent reduction for payment to doctors. Congress will probably act again on something and stop that from happening. Matter of fact, in the Baucus bill, I think that said, "Well, we'll give 'em a .5% increase, and then next year, we'll do a 25% cut."

So Congress is in the business all the time, doing it. So what I'm asking Congress to do is to just take a step back, take a breath, and say to the Secretary of Health & Human Services, in three years, we want to see Medicare paying for value, and stay out of their business. Let the Secretary get there, which means close the door to lobbyists. Because what I'm talking about will be painful for everybody. You've got to close the door to lobbyists to get there. (Applause).

MS. LEINWAND: It seems like everyone in the healthcare system has been asked to sacrifice and operate more efficiently except for the insurance companies. Do you think we can achieve true healthcare reform in this country without required the insurance companies to cut costs and operate more efficiently?

DR. CORTESE: No.

MS. LEINWAND: Any prospect of requiring young medical students to take courses in wellness education to prevent the self-inflicted, terribly expensive illnesses affecting so much of our society?

DR. CORTESE: Yes, that's an interesting question. The young medical students would love to be doing this. We get these people-- Because I do teach in our medical school. And when they're first coming in, they are enthused about really doing things to help people. We wash it out of them by the time they're finished, their residency. Because all the cases that they get, all the dynamic, exciting things are all done in the hospital, the sick patients, they got-- And you watch it on television. You see all of it.

The mundane stuff of keeping people well isn't flashy. It isn't there. So absolutely, there's interest. And we need to change the way we do education in our healthcare system right now today. All the academic medical centers need to change the way they select people to come in the medical schools. They have to be people who are used to thinking in teams, an approach to try to solve problems, have an approach to, not what they memorize, but how they handle knowledge (Where is it? Where's the best advice we can get?) and not feel that they have failed if they don't know the answer. The only time you fail is when you don't find the answer or you don't seek out advice to how to get the answer. We need to train them to work with nurses and other non-traditional providers.

And that is in the concept that we're trying to propose, that we introduce into the medical schools this idea of the science of healthcare delivery. How do physicians work with others to really improve the way care is delivered? And that requires a huge change in our whole system. But we're a proponent of that also.

MS. LEINWAND: With regard to aligning incentives, how do you see the vendors participating differently, for example, the people who provide joint implants? This must come from a joint implant surgeon.

DR. CORTESE: You mean who make the joint implants.

MS. LEINWAND: I guess who make the--

DR. CORTESE: Yeah, right, okay. I want to generalize that to the idea, on the device manufacturers and drug manufacturers in biotech and that sort of thing, genomics, proteomics, all of the group that are out there creating new knowledge, new discoveries. What role can they play to improve delivery in the healthcare system?

Well, if we believe that in this century, that individualized medicine is going to become more important-- What I mean by individualize medicine is that each of you in the audience is different than the next person next to you, and you're all different than me, and that yes, a new drug or pharmaceutical or a new diagnostic test may come out, and it may begin to identify that this medication or new drug will work in five of you, but not the rest of the 150 of us.

That's individualized medicine. In the old model, the fact that the drug only worked in less than three percent of the people means it was worthless. Can't sell it. No big blockbuster. It's not going to help everybody.

But a new model, we need to accept the fact that incremental value is produced when we're-- look at, at the individual level. The challenge is for manufacturers to join with the physicians in a way that they do comparative effectiveness research on an ongoing basis to find out where the incremental value is for their new discovery. It may be good for five percent of the people. And if it is, we shouldn't throw it out. Because if it's good for five percent, it's better than not.

So when you look at the use of Tamoxifen, the idea of using that kind of a medication for women with breast cancer, well, we have found with new genetic testing, that for those people who receive it, there's a percentage that cannot metabolize Tamoxifen correctly. So giving them that medication, which will help sell products, is of no value, even though it's cheap. Because it doesn't work. So something that's cheap but doesn't work is still no value.

However, the more expensive new medication that's been discovered happens to work for those people. And that five percent or ten percent or twenty percent should get that new drug, because it is effective for them.

MS. LEINWAND: Should most or all physicians be salaried and in groups?

DR. CORTESE: I'll take those in two points. First, the salary issue, everybody raises. The answer on salary is no. Many of the examples I gave you, those doctors aren't on salary. Mayo Clinic, we happen to use the salary mechanism. And that mechanism helps us reduce to the extent we can the conflict of interest and conflict of commitment that our physicians would feel when they're making decisions. So they don't have to operate on you if you don't need it.

Now, there are lots of other models that get really good outcomes too. And those doctors are on salary. Some of them have incentives. But the tendency for those incentives is that the incentive is linked to quality or linked to patient satisfaction. Have it linked to something that relates to value, is what we ask for in that model. So doesn't have to be salary.

The issue about being in groups, I think the answer to that is yes. I think physicians will have to be in groups as we go forward because we need to have some kind of a team approach. Now listen to me carefully — they don't have to be physically in groups. We have an electronic environment where people can be virtually working together. I can tell you, I have a physician network of people that I work with around the world, giving opinions, giving second opinions. They ask advice. And we're all doing it electronically. It's either by telephone or nowadays with BlackBerries. We can do that everywhere.

So the physicians need to be thinking of themselves as being a member of a larger body of people, where they can go to, to get knowledge. And they can do that electronically. Whether that's in their community, whether it's in their region, in their state, or it's national, doesn't matter. But they need to start thinking, teamwork and team approach. And the same is true for nurses and all the other non-traditional providers that we alluded to before.

MS. LEINWAND: Should neurologists and presumably other doctors be permitted to do their own MRIs?

DR. CORTESE: That means owning them, if that's what they're alluding to. I have a personal feeling about that, and this is a personal feeling. Mayo Clinic doesn't have an official position. But my answer is no. They should not.

MS. LEINWAND: Why?

DR. CORTESE: Because you have that conflict of interest floating there, no matter how you look at it. And I know that all of us feel that we're not affected, all of us, meaning doctors, that we're not affected by conflict of interest. But it's really difficult. And it's difficult to look the patient in the eye and say you don't have a conflict. It just doesn't seem the right thing to do when you're a professional. I know many doctors are going to disagree with me. But I've answered this as my own personal feeling about it.

MS. LEINWAND: What kind of reaction have you gotten from lawmakers to your suggestion about focusing on high value in Medicare? What are the arguments they're making against it?

DR. CORTESE: That's an interesting question. We've been at this now for a couple of years. And I would say-- Looking at Bruce Kelly, who's sitting in the audience too. But I think this is a wide open receptive area that we've been running into as we've talked to people. They're actually now trying to understand it more. They're asking for ways to do it. They're asking the right questions: "What do you mean by value? What are the outcomes?"

They understand safety and service now. It's the outcomes side. Because too many other groups are saying, "We can't measure outcomes." Too many people are saying, "We can't measure quality." And I completely reject that. It is measurable. And they're asking, "Okay"-- They're saying, "Cortese, okay, how do we do it?" And we're giving them examples. And there are many other groups that are giving examples. The Dartmouth group and others, with Elliott Fisher and Jim Weinstein, are all talking about these kinds of concepts with folks. So I think we've come, from wherever we were one year ago, a significant way down the road that people are actually open to the idea. We're seeing it in legislation. They don't all know exactly what that means. And it's not clear just yet. But the Institute of Medicine has been having meetings about, what is value? And how do we define it? Many folks are now discussing that. So I see a receptivity, an openness to it. This is an opportunity for us to move through that door and do the hard work to get there over the next two or three years.

And then the arguments against it, I frankly don't hear them, maybe because I just shut my ears. But I actually don't hear. I don't see how anybody can say that we don't need and want better outcomes, better safety, better service at lower cost. And I can't imagine anybody arguing against that without laughing.

MS. LEINWAND: Does the Mayo Clinic support HR-3200, the health reform bill?

DR. CORTESE: Okay, the HR-3200 is a bill that has not been passed. It's not done. The subcommittees have reported out some of their suggestions.

And I think there needs to be some melding there. There are components in that bill that-- By the way, Mayo Clinic doesn't back bills, just so you know, our official position. But when we measured against the standards that I just talked about, there are clearly elements in that bill, several elements in that bill that move us towards the pay for value type model, which is our number one measurement that we're looking for, from the Mayo Clinic perspective.

And there are elements in the bill that are moving towards an insurance set of reforms. And there's something relating to what it might look like with the public plan, or what have you. That'll all get washed out over the next several months, because you got the Senate doing what they're going to do. And they're all going to get together. And then it goes to a conference committee. We're going to keep our eye on the ball that we get something that comes out of all this that's focusing on value.

Both pieces of legislation that's so far just proposed do focus on value. They don't as far as we would like to. And we have given our opinion about moving it further if we can. And with regard to how we get everybody insured, that's going to have to play out in the political realm. So we're not here to back; we're here to give examples and ideas of how to get there.

MS. LEINWAND: What role do you think medical malpractice plays in the rising cost of healthcare?

DR. CORTESE: Well, I think it's a significant role from two standpoints. One, there is money that is being spent in that environment that to some degree might well be wasted. But that's not the biggest cost as I look at it. The biggest cost in the medical malpractice tort arena is that as a system of healthcare, which we don't have in The United States, but we don't really have a systematized activity. We lose a lot of learning capability through these malpractice suits because first, it can destroy careers of individuals who have made mistakes. And because of that, individuals tend to protect themselves by maybe doing more tests than they might otherwise.

But in addition, when something does happen, when a mistake happens, everybody goes to cover, go to ground, gets quiet. We don't share it. When an airline has a problem, the employees are required to report near misses within 24, 48 hours so that an engineering group will study it and try to figure out what we can learn, and distribute that information throughout the airline industry as quickly as they can, which could take several months.

In our environment, in healthcare, in which 98,000 people a year are hurt by medical errors alone-- Some people say, "Well, it's a lot less than that." Some people say it's double. The point is, it's more than one airplane crash per year. It's

more than one 747. As a matter of fact, 98,000 people is about one 747 crashing about every day and a half. And we would never tolerate that. But in our environment, because of the malpractice tort environment, there's no reporting. There's no mechanism that we can learn so that many of us in practice have found that one region of the country has been doing something thirty years before that have eliminated problems that the rest of the country doesn't know about.

We don't distribute this. Others have heard me talk about this before. This is the biggest problem and the biggest price we're paying because of this tort environment. Now, I'm not saying get rid of malpractice. I'm saying, create a safety reporting mechanism where people can actually report errors and near misses, that others can analyze and understand. And the exchange for that is some kind of a safe harbor where you go into an arbitration environment (arbitration, not tort) where patients actually get the payments that they deserve, but we at least learn something out of all this as we go forward. Right now we lose a huge opportunity.

MS. LEINWAND: Okay, this comes from a patient, Walter Kensiore(?) of Chicago, Illinois, who says he was treated at St. Mary's Hospital last April and spent over three weeks at the Rochester Clinic this Spring. On the reform Mayo advocates for U.S. healthcare, would everyone with this basic coverage be able to get treatment at the Mayo Clinic without \$5,000 dollar deposits or \$2,000 dollar co-payments?

DR. CORTESE: Well first the deposit part, absolutely. Depending on the insurance product, sometimes we ask for deposits. Most of the time we don't. It's rather rare that we actually ask for deposits.

As far as the co-payment, that depends on what the insurance companies do, and how the benefit package is designed. So the answer is yes. And we don't have any contracts with any insurance companies that require patients to come to us. Every single patient who comes to see us is doing that of their own choice. And frequently, they are coming out of network. So they end up having to pay some more. We'd really like to see a reform so anybody can come to Mayo Clinic who needs out type of care. So yeah, I'm hoping the reform will be able to answer the questions here as he was alluding, that we're going to get rid of some of those problems.

MS. LEINWAND: What is the ratio of the highest to lowest doctor salaries at Mayo? How does that compare with the country at-large? Are changes necessary to attract primary care physicians?

DR. CORTESE: Okay, there are three questions there. The ratio between our lowest and highest is about two-to-one roughly, maybe two and a half. I'd

have to think about it. But it's pretty close in that ballpark, so that the fact of the matter is, what we do in our organization is we-- And we do a market assessment of organizations that are like us. That's how we set our salaries. We set our salaries around the seventy percent range, seventy to eighty percent range of those benchmark organizations that are like us.

And the way that works is-- Frankly, I'm going to get in trouble when I go back to Mayo Clinic because people don't understand. We tend to pay our primary care and pediatrics a little more than they would get otherwise. And we tend to pay our higher paid people a little less than they would get otherwise, so a bit compressed in the middle. And that's been hard to manage, because of the competitive marketplace. It's just sort of driving things upward.

So that's a little bit on that. The other one was-- The second part-- ?

MS. LEINWAND: How does this compare with the country at-large?

DR. CORTESE: Frankly, I think overall, our salaries are a bit lower, just like I said, at the higher paid. And our primary care is a little bit higher on that. And then the last?

MS. LEINWAND: And then, how do you attract primary care physicians? Or do you have to have changes to attract primary care physicians?

DR. CORTESE: I think the country does need to do that. That's a country statement. We have a large primary care practice. Most people don't know that we do that for all of our communities. And actually we're in another 65 communities in Iowa, Minnesota, and Wisconsin. And we're providing local, primary, secondary, and tertiary care right in the community with groups of doctors and hospitals. We call them our Mayo Health System.

And yeah, it's a challenge sometimes to attract those folks. But it's an even harder challenge to get people to go into medical school and come out with an interest in going into primary care. So clearly, there has to be more respect and more recognition of the value of primary care as we go forward.

MS. LEINWAND: This comes from a psychiatrist who is actually paid to spend thirty minutes at a minimum with a patient, talking to a patient about their health. How can this be provided as a primary care service?

DR. CORTESE: The psychiatry or the thirty minutes?

MS. LEINWAND: The thirty minutes.

DR. CORTESE: Yeah, thirty minutes. At our institution, when a new patient comes to our institution, our physicians, we schedule one hour with the physicians to spend with those patients. And they can go longer if they need to. There's no really limit on how long they need to do that. Our follow-up visits are routinely about a half hour long in the way we schedule it. We feel that the most valuable thing that physicians can do when they're relating to patients in the outpatient setting is to have adequate time to sit down and talk to them, get to know really what their problems are and their concerns (because it's frequently not their condition; it's frequently something around the condition, that's related to it) and to spend time getting to know the families, and understand what really their desires are. And our ability to protect that has been under threat ever since price controls went into Medicare in 1983. And we're fighting very hard to protect that. It's time with patients is where the real value is generated.

So I'm glad she's got the half hour. But we schedule our routine internal medicine, primary care, they're all the same sort of categories.

MS. LEINWAND: Okay. We are almost out of time, but before I ask the last question, we have a couple of important matters to take care of. First of all, let me remind our members of future speakers. On September 28th, Ken Burns, the documentary filmmaker, will be here to discuss his new production on National Parks. On October 8th, John Potter, the Postmaster General of The United States Postal Service will give us the state of play at the Postal Service. And on November 13th, Chick-fil-A founder and chairman, Truett Cathy, and Chick-fil-A president, his son, Dan Cathy, will address the National Press Club speakers series luncheon. And it's a father and son team discussing their company's unprecedented sales growth in a struggling economy.

Second, I'd like to present our guest with the much coveted National Press Club mug.

DR. CORTESE: Thank you very much. (Applause).

MS. LEINWAND: I have to point out that for Dr. Cortese, that is the third in a series of mugs that you have gotten.

And for the final question, how do you best measure physician outcomes for end of life care?

DR. CORTESE: I think the best measure for that is to ask the family how they feel things went at the end of life. This is a very difficult time for everybody. Some of our results show that we're pretty efficient in the end of life care. When people have asked, what have we done, all I can say is, we don't do

anything to make that happen. We don't manage for it. We don't look at it. We didn't even know. Others have told us that. We were surprised.

What we do is just get to know the family. Our physicians understand the problem. They get to know the patient. And we do what seems to make sense for them. Because our core value truly is the needs of the patient come first. So what ends up happening, apparently when others have looked at it, is we end up having those people in the hospital fewer days in their final two years of life, in the ICU way fewer days, fewer procedures, fewer surgery (sic). Somehow the knowing of the patient and interacting with them and understanding what their wishes and desires are, you end up with perhaps a lower cost scenario. Okay?

However, you've got to ask the family, were they satisfied? Was the family satisfied? Was the patient satisfied? Did they really get what they want? So I would measure-- I would say, in time, the most important measurement we're ever going to have is really going to be the service components of what we do for people, and begin to measure that and ask questions. What do people really want? That's the way we try to do it.

MS. LEINWAND: Thank you. I'd like to thank you for coming today, Dr. Cortese. I'd also like to thank National Press Club staff members, Melinda Cooke, Pat Nelson, JoAnn Booz and Howard Rothman for organizing today's lunch. Also thanks to the National Press Club Library for its research.

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And I thank you very much. We are adjourned. (Gavel sounds.)

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