Moderator: Chris Gade
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11:00 AM ET

Operator: Good day, ladies and gentlemen, and welcome to the Mayo Clinic Health Policy Center. At this time, all participants are in a listen-only mode. Later, we will conduct a question and answer session and instructions will follow at that time. If anyone should require assistance during the conference, please press (*) than "0" on your touch-tone telephone. As a reminder, ladies and gentlemen, this conference is being recorded.

I would now like to introduce your host, Mr. Chris Gade. Mr. Gade, you may begin.

Chris Gade: Thanks, Pam. Hi, this is Chris Gade. I'm a spokesperson here at Mayo Clinic, and pleased to introduce and have some brief background remarks before we begin.

Our purpose today is to share and discuss the summary of some of the ideas that have emerged to date for patient-centered healthcare reform from the Mayo Clinic Health Policy Center. The Mayo Clinic Health Policy Center is about 18 months into a very participatory process, where we've heard from a broad range of patients, providers, businesses and employers, insurers, academics, and representatives of the government. All of these folks have been coming together to formulate what we call "action principles."

And the participants really have been a true cross-section of major organizations throughout the country, and I believe in your documents you have a sampling of some of those participants that we would draw your attention to. In truth, less than 10% of the overall participants have actually been from Mayo Clinic. We've been quite intentional in our efforts to draw in people from across the country in this process.

What we've formulated and what we'll highlight today represent what we call "action principles." These are broadly agreed upon fundamentals that we feel will contribute to the formation of public policy and produce positive change. These action principles we feel can best address two important elements of what's going on currently.

The first is the aging of the American population, and how can we, in the face of that aging of the American population, help ensure high quality, patient-centered healthcare moving forward. The other piece we want to draw your attention to before we begin with some opening remarks is that this is really a snapshot in time. This is an iterative process, and these principles are going to evolve over time. We began with a symposium last May held here in Rochester, Minnesota. That was followed by four forums, smaller groups of people coming together to further develop the ideas that were formulated at the symposium. And next March, March 9th through the 11th of 2008, we'll be gathering somewhere in the neighborhood of 400 to 500 people in Leesburg, Virginia for our second symposium, when we'll prioritize those action principles you'll hear about today; develop a specific action plan, both for government and the private sector; and we'll also hear directly from patients throughout this process. We've conducted some initial patient research; we're planning to get more perspective from patients leading up to that next symposium in March, where our process will continue to evolve and will develop further priorities and action plans. But this is a snapshot as to where we are at the current time.

Our participants in today's briefing -- we're welcoming Dr. George Isham, he's the chief health officer and planned medical director for Health Partners in Minneapolis,

Minnesota; Andrew Mekelburg, he's the vice president for federal government relations for Verizon, he's based in Washington, DC; Dr. Denis Cortese, who is the president and CEO of Mayo Clinic; and Robert Smoldt. Mr. Smoldt is the executive director for the Mayo Clinic Health Policy Center.

We're going to begin with some remarks from Dr. Cortese. Dr. Cortese?

Dr. Denis Cortese: I was asked to make some opening remarks about really why did Mayo Clinic get involved or start a role in health care reform. I'll mention a couple of reasons that transpired just for your information, then we'll proceed.

We started with the assessment of the urgent need for reform in this country, which is well-known now in this country, as we look at ensuring the future of quality healthcare in the United States. And the key issues that we were focusing on is the issue -- and these are the same issues that are discussed nationally -- access to affordable insurance and healthcare; quality, the quality of care in this country, meaning outcomes; safety; service; and the cost, the overall spending on healthcare. Which basically, when you look at quality, outcomes, safety, and service, relating that to the spending, we're talking about value of healthcare. So that's how we got involved, trying to contribute some thoughts to how to guarantee that.

The impetus to get involved now -- when I say now, we started about two years ago -- was our view of an impending catastrophe with Medicare that's looming in the next four to five years or maybe even sooner, that you're all aware of. What we did, as we try to figure out how to go about this, we basically started by asking ourselves two questions, and I'll ask you to ask yourself these two questions, too. Any of you in the audience listening to us who would like to go to a hospital tomorrow, even if it's the best hospital in the world, raise your hand. And the second question is, if you're sick, yes, you may want to go to that hospital, but who in this audience would like to be sick tomorrow? So raise your hand.

And we came to the conclusion that the answer has got to be focused around patients, not around hospitals, not around insurance companies, not around drug companies. So we look at our own internal philosophy at Mayo Clinic and we found that our core value is the needs of the patient come first. And our second component of that is that we solve problems by trying to pull together a union of forces; bringing people together to try to solve these problems. These has been our heritage since that quote was made -- the words I just gave you were a quote by Will Mayo from 1910, at the graduation of the Rush Medical School.

So what we've tried to do is bring a voice and bring interest of the patients to the healthcare debate. We've convened stakeholders who will, I hope, will come up with some workable solutions or at least workable visions that we can aim for; and the ultimate idea is that all of the sectors that are involved in healthcare will have to give up something, will have to lose something, so that overall we can all win in the long run.

Chris Gade: Thank you, Dr. Cortese.

As you've seen in your material, there's really four areas of focus in terms of our recommendations, and we'll talk more about those now.

The first is in the area of individual ownership of health insurance for all, that all citizens should have basic health insurance and access to basic healthcare, regardless of their ability to pay. The other area is the area of coordinated care, that patient care services must be coordinated across people, functions, activities, sites, and time, in order to increase value; and that patients should be active participants in the process. The third is

in the area of value, that we increase quality in patient satisfaction, decrease medical errors, costs, and waste. And the final is in the area of payment reform, that we need to change the way providers are paid in order to improve health and minimize waste.

We're going to begin with the topic of individual ownership of insurance for all, and Dr. Cortese has some brief remarks.

Dr. Denis Cortese: Just a few points to make about that. The health policy group so far in our meetings and our sessions with a wide group of folks have felt that it does make sense that health insurance should be available; that there's a basic health product that's available for all Americans, regardless of their ability to pay. To help make that happen, we're looking at the concepts that adults would be required to purchase private insurance for themselves and for their families. In other words, every patient should be expected to have health insurance.

We recognize not everybody will buy it. The model is like automobile insurance, and we recognize there are people who do not purchase it. But the expectation should be that everybody should be required to have health insurance and purchase it; and that they would then own it. Currently, if you lose your job, you lose your insurance, which contributes to people going for some periods of time without insurance, and they count as underinsured for that particular year. If insurance isn't tied to employment, you can take it with you when you move because you would own it.

On the other hand, employers can certainly continue to participate at their choice. They could continue to finance a portion of the healthcare expenses of their employees as a method of attracting and retaining talent. For instance, Mayo Clinic is a large employer. We have about 50,000 employees, 100,000 people in our insurance products. We offer them three options; but if they leave the institution, they have to go on Cobra, or they go without insurance. Having the ability for us to continue to provide insurance but that they own it would be a plus for our employees.

The next point is the sliding -- the government would participate. Government could participate by providing sliding scale subsidies. In other words, the government could participate as a helpful financier of this insurance that individuals would be required to purchase. In other words, all people would participate, and the amount a person pays would be a function of their ability to pay.

The last point is that people would not be really left on their own to just find health insurance on their own, in the current model of the insurance marketplace. We would have to change that model of the insurance marketplace. Perhaps there would be a coordinating group who would organize several market-based health insurance plans, from individuals would choose. The health policy discussions have come to a point where we think there should be an independent board who would be appointed. It could be a quasi-independent governmental board, something like the Federal Reserve Board in the way they function, would be appointed to help determine what would be included in the basic benefit package. The selection could be done in a model similar to the federal employees' health plan, where there are multiple insurance products available to the individuals.

I want to emphasize that this does not mean that we are saying an employer-based system could not exist. It could still exist and perhaps it should, because there are many good employers who are doing a good job in insuring their employees. But getting the employee to own it is really a key component that we're proposing.

Chris Gade: All right, thank you, Dr. Cortese. Next, we're going to move to the topic of value, with Andrew Mekelburg. Andy?

Andrew Mekelburg: Thank you. Appreciate the opportunity to talk.

To Verizon, value is sort of putting the consumers in charge; empowering them with information so they can make better decisions and work closely with the treating healthcare provider. We believe that the more they're engaged, the better the outcomes; and to us, information technology and having interoperable standards is one of the critical components to this, and it's the building block for the recommendations that are in the value component of this plan.

The goal of the value component is increasing quality and patient satisfaction; decreasing medical errors, cost, and waste. It's funny that we know more about buying a cell phone or a car than we do about picking a doctor or deciding whether we get a particular procedure or where we even go to get a particular procedure. So the types of things that the group envision is to create -- call it a consumer report on healthcare, whether it's a magazine that comes out monthly or a website that you can go onto, that give you information about the doctor, the hospitals, how much it costs, what procedures cost, and help consumers make value-driven decisions.

And this electronic information not only benefits patients in the way we choose, but it should greatly help doctors as well. First, on the individual patient level, having an individual with an electronic record will eliminate duplicate tests, inappropriate medication, and not having to rely on a patient's memory. How many times have you gone to your doctor's office and they said, "Can you tell me the names of the medications you're taking?" I know I don't speak Latin, so I have trouble remembering all of that. By being able to just tap in and have an electronic database that doctors can easily pull out the kinds of medication you're on.

But secondly, by aggregating some of this data, doctors and researchers and other health professionals, they'll have a great base in which to help identify appropriate and inappropriate treatments, procedures, medications. So really by increasing value, which is what we're talking about here, using the kind of technology that we use, whether it's in the phone industry or other business sectors, applying that to the healthcare sector, we believe that you're going to get better medical treatment; you're going to create an environment for continuous learning for medical practitioners; and allow consumers to take better control over their healthcare. And all of this should lead to having a more cost-efficient system. It can reduce rates and decrease medical errors.

Chris Gade: All right. Thank you, Andy.

The next topic is the findings related to coordination of care and more coordinated care. Dr. George Isham from Health Partners. George?

Dr. George Isham: Thank you. Thank you, Denis -- Dr. Cortese and the Mayo Clinic for convening this important conversation. I'm really excited that the conversation itself is moving to the point where we're reaching these important conclusions.

And the one that I have the opportunity to address with you is coordination of care. The goal, or the principle here, is that patient care services must be coordinated across people, functions, activities, sites, and time in order to increase value, and the patients must be active participants, and in fact central to the process.

In the course of our deliberations, the example was given that a liver transplant patient, in the course of a five-day hospitalization, interacted with 75 different caregivers over 11 different shifts. Here at Health Partners, when we've asked people -- what they would tell us in terms of confusions that are created when people move from inpatient to outpatient

settings, they'll tell us things like, "The doctor tells us one thing, the nurse tells us another." And so it's very -- this is a very important principle that get at the core source of errors in medicine; things that can harm patients; repeated tests that are wasted; the loss of the opportunity for the various specialists and talents that are required in complex medicine to work effectively together on behalf of the patient. So this is a very, very critical area, at the center for health care reform.

It's particularly important to a number of populations that are particularly vulnerable to fragmented and uncoordinated care. For example, children with special healthcare needs; the frail elderly; people who are cognitively impaired or who are having mental impairment; those with complex medical situations; those with disabilities; those at the end of life; those with low income or low literacy levels. So this is an important area to focus on. It gets at the core of the healthcare reform challenge, which is to not only change financing, not only change participation rates and coverage, but to get at transforming care so it serves the patient better.

There are four sort of major areas that I'd like to highlight in this. The first is that the patient must be the center of the healthcare system. Healthcare currently is organized for the convenience and efficiency of doctors and hospitals and other institutions in healthcare, and that leaves the patient sometimes in the lurch with respect to coordination. We must change to a principle which says we're going to organize around that patient and that they'll be a single point for medical coordination and interpretation for the patient of all the care they need.

The second of these is to form a more coordinated system in order to deliver on that promise for effective care of patients. This is a very fragmented healthcare system with a number of different silos; the inpatient silo, the outpatient silo, the cardiology silo, the oncology silo, and so forth. We need to break down those silos and create connections across them, so that information flows with the patient so that people are continually aware of the patient's needs, and so that communication is effective across those silos. Some of the important ways to achieve that are through group practices, where the infrastructure of medical records, a uniform culture across the group practice devoted to excellence in terms of patient care, and a number of tools and administrative aids and staff to facilitate the excellent care of the patient. A second way to do that is to form integrated networks of independent physicians that are tied together with some of these same modern emerging tools, like electronic medical records and standards to exchange information and so forth. And a third might be to address physician hospital organizations where you have a common center for the creation of the infrastructure, the communication infrastructure, the agreements for how one doctor will talk to another about a patient and so forth for the effective coordination of care.

The bottom line, I think, in our conversations, is that tolerating a fragmented, disjointed, ineffective, wasteful system is just no longer something that we can tolerate and expect to get a better healthcare system for.

A third of the points I'd like to make is the issue that a variety of incentives that encourage and focus on teamwork need to be developed. An example of that we use here at Health Partners is the measurement we use for the evaluation of diabetes, which is a chronic disease management -- which is a disease which requires the close control of blood sugar, the appropriate control of blood pressure, the management of blood lipids, ensuring that the patient doesn't smoke, and so forth. And by creating a measure of that performance for groups of doctors, not individual doctors, but groups of doctors working together in group practice situations, you give a strong incentive that they have to set up systems of care that meet those objectives of that measure. That's one kind of incentive. The other is to make sure, again, that electronic medical records are available to those

groups, and that you're rewarding performance of groups when they meet those objectives for chronic care of patients.

The last point I'd like to address is making sure that we provide complete and accurate information to patients so that they can make informed decisions about their treatment options. They should have easy access to their personal health information and electronic access to their personal health information from all providers, and they should have, at least as well as their physicians, a complete picture of their medical care situation. And that will require signing a unique patient identifier to each person so that we can collect that information across the healthcare system, and collect for the benefit of insuring that care is coordinated.

So those are a couple of comments that I'd make about the importance of not only thinking about financing, not only thinking about coverage, which are both very important topics, or value; but also thinking about what we need to do to insure the rebuilding and new development of an effective care delivery system for patients in this country.

Thank you.

Chris Gade: Thank you, Dr. Isham. The final piece and actually a lot of discussion was had about the topic of payment and payment reform. Bob Smoldt will provide an overview of that section. Bob?

Robert Smoldt: Thanks, Chris; happy to do this.

One of the interesting things that came out of this -- with these sessions, and it popped up all the time in each of the ones that we had, was that if we really want to get to more of an integrated coordinated care that Dr. Isham was just talking about, we may have to well come up with different ways to pay for care; because the majority of the care right now is paid pretty much on line-item pricing and payment with relatively high rates for procedures, and therefore it's probably not too surprising that what we end of with in the country is high use of procedures, fragmentation of care, and higher costs than we would need to have.

We actually had a separate session where we discussed this, how could we change that, what were other things that we could go to, what should we be striving to do, and the group really concluded first off that what we should be striving for is value. You've heard that phrase used several times by many of the speakers here today as it comes up, and the definition of value really is high outcomes, safe care, patient satisfaction, and you compare that to the cost over time, rather than the cost of a particular line-item, like a chest x-ray or whatever.

The group actually looked at a number of ways to do that, and there were about six or seven, I think, that all felt it would be worth trying to have some instances where we could try some of these new payment mechanisms. Three that really seem to have quite a bit of support in this; one was establishing actually a chronic care coordination payment. It's also been called a medical home in a variety of places. The concept there is that rather than the provider only getting -- collecting something if the patient happens to come in, there would be a separate payment, perhaps in addition to those times when the patient comes in, that would actually pay the provider, and that could be a team of physicians, nurses, other allied health staff, to try and track a whole group of patients; perhaps the diabetic patients that Dr. Isham mentioned. And if we did that, we'd likely get better coordination of care.

Another approach was what was called shared patient decision-making, and the concept there is especially for elective surgical procedures, that there have been some educational packages -- many of these are actually electronic -- where the patient could have an electronic session where they could ask questions and learn more about the disease, what the options are, what the pros and cons are of each of the options, and make a very informed decision.

And a third approach, then, would be to -- for the expensive episodes of care, to go to more what we called episode-based pricing. It would be taking beyond -- an example of this is transplants. Most transplants are done under contracts where the provider agrees for both the physician and the hospital charges to get a lump sum of money. It may even be for a year's period of time, some of them, rather than just the hospitalization. But it's for these expensive episodes, and to base it on lump sum pricing so that there really are incentives to look at better ways to get high quality and to do it as efficiently as possible, and to perhaps move then into -- beyond transplants, into other expensive areas. And this really could help -- it has the potential to help on the cost side because of the fact that 10% of the population has something like 77% of the cost. They're the patients that have these sick episodes.

So those were a few of the concepts. The interesting thing is they aren't necessarily mutually exclusive. You could do the medical home payment in addition to the episode-based pricing and that shared patient decision making; for instance, all three of those could actually exist. So there are some potential ways to move to other systems that might help get us to a more integrated system that could provide better value for patients.

Chris Gade: Thanks, Bob. We're going to open it up for questions and invite people to express their question now. Thank you.

Operator: Ladies and gentlemen, if you have a question at this time, please press the "1" key on your touch-tone telephone. If your question has been answered or you wish to remove yourself from the queue, please press the "#" key. Once again, ladies and gentlemen, if you have a question at this time, please press the "1" key on your touch-tone telephone.

One moment for questions.

Our first question comes from Emily Walker from Congressional Quarterly. Your line is open.

Emily Walker: Hi. My question is for Dr. Cortese. I actually have two questions. My first is you acknowledge that not everyone's going to participate in the mandating individual insurance, much how not everyone participates in having car insurance in states where that's mandated. Do you think this plan is actually going to boost the number of people who have insurance? And if so, how will it do that?

And my second question is I kind of wanted to get a little discussion of what type of costs are associated with this program, particularly in establishing electronic medical records and subsidizing insurance costs for those who can't afford it.

Dr. Denis Cortese: First question; both of these answers I'm about to give are personal answers. We haven't addressed either one of these in any detail in the health policy center. So Emily, first off, I want to make sure that if you do use any quotes, you're really reflecting maybe my personal opinion; and maybe others want to add to this.

Emily Walker: Sure.

Dr. Denis Cortese: The idea of boosting people who would be insured, well, first, it most likely would, because most of the people who are not insured now or underinsured or don't have insurance are people who have been employed or are currently employed and are either between coverage for a short period of time in a given year, or have chosen at their own risk to not purchase insurance because it's way too expensive to buy individual insurance. So I believe, yes, it would boost the number of people who'd be insured. As I said, there'll always be folks who will not get covered, but that's going to be true in almost any system that we have.

Your total point is what the total cost would be. I'm giving you just a personal observation. We have not priced this out. We would probably be doing that as part of this exercise in the next few months; just be looking at some of the costs. But frankly, everybody who is needing care is already getting it somewhere, somehow; and they're getting it way too late in their illness; they're costing the system much more than they would have to otherwise; and the fact that maybe you think you're not paying for it, but you really are, because the providers have been put in the position of cost-shifting; finding ways to cover these people who show up in the emergency room and elsewhere.

So frankly, I believe in the short-term, there may be required an increment of dollars, but in the long-term, everyone must remember we're already all paying for this, somehow; and this will improve it if we can actually get everybody covered and then turn our attention to the real issue of improving health care in the United States, and that is the delivery system, the paying for value and how do we coordinate the care, which is what George Isham was making, or was attending to.

Chris Gade: Okay. There actually has been discussion throughout the course of our process about whether the system needed more cost or more money put into the system as well, and there was quite a bit of discussion that that wasn't required. We just needed to provide care more efficiently.

Emily Walker: Okay.

Chris Gade: Other questions?

Operator: Your next question comes from Jeremy Olsen from St. Paul Pioneer Press. Your line is open.

Jeremy Olsen: When I look at this report, in many ways it's a compendium of great ideas that have already been expressed out there before in terms of "these are the directions we need to go in healthcare;" certainly reducing medical errors, the concept of medical home, just all of these ideas. So these ideas are out there, and we haven't evolved to them now. What makes putting them all together in this kind of format, in this kind of document and plan, any more likely that we're going to see them happen?

Chris Gade: Who would you like that directed to, Jeremy; anyone in particular?

Jeremy Olsen: Whoever wants to tackle it. It's an open question.

Dr. George Isham: This is George Isham. I think one element of this plan is that it has some emphasis on actually some of the delivery system reforms that are needed in terms on the coordinated care plank; and a lot of the conversation around healthcare reform is around the other elements, which we also have as part of this plan. But I see the only real difference as the fact that you've got people in this conversation that are concerned that we also take on making sure that care is better coordinated for patients; that we realize cost savings as well as increase in value and quality for that; and that it serves patients.

There's a tremendous amount of information, Jeremy, as I know you know, about how -- how the healthcare system does not serve patients as well as it could, and I think this is an important element of this plan.

Chris Gade: Go ahead, Dr. Cortese.

Dr. Denis Cortese: Jeremy, if I may, this is Denis Cortese here, too. I'd just like to address maybe a personal viewpoint on this also, and that is you're exactly right. These particular ideas are just a set of ideas that are among maybe a much larger set that is floating out there. But what our task now is to design a healthcare system for the United States. The fact that we pretend there is a healthcare system in the United States, and that's it's broken, makes us think we can come in and fix one part or another part. What we have to admit to ourselves is there is nothing to fix. There is no healthcare system in this country that functions as a system. Otherwise, I'd like to see who the system engineer was that designed it so we can blame it on him. Nobody actually designed a system.

Some what we're looking at is of the available ideas out there, what could be pulled together so we could create an orchestra? How do we pull these different ideas together so that we can begin to consciously move in a direction that we are progressing creating a system of healthcare in the United States?

Andrew Mekelburg: And if I could add something to that?

Dr. Denis Cortese: Go ahead, Andy.

Andrew Mekelburg: This is Andrew Mekelburg. I guess this is sort of my political background here. There's going to be a lot of talk, and there has been, about healthcare reform. Every major candidate will have a position and all that; and it seems to me most of the debate about that is really who pays; should it be the government, should it be the company, should it be individuals?

The part we seem to forget is that it doesn't really matter who pays. Until we really fix the system and make systemic changes, or even implement a system as Dr. Cortese says, it's going to cost more for everybody. So it is dysfunctional; we've got to figure out ways to make it work better, and I think this report is really helpful to start focusing, and not just on the "who pays?" part, but what are real, concrete ways to address efficiencies or deficiencies in what's out there today.

Chris Gade: All right, thank you. Other questions?

Operator: Our next question comes from Susan Wagner from ABC News. Your line is open.

Susan Wagner: Thank you. I have a question coming out of what some of the candidates are now proposing, and there seems to be a pretty distinctive split between those who say it should be national reform, and those suggesting that the states just reform individually. Could this -- what you're talking about, could this work if each state had to make this kind of a decision, and then some would perhaps not decide to do this kind of coordinated care payment reform? Does this have to be done from Washington, or do you think this can be done state by state?

Chris Gade: Bob, do you want to take that one?

Robert Smoldt: Again, we haven't actually addressed that issue from the policy center, so I'll be giving you my own views.

My own views are that if we really could get this put in place on a national basis, it would be better for the citizens of the country. If it's done on a state-by-state, it's going to be -- it will be haphazard. If a person happens to move from one state to the other, it may not -- you may find very different sorts of approaches. If you just take the issue of the various individual state mandates on insurance and how that on what you offer for insurance, and how that can impact some of this cost issues. So my own personal feeling is that this really would be best done, if we could do it, at a national level.

But if it doesn't get done at a national level, I think states will move ahead on their own, just as Massachusetts has done and a number of other states are looking at. That's my own personal opinion.

Dr. George Isham: This is George Isham from Health Partners, and to add to that, I think, given the fact that we not only have a fragmentation in the delivery system, we also have fragmentation in terms of payer source.

The federal program for Medicare beneficiaries operates often times under rules out of Washington for the nation. Medicaid programs are in the states, and as Andrew Mekelburg indicated, employers are both local, but they're also national across states. And so it's not an "either/or" in my mind. It's a -- it has to happen at both levels, and furthermore, it has to be coordinated. It can't be disjointed. It can't be one version for Iowa and another version for Minnesota and a third version for Florida. It has to be coordinated.

A doctor who, in practice with his colleagues, in any given locality in the country, will often see Medicare patients, Medicaid patients, as well as patients who have private paying insurance from employers who are local as well as national. They're all mixed together, and there need to be consistent approaches to encouraging the kinds of changes that are needed in care at that front-line level in order to get the kind of improved system that we would envision for folks.

I must say, some of these comments are my personal comments. I don't know if in all of the forums, we've gotten to this level of discussion, so please label those as my own view.

Chris Gade: That's a good reminder, Dr. Isham. As I mentioned earlier, this is an iterative process, and some of these specific issues we have not yet addressed as a policy center.

Other questions?

Operator: Our next question comes from Matthew Weinstock from Hospital & Health News. Your line is open.

Matthew Weinstock: Hi, good morning. My question is -- I'll throw it open to everyone there. As all of you now, we've gone back and forth on this idea, incremental reform versus wholesale blowing-up-of-the-system-type of reform. If you look at the model you guys have created, what pieces do you need to start with, given Congress' reticence to do very broad-based reform, obviously? Where do you start?

Dr. Denis Cortese: Well, I'll take a stab at it, and we'll go around. I'll make just a personal observation here. If we do have to pick and choose, Matt, as you're pointing to, I guess from the standpoint of the government perspective, I would strongly urge that the government take steps with regard to moving to the concept of individual ownership of insurance; and the second major concept is that they begin to find ways to pay for value; pay for what we really say in this country we're not getting. Because everywhere I go, I hear people saying we're not getting high value, we're not getting good access, we're not getting good outcomes, our safety's not where it ought to be, the service isn't very good, and our costs are very high.

Well, that's the value equation. So if you really want to improve getting value, you might as well pay for it, because in this country right now, particularly at government-level programs, they are paying the highest dollars and the highest amount of money to the regions of the country that are providing the worst coordinated care, getting the worst outcomes, the worst safety, and the highest cost. They're paying just the opposite of value.

So if you had to just limit me to my choices, I would pick -- let's go with the individual insurance and let's pay for value.

Chris Gade: Andrew, any comments on your perspective on that?

Andrew Mekelburg: Yeah. As the guy in Washington, I would say that there is actually something we've been working on, at least this year, is the whole health IT activity. That is something that Congress can do today, just getting processed to get interoperable standards; so people like Mayo Clinic who have tremendous electronic records and all that, but if I'm outside the Mayo system and I need access to it, it doesn't matter what state I'm in, I need that.

So that's a piece that we actually believe Congress could even do this year. We're involved with a group called HealthITNow Coalition, which is made up of various groups that are pushing for that. So that's probably the first and the easiest step. Let's start getting the system the way the banking system is, you can get money anywhere in the world out of an ATM.

Dr. George Isham: George Isham over here at Health Partners. I think there are a number of specific things that can be done. One, I agree with Andrew on the information technology idea, specifically encouraging policies that encourage the universal adoption of electronic medical records, and then the establishment of standards for the exchange -- the appropriate exchange of clinical information for purposes of referral and coordination; that would be a second one.

I think certainly the universal patient identifiers, so we make sure that all the information about a particular patient is gathered from the relevant sources and the appropriate people are aware of it so that safety and coordination can occur. The incentives for teams of physicians to work together to produce good outcomes based on teamwork, I think another idea would be standards for referrals from primary care to specialty physicians and back again; and of course, a lot of those ideas are not necessarily government, but private sector sorts of things that need to be worked on with government. So those are a couple of ideas.

Robert Smoldt: This is Bob Smoldt. I'll just throw in one other thing that Dr. Cortese mentioned. Actually, it's underlying all three of -- the commentators made this point on this issue, and that is to try and reward the areas where we are providing the value. And that's one of the interesting things to me because our country as a whole really doesn't do well, but there are places within the country that do very well on these things, and yet we don't reward them.

I just saw last week a statistic that the Commonwealth Foundation put together. I can't remember the exact title, but something like mortality for people under age 70 for diseases where medicine can actually do something about it, and the U.S. doesn't do real well when compared to other countries; but if you look at it by states, the state of Minnesota, for instance, has a very good rate on that, and it's actually better than any of the other national countries. So we have places where this is done very well in the United States. We need to learn what is happening in those places where it really gets done well. This gets into the learning system we have to become, so we can get that in other -- that

to be happening in other parts of the healthcare system. And perhaps, if you financially reward the areas that do it, we would get there quicker.

Chris Gade: All right. Thank you. Other questions?

Operator: Ladies and gentlemen, if you have a question at this time, please press the "1" key on your touch-tone telephone.

Our next question comes from Jeremy Olsen from St. Paul Pioneer Press. Your line is open.

Jeremy Olsen: Thanks. I just had a follow-up question for Dr. Cortese. You had mentioned at the start of this that everyone's going to have to give a little bit to make this work. From my recollections, Mayo obviously was touted to the Dartmouth-Atlas study as being very efficient, but I doubt you're getting rewarded for that; as a matter of fact, I think your budget's been getting ever slimmer and slimmer. At the same time, some of the health plans are starting to report in Minnesota that they're at an operating loss.

I'm just wondering, given the tight financial conditions, the tightening financial conditions, who's going to be the one -- who's going to give and who has to give first to make this go?

Dr. Denis Cortese: Well, yeah, I guess I can't answer that question. From a personal viewpoint, I really truly think after being involved now with this process, being involved with a similar group with various sectors coming to the table at the Healthcare Leadership Council in Washington, D.C., and now I'm chairing the evidence-based roundtable at the Institute of Medicine, which we have about 26 to 30 people participating from 9 different sectors, I am totally convinced everybody's going to lose something. And we absolutely have to, and many of the people around these tables are slowly beginning to accept that.

So the idea of who goes first, I think is the wrong approach. Everybody has to be willing to put something on the table. But I would emphasize that if one of the things we want to accomplish is long-term good wellness or prevention, prediction of health disease, prevention of it, keeping people out of hospitals, keeping them as healthy as we can, we should design a system that ends up rewarding all of the sectors who accomplish that; and that's what we mean by paying for the value, not just come across with payment cuts across the board. That's the wrong thing to do, because frankly, the most efficient providers suffer the most from those across-the-board cuts.

What we need to do is maybe cut those that don't perform very well, and those that are performing very well, at least don't cut them; at the very least, don't cut them. Somehow that a reward for value is built into this.

Jeremy Olsen: Thank you.

Chris Gade: Any other further questions?

Operator: I'm not showing any further questions in queue at this time.

Chris Gade: All right. Thank you, folks. Thank you for -- the news media who participated, and the participants for their remarks. Thank you very much.

Operator: Ladies and gentlemen, thank you for participating in today's conference. This does conclude the program. You may now disconnect. Everyone have a wonderful day.