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Senate Committee on Health, Education, Labor and Pensions

Mr. Chairman, I am very grateful for this opportunity to appear before the Committee to discuss the important topic of healthcare reform.

I am especially pleased that Senator Sherrod Brown of Ohio is a member of this Committee. Senator Brown is knowledgeable about the Cleveland Clinic and visited us earlier this week to discuss healthcare reform. We were also thrilled last week when President Obama cited Cleveland Clinic as a medical center that provides quality care at a lower cost.

I know the Committee has introduced the "Affordable Health Care Choices Act." I commend the speed and urgency you bring to the legislative process. Hopefully, I can add to your body of knowledge by telling you something about Cleveland Clinic's model of healthcare delivery.

Cleveland Clinic was conceived in the battlefields of World War One. It was founded by four Cleveland doctors who had served in the medical corps and were impressed by the model of care delivery which brought multiple specialists together to work as a unit. When they returned home, they planned a new kind of medical center, where specialists would collaborate selflessly for the good of the patient. Cleveland Clinic opened its doors in 1921.

The mission of Cleveland Clinic is, in the words of its founders, "Better care of the sick, investigation into their problems, and the further education of those who serve them."

In addition to our clinical practice, we operate a vibrant research institute and a large graduate medical education program with 1,100 residents and fellows. We also operate a

medical school focused on training physician researchers. That school graduated its first class of MDs this year.

Our research program and medical education programs are fully integrated with our clinical services. We believe that research and education carried out in the clinical setting add to the depth and quality of patient care. It promotes innovation and helps us expedite the movement of new treatments and technology quickly to the bedside.

Most Cleveland Clinic patients come from Ohio and the surrounding regions. Additionally, they come to us from all 50 states of the United States, as well as from more than 80 foreign countries. In 2008 alone, we had 3.3 million patient visits.

Cleveland Clinic is proud of its military legacy. The founders of Cleveland Clinic explicitly modeled their institution on the Army field hospitals of the First World War. Twenty-five years later, in the Second World War, Cleveland Clinic's Naval Reserve Unit established one of the first mobile hospitals in the South Pacific. In 1968, I had the personal honor of leading the casualty staging flight unit in Danang, Vietnam. Today, Cleveland Clinic proudly collaborates with our armed forces in programs to help wounded warriors and returning veterans.

Cleveland Clinic is co-leader of the new Armed Forces Institute of Regenerative Medicine (AFIRM). This multi-specialty consortium is dedicated to finding new technologies to assist in the recovery of wounded service members. Cleveland Clinic and U.S. Army Reserve have joined in a unique program to recruit and train soldiers who are interested in securing a position in the growing field of healthcare while they continue serve to our country. Under the program, Cleveland Clinic guarantees a job interview for all qualified participating soldiers no later than 30 days after completing military occupational specialty training. In addition, Cleveland Clinic will give priority placement consideration to qualified Army Reserve soldiers. Recently, we have begun collaborative activities with the Military Health System.

Cleveland Clinic is the world's second-largest group practice. We employ 1,800 physicians and scientists in 120 medical specialties and sub-specialties. The delivery of quality healthcare is the preoccupation of our entire organization. We believe that doctors are the principal drivers of quality care. To join our staff, physicians need to meet rigorous standards. There is no tenure. Every physician has a one-year contract. All physicians are paid a salary only. There are no bonuses or other financial incentives. Salaries and contract-renewal are based upon the results of a comprehensive annual performance review. Our physicians compete only against themselves, and work together to assure that every patient gets a correct diagnosis and the most effective treatment.

The Cleveland Clinic group practice model has benefits that parallel the cost-lowering goals of the "Affordable Health Care Choices Act". All of the elements of the system, including the hospitals, clinics, medical school, research institute, and physicians are part of one organization which is physician led. The group practice model allows us to control costs by controlling utilization, and measuring quality and safety. It does this by aligning the financial interests of the hospital and the physician who practices there. It allows the rational deployment of hospital resources for the benefit of the patient. Since physician and hospital are on the same financial page, there is no incentive for our doctors to order expensive devices, or unnecessary tests or procedures. All parts of Cleveland Clinic are completely integrated and share billing, finance, purchasing, legal and all other support and medical services. Since we are all part of the same organization, we work together to control and rationalize purchasing, expenses and the use of resources. Because we all share the same goals, we are able to standardize record keeping, establish benchmarks, and control quality.

We believe that value in medicine is defined by measurement of quality and outcomes. We believe that to improve value we need to measure costs against quality in terms of results. Further, we believe that results should be published and made widely available. Patients benefit when providers compete on the basis of results. Providers need to supply patients with data to help them make informed decisions.

Cleveland Clinic has a long history of measuring and publishing results in cardiac surgery. In 2004, we began measuring outcomes in every medical specialty. This meant finding the metrics for specialties that had never measured themselves. Each specialty is now responsible for finding metrics, setting benchmarks for improvement, and moving the metrics toward greater quality. Measurement provides insight, but to be most effective it must be coupled with transparency.

Cleveland Clinic is the first major medical center to publish annual outcomes and volume information for its medical specialties. Last year, we published 16 outcomes booklets. Each outcomes booklet includes comprehensive data on procedures, volumes, mortality, complications and innovations. We publish these guides consistent with our belief that transparency is an essential part of quality.

Each specialty continually refines their benchmarking and includes more sophisticated data every year. This is information that can be used by referring physicians or patients to choose a doctor or hospital for specific procedures and specialties. They promote competition based on quality, not cost or reputation.

In keeping with a policy of transparency, Cleveland Clinic became the first major medical center to publish the industry relationships of all of its physicians in our online staff directory, including the names of company collaborators, royalties, and fiduciary position and consulting relationships of more than $5,000 a year.

Finally, we have approved a new Open Medical Record Access Policy. This policy gives patients (or their designated emergency contact, next-of-kin, or holder of power-of-attorney) the option of reviewing their medical record in this hospital.

As a not-for-profit, Cleveland Clinic has no owners or stockholders. Income above expenses is used to support research, to supplement graduate medical education costs, and to provide a community benefit. In 2007, our most recent year of compilation, we

delivered more than $420 million of community benefit. Our community benefit includes charity care ($123.4 million in 2007), Ohio's largest Medicaid practice, neighborhood wellness and preventive care programs, support for minority health programs, extensive support for local schools, and the provision of necessary but unprofitable services.

Cleveland Clinic began as a single building at a single site. Over the years we have grown considerably. In the late 1990s, we merged with eight community hospitals to form a comprehensive regional health system. In addition, we have established 16 suburban family health and ambulatory service centers to serve. Altogether, we are the largest health system in Northeast Ohio.

Our main campus includes 50 buildings on 166 acres in a Cleveland inner-city neighborhood. We are proud to collaborate with neighborhood organizations to provide jobs, improve housing, and bring new businesses and employers to the area.

With 40,000 employees, we are the largest employer in Northeast Ohio, the second largest employer in the State, and the largest employer in the history of Cleveland.

Cleveland Clinic is one of the largest and busiest medical centers in the United States. We saw 3.3 million patient visits in 2008, and performed almost 73,000 surgical cases. Our patients are severely ill. We have the highest CMS case-mix index in the country.

Cleveland Clinic's effort to enhance care resulted in a massive reorganization beginning in 2007. We have abandoned the traditional physician-based silos of surgery and medicine. We have replaced them with 18 patient-centered Institutes.

Institutes are patient-oriented units based around organ systems or disease. All the disciplines relating to the system or diseases are co-located in the Institute and share a common leadership. The result is a movement from a physician-centered organization to one which is organized around patients' needs.

Our Heart & Vascular Institute, for instance, includes the departments of Cardiovascular Medicine, Thoracic and Cardiovascular Surgery, and Vascular Surgery. Our Neurological Institute combines the departments of Neurology, Neurosurgery, and Psychiatry & Psychology.

Institutes erase the barriers between disciplines and promote "flow" among services. Patients can stay in one location for all their care, including consults, tests and images. Diagnostic and therapeutic decisions become more authentically multidisciplinary. Duplication of services is reduced, innovation is fostered, and education broadened.

The history of Cleveland Clinic from 1921 to today is the story of intensifying focus on patient needs, expansion of our regional system, and greater integration of services across the continuum of care. These trends are being enabled today by our pioneering use of health information technology (HIT).

As a leader in the innovative use of HIT for the effective delivery of healthcare, we applaud this committee's support for investment in the widespread adoption and implementation of interoperable HIT services nationwide.

A national HIT system needs to be carefully planned. We believe that to maximize the value of a national HIT investment, it should be coupled to an integrated group practice healthcare delivery system. Such a system would include hospitals, physicians, sub-acute facilities and home healthcare professionals. They would share a common commitment to the delivery of coordinated care of the highest possible quality, supported by a secure and integrated information infrastructure. This infrastructure would bring the right information to the right person at the right time, whenever and wherever it is needed.

Looking forward, we see movement away from reliance on the brick-and-mortar hospital, and the growth of virtual systems of integrated, coordinated services, shared information and standardized quality on a broad geographic grid.

The need to move information across our system has its physical counterpart in our need to move patients from one location to another within our broadly dispersed service areas. It is not possible for all physicians to be all things to all patients. Concentration of patients in centers of excellence will drive quality. As a tertiary care center, Cleveland Clinic transports critically ill patients to our main campus on a daily basis. Many of these patients need immediate care from trained intensivists. We have established a comprehensive international air and ground fleet to make this possible. Our fleet includes fixed wing aircraft, helicopters, and ambulances. Each aircraft and ambulance is a mobile ICU. Each can carry a Cleveland Clinic physician directly to a patient anywhere on earth to begin care according to Cleveland Clinic protocols.

Respect for your time and attention limits the examples I could give to illustrate the many correspondences between our organization and practices at Cleveland Clinic and the goals of this Committee and the spirit of the "Affordable Health Care Choices Act".

We believe in the Cleveland Clinic model of medicine. Cleveland Clinic delivers high-quality care at a low cost to a large volume of patients with a high case complexity. We believe that this model of medicine can lower costs, improve quality, enhance value, improve access, and assure that every patient gets world-class care.

I would like to compliment the Committee on its comprehensive legislation to reform our healthcare system. You have recognized several critical issues and are confronting difficult decisions that must be made. Healthcare coverage for all and stemming the rising cost of healthcare in this country are essential elements of healthcare reform. By challenging the health care industry and employers to provide citizens with the necessary information and services to lead healthier lives, you are enabling Americans to take responsibility for their health and building the foundation of a healthcare system that will meet the demands of the future and in which we can be proud.

In order for this or any healthcare legislation to succeed, the American people must feel that it addresses their needs. It is too much to ask that reform be perfect from the beginning. It will, I believe, meet their expectations if they can look forward to having access to a system that provides quality, affordable healthcare for all in which coordinated patient care is the central concern. I believe that individuals are ready, with the proper amount of education, to assume the responsibility for their healthy well-being. We, as providers, must be structured so that those expectations will not be dashed. I believe that an integrated delivery system which I have described is best designed to carry out the mandates of reform across the multiple settings through which care is delivered.

Mr. Chairman and members of the Committee, thank you for the opportunity to participate in this historic hearing.