Objective 1: What are key trends that will most impact providers?

Objective 2: How can medical centers organize to best respond? What did Mayo do with governance/management?

Key point: What is the vision?

Overriding vision is to have the highest value healthcare

The healthcare value equation

\[
\text{Value} = \frac{\text{Quality* (outcomes, safety, service)}}{\text{Total Cost over a span of care**}}
\]

*May include any or all of these possible elements: outcomes, safety, service, access, readiness or productivity (individual, employee, workforce, military, student)

**Total spending over time for patient, a condition, a population, or a payer

• All factors in value equation are important
• Overriding issue now is healthcare costs. Why?
  • The biggest issue in U.S. government future debt
  • Affordability for the average U.S. citizen
  • Impact on U.S. jobs in a global economy

Total U.S. federal debt?

$14T

How much is $14T?
“Now $46,300”

Comparative debt burdens
Total government debt in the U.S. is getting close to the level of some of the most financially troubled countries in Europe

Entitlements are a major contributor to the rise in federal debt
Federal expenses vs. GDP, adjusted for inflation (1965-2010)

In addition to the Federal debt, the U.S. also has unfunded liabilities…

Entitlements = “Payments for individuals” (includes Social Security, Medicare, Medicaid, VA payments, etc.)
Federal financial hole – Social insurance programs

Unfunded social insurance promises (2009) $ trillions

<table>
<thead>
<tr>
<th></th>
<th>0</th>
<th>5</th>
<th>10</th>
<th>15</th>
<th>20</th>
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<tbody>
<tr>
<td>Social Security</td>
<td>7.7</td>
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<td></td>
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<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Medicare</td>
<td>38.2</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

Medicaid: Paid from general tax revenue each year and does not have a trust fund.

Unfunded social insurance promises are future Medicare and Social Security benefits for the next 75 yrs (estimates as of January 1, 2009, discounted to present value)


"...the entitlement programs are not self-funded. They are unfunded liabilities to a significant extent at this point. They are the biggest component of spending going forward.” – Ben Bernanke¹

"In an uncertain world, our currency and credit are well established. But there are serious questions, most immediately about the sustainability of our commitment to growing entitlement programs" – Paul A. Volcker²

Healthcare costs and affordability for the average citizen

Why cost is important?

Our kids/grandkids lives will be impacted

<table>
<thead>
<tr>
<th></th>
<th>2009</th>
<th>2020 est*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median annual family income for a working couple</td>
<td>$70,000</td>
<td>$133,510</td>
</tr>
<tr>
<td>Average annual family healthcare premium</td>
<td>$13,375</td>
<td>$24,080</td>
</tr>
<tr>
<td>Healthcare premium as % income**</td>
<td>19%</td>
<td>53%</td>
</tr>
</tbody>
</table>

¹“Statement of Economy: Views from the Federal Reserve”, testimony before the House Budget Committee, June 9, 2010
²Volcker PA, remarks at the Stanford Institute for Economic Policy Research, May 18, 2010

Observations of Craig Barrett, former CEO of Intel

• Health costs are driving U.S. jobs overseas
• Most pressing need is integrated health delivery
• Hospitals are organizing to try, but they have the wrong mind set

Why is integrated delivery of care the key?

Total Cost = Total Spending = Price x Use Rate
Use rate is the key

- "… utilization - not local price differences - drives Medicare regional payment variation…"1
- "Most of this variation (Medicare spending) was not due to differences in the price of care in different parts of the country, but rather to differences in the volume..."2
- There is a two fold difference between the MSA with greatest service use (Miami, FL) and the MSA with the least service use (La Crosse, WI). " (After adjusting for regional prices, added payments for GME, IME, etc., demographics and beneficiary health statues)3

1. Gottlieb et al.: "Prices Don’t Drive Regional Medicare Spending Variations", Health Affairs, March 2010
3. MedPac Report to Congress, January 2011, "Regional variation in Medicare services use." 19

What additional services are provided in high cost areas? Those services determined by physician practice style

Discrete: Effective care
- Reperfusion in 12 hours (heart attack)
- Aspirin at admission (heart attack)
- Mammogram, Women 65-69
- Pneumococcal immunization (Ever)

Discrete: Preference-sensitive care
- Total hip replacement
- Total knee replacement
- Back surgery
- CABG following a heart attack

Care delivery: Who/How often/Where
- Total inpatient days
- Inpatient days in ICU or CCU
- Evaluation and management (Visits)
- Imaging
- Diagnostic tests

Ratio of use rates (risk-adjusted)

<table>
<thead>
<tr>
<th>Service</th>
<th>High-spending regions</th>
<th>High-spending regions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Days*</td>
<td>Ratio to benchmark</td>
<td>Ratio to benchmark</td>
</tr>
<tr>
<td>Intensive care days</td>
<td>1.2</td>
<td>1.2</td>
</tr>
<tr>
<td>Intermediate care days</td>
<td>1.5</td>
<td>1.5</td>
</tr>
<tr>
<td>Ventilator days</td>
<td>1.8</td>
<td>1.8</td>
</tr>
<tr>
<td>Diagnostic tests</td>
<td>2.5</td>
<td>2.5</td>
</tr>
<tr>
<td>Integrated average</td>
<td>1.7</td>
<td>2.1</td>
</tr>
<tr>
<td>United States</td>
<td>3.7</td>
<td>2.1</td>
</tr>
<tr>
<td>Miami, FL</td>
<td>10.1</td>
<td>5.8</td>
</tr>
<tr>
<td>Los Angeles, CA</td>
<td>7.5</td>
<td>4.3</td>
</tr>
</tbody>
</table>

4. Dartmouth Atlas of Health Care

How to get to high value care?

Pay for it!

Bay Area Council Economic Institute Report October 2011: “Addressing California’s Healthcare Affordability Crisis”

- Main Conclusions:
  - Focus on health outcomes
  - Financially reward high value care
  - Embrace payment that maximizes health while preserving resources
  - Payers should quickly ramp up

Where to start on pay for value

- Expensive patients (those hospitalized)
- Expanded DRG lump sum payment (to encourage judicious use rates)
  - Expanded DRGs = Current DRGs + longer time than hospitalization + include physician services
  - Announce plan, give providers two years to self organize
  - Start with Medicare’s most expensive DRG and go DRG by DRG
  - Providers define outcomes
How to set the payment amount

- Not formulas
- Reality based pricing concept (Dr. Hal Luft)
  - Cost of resources used by medical centers getting best risk adjusted outcomes + 3%

Source: Luft: Total Cure, Harvard University Press, 2008

Hypothetical example of EDRG payments based on concepts suggested by Dr. Hal Luft

Experience of teaching hospitals for EDRGx

<table>
<thead>
<tr>
<th>Cost for EDRG “x” ($000s)</th>
<th>Outcomes for EDRG “x”</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Hospital</td>
</tr>
<tr>
<td>1</td>
<td>Hospital</td>
</tr>
<tr>
<td>2</td>
<td>Hospital</td>
</tr>
<tr>
<td>3</td>
<td>Hospital</td>
</tr>
<tr>
<td>4</td>
<td>Hospital</td>
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<td>5</td>
<td>Hospital</td>
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<tr>
<td>9</td>
<td>Hospital</td>
</tr>
<tr>
<td>10</td>
<td>Hospital</td>
</tr>
</tbody>
</table>

Median Cost all teaching hospitals

Top 1/3 of hospitals on outcomes

Proposed pricing point

Median cost of top 1/3 of hospitals on outcomes

Source: Luft: Total Cure, Harvard University Press, 2008

The Advisory Board’s top implications of reform for providers

- The transition to outcomes-focused reimbursement will increase risks to revenue growth
- Operating efficiency will challenge growth as the driver of profitability
- Providers will maintain tighter and fewer affiliations across the delivery system
- Information-driven care, not simply information technology adoption, will ascend as a competitive differentiator
- Strategy will focus increasingly on functional integration

Source: The Advisory Board Company, Washington Update from Chas Roades, July 1, 2009

How can medical center provide high value care?

- Concentrate on all elements of value equation:
  - Patient outcomes
  - Safety
  - Service (patient satisfaction)
  - Cost per patient over time
- Integrated delivery between hospital and outpatient settings
- Integrated delivery between specialties
- Integrated delivery between physicians and allied health
- Integrated leadership between physicians and administrators
- Overall governance structure that:
  - Allows above to happen
  - Is not cumbersome that decisions are hard to make
  - Holds leadership responsible for actually delivering high value to the patients

Steps Mayo has taken over past decade to accomplish higher value

- Realized our governance and management structure was too cumbersome, making key decisions difficult and some just not made.
  (Remember: “Not to decide, is to decide.”)
- Carried out thorough review of how to get leadership on the same song in the same orchestra:
  - Vision and key value
  - Key strategies and tactics to always improve on vision while maintaining key value
  - How to reach key strategies and tactics with input, but not too time consuming
  - How to communicate key points (need to say 8 times)

Some key tenants of Mayo success

1. Clear and consistent vision
   - The main thing is the main thing: “Needs of the patient come first.”
   - Research and education key components – but only to support the practice

2. Culture of learning
   - You can always improve
   - Learn both internally and from others
   - Effectiveness and efficiency both needed – science of healthcare delivery

3. Team-based approach
   - Rotating leadership – departments and organization as a whole
   - Physician and administrator partnership – Mayo overall, committees, departments
   - Want staff to feel like team members, not just employees
   - Staff compensation should encourage teamwork, not silos

4. Efficiency
   - Use all resources needed for the individual patient – but only the resources needed
   - We don’t help our patients if we bankrupt them
   - We are one family with one banking account

5. Clear and consistent communication
   - What I do is more important than what I say. But what you say, say consistently and say 8 times.
   - It should be understood which physician is coordinating and taking responsibility for a patient’s care
   - Remember, the main thing is the main thing
Steps Mayo has taken over past decade to accomplish higher value
- Carried out thorough review of overall governance and management
  - Exercise regarding key decisions
  - Level of annual capital expenditures
  - Approval of a large capital spending project
  - Selection of department chairs
  - Selection of site CEO and CAO
  - Selection of overall Mayo CEO and CAO
  - Etc.
- Discussion about who and how decisions should be made
- Background to develop in writing: “Mayo Clinic: Governance and Management Structure”

Example: Board of Trustee’s responsibilities
1. Oversight of Mayo’s affairs to be sure keeping with best interest of those served
2. Ensure President/CEO leads appropriately
3. Execute responsibilities of standing committee’s (e.g., Audit Committee, Business Planning Committee, Investment Committee, etc.)
4. Confirm overall Mayo strategy
5. Approve operating and capital budgets
6. Ensure Mayo meets operating plans
7. Preserve tax-exempt status
8. Annually review the performance of the President/CEO

Mayo Clinic: Governance and management structure
1. Responsibilities, Accountability, and Authority of Mayo leadership
   a. Board of Trustee’s
   b. President/CEO and CAO
   c. Internal Board of Governors
   d. Mayo Management Team
   e. Site leadership
2. Selection and evaluation for President CEO, CAO and Vice Presidents
3. Selection, membership criteria, and evaluation for internal Board and Management Team