



# MAYO CLINIC HEALTH POLICY CENTER



BUILDING A NEW VISION  
FOR HEALTH CARE IN AMERICA

*A summary of recommendations*

YOUR  
VOICE *New  
Vision*



*"My hope is that our principles will set a vision for the country."*

*Denis Cortese, M.D., Mayo Clinic*



# BUILDING A NEW VISION FOR HEALTH CARE IN AMERICA

*Diverse voices recommend common  
ideals to guide health care reform  
in the United States*



# CORNERSTONES OF A NEW APPROACH

Mayo Clinic believes America's health care system urgently needs reform to ensure the future of quality patient care. Over the last two years, Mayo Clinic Health Policy Center (the Center) has convened more than 400 national thought leaders for a series of events — one symposium and four forums — to help develop new, consensus-driven principles to guide the reform process. This report summarizes these activities to date.

To reform health care, providers, academics, medical industry leaders, business people, insurers, political leaders and patient advocates recommend four areas of focus: universal insurance coverage, coordinated care, value and payment reform.

## UNIVERSAL INSURANCE COVERAGE

*Provide health insurance and access to basic health care for all Americans — regardless of their ability to pay.*

- Move from employer-based insurance to portable, individual-based coverage. Employers could still help finance a portion of their workers' health care expenses and should be encouraged to promote employee wellness.

- Create a simple mechanism (similar to the Federal Employees Health Benefit Plan) to offer private insurance packages to buyers.
- Require individual ownership of health insurance, with sliding-scale subsidies for people with lower incomes.
- Appoint an independent health board (similar to the Federal Reserve) to define essential health care services. Allow people to purchase more services or insurance, if desired.

## COORDINATED CARE

*Patient care services must be coordinated across people, functions, activities, sites and time in order to increase value. Patients must be active participants in this process.*

- Center care around the needs of the patient.
- Realign the health system toward improving health rather than treating disease.
- Form coordinated systems to deliver effective and appropriate care to patients.
- Develop a “portfolio of incentives” to encourage teamwork among health care professionals.
- Increase support for health care delivery science, which generates

new knowledge by using common tools such as information systems, process improvement techniques and outcomes measurement.

- Provide complete and accurate information so patients can make informed decisions about their care.

## VALUE

*Increase quality and patient satisfaction. Decrease medical errors, costs and waste.*

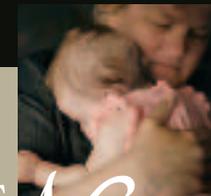
- Develop a definition of value based upon the needs and preferences of patients, measurable outcomes, safety and service, compared to the cost of care over time.
- Measure and publicly display outcomes, patient satisfaction scores and costs as a whole. Create competition around results through pricing and quality transparency.
- Create a trusted mechanism to synthesize scientific, clinical and medical information for both patients and providers.
- Reward consumers for choosing high-quality health plans and providers.
- Hold all sectors in health care accountable for reducing waste and inefficiencies.

## PAYMENT REFORM

*Change the way providers are paid in order to improve health and minimize waste.*

- Design payment systems to provide patients with no less than the care they need and no more than fully informed, cost-conscious patients would want.
- Create payment systems that provide incentives for colleagues (physicians, hospitals) to coordinate care for patients, improve care and support informed patient decision-making.
- Pay providers based on value. (See item #1 in “Value” section.)
- Further develop and test models of payment based on chronic care coordination, shared decision-making and mini-capitation (i.e., one bundled fee for the physicians and hospital delivering acute care).

*(See pages 8-16 for further development of these principles.)*



YOUR  
VOICE  
*New  
Vision*

SOLUTIONS  
identify opportunities  
*generate momentum*

## THE PATIENT — FRONT AND CENTER

Mayo Clinic Health Policy Center is committed to bringing patient voices to national health care reform discussions. During the fall and winter of 2007, the Center will seek deeper patient input through focus groups, a national survey and other means to offer the public an opportunity to lend their individual voices to the health care reform debate. A true cross-section of consumers — representing various ages, genders, races, life stages and medical conditions — will ensure that our final principles reflect the values of the American public as a whole.

The following are excerpts from patient letters and stories on [Mayoclinic.org/healthpolicycenter](http://Mayoclinic.org/healthpolicycenter) and patient advocacy Web sites. They reflect common concerns expressed by patients.

*Voices*



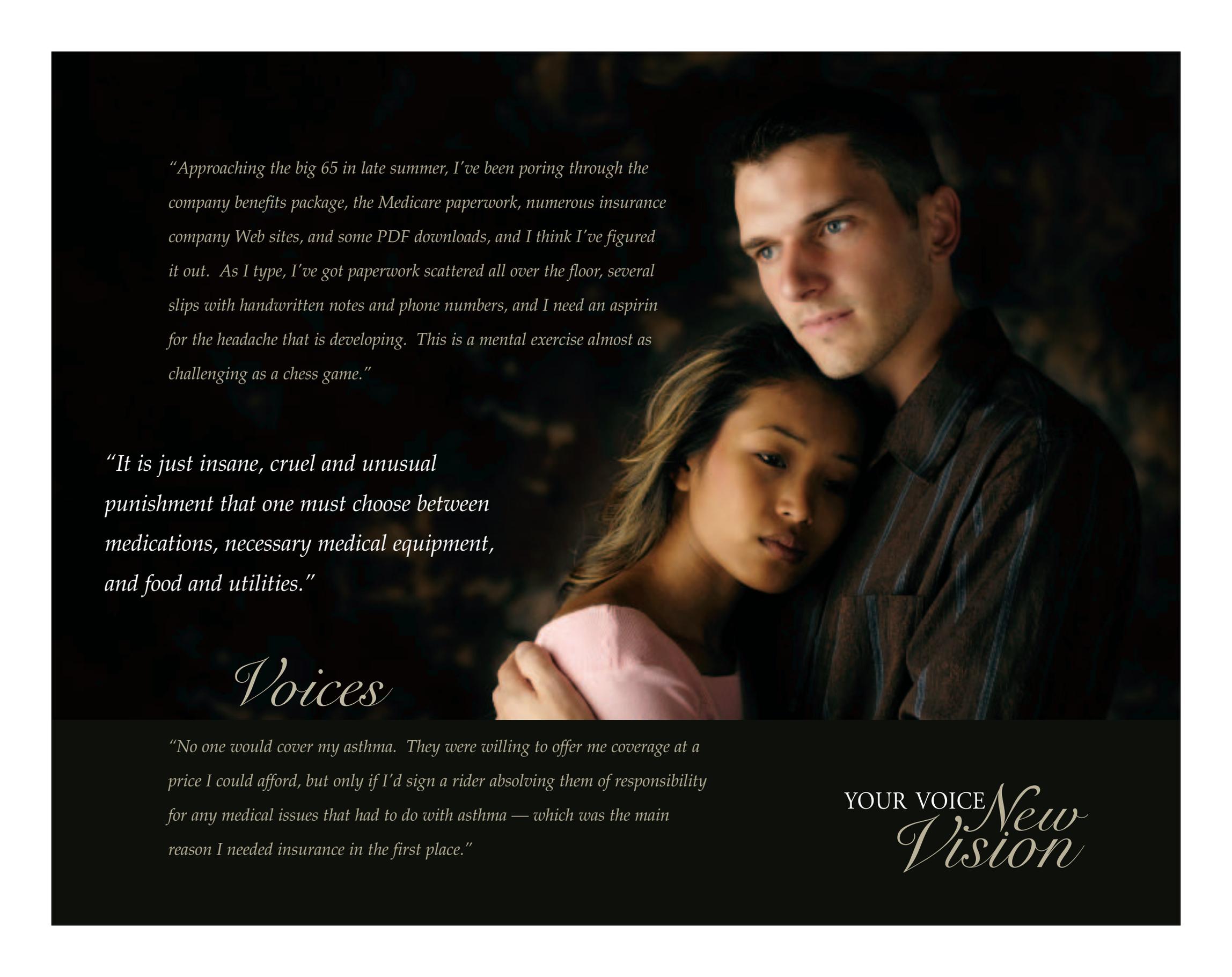
*“You have to be rich to get good health care.”*

*Voices*



*“Not only are Americans uninsured and underinsured, many have adequate insurance that is just a nightmare to use. I was fortunate that I was well enough to make all the phone calls, deal with the paperwork, and pay all the out-of-pocket expenses. I still believe the claims processing must have cost more than my care.”*

*“The (Medicare) program is so confusing to so many people. I’ve seen people throwing up their hands and saying, ‘who can understand this?’”*

A man and a woman are shown in a close embrace. The man, on the right, has short dark hair and blue eyes, looking off to the side with a serious expression. The woman, on the left, has long dark hair and is looking down with a somber expression. They are in a dark, textured environment, possibly a cave or a forest at night, with some light reflecting off the surfaces around them.

*"Approaching the big 65 in late summer, I've been poring through the company benefits package, the Medicare paperwork, numerous insurance company Web sites, and some PDF downloads, and I think I've figured it out. As I type, I've got paperwork scattered all over the floor, several slips with handwritten notes and phone numbers, and I need an aspirin for the headache that is developing. This is a mental exercise almost as challenging as a chess game."*

*"It is just insane, cruel and unusual punishment that one must choose between medications, necessary medical equipment, and food and utilities."*

## *Voices*

*"No one would cover my asthma. They were willing to offer me coverage at a price I could afford, but only if I'd sign a rider absolving them of responsibility for any medical issues that had to do with asthma — which was the main reason I needed insurance in the first place."*

YOUR VOICE *New  
Vision*

## UNIVERSAL INSURANCE COVERAGE

---

*Provide health insurance and access to basic health care for all Americans — regardless of their ability to pay.*

Statistics from the U.S. Census Bureau show that the number of Americans without insurance increased by about 1.3 million from 2004 to 2005. During the same period, the percentage of Americans receiving employer-sponsored insurance dropped slightly, while the number of uninsured children increased from 7.5 million to 8.3 million.

“The health care system in the United States is broken,” notes participant John Rother, J.D., AARP. “We have to change. The consequence of failure is simply too expensive and too costly in terms of human life.”

Participants noted that lack of insurance also creates significant economic problems for health care providers and employers. The American Hospital Association reports that hospitals provided \$28.8 billion in uncompensated care to the uninsured and underinsured in 2005. And many companies — finding it difficult to compete globally when faced with paying billions of dollars to insure employees, retirees and dependents — are reducing or eliminating health insurance coverage.

“Every dollar that gets shifted to health care comes out of our customers’ pockets,” says Linda Dillman, Wal-Mart Stores, Inc.

For both humanitarian and economic reasons, participants at Center events overwhelmingly supported the idea that all Americans should

have health insurance, regardless of ability to pay. They agreed that the issue must be considered within the entire framework of health care reform.

### **ACTION PRINCIPLES**

Participants envisioned several ways to move toward comprehensive insurance coverage. Participants emphasized that current insurance models should not be dismantled until a new system is in place.

**Move from employer-based insurance to portable, individual-based coverage. Employers could still help finance a portion of their workers’ health care expenses and should be encouraged to promote employee wellness.**

Most participants agreed that individuals — not employers — should be accountable for having health insurance.

The group endorsed a new role for employers: financing a portion of health care expenses (perhaps by providing employees with a stipend to offset premium costs) and promoting employee wellness in the workplace.

Participants also discussed that making the change to individual ownership may require reforming the way health insurance is treated for income tax purposes. The current tax system provides favorable tax treatment to employer-provided insurance, and the tax subsidy is greatest for higher-income workers.

**Create a simple mechanism (similar to the Federal Employees Health Benefit Plan) to offer private insurance packages to buyers.**

The group generally rejected a government-run single payer system, but expressed affinity toward the idea of individuals purchasing health insurance through organized purchasing pools.

**Require individual ownership of health insurance, with sliding-scale subsidies for people with lower incomes.**

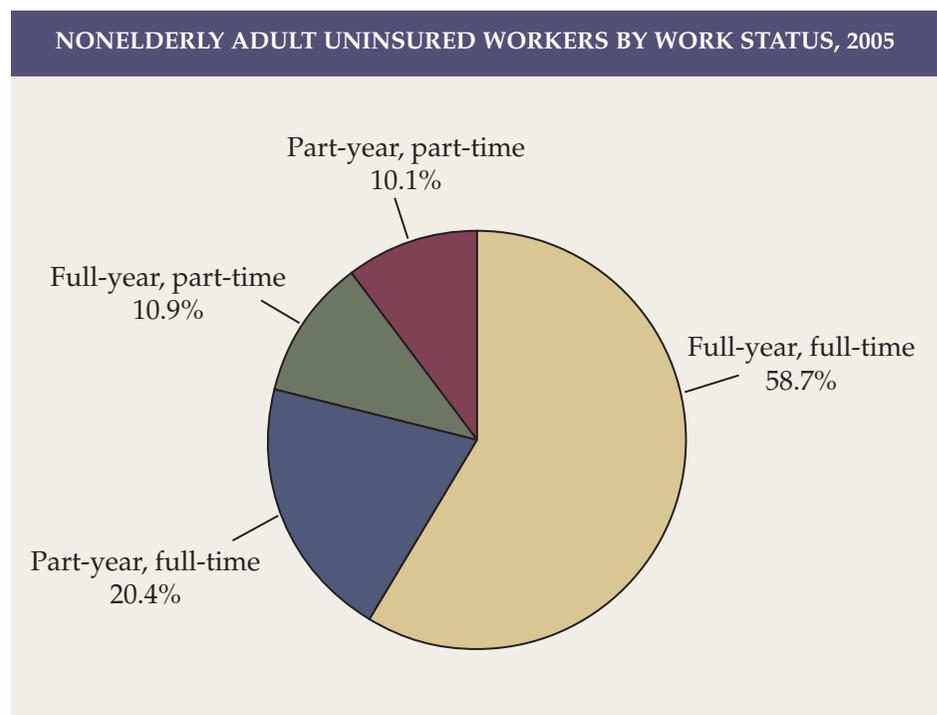
Group members supported the idea of moving to individual ownership of health insurance, similar to auto insurance standards currently in place in our country. Individual ownership allows for portability, accessibility and freedom to choose plans and providers.

Some attendees noted that moving to individual ownership of insurance would, over time, allow citizens to keep their own insurance throughout their lifetimes, and eventually could eliminate the need for Medicare, Medicaid and other government-run programs. This would also create a stronger incentive for insurers to cover preventive care for younger individuals, knowing that savings would result in the long run.

**Appoint an independent health board (similar to the Federal Reserve) to define essential health care services.**

Attendees concurred that an essential package of health care services may include primary care, preventive care and coordination of care. They emphasized that services in the basic package must be rigorously evaluated from both a scientific and actuarial standpoint, suggesting that an independent health board (shielded from the political process)

could help formulate the offering. The group also agreed that Americans should be given the option of buying additional health care services beyond the covered essential services.



Source: Employee Benefit Research Institute estimates from the March Current Population Survey, 2006 Supplement. Last Updated: June 11, 2007  
<http://covertheuninsured.org/databank/display.php?ChartID=40>

## COORDINATED CARE

*Patient care services must be coordinated across people, functions, activities, sites and time in order to increase value. Patients must be active participants in this process.*

If playing a symphony requires a well-rehearsed orchestra, then caring for a sick patient takes a devoted team of medical professionals.

At the RAND Corporation forum on integrated systems, Mayo Clinic’s Robert Smoldt presented an example of a liver transplant patient who, in the course of a five-day hospitalization, interacted with 75 different caregivers over 11 different shifts. He said the opportunity for problems with the number of hand-offs involved in patient care makes coordination critical.

“Health care, by its very nature, is a team sport,” notes participant Larry Harrison of Scripps Clinic. “Those who must be the captain of their own ships should know that single-piloted boats are sinking.”

The call for more coordinated care — whether through group practices, integrated networks of independent physicians or physician-hospital organizations — was a common refrain at all Center events. Still, the American Medical Association reports that only one-third of all physicians currently practice in group settings, with the majority in single-specialty groups of nine or fewer.

A 2006 Commonwealth Fund Survey found that, across the board, American adults endorse the importance of well-coordinated care, perhaps because more than 40 percent of Americans have experienced

### STRONG PUBLIC SUPPORT FOR WELL-COORDINATED CARE

How important is it to you that:	Somewhat important	Very important	Total (%)
You have one place/doctor responsible for primary care and coordinating care?	17	75	92
All your doctors have easy access to your medical records?	16	77	93
Care from different doctors is well-coordinated?	17	79	96

Source: Commonwealth Fund Survey of Public Views of the U.S. Health Care System, 2006

“poorly coordinated, inefficient or unsafe care” at some point in the last two years.

“The only real point of integration right now is the patient himself,” says Douglas Eby, M.D., Alaska Native Medical Center. “A provider’s responsibility is to be in continual conversation, walking alongside in partnership with the patient.”

### ACTION PRINCIPLES

Participants recommended that providers partner with patients to move toward a more coordinated delivery system. Guiding principles include:

---

**Center care around the patient.**

Patients must be at the center of the care system. Participants agreed that our current model is provider-centered, not patient-centered. What is most needed is a system that gives patients a single point of coordination and interpretation.

**Realign the health care system toward improving health rather than treating disease.**

Participants agreed that many changes are needed to realign the health system toward improving health. One important step is to encourage measurement and reporting of quality performance at the organizational level. Another is to create care models that allow electronic data and information to be shared.

**Form coordinated systems to deliver effective and appropriate care to patients.**

Participants concurred that it is important to foster an attitude of interdependence rather than independence among providers. There was also strong agreement that coordinated systems should extend to the local level and that providers at all levels should work together to improve health.

Group members also emphasized the need to conduct and broadly disseminate more research about the structures, processes and leadership that produce the best coordinated care.

Another high priority was relief from antitrust laws that discourage separate entities from joining forces to improve coordination.

**Develop a “portfolio of incentives” to encourage teamwork.**

Participants felt that a “portfolio of incentives” should be developed to encourage health professionals to work together. These could include financial, outcomes reporting and electronic medical records. The group agreed that transparency and dissemination of outcomes data would be strong drivers of integration.

**Increase support for health care delivery of science.**

Group members endorsed the critical role of health care delivery science, which generates new knowledge by using common tools such as information systems, process improvement techniques and outcomes measurement.

**Provide complete and accurate information so patients can make informed decisions about their care.**

Attendees recommended that patients have appropriate, evidence-based care when they need it, and easy access to their personal health information from birth to death. The group supported a unified patient identifier to promote portability of information.

*“Our research suggests that you’re better off being cared for by a team of people.”*

**Elizabeth McGlynn, Ph.D.**  
RAND Corporation

## VALUE

---

*Increase quality and patient satisfaction. Decrease medical errors, costs and waste.*

Research from RAND, the Institute of Medicine and the Dartmouth Atlas of Health Care reveals three fundamental problems with health care in America: 1) More than half of physician care is not based on best practices; 2) Nearly 100,000 Americans die annually as a result of medical errors; and 3) Medical professionals who provide high-quality, cost-effective care are “rewarded” by getting paid less.

“I think of our health care system in the United States as the poster child for underachievement,” says Stephen Shortell, Ph.D., University of California, Berkeley. “We are in no way realizing our potential.”

To address these issues and improve the effectiveness and efficiency of care, Mayo Clinic Health Policy Center participants recommended a fundamental restructuring of our current delivery and reimbursement systems, with improvements funded by eliminating waste.

“If we do the right thing, five years from now we’ll have a system that’s safer, more effective and more patient-centered,” says Don Berwick, M.D., Institute for Healthcare Improvement. “If we really do the right thing, it’s also going to be far less expensive than the system we’re paying for now.”

Participants agreed that increasing the value of the health care system would afford every American the opportunity to contribute to and benefit from the creation, dissemination and use of health care knowledge.

Denis Cortese, M.D., Mayo Clinic, proposed that health care must become a learning system in which medical professionals freely share successes and failures, so all patients can benefit.

### **ACTION PRINCIPLES**

Participants created the following principles to guide the development of a health care system that creates and rewards value:

**Develop a definition of value based upon the needs and preferences of patients, measurable outcomes, safety and service, compared to the cost of care over time.**

Participants estimated that a large portion of health care activity doesn’t add value to patient care and should be removed from the system.

The group strongly recommended that a common value equation — cast from the patient’s perspective — be created so that stakeholders could collectively evaluate and improve factors that contribute to the overall care experience. The group also agreed that payment should be based upon episodes of care delivered over longer time periods, rather than paying for discrete services.

**Measure and publicly display outcomes, patient satisfaction scores and costs as a whole. Create competition around results through pricing and quality transparency.**

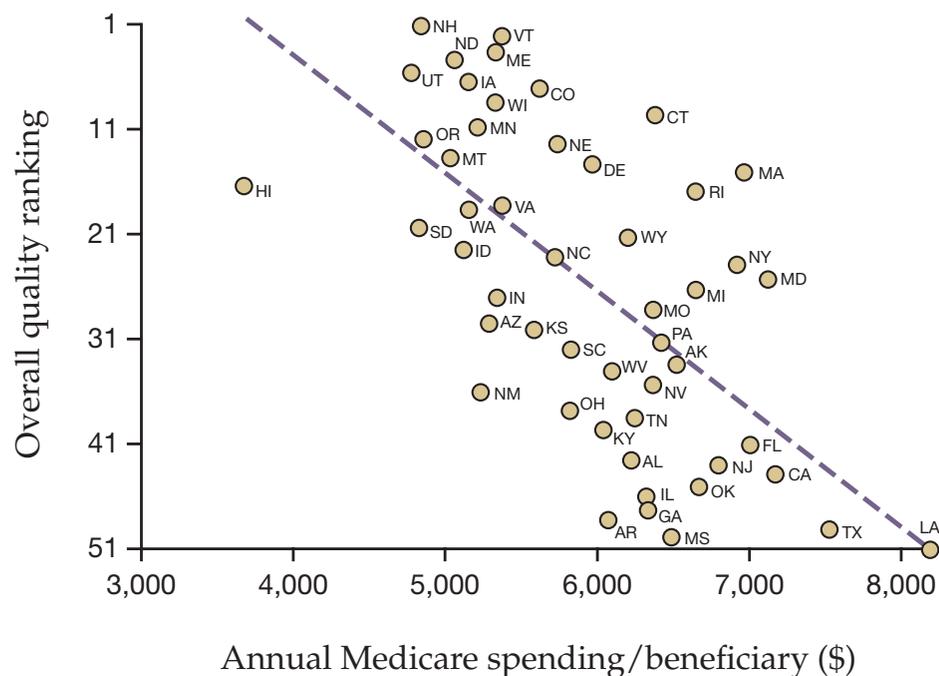
Transparency and standards of measurement are critical if stakeholders are to make value-based choices. Most attendees agreed that providers should measure and publicly display their outcomes, patient satisfaction scores and costs as a whole. The group agreed that health care providers

must begin to compete on these elements — rather than focusing on cost shifting and bargaining power — to increase value to the patient.

*“I think taxpayers are very concerned about putting more of their tax dollars into the health delivery system when they read every day that it’s not working especially well for any group.”*

Sylvia Drew Ivie, J.D.  
South Los Angeles Community Kitchen

MEDICARE SPENDING AND QUALITY OF CARE BY STATE, 2001



Source: Balcker, K., and A. Chandra, “Medicare Spending, the Physician Workforce, and Beneficiaries’ Quality of Care,” *Health Affairs Online*. Copyright 2003 by Project Hope.

**Create a trusted mechanism to synthesize scientific, clinical and personal medical information for both patients and providers.**

Participants acknowledged the deluge of medical information that clinicians and the general public must sort through each day. They recommended creating a group — funded by the government but not influenced by politics — to synthesize and disseminate knowledge that would improve patient care.

**Reward consumers for choosing high-quality health plans and providers.**

To help patients choose high-value health plans or providers, participants recommended that consumer information be easily accessible and understandable.

**Hold all sectors in health care accountable for reducing waste and inefficiencies.**

The majority of participants endorsed the basic tenet that any reform proposal must demonstrate how it would reduce waste and inefficiencies, not simply shift cost to another sector. Group members bemoaned the silos — hospitals versus physicians; insurers versus providers — that fracture our delivery system, and recommended building agreement and accountability across multiple parties.

## PAYMENT REFORM

---

*Change the way providers are paid in order to improve health and minimize waste.*

Because our current reimbursement system rewards piecework — performing diagnostic tests, procedures and surgeries, for example — it's natural that U.S. health care is laden with these expensive, fragmented pieces of care that often don't form a coherent picture.

"The incentives are absolutely perverse," says Stephen Shortell, Ph.D., University of California, Berkeley. "We pay doctors the same amount or even more money regardless of whether or not they give good recommended care."

Participants at all Center events spent significant time discussing current payment systems in which incentives are skewed to foster the inefficient, expensive and often inappropriate care that riddles health care today. Some participants felt that tackling the financing system would be a good first step toward reform because other problems (i.e., overuse of many services and tests) would be resolved if the system paid for care differently.

Group members noted several problems with the current payment system. For example, there are financial penalties and disincentives for providing certain kinds of care (lower-cost services, "cognitive" care, preventive care) and incentives to offer expensive specialty care, procedures and repeat office visits. Participants also noted that providers offering coordinated, cost-effective care are often financially penalized.

"Currently, if you provide more efficient, high-quality care, you get paid less," says Don Fisher, Ph.D., American Medical Group Association. "You lose money at the end of the day."

### NEW PAYMENT APPROACHES

Participants strongly endorsed the idea that providers should be paid based upon the value that they offer to patients (as defined in the "Value" section of this document). Overall, the group expressed very little support for the current Medicare pay-for-performance programs. For all other payment methods, however, there was wide variability of opinion about how the individual option might affect health care costs and quality. In the end, attendees felt that the following three payment approaches — which aren't mutually exclusive — should be explored further.

#### Chronic Condition Coordination Payment

Patients with chronic conditions would choose a "medical home" — a place with resources and infrastructure to organize and coordinate care over time — for their care management and preventive care. The medical home would receive a single periodic, prospectively defined

*"We have a payment system that drives more care irrespective of whether the patient needs it or not."*

Francis J. Crosson, M.D., *Permanente Federation*

“care management payment” to cover all of these services. The amount would be adjusted for the severity/risk of the patient’s condition. Major acute episodes and long-term care associated with the chronic condition would be paid separately.

*Advantages*

Participants thought that a “medical home” (which would be required to meet certain qualifications and publish outcomes) could potentially improve the quality of care and reduce waste associated with the lack of coordination that commonly characterizes chronic disease treatment. Several medical home pilots exist in Louisiana, Pennsylvania and California, and participants noted that hospice is a variation on this model.

*Challenges*

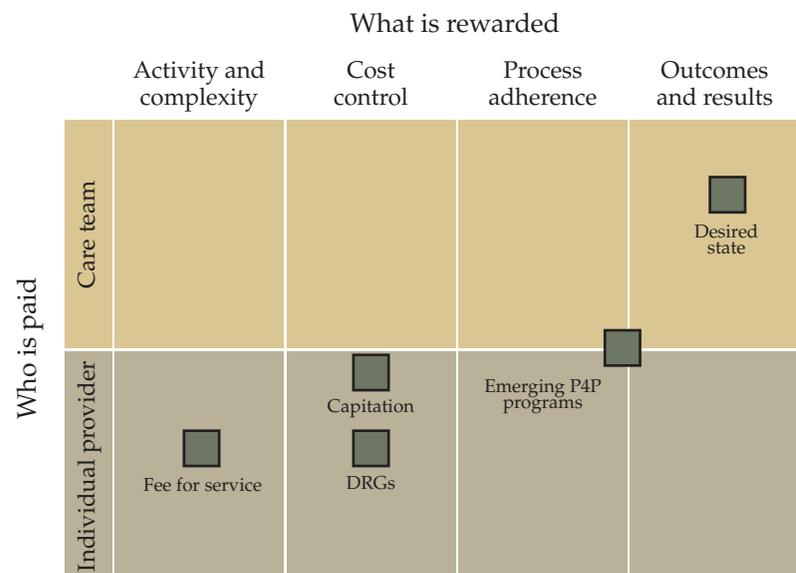
Patient advocates expressed interest in this payment mechanism as a way for the chronically ill to gain access to needed services, but cautioned that the system must provide patients with a substantial amount of trusted information prior to enrollment.

Members of the group also emphasized that the medical community must conduct research to define validated clinical pathways — and the associated costs — to manage these patients over time.

**Certification of Shared Decision-Making for Major Elective Surgery**

Medical centers would be compensated for establishing a formal program in which patients actively participate in making treatment decisions. All candidates for elective surgery would be offered the

**CURRENT PAYMENT MODELS IN HEALTH CARE**



Source: Booz Allen analysis

program. Medical centers with high-quality patient-decision scores would receive a bonus payment.

*Advantages*

Participants felt that this payment system would promote informed patient choice, and increase the quality of care while decreasing costs and waste. This model could be expanded to other areas, such as the use of drugs, and could be implemented now or together with other payment systems. Surveys show that when patients have used quality

## PAYMENT REFORM

---

decision aids, they have been highly satisfied. Organized care groups would be best positioned to implement these tools.

### *Challenges*

The group acknowledged that it could be difficult for providers to agree on quality measures for the decision guide, and wondered if implementing such a program would compound low provider job-satisfaction scores that exist across the nation.

From an administrative perspective, participants noted that the payment system should address the discrepancies between procedural payments and payment for time spent on shared decision-making. They also recognized that implementing shared decision-making aids probably would reduce surgical rates, creating short-term financial issues for some providers.

### **Mini-capitation (package pricing)**

This method provides a single bundled payment to hospitals and physicians managing the hospital care for patients with major acute episodes (heart attack, for example). One lump sum payment for both physicians and the hospital would encourage the two groups to work together to integrate services for patients. The length of the episode could include the hospitalization alone, or periods before and after the inpatient visit.

### *Advantages*

Participants pointed out that mini-capitations have been used for more than a decade to pay for transplants. The group felt that this payment

strategy could help improve quality of care if the lump sum payment required providers to publicly display pertinent quality measures. Bundling the top 10 diagnosis related groups (DRGs) by cost and quality could be a starting point for implementation.

### *Challenges*

Some participants pointed out that mini-capitation could give providers more negotiating power with insurance companies and might inadvertently drive up costs.

## PRINCIPLES TO GUIDE PAYMENT REFORM

The group advocated the following principles to guide the design of new payment systems:

- Design payment systems to provide patients with no less than the care they need and no more than fully informed, cost-conscious patients would want.
- Create payment systems that provide incentives for colleagues (physicians, hospitals) to coordinate care for patients, improve care and support informed patient decision-making.
- Pay providers based on value. (See item #1 in “Value” section.)
- Further develop and test models of payment based on chronic care coordination, shared decision-making and mini-capitation.



## MAYO CLINIC'S COMMITMENT TO HEALTH CARE REFORM

---

Mayo Clinic's strong patient focus underlies the decision to take a more active role in national health care reform through the creation of the Mayo Clinic Health Policy Center. Mayo Clinic is convinced that American health care urgently needs reform to ensure the future of quality patient care. Through this Center, Mayo Clinic works to create change by identifying common ground among stakeholders from disparate sectors.

### PHILOSOPHY

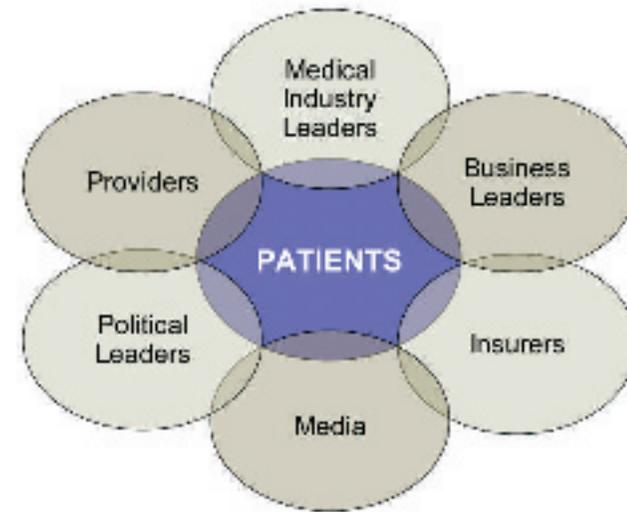
Mayo Clinic's primary value is "the needs of the patient come first." This focus will help keep the Center's discussions grounded in the real world needs of patients and ensure that the patient's voice is heard in the national reform discussions. The Center will remain independent of any particular interest group or political stance. It will provide an



*"The best interest of the patient is the only interest to be considered, and in order that the sick may have the benefit of advancing knowledge, union of forces is necessary."*

A handwritten signature in cursive script that reads "W. J. Mayo".

*William James Mayo, M.D., 1910*



impartial and objective voice that is based upon the premise that the good of the whole is more important than the interests of a few. Through a network of nationally respected collaborators from all disciplines, the Center will ensure that issues are analyzed from every perspective. Credibility and expertise will come not just from Mayo Clinic, but from all the members of the Center's network.

### PROCESS AND NEXT STEPS

During the past two years, panels of thought leaders from across the nation have brought their best ideas for health care reform to a series of events — one symposium and four forums — hosted by Mayo Clinic Health Policy Center and leading public policy organizations. The

interaction of this dynamic group resulted in engaging discussions, extensive opportunities for input and finally — with the help of an audience response system — solid, actionable reform recommendations.

The recommendations presented in this report — along with input gathered from patients nationwide — will be reviewed at a second symposium on March 9–11, 2008, in Leesburg, Va. Participants will identify and prioritize actions that different sectors can take to contribute to positive health care reform and begin creating an action plan to build a mandate for change.

## SPONSORSHIP

Mayo Clinic Health Policy Center is the cornerstone of Mayo Clinic's dedication to patient-centered health care reform. We have committed more than \$1 million to this effort, and more needs to be done. Philanthropic support is crucial to our success.

We gratefully acknowledge the following benefactors for their generosity:

*Kurt Salmon Associates  
Mr. and Mrs. Raymond and Roma Wittcoff  
Kaiser Permanente  
An anonymous foundation*

The Center continues to seek support from individuals, corporations and foundations that are committed to finding patient-centered solutions to the U.S. health care crisis. Please join us in this significant endeavor.

## LEADING CHANGE



*Denis Cortese, M.D.*



*Robert Smoldt, M.B.A.*

Denis Cortese, M.D., president and CEO of Mayo Clinic, and Robert Smoldt, executive director, Mayo Clinic Health Policy Center, lead Mayo Clinic's health reform initiative. *Hospital and Health Networks Online* recently described this effort in an article called "The Mayo Plan." An excerpt follows.

*"Over the past few years, Cortese, Smoldt and many of their colleagues have worked diligently to use the strength of Mayo's reputation as a catalyst for significant reform. The preponderance of the quality, cost and access problems facing health care today are piled at the bottom of the organizational walls built between specialists, departments, payers and providers, as well as between medicine and management. Mayo is a proven example of the power of knocking down walls."*

## A SAMPLING OF PARTICIPANTS

---

### ACADEMIA

**Colleen Conway-Welch, Ph.D., R.N., F.A.A.N.**  
*Vanderbilt University School of Nursing*

**David Cutler, Ph.D.**  
*Harvard University*

**Alain Enthoven, Ph.D.**  
*Stanford University*

**Eugene Litvak, Ph.D.**  
*Boston University Health Policy Institute*

**Elizabeth Olmsted Teisberg, Ph.D.**  
*University of Virginia*

**Stephen Shortell, Ph.D., M.P.H.**  
*UC Berkeley School of Public Health*

### BUSINESS

**Helen Darling**  
*National Business Group on Health*

**James Haslam II**  
*Pilot Oil*

**Sean Hogan**  
*IBM Corporation*

**Clarion Johnson, M.D.**  
*Exxon Mobil*

**Mark Litow, F.S.A.**  
*Milliman, Inc.*

**Andrew Mekelburg**  
*Verizon Communications Inc.*

**Anthony Wisniewski, J.D.**  
*U.S. Chamber of Commerce*

### GOVERNMENT

**Sen. Howard H. Baker Jr.**  
*Baker, Donelson, Bearman & Caldwell*

**Sen. Max Baucus**  
*United States Senate*

**RADM Susan Blumenthal, M.D.**  
*Georgetown University School of Medicine*

**Carolyn Clancy, M.D.**  
*Agency for Healthcare Research and Quality*

**The Honorable Louis Sullivan, M.D.**  
*Public Health Policy Advisory Board*

### INSURERS

**Chuck Abrahamson**  
*UCare Minnesota*

**Michael Cascone Jr.**  
*Blue Cross Blue Shield of Florida*

**George Isham, M.D.**  
*HealthPartners, Inc.*

**Michael Morrow, M.B.A.**  
*Blue Cross Blue Shield of Minnesota*

**Norman Payson, M.D.**  
*NCP, Inc.*

**Michael Stocker, M.D., M.P.H.**  
*WellPoint, Inc.*

*“Congress does not act wisely and well all the time. But it usually recognizes when the time has come to solve an issue. It’s now time to formulate a health care policy that can be supported by the American people and Congress.”*

**Sen. Howard Baker Jr.**

## PATIENT ADVOCATES

**Anne DeBiasi**

*National Breast Cancer Coalition*

**Sylvia Drew Ivie, J.D.**

*South Los Angeles Community  
Kitchen*

**Charles Inlander**

*People's Medical Society*

**Mary Richards**

*Parkinson's Action Network*

**John C. Rother, J.D.**

*AARP*

**Marina L. Weiss, Ph.D.**

*March of Dimes*

## PROVIDERS

**Denis Cortese, M.D.**

*Mayo Clinic*

**Douglas Eby, M.D.**

*Alaska Native Medical Center*

**Albert Holloway**

*The IPA Association of America*

**Brent James, M.D.**

*Intermountain Healthcare*

**Gary S. Kaplan, M.D.**

*Virginia Mason Medical Center*

**Jack McCallum, M.D., Ph.D.**

*North Texas Specialty Physicians*

**Nancy Nielsen, M.D., Ph.D.**

*University of Buffalo  
American Medical Association*

**Richard Umdenstock**

*American Hospital Association*

## INSTITUTES & RESEARCH ORGANIZATIONS

**Robert Berenson, M.D.**

*Urban Institute*

**Donald Berwick, M.D., M.P.P.**

*Institute for Healthcare Improvement*

**Marcia Comstock, M.D.**

*Comstock Consulting Group, LLC*

**David B. Kendall**

*Progressive Policy Institute*

**Jeanne Lambrew, Ph.D.**

*Center for American Progress*

**Ian Morrison, Ph.D.**

*Institute for the Future*

**Anthony Shih, M.D., M.P.H.**

*Commonwealth Fund*

**Grace-Marie Turner**

*Galen Institute*



*Robert Holmen with Mary Grealy  
of the Healthcare Leadership Council*

IN MEMORY OF

ROBERT HOLMEN

(1937—2007)

*A trusted colleague and  
friend, who was instrumental  
in Mayo Clinic Health  
Policy Center's effort to  
create the common vision  
for U.S. health care that is  
described in this report.*

## ADVISORY PANEL

---

**Francis J. Crosson, M.D.**

*Executive Director  
Permanente Federation*

**Sen. Tom Daschle**

*Alston & Bird, LLP*

**Linda Dillman**

*Exec. Vice President, Risk Management,  
Benefits & Sustainability  
Wal-Mart Stores, Inc.*

**Ezekiel Emanuel, M.D., Ph.D.**

*Chair, Department of Clinical Bioethics  
National Institutes of Health*

**Donald Fisher, Ph.D.**

*President & CEO  
American Medical Group Association*

**Chris Gade**

*Chair, Division of External Relations  
Mayo Clinic*

**Mary Grealy, J.D.**

*President  
Healthcare Leadership Council*

**Jerome Grossman, M.D.**

*Director, Harvard/Kennedy School Health Care  
Delivery Policy Program  
Harvard University*

**Alan C. Lowe**

*Executive Director  
Howard H. Baker Jr. Center for Public Policy  
University of Tennessee*

**Michael Manganiello**

*Principal  
Whyte Hirschboeck Dudek Government Affairs*

**Elizabeth McGlynn, Ph.D.**

*Associate Director  
RAND Health*

**Rob Nesse, M.D.**

*President and CEO  
Franciscan Skemp Healthcare*

**Rep. Tim Penny**

*Humphrey Institute Policy Forum*

**John Wennberg, M.D., M.P.H.**

*Director, Center for the Evaluative  
Clinical Sciences  
Dartmouth Medical School*

### *In gratitude*

*We thank the many participants who  
have helped form these recommendations.  
The summary reflects the ideas that received  
widespread support through a consensus-  
driven process.*

*We also thank the following organizations  
that co-hosted Center forums:*

*Howard H. Baker Jr. Center for Public  
Policy; University of Tennessee, Knoxville*

*The John F. Kennedy School of Government,  
Harvard University*

*RAND Corporation*

*The Center for the Evaluative Clinical  
Sciences, Dartmouth Medical School*

*"We're either going to solve this together, or it isn't going to get solved. Mayo has brought together a very wide array of stakeholders, people with varying opinions and different positions, but we're struggling with the same problem. Maybe we're going to find some daylight together."*

**Don Berwick, M.D.**  
*Institute for Healthcare Improvement*



Ensuring the future of quality patient care

YOUR  
VOICE *New  
Vision*

YOUR  
VOICE *New  
Vision*

Ensuring the future of quality patient care

[www.mayoclinic.org/healthpolicycenter](http://www.mayoclinic.org/healthpolicycenter)

MC5697-40