

NATIONAL PRESS CLUB LUNCHEON WITH DR. DELOS "TOBY" COSGROVE OF THE CLEVELAND CLINIC

SUBJECT: CLEVELAND CLINIC'S CHIEF EXECUTIVE DR. DELOS "TOBY" COSGROVE WILL DISCUSS HEALTHCARE POLICY IN THE WAKE OF THE SUPREME COURT'S HISTORIC AFFORDABLE CARE ACT RULING.

MODERATOR: THERESA WERNER, PRESIDENT, NATIONAL PRESS CLUB

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THERESA WERNER: (Sounds gavel.) Good afternoon, and welcome to the National Press Club. My name is Theresa Werner, and I am the 105th president of the National Press Club. We are the world's leading professional organization for journalists, committed to our profession's future through programming with events such as these, while fostering a free press worldwide. For more information about the National Press Club, please visit our website at www.press.org. To donate to programs offered to the public through the National Press Club Journalism Institute, please visit www.press.org/institute.

On behalf of our members worldwide, I'd like to welcome our speaker and those of you attending today's event. Our head table includes guests of our speaker as well as working journalists who are Club members. And, if you hear applause in our audience, please note that members of the general public are attending. So it is not necessarily evidence of a lack of journalistic objectivity.

I'd also like to welcome our C-SPAN and our Public Radio audiences. Our luncheons are also featured on our member-produced weekly Podcast from the National Press Club, available on iTunes. You can also follow the action on Twitter using hashtag #NPCLunch. After our guest speech concludes, we'll have a question and answer. And I will ask as many questions as time permits.

We are gathered here at the National Press Club, which has come to be known as a place where news happens. So it is fitting that, right now, we acknowledge the horrific events in the news today in Aurora, Colorado, which is on all of our minds and weighs on our hearts. Our thoughts and prayers are with the victims and their families. And, as we have done for so many times in our history of our 100 and plus years, we will continue to explore the pressing issues of the day, which is what we do as journalists and as engaged citizens.

So, having said that, I would like to introduce our head table guests. And I would ask each of you to stand up briefly as your name is announced. Alan Schlaifer, President of the Wharton Club of Washington, D.C. and contributing editor for *Resort Trades*. Myron Belkind, adjunct professor at George Washington University and Press Club treasurer. Sabrina Eaton, Washington correspondent, *Cleveland Plain Dealer*. Former U.S. Senator Don Nickles, of Oklahoma, Chairman and CEO of the Nickles Group and guest of our speaker. Rich Daley, Washington reporter, *Modern Healthcare*. Former U.S. Secretary of Defense William Cohen, CEO of The Cohen Group and a guest of our speaker. Doris Margolis, President of Editorial Associates and the National Press Club Speakers Committee member who organized today's luncheon.

I'm going to skip our speaker for just a moment. Mark Hamrick, business correspondent and video producer, Associated Press Broadcast and immediate past President of the National Press Club. Former Press Secretary to President Clinton Mike McCurry, a partner at Public Strategies Washington and a guest of our speaker. Peggy Eastman, President, Medical Publishing Enterprise. Natalie Dilasio, reporter, *USA Today*, and a new member of the National Press Club. Tim Holman, Congressional Reporter, *Bloomberg News*. Thank you all for joining us today.

[applause]

Today's speaker heads up one of America's most respected medical institutions, Ohio's Cleveland Clinic. As CEO, Dr. Toby Cosgrove presides over a \$6 billion dollar healthcare system comprised of the Cleveland Clinic, eight community hospitals, 18 family and ambulatory surgery centers, a hospital in Florida, a center for brain health in Nevada, a wellness and executive health center in Toronto, and a hospital currently under construction in Abu Dhabi.

His leadership has emphasized patient care and patient experience, including the reorganization of clinical service into patient center, organ and disease-based institutes. He has launched major wellness initiatives for patients, employees, and communities. Under his leadership the Cleveland Clinic has consistently been named among America's 99 most ethical companies by the Ethisphere Institute.

Dr. Cosgrove is a graduate of the University of Virginia School of Medicine and completed clinical training at Massachusetts General Hospital, Boston's Children's Hospital, and Brook General Hospital in London. He was a surgeon in the U.S. Air Force and served in Vietnam as the chief of U.S. Air Force Casualty Staging Flight. He was

awarded the Bronze Star and the Republic of Vietnam Commendation Medal. He joined the Cleveland Clinic in 1975 and was named Chairman of the Department of Thoracic and Cardiovascular Surgery in 1989.

Under his leadership, the Clinic's heart program was ranked number one in America by *US News World Report* for 10 years in a row. He has performed more than 22,000 operations and earned an international reputation for expertise in all areas of cardiac surgery, especially valve repair. He has 30 patents for developing medical and clinical products used during surgical environments.

His visionary thinking, medical and business expertise, and dedication have earned him numerous awards and honors. He is a member of both the Cleveland Medical Hall of Fame and the Cleveland Business Hall of Fame. He topped inside business power 100 listing for Northeast Ohio and is highly ranked among Modern Healthcare's 100 most powerful physician executives.

Among Dr. Cosgrove's many attributes, he is known for his ability to provide high quality care while holding costs down. He is also known for his concern that healthcare reform might stifle medical innovation. We look forward to hearing his views on these and other issues affected by the Supreme Court's ruling on the Affordable Health Care Act.

Ladies and gentlemen, please join me in welcoming to the National Press Club Dr. Cosgrove.

[applause]

DR. DELOS COSGROVE: Well thank you very much. That's the nicest introduction I've had today. [laughter] Well, I'd like to share with you some of the experience and some of the things that are going on around the Cleveland Clinic and how it reacts to the Affordable Care Act. First of all, let me tell you a little bit about our organization. We are a very innovative organization. We're 91 years old. We're a not-for-profit. We have a tripartite mission of research, education and clinical care. We are physician-led. And all of us are salaried and employed by the institution.

There are no financial incentives to do more or to do less, which is an important aspect of what we are. We all have one-year contracts. And there is no tenure. And each year we have an annual professional review, which is part of maintaining the quality of our organization.

Now it's interesting to look at healthcare and see exactly where we came from and how we are organized. The design that we currently have dates back to 1950. And much of it relates to the Hilburton Act which encouraged communities across the United States to develop hospitals and be responsible for the care of that community. Since that time, healthcare has improved. Longevity has extended. And with that, we've seen diseases change as well as therapies change.

And it's now, we're dealing with chronic diseases. Six of the seven major causes of death in the United States are chronic diseases. So it's no longer possible to have all the technology in one hospital. And no hospital can be all things to all people. So what is the crisis that we're currently dealing with, that we've heard so much about in the United States? And what did the Affordable Care Act, and how did it try to address these things?

Well, there are three main things that we've tried to address. The first is access. And you've heard about how the Affordable Care Act put another 32 million people who currently did not have insurance currently have insurance. And this is a major step forward. The other problems that were around quality. And quality was variable across the country. And finally, cost, which was escalating.

Right now, with the \$16 trillion dollar obligation that the United States has, 50 percent of that is related to Medicare. And the healthcare bill will do little to affect that obligation. In fact, we probably will see increasing costs. So how are we, as an organization, and how is healthcare, as an organization, beginning to deal with these issues as we go forward?

Well let's take them one at a time. And we'll talk a little bit about how we as an organization begin to deal with these. First of all, access. Insurance doesn't necessarily mean that you get to see your physician. Now one of the individuals in the audience today came to me and said that here in Washington, it was now difficult to see a physician. And there is a number of steps that you go to, to try and get to see a physician.

So we have begun to try to address each one of these. The first thing that we did is we put in place nurse on-call. So at two o'clock in the morning, when your child has a temperature of 103, you can get on the telephone and get some good advice from a nurse or get a suggestion about where you might go to get that sort of therapy. Last year we had 20,000 phone calls. This is a free service of the Cleveland Clinic.

The second area that we did is frequently, when you call up, it's hard to get through on the telephone. So we put together a call center. The call center now has an average of 40 seconds to answer the phone and only a three percent dropped rate on your phone calls. And, when you call to make an appointment, each time you're asked, "Would you like to come today?" Last year we saw one million same-day appointments. The ability to see those appointments, we were able to make 95 percent of those appointments available on a same-day basis.

Then there is the emergency room. Everybody would complain about the waits that there are in emergency rooms. We changed our method a year ago on how we see people in the emergency room. And now, the average wait is under 30 minutes from door to seeing a doctor in all of our emergency rooms across our entire healthcare system. So we've tried to begin to address actually the day-to-day needs of access.

The second issue is quality. And I would point out to you that quality is really not one thing, it is three things in healthcare. First of all, it's a clinical experience. It's a physical experience. And it's an emotional experience. The clinical experience we've begun to address with the electronic medical record. The electronic medical record now begins to make your data available to you across the entire organization. You can move from outpatient facility to a community hospital to the main campus with your electronic medical record going with you all the time. And so, any time you see a doctor, that information is available at that point.

The other thing we thought was incredibly important is beginning to have transparency. And transparency comes in a lot of forms. Starting some 30 years ago, we began to look at outcomes and begin to try to understand how you understood what outcomes were. And each time we looked at those, we always found that there was an issue that we could do better at.

And so, starting eight years ago, we said, "We'd like each one of our institutes to put together an outcomes book and make it publicly available." These outcomes books are published, and they are available on our website. And that is part of transparency around our quality. And additionally, we think that the transparencies about what's going on in your care should be available to you at any point.

So we opened the medical charts. And you can see your chart any time that you want in the hospital by simply asking for it. So further, you should be able to know about your medical history and your medical record when you're not in the hospital. So we have electronic medical records which can be available to you over the internet. And we have almost 500,000 people who now have access to this.

Interestingly, we now know that people who use this take better care of themselves. The diabetics know their blood glucose levels. And they take better care. So we encourage people to actively participate in their care along the way. Further, we have begun to understand complications within the hospitals. And we've looked specifically and been very transparent, not only about the entire organization, but the individual departments and the individual physicians' outcomes. And we post those publicly for the physicians.

Now, interestingly, I would tell you, there is no more competitive group of people than doctors. And doctors do not like to see themselves on the bottom of a list. And, if you want to improve the quality of a physician, all you have to do is rank them and make it public. And it's amazing how fast things move up. So we've had a lot of good experience that way.

The physical part of coming into the hospital is also part of everybody's experience. So we have begun to look at everything as far as the physical experience in the hospital is concerned, from the architecture, from the light coming into the room. We've increased glass across to bring more natural light in. We've begun to bring art into the hospital.

The speakers no longer spend all their time paging people. They play in the public spaces classical music as you come in, which adds nothing to the cost but greatly enhances the atmosphere of the facility. And we bring in art therapy, music therapy, and even amazingly, we have dogs walking around our hospital. I laughingly say there's nothing better than a lick from a lab. And the pediatrics sees that regularly. So we like to have the physical experience be a positive one as well, because it helps with healing.

The third and perhaps the most important aspect is the emotional aspect of being in the hospital. We were very concerned about this because anybody of the 43,000 people who work for the Cleveland Clinic can ruin the experience of a patient in the hospital. And I had one of those experiences one time when a relative called me to the room-- a relative of my wife's called me to the room and said, very upset family. And I wanted to know why they were so upset. The heart surgery had gone great. They were upset because, underneath the bed, there were dust bunnies. That ruined their entire experience.

So we brought all of our 43,000 people together and took them offline for three hours. We sat them around round tables like you have here, with doctors, nurses, environmental service people, people who drove buses, people who worked in loading docks. And we talked about the Cleveland Clinic experience.

And that has been a major factor in changing how these people are engaged. And we no longer address them as staff and doctors. Everyone at the Cleveland Clinic is addressed as a caregiver. And that has changed the atmosphere. And with that, we now find ourselves in the top 90th percentile in the country, as far as HCAP scores and patient satisfaction is concerned. An important factor in people's experience when they go to the hospital.

Finally, let me talk about cost. And one of the important things we have to realize about cost is we have perverse incentives. One of the major things about reducing cost is employing physicians. All of the physicians at the Cleveland Clinic are employed, myself included. I get a straight salary. So it did not make any difference whether I did three heart operations a day or four, I got paid exactly the same amount. So there was no incentive to do more.

Our system really encourages people to do more. Essentially in the trade, it's knowing eat what you kill. A little strange. [laughter] But, nonetheless, the incentives are wrong. And so, as we need to begin to move to an incentive that does not incent you to do more, but, in fact, incents you to take care of the patient and be paid for that. Now the involvement of the doctors has been proven that the salaried doctors, have been proven that it reduces costs. The Dartmouth Atlas looked at top organizations around the country. And the two that came out with the lowest Medicare costs were Mayo Clinic and the Cleveland Clinic, both of which employed physicians.

The other thing that physicians do is they bring-- employed physicians is it brings them around to involvement in the organization. We involve our physicians in

everything. We're physician-led. We involve them in our purchasing decisions and our utilization decisions, all of which helps bring about lower costs. The other aspect of bringing about lower costs is integration of healthcare systems. We are completely integrated across our organization.

And so that has allowed us to do a couple of very important things. First of all, we have reduced duplication of services. We have rationalized services. We have rationalized and gone around and consolidated pediatrics, trauma, rehabilitation, heart surgery, obstetrics, and gone to places which do a bigger volume. And, as a result of doing bigger volumes, they do more. And, as a result of that, they get better quality and more efficient. And that certainly has been proven to be the case in multiple studies across the country.

We also recognize now that healthcare is changing. Where it is done is changing. The hospital is becoming less and less the epicenter of care delivery. Care delivery is going from in-patient to out-patient to homecare. And we now can see that hip replacements and knee replacements are done with 24-hour stays, and many people going home the same day as they've had those procedures. It's simply the advance of care. It is also the advance and change in the type of diseases we're dealing with, more chronic diseases, less acute diseases, and the acute diseases and the surgical diseases are now more taken care of as out-patients than in in-patients.

Now the other perverse incentives is around all of us. There is no incentive for us to take care of ourselves. We smoke. We become obese. We don't exercise. And we go to get healthcare and expect to get great care. Let me just give you a couple of examples. First of all, you have to realize that 40 percent of premature deaths in the United States are secondary to three things: smoking, eating, and a lack of exercise.

Let's taking smoking for example. The incidence of smoking in the United States is 20 percent. And the scary part is, it's rising. It is associated with the majority of cases of cancer in the United States. So we began a very aggressive approach to this. We started out by having no smoking allowed, not just in our buildings, but anywhere on our campuses, our parking garages, anywhere property of the Cleveland Clinic.

Then we had smoking cessation for all of our employees, free. Then we decided that we'd make a bold step and stopped hiring smokers. We test people. By the way, it's legal. [laughter] I checked. [laughter] One of the smart things I've done. [laughter] And then rolled this program out of smoking cessation into the community and helped drive smoking cessation laws in public places in the State of Ohio. And in Cuyahoga County, where we're located, the incidence of smoking has gone from 28 percent to 15 percent in five years. So you can make a difference. And perhaps we've saved more lives by doing that than one would in a cardiac surgical career.

The epidemic of obesity is terrifying. Right now one-third of the United States is overweight. One-third is obese. Obesity is leading the epidemic of diabetes. Right now, 10 percent of the cost of healthcare in the United States is secondary to obesity. And the

projections are, in the next 10 years, that that will go to 20 percent. So we will not control the cost of healthcare in the United States unless we control the pandemic of obesity.

So again, we've figured that we needed to begin to address this. So we started out with food. We took the trans fats out of all the food we serve in the hospital. We've made 40 changes in the cafeterias of the food that we serve. We took the candy bars out of vending machines, the sugar drinks out of the vending machines. And then we turned to exercise. We gave our employees free Curves, free Weight Watchers, free yoga, free access to our gyms. And, over the last two years, we've lost 330,000 pounds. [laughter] It's a start.

But so these-- these, I think, represent an effort that you can also take out into the country. And we need to begin to address these. Let me just, for a moment, tell you a story. And I think you will understand the reason for this story. Two and a half years ago, a 25 year old opera singer was flown into the Cleveland Clinic in the dead of the night from here, as she was end-stage lung disease. And, had she not had a lung transplant, she clearly would have died.

She received a lung transplant, a double lung transplant. Was extremely sick. Kept in a medically induced coma for four weeks. Eventually recovered. Left the hospital. Came back to sing opera three months later for the team that had looked after her. That summer, she married the man who had stood by her through this entire event. And then she began to get short of breath again.

She came back to the Cleveland Clinic after extensive medical therapy and could not be sustained or improved on that therapy. She was placed on an artificial lung for three weeks waiting for a second set of lungs. She received those second set of lungs and is now living in Washington and singing opera again. I'd like to have you meet Charity Tillemann-Dick, who is with us today. [applause]

Charity, I think, is here with her grandmother. Her grandmother is Tom Lantos's wife. Tom was a Congressman. And last time she was here, he spoke before this group. He was a Congressman from California for 27 years. Mrs. Lantos, would you stand up? [applause]

I introduced this to you because I think this is an example of American medicine at its very best. And we need to address the three issues that I talked about: access, quality and cost if we're going to be able to continue to drive this sort of quality medicine in the United States and provide quality care so people like Charity can return and sing opera for us and contribute to our society. Thank you very much for the privilege of talking to you today and sharing some of our experiences.

[applause]

THERESA WERNER: How has the Cleveland Clinic managed to reduce costs without sacrificing the outstanding care for which the Clinic has long been known for?

DR. DELOS COSGROVE: I think one of the main things we've done is we've involved the physicians in our decision-making. And the physicians understand about the things that they can do. For example, they came together around pacemakers, hips, knee replacements, purchasing. And we reduced our purchasing by about \$125 million dollars in the last two years.

THERESA WERNER: What can be done about the decreasing number of doctors? And who will take care of our growing population?

DR. DELOS COSGROVE: The number of doctors actually is not decreasing. The problem is, that we have never produced enough physicians in the United States to look after the demands. We've been a net importer of physicians forever. We're going to have a shortage of about 90,000 doctors across the United States. And we are similarly going to have a shortage of nurses, of bordering on a million nurses. And so we're going to have to find other people to be the caregivers. Physicians' assistants are becoming increasingly used. That allows everybody to practice at the top of their licensure. And technicians are coming in to replace much of the work that nurses have previously done. No need to have a nursing degree in order to take a blood pressure or record a temperature.

THERESA WERNER: Do pharmaceutical companies reward physicians who prescribe their medicines? If so, how?

DR. DELOS COSGROVE: Well I think all of us have seen many stories about pharmaceutical companies and device companies encouraging physicians to do that. I think that is being less and less an issue in the healthcare world. There used to be a lot of entertainment that went that way. That is almost completely gone, to the best of my knowledge.

THERESA WERNER: Is the Cleveland Clinic more or less likely to hire employees as a result of the Affordable Care Act?

DR. DELOS COSGROVE: Well-- I don't think we know, yet, how the Affordable Care Act is going to be affect us. We haven't seen, yet, the implications in terms of the number of patients that we're going to see, and figure out how we're going to take care of them. Clearly, any healthcare organization, the major cost is people. It's about 60 percent of the cost of running the Cleveland Clinic right now. And obviously, we'd like to do that in the most efficient way that we can. And we'll have to wait to see what the demands require.

THERESA WERNER: Tens of thousands of patients die each year from infections contracted in hospitals and doctors' offices. How can we reduce that staggering toll?

DR. DELOS COSGROVE: Yeah, that's a-- that's a great question. And, you know, that is one of those things that has been brought to the attention. We've seen probably a 50 percent reduction in the incidents of central line infections across the country, simply by bundling and using standard procedures. And I think that we're increasingly looking at the same thing that pilots look at, checklist. Atul Gawande, I think, was particularly effective in bringing checklists to medicine.

Interestingly, now, part of the other major issue in cost is the end of life. And we think that there is a lot that we can do to both make that a more civil and kind experience, and, at the same time, let people pass in a less costly way. And so we are looking at a checklist. And Atul Gawande and the Cleveland Clinic are now doing a research project, trying to develop those sort of end of life checklists that will remind people about where you are in the process. Have you talked to the family about it?

And I might just say, parenthetically here if you don't mind, I think this is an important topic. And I would encourage you all to think about this yourselves. And I know many of you have had this experience. Both physicians and family and patients are stressed at the end of life. The worst thing that can happen is not to have the discussion about the difficulty that this represents for those people.

I found in my surgical career that, if I would enter into a discussion with a family and say, "I will do everything possible to keep your loved one alive if I think they can return to a useful member of society. At the end of that time, if I think that we've come to the point where I don't think that's going to happen, I will come to you, and we will have a discussion about this. And I will not make life go on just endlessly for keeping your loved one alive."

I have always been greeted by, "Thank you so much, doctor. I'm really pleased that-- and I look forward to those discussion. And I'm greatly relieved that you had that discussion with me." It takes-- And, if you will enter into those as individual laymen, and have that discussion with your physicians, it will be good for the patient. It will be good for you. And it will be good for the doctor.

THERESA WERNER: Are there growing risks from antibiotic-resistant bacteria? And how serious are those risks? And what needs to be done in prescribing antibiotic development process?

DR. DELOS COSGROVE: I'm clearly in over my head here now, as somebody that just cuts and sews. Clearly, antibiotic therapy is something that increasingly, people are concerned about getting resistant strains. We've seen this in tuberculosis and in staff infections that we have selected out by our use of antibiotics. And I think it's important that antibiotics be used judiciously and that the pharmaceutical companies be encouraged and supported as they develop increasing antibiotics to take care of those currently resistant strains.

THERESA WERNER: How can health insurance companies reduce their costs so that they can devote more of their income to providing needed health services to their clientele?

DR. DELOS COSGROVE: I'm going to plead total ignorance on that. I'm not in the insurance business.

THERESA WERNER: Prostate cancer is often in the news these days, with differing medical opinions as to watchful waiting versus immediately treatment, PSA tests and surgery. What is your take on this?

DR. DELOS COSGROVE: It's interesting. Now we're beginning to understand the differences there are in prostate cancer. And that has been done out of a study that is now almost 10 years old, done at the Cleveland Clinic, looking at the genetics of the prostate cancer. We realized that some are very aggressive and some are not aggressive at all. And, by differentiating between those, we can begin to decide what is the most appropriate type of therapy.

THERESA WERNER: When omega-3 fatty acids were discovered to improve heart and blood vessel ailments, some pharmaceutical companies were very concerned that this would reduce sales of their heart and blood vessel drugs. Has this happened? And how do these fatty fish acids help improve heart health?

DR. DELOS COSGROVE: I'm sure that you're aware that we've seen about a 30 percent decrease in the incidence of cardiac death in the United States in the last 25 years. And I think this has been a result of several things. It's not just coronary stents and coronary bypass surgery. It's about the fact that there is better awareness of taking care of yourself, more increasing use of fish oils, etcetera, and better diet and exercise. And I don't know that any of these drugs have been substantially decreased in their use.

THERESA WERNER: What do you think of steps such as Mayor Bloomberg proposed to cap soft drink bottle sizes or other steps to prevent some items from being sold?

DR. DELOS COSGROVE: Well first of all, I think you have to salute Mayor Bloomberg for many of his proactive stances in encouraging wellness across New York City. He was one of the first people to begin to take trans fats out of the food. He raised our awareness on many issues. Whether this is the solution to the obesity problem, with the size of your drinks and the size of your cup, remains to be seen. I'm not particularly optimistic about it.

THERESA WERNER: You said that you no longer hire smokers. Do you hire folks at the Clinic that are obese?

[laughter]

DR. DELOS COSGROVE: The Americans With Disability Act protects-- [laughter]-- protects people from discriminating against people who are obese. And, under advisement, we do not discriminate against people who are obese. [laughter]

THERESA WERNER: If a patient who received care at the Cleveland Clinic later sees a doctor who is not affiliated with the Clinic, under your system of record access, will the doctor have access to those records?

DR. DELOS COSGROVE: Yeah. We like to provide access to the records. But, without being involved in the electronic medical record, it's not possible to send the electronic medical record. But we can give the electronic medical record to the patient. And the patient can take it to his referring doctor. So, if you get treated at the Cleveland Clinic, and you get sick in Los Angeles, you have access to your record. And you can take it with you.

THERESA WERNER: How serious an issue is noncompliance by patients failing to take the full dosage of prescribed medications?

DR. DELOS COSGROVE: This is very big-- Noncompliance is a big issue. And we're trying to figure out how we can begin to address this. We have realized that just making a phone call and saying, "Did you take your pill today?" doesn't do it. And we're actively involved right now in an interesting discussion with Time-Warner Cable, who can bring into people's television sets a way to communicate back and forth between the doctor.

So you can actually say to the patient, "Would you hold up your bottle of pills? And did you take one of those today?" And I think that this is the next step beyond the phone call, which started out as a routine office visit, then the phone call reminder, and then a group of ways to do this in Skype-sort of fashion. And I think this is the next step, hopefully for the future, to begin to drive compliance.

THERESA WERNER: A news report yesterday indicated that there have been 18,000 cases of whooping cough in the U.S. this year. And the original vaccine is not sufficient. What should be done to prevent or reduce further outbreaks?

DR. DELOS COSGROVE: You know, I think that the concern about whooping cough is a major concern. It's mainly driven by the fact of the scare about autism. And that mothers and fathers are not getting their children immunized because of the fear of autism. I think that has been pretty much disproven. I don't think there's much question about that now. But this whooping cough epidemic would not happen had we had a continuation of the immunization. And I think that's the reason for it.

THERESA WERNER: COPD is the third largest killer of Americans, second leading cause of disability in the U.S. What is the importance of research into lung disease? And does the Clinic plan to increase such research?

DR. DELOS COSGROVE: Yeah. I think-- My father died of COPD. And he was a smoker. And I don't think I have ever seen someone with chronic obstructive pulmonary disease who, frankly, was not a smoker. And the biggest thing we can do is begin to drive smoking out of the general public. This is a huge public concern. And we're not going to get that improved until we do the-- take care of the major cause, which is, really, smoking.

THERESA WERNER: How can healthcare institutions better work together to share or codevelop more effective and/or innovative processes, technologies, or clinical capabilities?

DR. DELOS COSGROVE: I'm starting to feel like Dr. Oz here. [laughter] By collaboration. And I think there's a-- Let me take this to a little higher level, if I could. We're starting to see, now, a tremendous change in hospitals across the country. The hospitals are coming together in systems. Systems are collaborating. We're starting to see systems talk to systems. And, as we begin to head in-- and just one little fact here. Sixty percent of the hospitals now in the United States are part of a system. And, as we have systems come together, we start to get more standardization of care, more efficiency, and more collaboration going on there.

THERESA WERNER: Speaking of Dr. Oz being a popular TV figure, what more can the media do to educate and motivate the public about better healthcare practices?

DR. DELOS COSGROVE: Well I think that there is a tremendous need for medical education. And this goes television, print, everything. And there's going to be a big process of educating people about what the current healthcare act entails. I think very, very few people recognize exactly what's in that bill and what the implications are, both for your personal care, and for the health of the nation. So that's going to be a big educational process for you all, too.

But I don't think you can do too much to emphasize the importance of people taking care of themselves, in terms of smoking and obesity. And so frankly, my major concern is the public generally has not come to grips with the pandemic of obesity. And, just to put that in some sort of perspective for you, if you look at the disability, the total disability of employees at the Cleveland Clinic, and you take out people who have cancer, 90 percent of those on permanent disability are morbidly obese. That's how big the problem is.

THERESA WERNER: A number of states have indicated they are unwilling to expand Medicaid as part of its Affordable Health Care Act. What will this do to the healthcare systems like the Cleveland Clinic?

DR. DELOS COSGROVE: Well, if we don't have Medicaid patients covered, we're going to have more patients who are not-- are not pay patients. Currently, we are

the largest Medicaid provider in the State of Ohio. And this is going to have just more patients without any reimbursement for us. So, and that will cause the rest of us who buy insurance to have their premiums go up.

THERESA WERNER: How did your hospital in Abu Dhabi come about? And are you planning other hospitals in more countries?

DR. DELOS COSGROVE: It's an interesting sort of history. 9/11 happened, we were operating on about 35 patients a month particularly from the Middle East. And, at that point, it went to five in about two weeks. And so my predecessor CEO said, "Why don't we try and meet them halfway. And we'll establish something in London." And we tried to buy a hospital in London. We tried to lease a hospital in London. We looked at Greenfields. And, in the meantime, people began to realize that perhaps the Cleveland Clinic was willing to go offshore. We had inquiries of one type or another from 70 countries. And we looked at many of these. And, by far, the most attractive was Abu Dhabi.

And I think it's important that we point out to you that our arrangement in Abu Dhabi is not such that, instead of spending money in Northeast Ohio we are investing in Abu Dhabi. That's not the case. In Abu Dhabi, they are building-- the government is building the hospital. They are paying our salaries. And they are paying us a management and consulting fee. Now, and so, essentially we're using our intellectual capital there to drive your petro dollars back to Northeast Ohio. [laughter]

Now, in a bigger scheme of things, if you look at what the world wants from the United States right now, they're not particularly interested in our steel or our refrigerators, in many cases our cars. But they do want our entertainment, our innovation. They do want our graduate education. And they do want our healthcare. And our facility is the first facility from the United States that's taken the challenge of going entirely overseas and staffing the hospital, bringing the design to the hospital, bringing the protocols to the hospital, and taking responsibilities for doing it. And it's a great opportunity to begin to help design a healthcare delivery system for a country.

THERESA WERNER: Given the success of the Cleveland Clinic, and it being replicated in other countries, why aren't there more hospitals like yours here in the United States?

DR. DELOS COSGROVE: The Cleveland Clinic was started as a system that was looked at as very innovative and radical at the time that it was founded, with employed physicians. And, in fact, they were looked at as medical Bolsheviks at the time that it was started. And then that has not been the tradition. It is very difficult to change from the system that currently exists in most places to what we are, because most physicians are very entrepreneurial.

Now, what's happening right now across the United States is changing that enormously. Right now, 60 percent of the doctors in the United States are employed. And

75 percent of the medical graduates now are going to be employed instead of being self-employed. So you're seeing hospitals come together in systems, hospitals employing physicians. Essentially, that is looking increasingly like the Cleveland Clinic over a period of time.

And I think that you are beginning to see that change happening. It will not happen fast. But it is important, I think, for the long time affordability, that it does happen.

THERESA WERNER: You talked about your staff being on salary. How serious are the other cited concerns that physicians cannot afford to practice, or don't find the pay compelling? Has that been a problem that you have had in your profession?

DR. DELOS COSGROVE: I think it's worthwhile talking a little bit about how we pay and how we set salaries. We look at what the average salary of academic medical centers across the United States. And we try and pay for a department in the average in the 90th percentile of that. And that means that pediatricians don't get paid the same as neurosurgeons do. But we pay according to the specialty, the expertise that the individual has within his specialty, and what the national standard for that specialty is.

THERESA WERNER: To what extent do medical malpractice lawsuits and premiums weigh on places like the Cleveland Clinic? And is this situation getting better or worse?

DR. DELOS COSGROVE: Well tort reform has been something that was clearly not a part of the Affordable Care Act. And I think it's an important thing that we're going to have to eventually deal with. In Ohio, we have had tort reform. And it has decreased our costs of malpractice very significantly. We think that it there is estimated that about four percent of the healthcare costs in the United States are attributable to malpractice and people trying to avoid it.

THERESA WERNER: What are the costs and benefits of medical tourism, where Americans go to other nations for major procedures that are very costly in the U.S.?

DR. DELOS COSGROVE: It's interesting that there has been a great deal made out of people leaving the United States to get care outside of the United States. And the data essentially looks at medical tourism principally to places like India and Singapore. And they always give the data about the numbers that go there. Now the vast, vast, vast majority of those are from Southeast Asia and the Middle East and not from the United States. So there's a trickle of people who leave the United States for healthcare outside. And I think it has almost negligible economic influence on healthcare costs in the United States.

THERESA WERNER: Do the people who utilize your 24-hour call service have to have insurance?

DR. DELOS COSGROVE: No.

THERESA WERNER: Aren't there other factors beyond smoking and obesity that cause ill health, like chemicals, air and water quality? And what are you doing about these?

[laughter]

DR. DELOS COSGROVE: You guys are mean. There is no question that there are multiple other things that affect healthcare. But those are-- And those are three really big ones. The thing that concerns me, quite frankly, is the epidemic of autism. Autism frankly was something that was not seen when most of us were kids. And now it's one in 88 live births. The implications for that, both for society and for the economics are stunning.

At the other end of life, the other thing that concerns us is Alzheimer's disease. If you get to be 80 years old, your chances of having Alzheimer's is 25 percent. The economics of that, and it's now risen into one of the top seven causes of death in the United States, the implications of those two things, at the beginning and the end of life, are stunning. And, until we begin to identify whether it's an environmental factor or just other factors, and begin to deal with those, is going to put a huge burden on the cost of healthcare, both in the United States and around the world.

THERESA WERNER: What recommendations do you have to get schools to change their lunch menus and vending machines away from junk food drinks to healthier offerings?

DR. DELOS COSGROVE: Yeah. We're very fortunate at the Cleveland Clinic to have Mike Roizen who is our chief wellness officer at the Cleveland Clinic. And he has reached out into the schools of Cleveland. And we have begun to actively help them improve the quality of their lunch meals that they serve. And this has been a big effort that's gone on a long time.

The other corollary of that is the epidemic of childhood obesity, which is directly related to school grades. And we have done a great deal of research on that particular topic as well. So the food issue in schools is acute. We're trying to deal with it locally. I think that this is going to have to be something that's going to be taken up on a national issue, probably right here in Washington. There are 30-some agencies, by the way, here in Washington, that regulate food in one way or another, at this point.

THERESA WERNER: How will the Affordable Care Act affect medical innovation?

DR. DELOS COSGROVE: I'm a little concerned about the beginning to look at the efficacy of a drug or a device when it's in practice, to decide whether you're going

to pay for it or not. And let me give you an example. If you develop a heart valve, it takes you about 10 years of work in animals, and through the regulatory process, to get that approved by the FDA to be sold. If you're going to tell whether one heart valve is better than another heart valve, it's going to take you another 10 years to be able to understand that.

I don't think there are very many venture capitalists who are willing to invest in a 20-year project. So I'm concerned, frankly, that beginning to fund things on that basis will begin to drive a lot of the innovation out of healthcare in the United States. And you have to realize that healthcare and products that are developed here are sold all over the world and one of the major exports from the United States, whether it be pharmaceuticals or devices or other things used in healthcare.

And that may well slow because right now, we know, quite clearly, that the regulatory process is a lot faster outside the United States than it is inside the United States. And I think we also have to remember, sort of on a bigger scale, that you can't do anything new without an attendant risk. And if a society becomes so risk-adverse, we are not going to see an innovation that has driven healthcare to the point which has doubled the life the expectancy in the United States in the last 100 years.

THERESA WERNER: Republicans in Congress have talked about a need to repeal and replace Obama's healthcare law. Are there any aspects of the law you would repeal? And what would you replace them with? [laughter]

DR. DELOS COSGROVE: Let me defer just a little bit on that. [laughter] I think, more importantly, we have to say that the law does a couple of things very well and some things that it doesn't do quite so well. First of all, we know that it's not going to control costs. And so we're going to have to do that. And that's probably going to be led by the private sector. And one of the things about controlling cost is there's not a lot in this law about providing incentives to take care of yourself. And I would like to see more incentive for people to do that.

And, interestingly, just recently, we helped Senator Wyden and Senator Portman introduce a bill in the United States Senate that would set up criterion for people under Medicare to begin to have financial incentives for meeting various milestones, keeping their weight under control, to blood pressure, etcetera. And we've found that very small incentives, financial incentives drive significant behavior.

And by that, I mean we found, for example, we had 3,000 diabetics at the Cleveland Clinic. Only 15 percent of those were seeing a doctor regularly. And we were shocked when we found that. So what we did is we put a series of incentives in place. Now 50 percent of the people with chronic disease are in chronic disease management. With the wellness that I talked to you about before, with those financial incentives, we've now seen our cost curve flatten. So we are no longer seeing inflation in our costs of looking after our patients.

THERESA WERNER: Which other healthcare facilities do you consider to be innovative? Have any other clinics had ideas you find impressive?

DR. DELOS COSGROVE: Innovation can happen anywhere. And we see it coming across all sorts of places. I don't think that you can look at healthcare and expect it to come from one organization. I think there are great things happening on multiple locations. I think the important thing is to go and try and find those and incorporate them boldly into your organization.

A number of years ago, I told every one of the employees, doctor employees of the Cleveland Clinic, that I would ask them to take one trip a year, just go and learn something new somewhere. I didn't care where in the world they went. And so I thought we were turning loose a couple thousand spies to go out and find really good things. And so I think there are lots of places. And we have to look for new ideas where we can find that.

THERESA WERNER: What is the impact of providing more home-based medical care for elders?

DR. DELOS COSGROVE: Yeah. The thing that is driving homecare is the fact that the diseases have changed. People now have chronic diseases that are not going to be looked after in the hospital. And they're better to be looked after at home. The implications are that, first of all, we have to build the system to do that. And secondly, it's going to reduce the cost of looking after patients. And they're going to be better cared for at home. And I don't think anybody would rather be in the hospital than be at home. And that's the direction we're trying to move.

THERESA WERNER: We're almost out of time. But before asking the last question, we have a couple of housekeeping matters to take care of. First of all, I would like to remind you all of our upcoming speakers. On July 24th, Judy Woodruff and Gwen Ifill, co-anchors of PBS News Hour 2012 Election Coverage, will discuss the complex issues in play in the run-up to the November 6th general election. On August the 28th, General James Amos, Commandant of the U.S. Marine Corps will discuss the role of marines as America's crisis response force. And, on September 6th, Kathleen Turner, iconic film and stage star, and chair of Planned Parenthood's Board of Advocates, will discuss reproductive rights and the state of women's health. And on October 2nd, Secretary Arne Duncan, U.S. Department of Education will be here.

Second, I would like to present our guest with the traditional National Press Club mug, to be used, of course, for low-calorie healthy beverages. [laughter] And the last question. Traditionally, hospital food has been regarded as being pretty terrible, bland, and uninspired. Do you sample patients' food? And any advice for other hospital systems?

[laughter]

DR. DELOS COSGROVE: I sample-- I sample patients' food every day at lunch. [laughter] And thank you very much for the opportunity to be here, and the mug.

[applause]

THERESA WERNER: Thank you for coming today. I would also like to thank the National Press Club staff, including its Journalism Institute and Broadcast Center for organizing today's event. Finally, here is a reminder that you can find more information about the National Press Club on our website. Also, if you would like to get a transcript of today's program, please check out our website. Again, it's www.press.org. Thank you. We're adjourned.

[gavel]

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