The Cleveland Clinic: Improving the Patient Experience (Abridged)

_The patient is not only an illness...he has a soul._1

— Dr. René Favaloro, Cleveland Clinic surgeon, performed the world’s first coronary bypass, 1967

In September 2010, Dr. James Merlino, a colorectal surgeon and chief experience officer for the Office of Patient Experience (OPE) at the Cleveland Clinic (CC) located in Cleveland, Ohio, looked up from the article he had been reading in _The New Yorker_ magazine from April of that year. Picking up a pen he marked a single paragraph that had caught his attention:

Recently, clinicians at Children’s Hospital Boston adopted a more systematic approach for managing inner-city children who suffer severe asthma attacks, by introducing a bundle of preventive measures. Insurance would cover just one: prescribing an inhaler. The hospital agreed to pay for the rest, which included nurses who would visit parents after discharge and make sure that they had their child’s medicine, knew how to administer it, and had a follow-up appointment with a pediatrician; home inspections for mold and pests; and vacuum cleaners for families without one (which is cheaper than medication). After a year, the hospital readmission rate for these patients dropped by more than eighty per cent, and costs plunged. But an empty hospital bed is a revenue loss, and asthma is Children’s Hospital’s leading source of admissions. Under the current system, this sensible program could threaten to bankrupt it.2

He resolved to discuss this paragraph with some of his colleagues the following day. The scenario described in the article reminded him of the challenges he often faced at CC to improve the patient experience. With medical costs rising, Merlino was all too familiar with the pressures to keep costs down and revenues up while also ensuring positive medical outcomes.

Merlino was extremely focused on improving the patient experience at CC. He led the OPE which had the mission of “ensur[ing] care that is consistently patient-centered by partnering with the caregivers to exceed the expectations of patients and families.”3 Overall Merlino’s goal was to show how patient experience could fit into CC’s larger organizational objectives of achieving positive clinical outcomes and efficiency. Merlino was well aware that patient-centered care and patient experience were key components of Cleveland Clinic’s strategic plan. The goal was to achieve a
coordinated, enterprise-wide care delivery model that integrated patient experience with clinical outcomes, quality, safety and employee experience.

A Brief Description of the Cleveland Clinic

Founded in 1921, CC was a general medical and surgical facility and a teaching hospital. In the past year, 50,465 patients had been admitted and 25,210 inpatient and 48,277 outpatient surgeries had been performed. In 2010, CC was a large health care organization with 11 hospitals in Northeast Ohio, and operations in Toronto, Ontario; Weston, Florida; Las Vegas, Nevada; and Abu Dhabi, United Arab Emirates. The anchor and original hospital in Cleveland, Ohio had just over 1,200 beds and employed over 1,700 physicians and dentists and almost 3,400 registered nurses full-time. Patients not only came from the local area but also from across the country as well as from over 80 countries worldwide.

CC had consistently been listed by U.S. News and World Report as one of the country’s top hospitals. In the magazine’s “2010-2011 Best Hospitals Honor Roll,” CC had been ranked as the fourth best hospital in U.S., and CC’s heart and surgery program had been ranked number one for 15 consecutive years. Fourteen other adult specialties had also placed in the top ten. Moreover, CC had fostered many medical breakthroughs, including the world’s first near total face transplant in 2008. (See Exhibit 1 for a partial list of other CC medical firsts.)

Additionally, CC was an innovator in business processes. A 2009 Newsweek magazine article characterized CC “as a hospital trying to be a Toyota factory” with its emphasis on continuous cycle improvement. In one example, CC cut a standard visit for patients receiving blood thinning drugs from 30 minutes to 15 minutes by mapping each part of the visit and even creating a DVD for patients to watch instead of having doctors deliver the same introductory talk to every patient that came to the clinic. Moreover, to keep tabs on wait times, CC had invested in an electronic dashboard that displayed real time wait times in assorted departments throughout the hospital and updated the information every half-hour so that patients always knew how long their appointment wait times were. CC was organized differently than many other hospitals. For example, doctors received a salary instead of being compensated by number of procedures performed. This enabled CC to save money on medical supplies and devices. The chairman of thoracic and cardiovascular surgery explained, “Because we’re all on a team instead of stocking 30 different heart valves, we stock two or three, unless there is a good medical reason to do otherwise, that’s what we use.” Indeed as part of his campaign to reform health care, President Obama had pointed to CC as providing “the highest quality care at costs well below the national norm.”

Moreover, the Cleveland Clinic Lerner College of Medicine (CCLCM) of Case Western Reserve University was one of the few medical schools in the country that did not charge its students tuition. The program had begun in May 2008. CCLCM covered the tuition expense of a medical class of approximately 30 students, through a combination of endowment income and clinical revenues, with the hope that endowment income would eventually cover the costs of the entire program. Explaining the tuition policy change CC president and CEO, Dr. Delos M. (Toby) Cosgrove stated, “The average debt for students graduating from private U.S. medical schools, such as the Lerner College of Medicine, is more than $150,000, making many graduates less likely to pursue careers in academic medicine. By providing full tuition support, we want to ensure academic careers as physician scientists.” In 2010, tuition costs were just over $47,000 a year. Students were still expected to pay for living expenses, fees, books, equipment and other miscellaneous expenses that amounted to approximately $26,000 a year.
A Transformational Experience

The idea for emphasizing patient experience and creating the OPE and hiring a chief experience officer at CC crystallized for Cosgrove after he attended a class at the Harvard Business School in Boston, Massachusetts, in the fall of 2006. Cosgrove recalled, “I attended two classes. The first class was good. In the second class, a student raised her hand and asked, ‘Dr. Cosgrove, what are you doing to teach your doctors empathy?’”

The young woman, Kara Medoff Barnett (HBS MBA 2007), went on to tell Cosgrove that her father—a physician in North Carolina—had needed a Mitral valve repair in 2000. She explained, “As a physician and father of six children, my father cared deeply about outcomes and technical skill in selecting a hospital and a surgeon, but there were other factors impacting his decision. My parents, who would be traveling far from home in pursuit of the best care, expected meaningful communication before and after open heart surgery. They had heard that this was not always the case at Cleveland.” Ultimately Barnett’s father had decided to have his surgery at the Mayo Clinic (Mayo) in Minnesota even though the Mayo heart program was not as highly ranked as the CC program. Barnett recalled, “My father made his decision based on reputation and anecdotal evidence.” Barnett’s father’s surgery was a success and the family was extremely pleased with the care he received while recovering at the Mayo.

Although Cosgrove adopted the slogan of “patients first” in 2004 when he took over as CEO, Barnett’s question left Cosgrove speechless. Reflecting on the incident later in an article for the Cleveland Clinic Magazine, Cosgrove wrote,

Here at Cleveland Clinic, we always positioned quality in terms of outcome. But I have come to understand that there is more to quality healthcare than great outcomes. There is the entire experience that patients have, from the moment they call for an appointment to the moment they arrive at the hospital—fearful and concerned—to the moment they get in their cars and drive away.

The patient experience encompasses many aspects of care, from the physical environment to the emotional. . . . It is about communication and the expression of care and concern at times when they are most needed. . . .It is our duty to remember that empathy lies at the very heart of the healthcare profession.

In 2007, Cosgrove formed the OPE with the goal of improving the patient experience at CC.

The Broader Healthcare Context

Other healthcare leaders also raised awareness of patients’ desire for empathetic care. For example, in May 2010, Donald M. Berwick the newly appointed CMS administrator, delivered the Yale Medical School graduation address which emphasized the importance of the patient experience. He told the class about an email he had received from a stranger describing the care her husband, a former psychiatrist, had received at the end of his life. Berwick quoted from the email:

—a The mitral valve is the inflow valve for the left side of the heart. The mitral valve opens to allow blood to flow to the heart and closes to make sure that the lungs do not feel with blood. A mitral valve repair is an open heart procedure that treats either the narrowing or leakage of the mitral valve. Adapted from Encyclopedia of Surgery, www.surgeryencyclopedia.com and Society of Thoracic Surgeons, www.sts.org, both accessed October 2010.
My husband was Dr. William Paul Gruzenski, a psychiatrist for 39 years. He was admitted to (a hospital she names in Pennsylvania) after developing a cerebral bleed with a hypertensive crisis. My issue is that I was denied access to my husband except for very strict visiting, four times a day for 30 minutes, and that my husband was hospitalized behind a locked door. My husband and I were rarely separated except for work... He wanted me present in the ICU, and he challenged the ICU nurse and MD saying, “She is not a visitor, she is my wife.” But, it made no difference. My husband was in the ICU for eight days out of his last 16 days alive, and there were a lot of missed opportunities for us.

Mrs. Gruzenski continued: “I am advocating to the hospital administration that visiting hours have to be open especially for spouses... I do not feel that his care was individualized to meet his needs; he wanted me there more than I was allowed. I feel it was a very cruel thing that was done to us...”

After reading the email Berwick reminded the newly minted doctors, “What is at stake here may seem a small thing in the face of the enormous healthcare world you have joined. It is as a nickel to the $2.6 trillion industry. But that small thing is what matters. I will tell you: it is all [emphasis in the original] that matters. All that matters is the person. The person."

At the same time there was a renewed emphasis on understanding the patient experience and perspective, hospitals across the U.S. faced extraordinary economic challenges as healthcare costs continued to grow. Cosgrove, in an August 2010 speech to the City Club of Cleveland, stated, “The recent healthcare debate has highlighted the skyrocketing cost of healthcare in the United States. Healthcare costs were more than seventeen percent of the GDP in 2010 and will shoot up eighteen percent next year.” Cosgrove felt, “Ultimately, healthcare systems will be judged, like most things, on the value they deliver by producing high quality care a lower cost.” Despite these challenges, Cosgrove remained optimistic: “We must think and act anew in responding to the challenge of providing high quality, coordinated healthcare. ... We will continue to put our patients first. ... We will take risks with our ideas. We will be creative and continue to drive innovation. ... We have the vision to think anew and the courage to act anew.”
Exhibit 1  Partial List of Medical Breakthroughs at CC (1940—2009)

- Isolation of serotonin, a key factor in hypertension (1940’s)
- Development of “no-touch” colorectal surgery (1950’s)
- First coronary angiography (1958)
- Development and refinement of coronary bypass surgery (1967)
- First minimally invasive aortic heart valve surgery (1996)
- First successful larynx transplant (1998)
- Discovery of first gene linked to juvenile macular degeneration (2000)
- Discovery of first gene linked to coronary artery disease (2003)
- Pioneering success in deep brain stimulation for psychiatric disorders and minimally conscious state (2006)
- First kidney surgery performed through patient’s navel (2007)
- Nation’s first near-total face transplant (2008)
- World’s first heart/liver transplant in patient with total artificial heart (2009)

Endnotes

1 The Cleveland Clinic 2008 Annual Report.


13 The Cleveland Clinic 2004 Annual Report.


