Cleveland Clinic

February 23, 2016

The Honorable Lindsey Graham
Chairman
Subcommittee on Personnel
Armed Services Committee
United States Senate
Russell Senate Building, Room 228
Washington, DC 20515

The Honorable Kirsten Gillibrand
Ranking Member
Subcommittee on Personnel
Armed Services Committee
United States Senate
Russell Senate Building, Room 228
Washington, DC 20515

Chairman Graham, Ranking Member Gillibrand, and esteemed members of the Senate Armed Services Subcommittee on Personnel:

The Cleveland Clinic is honored and privileged to provide this testimony as you examine the current state of the Military Health System and recommend reforms to ensure our military men and women and their families are provided with high quality health care.

The Cleveland Clinic Health System is located in Northeast Ohio, with a main hospital, 13 community hospitals, 23 family health centers, 30 specialty clinics and more than a hundred community practice sites. Last year, we saw 1.9 million unique patients in 6.3 million individual encounters at our clinics in Ohio, Florida, Nevada, Toronto and Abu Dhabi. Our commitment to excellence in military health care stems back to our founding nearly 100 years ago by four military surgeons after their return from World War I, and the commitment to "act as a unit" through the strength of integrated group practice that is stronger than ever today.

In reviewing the January 2015 final report of the Military Compensation and Retirement Modernization Commission to this Committee, I am struck by the parallels between the challenges that were reported within the Military Health System (MHS) and those faced by the Cleveland Clinic Health System just a few years ago. The report cited lack of access and long wait times, a difficult to navigate appointment system, lack of access to the right doctor at the right time and place, narrow network constraints on access to care, quality issues attached to low volume, inefficiencies related to multiple command structures, and the challenges of managing dual objectives of force readiness and peacetime services on a system with limited resources.

The parallels between these issues in the Military Health System and modern civilian hospital systems like Cleveland Clinic cannot be overstated.

In 2007, the Cleveland Clinic was known for excellence in the practice of medicine, but we were not as well known for delivering excellent care. Our patient satisfaction numbers were below 55%. Our care organization was fragmented and compartmentalized, with little communication between providers, and even less between our patients and caregivers. Patients were faced with waiting days, sometimes

weeks, for appointments with specialists and primary care providers alike. We found ourselves so focused on managing administration of our care of the sick that we had nothing left to devote to keeping people well. Our costs were skyrocketing, and not the least the cost to provide healthcare to our then 43,000 employees. And for all our skill, our quality numbers were not in the "world class" category we were so proud to proclaim. Something big had to change, so we undertook to fundamentally transform the way we delivered healthcare.

The result has been the development of the Cleveland Clinic Integrated Care Model, which has these attributes at its core: It is personalized healthcare: patient-focused, integrated, continuous, and transcends time and physical location. The goal is to deliver the right care at the right time and right place, integrating across both primary and specialty care.

Our first move was to abandon the traditional department model for an institute model of care delivery that focused on patients, conditions and diseases, not siloed administration. In addition to streamlining and, in some cases, eliminating the administrative structure that was so pervasive in departments, we simplified and centralized the administration of our regional hospitals wherever it made sense. The result is a lighter-weight administration that works daily to strike a balance between standardizing and centralizing those functions that can and should be shared across all departments and regional hospitals, while preserving the individual needs and character of each care location and allowing it to thrive in a way that makes each individually successful. It's a careful balance that takes hard work, wisdom and a commitment to continuous improvement, but the payoff for patients is more than worth the effort.

In an effort to build and maintain a high-reliability organization, we have undertaken to develop evidence-based Care Paths ensure that we can deliver reliable, high-quality care across the enterprise and the continuum of care, whether at one of our hospitals, outpatient offices, skilled nursing facilities or at home. Care Paths provide a standardized, template approach to ensure that each and every patient receives appropriate care, and that we can measure both our compliance with our own processes and treatment outcomes. This is not to remove the discretion and skill of the physician caregiver in the process. Rather, Care Paths allow us to understand, document, and measure the effectiveness of individual practice variances and propagate best practices that positively impact patient outcomes and deliver best value. To date, we have developed and implemented more than 130 Care Paths across the enterprise.

It is well-documented nationally that low volume procedures suffer from inconsistent cost and quality outcomes, and our experience at Cleveland Clinic was no exception. The quality variation between our main hospital and regional hospitals, and between our individual regional hospitals on surgeries such as joint replacement and cardiac catheterization, for example, was measured in quartiles, not deciles, and the costs could vary by as much as 20% between facilities. In order to optimize both our outcomes and our cost efficiency, we have adopted a model where patients needing certain specialty care are treated at the facilities that have consistently performed with the best outcomes and value – Centers of Excellence. For example, patients needing a total joint replacement of the knee or hip are directed to Cleveland Clinic regional hospitals on the west and east sides of Cleveland (Lutheran Hospital and Euclid Hospital, respectively) where we concentrated expertise in our surgical staff, our nursing staff and

physical therapy staff. The concentrated expertise and caregiver alignment afforded by this model has also allowed us to create pilot programs, such as our funded demonstration programs through the Center for Medicare and Medicaid Innovation (CMMI) that further transform care. Our Rapid Recovery Program is designed to reduce inpatient stays around primary total joint recovery, increase post-surgical discharge to home, reduce cost, and improve outcomes. Patients are identified at surgical consent as Rapid Recovery patients, and the care team engages both the patient and family caregivers in an activation and education program to prepare for post-surgical recovery. Patients learn about their surgery, their inpatient physical therapy regimen, their post-surgical care, and how to best prepare themselves for success. Their post-surgical physical therapy is more aggressive, starting the day of surgery, and they are prepared to discharge to home, with in-home nursing and physical therapy follow-up.

The outcomes are dramatic. Average length of stay has been reduced by more than a day for both hip and knee replacement. Discharge to home has increased from an average of 42% to more than 70%. Costs are 7% lower, even with in-home rehabilitation care. Most importantly, however, patient satisfaction is significantly higher and these patients report better average outcomes at 6 months. This sort of program is only possible because of the stability and dedication of the caregiver team and the engagement of all caregivers at these centers of excellence to improving outcomes and satisfaction.

Excellent care can only be delivered if the patient and the caregiver can connect. In 2013, Cleveland Clinic adopted a policy that no new patient should wait more than a week for an initial consult, and whenever possible should be seen the same day if a request is made. This standard is enforced without regard to acuity or specialty. The reason for this is simple – if a patient is ill, he or she just wants to get well. In 2015, Cleveland Clinic accommodated more than one million patient visits in same day appointments. Similar targets are set for post-discharge care for patients treated in our facilities. Most patients are seen in an outpatient or home-care setting within 48 hours of discharge.

The key to achieving these access standards is the development of a unified call center. Every Patient Service Representative (PSR) in the call center has access to each patient's complete appointment schedule, as well as access to physician openings across the entire enterprise of 13 hospitals, 23 family health and surgery centers, and 30 specialty care centers (plus more than 125 additional service sites across the enterprise). Further, these representatives have immediate connectivity to on-call and doctor's nurses to better triage and assess the specific needs of each patient – while still connected to the patient on the phone. Templates maintain consistency through the scheduling process, so each patient's encounter with scheduling is consistent and efficient. Call Center metrics focus on the patient experience: First contact resolution, speed of answer, and abandonment rate are all critical metrics.

Finally, we have recognized the importance of balancing the need to treat the sick with an ever-growing need to maintain individual and community wellness. This has caused us to make an enormous shift in our approach to delivering care. Our Care Transformation efforts now look holistically at the physical, behavioral, environmental and psycho-social determinants of health and recognize the need to address all of these to ensure that the healthy remain well and the sick get the care they need. We expanded our

care delivery model to include environments of care and different care providers, to better meet the complex needs of our evolving patient demographic. Where patients might have seen a doctor in an office or family health center, they may now see a nurse in their community center or a team of caregivers via a telehealth link. Our registered nurse care coordinators are embedded with the primary physician team and serve as the quarterback, educator and facilitator for our patients and patient family members. By identifying and targeting patient risk factors, we can control chronic diseases more effectively, increase wellness and reduce costs to both the organization and our payers.

At the core of all of this is the philosophy of Patients First. Our commitment to Patients First began with the establishment of our Office of Patient Experience, now under the direction of Adrienne Boissy, M.D. Patients First re-affirms our commitment to open, transparent communication, delivering care when and where it is most appropriate to the patient, and preserving patient involvement and dignity.

All aspects of the Cleveland Clinic Integrated Care Model are supported by an information technology infrastructure that enables meaningful communication and transfer of health information between providers, patients and family caregivers.

These efforts pay off. We have developed more than 130 evidence-based care paths in less than 24 months. Our efforts to institute care coordination with our employees with chronic diseases have reduced our own healthcare costs by more than $23 million. Our commitment to Patients First increased our patient satisfaction scores from 55% to 92% in just four years. The transformation has involved every single employee of the Cleveland Clinic, each of whom is considered a caregiver and can articulate the role they play in ensuring that every Cleveland Clinic patient receives the best care we can deliver.

Our nation's military health system has a proud tradition of providing excellent care to the men and women who serve our nation, and their families. We owe it to them, as well as the myriad caregivers in the Military Health System (MHS) organization, to help enable the MHS to make the important transformation in its own systems to help it keep pace with a constantly evolving demographic. To this end, we recommend the adoption of several policy changes:

- Create partnerships between the MHS and civilian health care systems to refer patients outside the system when the right provider is not available or when wait times are unacceptably long, with TRICARE reimbursement rates that mirror Medicare rates to ensure access to a broad network of expert providers. This will reduce wait times for care, create access to the right providers at the right time, and to concentrate services at those facilities where the best expertise exists and be leveraged for optimal quality and cost. Create Centers of Excellence within and between the branches and in partnership with the civilian sector.
- Further consolidate the command structure military medical corps, including additional transparency and cooperation among the hospitals of the corps for each branch. While the health service of each branch has its unique strengths and challenges, the current system is siloed and redundant, from the Surgeons General down to the daily operations. This is not to say that the corps and commands should be abolished; each has its own important function and history that best reflects the needs of the patients it serves. Rather, identify the unique and vital

strengths of each branch and retain the value of those strengths, but eliminate redundancy in the administration across those functions that are common to all. We have seen ourselves that this sort of partnership, while not easy, can be done and done in a way that honors and preserves the best of what each organization has to offer.

- Re-focus the MHS and TRICARE to directly deliver only those services that bring the most value and focuses on what the MHS does best – care for the sick and wounded service member and maintain force readiness. Serving the health needs of military family members is vitally important to force readiness and resilience, but does not need to be directly delivered by the Military Health System. Helping TRICARE shift its role from provider-based to more purchased-based can free up vital resources for the direct services that are highest value.

In service to our nation, the Cleveland Clinic is prepared to advise, share best practices and work with the Military Health System to understand how and where models like our Integrated Care Model might ensure excellence and sustainability in care for our military personnel and their families.

Thank you for this opportunity to share with you our transformation story and to offer the Cleveland Clinic in service of your own mission.