National Press Club Luncheon

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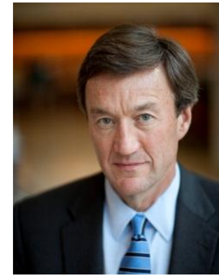
Three Imperatives to Transform Health Care in America



John Noseworthy, M.D.

Outline

I. DELIVER KNOWLEDGE

- Americans want and deserve excellent health care
- Mayo Clinic has come to realize that Mayo's most scalable product is our knowledge – both "what we know" and how we deliver that knowledge.
    - Ask Mayo Expert; Knowledge Management System – updated once, available everywhere
- A critical step is integrating that knowledge, sharing it with providers working as teams around the patient – Mayo Clinic Care Network

II. CREATE VALUE

- Elusive goal – high quality care at lower costs
- Must recognize the spectrum of care: primary, intermediate, complex.
- The promise of Optum Labs – for the first time, marriage of cost and clinical data
    - Potential: transform health care to pt-centered, value-driven model

III. FUND EXCELLENCE

- Support scientific discovery and align payment efforts to reward excellence across the spectrum of health care.
- *United States must fund innovation*
    - Funding of NIH – essential; 1) advance science; 2) grow the economy.
- *Accomplish payment reform in two ways*

    #1: Financing of healthcare must be data driven

    - Create a competitive marketplace where data on outcomes/costs drives innovation and better care for intermediate and complex care

    #2: Reimbursement must recognize and reward the spectrum of care

    - Payment system must include incentives and rewards for the proper management of complex cases.
        - Repeal SGR
        - Create transitional reimbursement schedule at Consumer Price Index
        - Establish new negotiated payment models. Tie reimbursement to patient-centered care and quality outcomes along the spectrum

CONCLUSION

- In the post ACA world, more work is needed
- This is a turning point in the transformation of health care in America – a turn toward making high-quality care available and affordable, from primary to complex care.

Transcript

AGK: Angela Greiling Keane, National Press Club (President)
JN: John Noseworthy, M.D., Mayo Clinic (President and CEO)

INTRODUCTION OF DR. NOSEWORTHY

AGK: Good afternoon and welcome to the National Press Club. My name is Angela Greiling Keane. I'm a reporter for Bloomberg News and I'm the 106th 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 this while fostering a free press worldwide. For more information about the Press Club, please visit our website at press.org. To donate to programs offered through our National Press Club Journalism Institute to the public, please visit www.press.org\institute.

On behalf of our members worldwide, I'd like to welcome our speaker and those of you in our audience today. Our head table includes guests of our speaker as well as working journalists who are club members. If you hear applause in our audience today, we note that members of the general public are also attending, so it's not necessarily evidence of a lack of journalistic objectivity. I'd like to welcome our C-SPAN and Public Radio audiences as well. Our luncheons are featured on our weekly member-produced podcast from the National Press Club available on iTunes. You can follow the action today on Twitter using the #npclunch. After our guest speech concludes, we'll have a question and answer period. I will ask as many questions as time permits.

Now it's time to introduce our head table guests. I'd ask each of you to stand up briefly as your name is announced. From your right, Devin Henry (Washington correspondent from MinnPost); Amy Morris (morning drive anchor for WNEW radio, CBS's DC affiliate); Jessica Zigmond (Washington Bureau Chief for Modern Health Care); Marlene Malek (President, Friends of Cancer Research); Deidtra Henderson (Program Officer with the Round Table on Value and Science-Driven Health Care at the Institute of Medicine); His Excellency, Rudolf Bekink, of the Netherlands; skipping over the podium, Matt Mlynarczyk (President of the Advocatus Group and the speaker's committee member who organized today's event)—thank you, Matt; skipping over our speaker for a moment—Michael Powell (a Mayo Clinic trustee, a former FCC chairman, and currently the head of the National Cable and Telecommunication Association); Carolyn Bloch (Editor with the . . . . . . with Federal Telemedicine News); Cynthia Carter (President and CEO, FDA News); and Brenda Craine (Director, Media and Editorial for the American Medical Association).

Our guest today runs a place with such name recognition that it's known simple as "The Clinic." The Mayo Clinic is a not-for-profit healthcare system dedicated to medical care, research, and education. The Clinic has more than 61,000 employees, operates in six states, and is based in the city of Rochester in the great state of Minnesota. Every year, more than a million people from every state in the U.S. and nearly 150 countries come to the Mayo Clinic to receive care. Dr. John H. Noseworthy is its President and Chief Executive Officer. Dr. Noseworthy joined the Mayo Clinic in 1990. Prior to his current appointment, he served as Chairman of the Department of Neurology, Medical Director of the Department of Development, and Vice Chairman of the Mayo Clinic Rochester Executive Board. He is also a Professor in the Department of Neurology and continues to practice medicine and consult with patients. His specialty is multiple sclerosis, and he has spent more than two decades designing and

conducting controlled clinical trials. Dr. Noseworthy also is the author of more than 150 research papers, chapters, editorials, and several books. He has served as Editor-in-Chief for Neurology, the official journal of the American Academy of Neurology.

Born in Melrose, Massachusetts, Dr. Noseworthy received his medical degree from Dalhousie University in Canada. Peers say he has an excellent understanding of differing health care delivery systems and priorities because he has lived in both Canada and the United States; and they also say that as the son of a minister, he has developed values that are altruistic and highly ethical. During his tenure as CEO, Dr. Noseworthy and his leadership team developed a strategic plan designed to ensure the Mayo Clinic remains a trusted resource for patients amid a rapidly changing health care environment. The goal is to extend the Clinic's mission to serve new populations providing care through more efficient delivery and increasing the personalization and immediacy of health care for all people.

In Minnesota, the Clinic's plans raised eyebrows when they announced they were going to ask for infrastructure funding and asked the state to help out with $585 million of taxpayer money. The idea is that the infrastructure will benefit the facilities and help bring more revenue to the state as it conveys more patients. The Clinic argues that enhancements will bring more revenue, and it's entitled to some of the money in return. Despite the eye-popping number in a state that has struggled with finances in recent years, the plan has won endorsement of much in the Minnesota media and the support of Rochester lawmakers.

The Clinic has also accelerated in the transition of research in patient care and was the first facility approved by the U.S. Food and Drug Administration to produce and administer choline C-11 injections, which help detect recurrent prostate cancer earlier, providing patients with more immediate access to new individualized and targeted treatments.

The Mayo Clinic reported annual revenue of $8.8 billion in 2012, with expenses rising 9.6% to $8.4 billion. Dr. Noseworthy said he expects the Clinic to receive 20-40% less revenue for its services over the next five years due to the aging population and cost of Medicare, a challenging economy, a change in pension plans, and health care reform. With that in mind, the Mayo Clinic is trying to redesign its practice to create higher quality of care at lower costs.

Today, Dr. Noseworthy will share his thoughts on how to create such a system in a speech titled, "Three Imperatives to Transform Health Care in America." Please join me in giving a warm National Press Club welcome to Dr. John Noseworthy. (applause).

ACKNOWLEDGEMENTS

JN: Thank you, Angela, for the invitation to address members of the National Press Club, Senator Amy Klobuchar, Members of WomenHeart and The Links, Incorporated, His Excellency Rudolf Bekink and Gabrielle de Kuyper Bekink of the Netherlands, Mayo Clinic trustee Michael Powell, Marlene Malek, president of Friends of Cancer Research, representatives of the European Union and the embassies of Belgium and Germany, distinguished friends and colleagues.

INTRODUCTORY REMARKS

I come here today as the President and CEO of Mayo Clinic.

Each year, more than 1 million patients come from 50 states and last year 137 countries to Mayo Clinic seeking hope and solutions. Our unique and distinguishing characteristic is the Mayo Clinic Model of Care, a trusted and collaborative approach to medicine that is complemented by a constant quest for knowledge and innovation and dates back to the founding of the Clinic 149 years ago. Medical research and education have been core to our mission from the very start.

Today, the spirit of the Clinic is brought to life through work with groups like WomenHeart: The National Coalition for Women with Heart Disease and The Links Incorporated, and their impactful efforts to empower and engage patients. Our more than 50,000 physicians, scientists, and allied health staff are our most precious resource. They are a unified team linked by a singular primary value: “the needs of the patients come first.”

Our staff’s relentless and unwavering commitment to excellence spawned health care innovation across three centuries. The first to adopt a unified medical record in 1907– a stunning innovation that has now been embraced by almost two-thirds of practices in this country. The nation’s first and largest multidisciplinary, academic medical group practice. The first microscopic system for grading cancer. The Nobel Prize for cortisone. The invention of the heart-lung machine, and countless more.

Every day, our staff do pioneering work in surgery, in the Kogod Center on Aging, the Mayo Clinic Cancer Center, and across all medical specialties. We’re leaders in applying the tools of social media to patient care and clinical research. As a humanitarian, not-for-profit health care organization, our commitment is to discover, interpret, and share knowledge to create exceptional, affordable health care for people everywhere.

We believe that learnings from the Mayo Model of Care, deeply rooted in innovation, can and should be broadly applied as health care in America faces perhaps the most profound challenge in our history. We have something to offer America and we’re committed to sharing it.

The Affordable Care Act, or ACA, signed into law three years ago, was the largest health care reform package in nearly 50 years. While the ACA provides insurance to millions of uninsured Americans, profound challenges remain. We have an aging population with a growing number of seniors with multiple health problems; fragmented care with patients struggling to know where to turn; rising health care costs that now total nearly 18% of our GDP.

These challenges pose real and significant threats to American families and the economic health of the United States. Families struggle to pay their bills; businesses struggle to remain competitive. The United States desperately needs innovation that addresses our most pressing problems: uneven health care quality, skyrocketing costs, and the lack of tools to help us spend wisely when it comes to health care.

Today, I will outline three imperatives to transform health care in America by creating higher quality, patient-centered care at lower costs. The first imperative: Put proven knowledge into practice quickly and consistently to benefit patients; "Deliver Knowledge." Imperative 2: Embrace the need for value–create high-quality care at lower costs; "Create Value." And (for the government) Imperative 3–and fund discovery science, innovation and fund excellence in patient care; "Fund Excellence."

IMPERATIVE #1: DELIVER KNOWLEDGE

The first imperative, deliver knowledge. We need to put proven knowledge into practice quickly and consistently.

Americans expect and deserve contemporary health care. They should reap the benefits of the research they support through their tax dollars. Government funding of NIH and other agencies play a critical role in generating much of the new knowledge that can help patients, and I'll return to this in a moment when discussing the third imperative.

The challenge is to quickly and consistently push proven discoveries into everyday medical practice so patients benefit. This is much more easily said than done. For example, after researchers discovered that beta blockers benefit patients after heart attacks, it took 25 years for that practice to spread widely through medicine. Why does it take so long? It's in large part because we are inundated with new knowledge. More than 1.5 million journal articles are published annually, and there's no central mechanism for synthesizing and applying this key information.

At Mayo Clinic, we have challenged ourselves. Every patient at every Mayo Clinic location will receive the highest value Mayo Clinic and the best and brightest in health care from around the world, collectively, know how to provide every patient. We've invested in three centers to press forward in some of the most exciting frontiers of medicine: individualized medicine, regenerative medicine, and the science of health care delivery. We have developed one of the largest electronic medical record systems in the world. Everything related to patient's care is immediately available to Mayo caregivers and their patients. And because most of our local patients allow their records to be used in medical research, we and our partners have been able to build the NIH-funded Rochester Epidemiology Project, making Olmsted (County), Minnesota, one of the few places on the globe where researchers can study diseases, their causes and treatments, in a defined geographic population.

We have come to realize that Mayo's most scalable product is our knowledge – both "what works" and "what we know about how to deliver what we know to our patients." We are creating a Knowledge Content Management System – an electronic book of Mayo-vetted knowledge about "best practice" protocols, hospital orders, patient and education materials, as well as information for the public and potential business customers. What does that mean for our patients? It means safer care, better outcomes, fewer redundancies, and cost savings. New information is added constantly. We

maintain a portfolio of our consensus knowledge and recommendations in a tool called "Ask Mayo Expert." This provides answers and enables physicians to deliver safe, integrated, highest quality care. Through our electronic systems, this knowledge can be updated once and made available anywhere.

This striking innovation allows us to share what we know with others who want to partner with Mayo Clinic to provide better care to their patients. This commitment to deliver knowledge is the basis of our strategy in this era of health care consolidation, consolidation of hospital systems and payers that you've heard so much about.

Mayo Clinic has chosen a different path than many others in the industry. We are pursuing a business model based on knowledge management and diffusion of knowledge as our integration tool rather than consolidation, mergers, and acquisitions of assets because this is our most scalable asset is what we know, and we believe this will help provide better care to the patients. Th**e important next step is sharing that knowledge more broadly** through accessible tools, promoting integrated care by providing doctors and nurses organized as teams with the information that they need to care for their patients.

With our rapidly growing, non-owned, affiliate practice network – The Mayo Clinic Care Network - we identify high-quality practices across the country and internationally, who share common patient-centered values and would like to partner with us to provide better care to their patients locally by using our knowledge sets to enhance the quality of their practice. To enable teams of doctors and nurses to provide better care to their patients in Montana, Illinois, Missouri, Michigan, Kentucky, Puerto Rico and on and on with our help to call upon us with electronic consultations or referrals as necessary to come and see us if they feel that is best. Fifteen of the highest-quality health care organizations in the country have joined the network since its creation in 2011, and we expect that number to double in the next 18 months.

Deliver Knowledge – as fast as it is known, to support health care professionals in their communities, and provide better care locally at lower cost. This is what we're doing—integration of care—not consolidation, not mergers and acquisitions – integration for our patients.

IMPERATIVE #2: CREATE VALUE

We need to embrace the **elusive goal of value – higher quality at lower cost.**

Each of us as patients have different health care needs throughout our lives. We all experience a **spectrum of care.** Most of the time, we need primary care. Usually, we are healthy; we need preventive services; we have one or two manageable chronic illnesses, require immunizations or antibiotics, and can be helped by primary care physicians, community internists, pediatricians, and nurses often using best-practice protocols, tailored as needed to meet our needs; and that makes up a large part of the spectrum of care.

At other times, however, we may suffer a heart attack or need knee replacement or gall bladder surgery. That requires intermediate care – another part of the spectrum of care, and that may be delivered at a hospital with special expertise.

Finally, a small percentage of us – each year, perhaps 1 in 1000 – will need complex care because we have become very sick; perhaps, we can't get an accurate diagnosis or require complex care from a team of specialists or need cutting-edge therapies. We move to the portion of the spectrum of care where the needs and services and the expertise provide the best care for us and in this situation, the most complex part of the spectrum. And then when our needs are met with either intermediate or complex care, we move rapidly back to the primary care where we can be cared for very well by our own physicians. And most of us will move across the spectrum throughout our lives and especially as we age.

The ACA takes important steps to improve primary care, but more work is needed to create and ensure high quality across this spectrum of care for all Americans.

Recognition that there is a spectrum of care is a first step toward true payment reform. Without recognition of the spectrum of care, it will be impossible to accomplish high-value care delivery linked to value-based payment reform. As physicians and allied health staff manage the health of a population, they are responsible for helping patients to navigate the spectrum of care to receive the highest quality of care delivered most cost effectively. That's value-based care delivery. With value as the highest common goal, health care professionals in all care settings can turn traditional thinking on its head and find better, more affordable ways to care for patients.

Patients, providers, and taxpayers alike get into trouble when patients "churn" in the wrong part of the spectrum of care; when health care professionals fail to coordinate care and smooth the transition to the next level of care. Health care costs skyrocket with inappropriate and duplicate testing, and there may be poor quality and unsafe care.

To understand what works and to advance the science of health care delivery, we need data both on the desired outcomes of care across the spectrum and on the total cost of care over time. That's what makes **the promise of Mayo Clinic's new strategic research alliance with Optum**, a subsidiary of United Health Group the world's largest insurance company, so exciting. This new entity, Optum Labs, brings together clinical and cost data that can provide a window into better outcomes as opposed to simply measuring and the process of care and long-term cost. By analyzing both quality and cost, we create value. At the core of the potential is the vast reservoir of clinical and claims data stripped, of course, of all personal identifying information to protect patient privacy that these two founding partners of the strategic alliance possess. The alliance brings together clinical data "health outcomes" on five million Mayo Clinic patients with Optum's cost of care data on 109 million patients collected over two decades to answer this pressing question in health care, questions that up until now, we've not been able to address.

The potential for this open "learning innovation lab - Optum Labs" is extraordinary, and the potential will be made even more remarkable when others join the alliance – academic medical centers, research universities, pharmaceutical and device companies, policymakers, other payers. This alliance will allow us to create a data-driven, transparent system to identify "what works." How much does it cost? Who's doing it best? It is a necessary springboard for future innovation to drive up the quality of the care that we give and drive down the costs of health care. As results are known and broadly shared, patients, providers, and payers can seek and reward those who are providing the highest value.

Some have told us that they believe this alliance holds the potential to change everything in health care, and we would not disagree. This alliance will accelerate the creation of value from a brisk walk to a sprinter's pace.

There is much that Mayo Clinic and other health care providers can do to provide and deliver high-quality, affordable care – value-based care – across the health care spectrum: primary, intermediate, and complex care. At Mayo Clinic, we know we can do this. There is no trade-off between improving quality and lowering cost. Indeed, higher productivity and lower cost result in higher patient satisfaction and safer care. We are committed to doing our part. It's in the cultural DNA of our organization, but we can't do it alone. What do we need government to do? To realize the full potential of these two imperatives, these two innovations – delivering knowledge and creating value – to transform health care, we need the third imperative – Fund Excellence.

IMPERATIVE #3: FUND EXCELLENCE

We must **support scientific discovery and align payment mechanisms to reward excellence across the health care spectrum.**

Since we're in our nation's capital, I want to take this opportunity to ask the **Congress and the White House to invest in innovation**, create a payment system that recognizes the different levels of care and rewards quality and value at each level, and to overhaul Medicare's payment structure.

First, fund innovation. As a nation, we're sliding off the top. For example, the U.S. has been falling against other developed nations in perhaps the most important measure of health care quality – life expectancy. We must reverse this trend. The NIH invested more than $30 billion on medical research in 2012, and Mayo Clinic received approximately $220 million of that. Funding for the NIH and other agency is critical to research, scientific discovery, technology, engineering and math, to strengthen our economy. It must be preserved.

Mayo Clinic has many partners in discovery, including generous benefactors and public- and private-sector initiatives. Our partnerships include work with colleagues in the Netherlands to improve quality of life in aging. A European Union- and Czech-government financed project with St. Anne's Hospital in Brno to develop the new International Clinical Research Center. We also learn much from the cutting-edge work of others: innovative startups like Rock Health, progressive insurers like Kaiser Permanente, and our colleagues at other fine academic medical centers like Harvard and Hopkins. Funding from NIH is central to health care's ability to advance medical science, to innovate, and contribute favorably to the nation's economy.

Secondly, the **financing of health care must be data-driven.**

Government policies must help to create a competitive marketplace where data drives innovation and better care at lower cost for intermediate and complex care across the spectrum. This approach is reflected in the promise of our partnership with Optum, the marriage of clinical and insurance claim data to show how to achieve the best patient outcomes and the lowest cost on a large scale.

We urge government to encourage and help drive collective and cooperative work in health care to understand what works best, especially for patients whose conditions require intermediate and complex care. We must learn from each other; if someone else does it better, we should do it that way as well. If we implement a data-driven model of financing health care, we can build a sustainable, value-based model of health care and create a competitive health care marketplace, competing with data on better outcomes at lower cost. Our nation and all of us as patients will win.

Third, **reimbursement must recognize and reward the spectrum of health care delivery across primary, intermediate, and complex care.**

We propose creating a payment system that acknowledges how our country uses health care, one that recognizes the different types of care and rewards the quality and value of each, whether primary, intermediate, or complex.

The ACA addresses primary care by creating accountable care organizations with risk-adjusted global payments and shared savings, but most of us will need more than primary care at some point in our life as I mentioned.

Patients with complex conditions, and even many needing intermediate care, do not always fit into neat categories. Although these patients with intermediate and complex care may share some similarities with each other and may be grouped accordingly, often there are important individual characteristics that necessitate that they be treated as exceptions. Even in one of the most common “intermediate” procedures, knee replacement, patients may have one or more co-existing medical conditions, or advanced age, or previous surgery, or an infected joint, all of which contribute to the complexity of the case and need to be measured in terms of value and outcomes.

When it comes to highly complex care, no two patients are alike. Let me give you one example from a cardiologist dealing with two patients with blackouts. In the first, the blackouts were found to be due to neuro-cardiogenic syncope with focal epilepsy. In the second patient with blackouts, the autonomic nervous system was failing because the patient had a condition called multiple systems atrophy, a form of Parkinson’s disease. Both of the patients had blackouts, but that’s where the similarities ended. Aligning how we pay for care with how we diagnose and treat patients will appropriately reflect the meticulous medical detective work that this doctor and his care team orchestrated.

Within this part of the spectrum of care, data on desired outcomes must be used to create a sustainable continuum of care, and these outcome and cost metrics must be readily available so patients and families and payers can make informed decisions about where to seek care. Our health payment system must include incentives and rewards for the proper management of these complex cases.

We believe payment reform must address the Sustainable Growth Rate, the SGR, a complex formula that determines Medicare physician payments. SGR is broken. The original intent of the SGR was to more closely control the use of physician services and costs. However, every year since 2003, Congress has postponed the SGR update to physician payments, and this has accumulated to a potentially devastating 30% cut to physician payments. The next scheduled SGR payment will be in January unless Congress acts this year. Left unchecked, its impact will be profound. At Mayo Clinic alone, it will mean

a $128 million funding reduction in the first year to treat our Medicare patients, and 55% of the patients that we care for at Mayo Clinic are Medicare; 128 million in the first year. The SGR has not effectively controlled the volume of physician services. It does not distinguish between doctors who provide high-quality care to beneficiaries and those who provide unnecessary services. Physicians who provide the most efficient care are penalized under Medicare's current payment system, while physicians who order more tests or perform more procedures are paid more.

After a decade of temporary fixes, Congress must seek a permanent solution to the SGR, and we recommend: repeal the SGR, create a one- to three-year transitional reimbursement system at the Consumer Price Index, and establish new, negotiated payment models that tie reimbursement to patient-centered care and quality outcomes along the spectrum of care as I've mentioned.

To answer the challenges that we face will not be simple; but if we align how we pay for care with how we diagnose and treat patients, we can reach our goal of high-value care for every patient.

CONCLUSION

As I close, to transform health care in America, to create high-quality, patient-centered care that the nation can afford, we need to better deliver knowledge . . . . . . what works. We need to create value, better outcomes at affordable costs in a system that invests in excellence. There is much that Mayo Clinic and our colleagues in health care can do on our own and collaboratively to drive innovation, improve quality and control costs, but we can't do it alone. We need help from the policymakers. Washington must invest in health care innovation, particularly the NIH. We must create a payment system that recognizes the spectrum of care delivery and rewards quality and efficiency across that spectrum. We believe a starting point for payment reform is an overhaul of Medicare's complicated payment structure. Fix the SGR. Americans want and deserve excellent health care. I am a neurologist, not a pundit, but I suspect that history will view this period as a turning point in the transformation of American health care, a turn-around toward making high-quality health care available and affordable to all. Thank you for allowing me to share our vision for transforming health care in America, and I look forward to your questions.

Questions & Answers

FEDERAL BUDGET CUTS

AGK: Thank you, Dr. Noseworthy. You talked about research and how important it is. You mentioned the NIH there at the end. Tell us how your research efforts, particularly those you've just announced in the partnership with United Health Care, might be affected by federal budget cuts; obviously, the purpose of the research that you talked about is to cut costs but it still costs money to do the research up front.

JN: So one example would be sequestration. A 2% cut translates to $47 million in one year to the Mayo Clinic. Half of that comes out of patient care; half of that comes out of research. That means we can't do as much research; we can't hire the young people to move that agenda forward, and it slows us down. It's not a time to restrain race horses in America.

IMPLEMENTATION OF UNIVERSAL HEALTH CARE

AGK: Many people think the implementation of universal health care is significantly behind schedule with the administration behind on setting up health care exchanges. By the time the law takes effect fully, consumers in a lot of states will only have one choice. What are your thoughts on the implementation of universal health care?

JN: Well, it's been acknowledged that the government is running behind schedule. They're doing what they can to catch up. It turns out this is more complex than they thought. That wasn't meant to be a political statement. We're working with the government to help them understand how to do this, but it is behind. It does put certain states at a disadvantage. It puts certain subsets of patients/citizens at a disadvantage in certain states. It's not being developed equitably across the country. This is complex stuff.

EFFECT OF MEDICARE CUTS

AGK: You talked about the effect of Medicare cuts, mentioning $128 million in less money coming in, in the first year alone based on what you're projecting. Tell us what that means for your medical staff, for patients. Put it in a perspective that's more than dollars and cents.

JN: Well, I think any of you who are in the business community recognize that if you're reimbursed less for every unit of work you do, it puts huge pressure on the organization to be successful. And Mayo Clinic's not about making money; we're a not-for-profit and every penny we make, we reinvest in research and education and technology and in having the best staff in the world, recruiting and retaining the best people. Health care margins are very narrow. They're anywhere, generally, from 2 to 5%. If you have a 20 to 40% reduction in the payment for the work that you do and close to 60% of the work we do at Mayo Clinic is in patients over the age of 65, there's a huge financial burden on the organization, which drives innovation—sure; it drives efficiency—sure; but it also could easily slow the pace of research and as much as we're doing everything we can to avoid people losing their jobs, there gets to a point where it's very difficult to maintain the best work force when your revenues are under such pressures. So this is a big deal. This is a serious, serious situation for all of us.

ACCEPTANCE OF MEDICARE PATIENTS

AGK: Would Mayo consider stopping accepting or limiting acceptance of Medicare patients?

JN: I've been asked that question repeatedly. We love to see Medicare patients. I think we do our best work with the elderly. They often have very complex conditions. They're often on an awful lot of medications and they need our help. Our integrated patient care model serves us well with these complex elderly patients, and a number of you have already spoken to me today at the reception about what we did for your relative, many of whom were in the Medicare age group. We would not want to turn away Medicare patients. We simply wouldn't want to do that. We're a service organization. We have professionals who care deeply about the needs of the patients, and we do not want to turn patients away who we can help. It just gets to be very, very difficult if you can't get paid for that work.

E-EXCHANGE OF A PATIENT'S MEDICAL INFORMATION

AGK: You talked about electronic medical records and the role those are playing in the future of delivery as well as in cutting costs. Questioner asks, 'How are you going about doing E-exchange of a patient's medical information both within Mayo and among outside medical organizations? How do you do that while insuring against theft, tampering, and intrusion?'

JN: That's a very important question. So sharing of patient information is complex. It's difficult and must be done well. We all want our health care privacy protected. We do that extraordinarily well within the Mayo Clinic system. Across the country, that's difficult to share records; and across countries, it is as well. Mayo Clinic is one of the founding partners in something called the "Care Connectivity Consortium." There are five other great groups that I could mention—Kaiser Permanente, Group Health, Geisinger and others are in that group—trying to sort out—how do we exchange medical information across the country with new systems that do that? We're working with the government to make that happen. That's extraordinarily difficult, but we will get there.

HELPING SMALLER PROVIDERS

AGK: Does Mayo or any other large medical provider play any role in helping smaller providers, who may refer their patients to you, transition to electronic medical records?

JN: We're always available to help providers and patients with their needs; and every week, countless teams of practitioners, nursing schools, health organizations from around the world turn to Mayo Clinic for advice and for help. The numbers are such that we've now actually gone, in part, to creating about four sessions a year for folks that say, 'We want to come and learn from Mayo's models,' and we have day-long symposiums to teach them to do that to help with inefficiencies. But again, we would never turn away someone who we thought we could help.

DISCUSSIONS WITH CONGRESS

AGK: When you're on the Hill this afternoon, what discussions will you be discussing with members of Congress?

JN: Fund excellence. Well, seriously, that's terribly, terribly important. We're now in the post-Affordable Care Act world. We're off to the first step. It's now important to recognize the second step, which is to understand the spectrum of care I talked about and the fact that there's a spectrum of quality, and it's now possible to measure that and to measure the cost. If we simply go to reduce the budget and pay everybody less, essentially you've turned health care into a commodity, and I would argue that it isn't a commodity . . . . . . that the very best should show the others how to do it better, and you need to have that competitive marketplace. We can do that now with data, and I'm very excited about. I think this is a breakthrough that really can help inform the government to do the right thing. I'll be at the Hill this afternoon. I was working with them yesterday. This is starting to catch on. It's just a difficult concept—the idea that you can measure health outcomes in the numerator and truly measure costs in the denominator and then call that a ratio and call that value. That was hard in school to do that. It's hard to think about driving up the numerator, driving down the denominator. And what was said is, 'Let's keep it simple. Let's create some rules around which that happens and then let's create a numerical system, a transparent data system, and I always do this with my staff. I point to the perimeter of the ceiling and say, okay, pick your favorite hospital, your favorite group, whatever, and then pick what it is they're working on and what number are they trading at, if you will, much like the stock exchange. So, knee replacement—Mayo Clinic, Duke, Cleveland Clinic, UCLA, Georgetown, whatever—and you look at you say—boy, that group is ahead of that group. What are they doing that we could learn from? A competitive marketplace with transparent data that patients can see where their health care dollars are going and where they want to go for their care—that's what I'll be talking about.

VALUE OF PREVENTION

AGK: Where does prevention fit into your plan? Questioner says, 'How would you increase the value of prevention when it is not currently well measured?'

JN: Well, we can measure prevention. The trouble is—it takes a long time to measure it. That's one of the advantages of being around for 149 years is you have a great records system, and I mentioned the Olmsted County where we study the heck out of anybody who lives in that region, and we know what works, and we know the cost of that. And actually the Affordable Care Act does a pretty good job of getting that preventative services onto the front line. That's a good step in that primary care part of the ACA. It's huge and we know what Americans need to do. We just have to help them do it.

CHRONIC DISEASE MANAGEMENT

AGK: In terms of controlling costs, data suggests that chronic diseases represent a disproportionate burden on the total health care spent. How should you as an industry and Mayo, in particular, approach chronic disease management in lower cost settings?

JN: It's a terrific question. It's a terrific question. The majority of the health care costs in the primary care, if you will, spectrum of care is the management of chronic diseases; and now we

have what we know what works. We can push that through in the knowledge delivery part to primary care physicians and nurses using protocols to manage the costs of care in a population. This is one of the best parts of the Affordable Care Act, and we can manage chronic diseases much better at lower cost by doing that, and we will see some benefit from that. We're very excited about the work we're doing. We call that population health management. It's a big deal and the Affordable Care Act has actually moved that discussion in a very positive way, Angela.

DESTINATION MEDICAL CENTER

AGK: Looking locally to Rochester, can you explain to a national audience Mayo's current expansion plans and how you believe that, that will help improve medical care? Questioner asks, 'Do you believe the Minnesota legislature will approve the infrastructure funding that Mayo has requested?'

JN: Can I see that just for a second? I want to hit the right points. Thank you.

AGK: You're welcome.

JN: So, Rochester, Minnesota, is a town now of a little over 100,000 people. There are about 30,000 health care folks that live in this little town. It's a very special place, wonderful community in a wonderful state, and they've had a relationship with the community that's been very strong, as I said, for 149 years, and Angela's family hailed from there. We've worked with the community for this last century, the 20th century, with 20-year plans of what's going to happen at Mayo Clinic. We have a very good relationship with the community. And essentially, what this plan is all about is—'What is Mayo planning to do in the next 5 years and the next 20 years, if you will, working with the plan so the city and Mayo work together?' If one looks back 20 years and one looks ahead 20 years and just sort of overlooks a little bit where the economy is in the moment because it is improving, and it will cycle . . . . . . we expect that Mayo Clinic will invest $3 to 3.5 billion in Rochester in the next 20 years. We know from the private sector that there's probably going to be something like $2 billion of private investment into Rochester in this Destination Medical Community plan to develop a vibrant city that supports the international traffic, as I mentioned, 137 countries coming there last year. So it's a livable city, both for the patients and the families who come with them and our remarkable staff. Now Rochester is a small town. It doesn't have the tax base, because it's a small town, to build the sidewalks, bridges, and sewers that will be needed for this. Mayo Clinic is not asking for one penny from the state for Mayo Clinic. We're simply saying the tax base will grow with $6 billion over 20 years. We anticipate up to 40,000 new jobs, and all we're saying is, 'Can Mayo Clinic get a piece of that tax revenue to pay for the sewers and the sidewalks and the bridges.' It doesn't sound very elegant when you say it that way. But other states, and I won't mention them, are putting a ton of investment in outstanding marquee medical brands like Mayo Clinic to grow their facilities in order that they can become destination cities like Mayo Clinic has been for over 100 years. Mayo has grown every year. We know people will come. We anticipate they'll continue to come. We're simply asking, 'Once the money is in and measured and the revenues are grown, can we take a portion of that to pay for the infrastructure in the town?' I hope this happens. We've told the state we want to grow. We know Mayo Clinic will continue to grow. We want to grow in Minnesota. Mayo Clinic is the largest private employer in the state of Minnesota. We're responsible for 70,000 jobs, 140,000 jobs nationally, and $9.6 billion in revenue to the state of Minnesota. So, we think they should just help us build some

sidewalks and sewers and promise to do that . . . . . . because if we can't . . . . . . we have to decide where we're going to invest. If we're going to invest $3 billion over the next 20 years, we just have to know that we're going to invest it in a place that will allow us to grow. We have tremendous support, bipartisan, bicameral, labor, commerce. We think . . . . . . I think it should . . . . I hope it . . . . . . I don't know whether it will pass! I'm sorry, I shouldn't have said that on national television, I suppose, but it should pass. It's the right thing for Minnesota. All boats will rise. We're good for the economy of Minnesota, and we hope that the legislature will pass this, but we'll see.

LYME DISEASE

AGK: As you can imagine, there's a lot of questions on particular illnesses. We can't get to them all, but one asks one on Lyme disease, which had a lot of questions. 'Does Mayo Clinic have any plans to change its adherence to the CDC Lyme disease treatment and/or testing guidelines?'

JN: So, Lyme disease is a tick-borne illness that many of you know about. It can be mild or asymptomatic, or it can be really quite severe and cause important complications and suffering for the patients who have Lyme disease. It's a complex disease to understand and to treat and to eradicate. Mayo Clinic sees patients with Lyme disease, and we believe and we work with the Center for Disease Control, the CDC; and at the moment, they have guidelines in place how Lyme disease is best and most accurately and safely diagnosed, and we follow those. It's a two-step process where we do what's called an immune enzyme test; and if it looks positive, we then go on to something called the immune blot test. We believe that's the right way to go. We think they're the most knowledgeable in the industry, and we follow their guidelines. And if we or they feel that the guidelines should be changed, we will change for our patients. But there's a large group of folks out there who think the guidelines are flawed. We think the guidelines are where we are today in today's knowledge. So we don't intend to change those unless there's data to suggest that we should.

MENTAL HEALTH

AGK: And on mental health, the questioner asks, 'What recommendations does Mayo have toward implementing Senator Paul Wellstone's (from Minnesota, of course) Mental Health Parity Act passed in 2008 but yet to be put into practice?'

JN: Thanks, Angela. Mental health is a huge problem in this country. It's underappreciated, the degree of patient suffering and family suffering, as you all know. I'm afraid I can't speak specifically to that policy. I just don't know enough about that particular act. We invest very heavily in research and psychiatric and behavioral disorders. We work very hard with our community to provide the best care we can to those who suffer from mental disease, and many of these folks are very disadvantaged, and we do our very best to provide high-quality, low-cost care to them; but I'm afraid I just don't know enough about that policy. I'm sorry.

BREAST CANCER

AGK: Questioner asks about a recently released four-year Mayo study looking at breast cancer. The questioner says, 'The study will help find those who are most at risk for certain cancers, including breast cancer, and get the testing they need before the disease surfaces and would like to know a little bit more about that study's results.'

JN: I'm sorry. I'm a neurologist and a CEO. I don't mean to be disrespectful, but I don't know everything, and I don't know that specific study. So, I'll have to defer that question our team here to try to get the right answer to that patient. I will say that cancer prediction and prevention and treatment is an area of great interest at Mayo Clinic, and there is reason for great excitement about the new biology as we understand more about the genetics and genomics of cancer, both for the patients and the tumors that grow in patients, and that dictates how we treat our patients so that they get individually tailored treatment to best benefit. One little story I might just tell you, for those of you who haven't followed this, we had an example last week with an individual . . . . . . we have individualized medicine, which is this business about—what do your genes tell you about your health and what do your genes tell you about how you're going to respond to a certain treatment? We had a patient with breast cancer. She has had multiple treatments and has responded and then failed and relapsed, responded, and failed, and then relapsed. She came to the Individualized Medicine Clinic at Mayo Clinic, which is the first clinic of its type in the country. We did a genomic sequence on her and on her tumor, and we found that her tumor, although it's a breast tumor . . . . . . and a recurrent, severe, advanced breast tumor . . . . . . it shares characteristics and a genetic fingerprint of a lung cancer, not a breast cancer; and so we're treating her now with treatment that we know works in lung cancer. So, again, this is where we're advancing in terms of individualized medicine and individualizing our care, and that's very exciting.

HOW DOES MAYO CLINIC ATTRACT SO MANY EXCELLENT PHYSICIANS

AGK: We are almost out of time. Before asking the last question, I've got a couple of housekeeping matters to take care of. First of all, I'd like to remind you of our upcoming luncheon speakers. On April 12th, this Friday, Ken Burns, documentary filmmaker, will discuss his new documentary, 'The Central Park Five.' On April 15th, Ólafur Grímsson, the President of Iceland, will discuss 'The Global Race for Resources in the Arctic.' And on April 17th, we will host Gil Kerlikowske, the Director of the Office of National Drug Control Policy. Second, I would like to present our guest with the traditional National Press Club coffee mug. I appreciate you coming today and we have one last question for you. Questioner says, 'How does the Mayo Clinic attract so many excellent physicians from New York City, San Francisco, Chicago, etc., to Rochester, Minnesota? What is the pitch you make to them, and what is the success rate?'

JN: Alright, time for a little humor. I had a friend of mine come and visit me when I was Chair of the Department of Neurology, and he was from New York City. And he said, 'How can you stand it here?' He's my guest! 'How can you stand it here?' And I said, 'Well you get a warm coat and hat and mitts.' He goes, 'No, no, no'. He said, 'There's no tension.' I said, 'What do you mean?' He said, 'In New York, we're always trying to beat the other hospital, take over their medical school, whatever, whatever.' He said, 'Everybody gets along here.' And I said, 'Well, we spend our time fighting disease, I guess. It just depends on what you want to do.' Thank you all.

AGK: Thank you, Dr. Noseworthy. Thank you all for coming today. I'd also like to thank the National Press Club staff including its journalism institute and broadcast center for helping organize today's event. Finally, here's a reminder that you can find out more information about the National Press Club, including about becoming a member, on our website; and if you'd like a copy of today's program, please check that out at www.press.org. Thank you. We are adjourned.