Cleveland Clinic: Enabling Today While Inventing Tomorrow

Cleveland Clinic knows that continued transformation is necessary. To achieve their goals for primary care, the organization initiated three pilots, which included 20% of Cleveland Clinic providers and 60,000 patient lives.
Cleveland Clinic is a multispecialty academic medical center that integrates clinical care with research and education and serves as the hub of a multisite healthcare delivery system with local, national, and international reach. Four years ago, Cleveland Clinic started a formal multidisciplinary and enterprise-wide journey from volume to value. They recognized that redesigning their care models to standardized care, improve patient experience, and optimize outcomes was critical for sustainable success. Their work started to coalesce and support several extremely important initiatives that needed to become more focused and synergistic with each other.

Three pilots were initiated which included 20% of Cleveland Clinic providers and 60,000 patient lives:

- **Team-Based Care Model.** This model of care tested the theory that if a physician had assistance with documenting a patient’s visit, the visit would be more thorough and interactions between the physician and the patient would be more satisfying.

- **Macro Model (MD/APN/MA).** This model optimized the care team by emphasizing the role of the advanced practice provider and adding a medical assistant to do pre- and post-visit planning.

- **Integrated Care Model (MD/RN).** This model focused on building an effective team around the patient. The team included one registered nurse care coordinator per physician, eight medical assistants (for pre-visit planning), a clinical pharmacist, and a diabetes educator when applicable.

In early 2013, a pilot began, applying The Joint Commission (TJC) primary care medical home certification criteria. By fall 2013, Cleveland Clinic became the first organization to achieve Primary Care Medical Home (PCMH) Certification for Hospitals from TJC. In 2016, the Centers for Medicare & Medicaid Services (CMS) announced Cleveland Clinic as the top Accountable Care Organization (ACO) first-year performer for the Medicare Shared Saving Program.

A stroke care path was the first care path developed by the Cleveland Clinic health system and made available enterprise-wide. To promote compliance, the care path is embedded in the electronic medical record, making it part of the workflow of every caregiver providing stroke care. The results of adherence to the stroke care path have been striking:

- 63% of patients’ stroke scale (NIHSS) scores improved from admission to discharge; 25 percent of patients remain stable
- 24.5% reduction in daily direct cost
Significant reduction in observed/expected inpatient mortality

Significant reduction in hospital length of stay

In September 2016, Cleveland Clinic was named a 2016 Acclaim Award honoree for their initiative “Enabling Today While Inventing Tomorrow.” As part of the application process, the organization was asked to highlight two narratives describing the design and deployment of two major components—projects, phases, or tactical plans—that were part of their plan to transform the way they deliver health care in order to more fully achieve the AMGA High-Performing Health System™ attributes, improving both the quality and cost of care. Following are details about one of these components.

Community-Based Care: The Evolution of Primary Care

Their transition from volume to value continues as Cleveland Clinic responds to strategic imperatives and market forces to transform the way that care is delivered. Ensuring that their focus remains on providing patients with exceptional quality, safety, experience, affordability, and access is fundamental.

Although they achieved NCQA certification, Cleveland Clinic knew that continued transformation was necessary. Considering NCQA requirements and the capabilities they wanted for each primary care practice, they needed to implement transformational change in order to move forward. They identified these key capabilities:

- A focus on chronic disease management and care coordination to manage high-risk patients

An enhanced in-office intake process to ensure the most informed visit possible

A pre-visit planning function to ensure patients were optimized for their visits and physicians were well positioned to provide excellent care

A model for team care to enhance patient access and throughput

An integrated care team with team members working at the top of their license

Workflows redesigned to be patient- and provider-centric

Informatics/analytics to standardize care processes and optimize flows for patients and providers

In order to determine how to best achieve these capabilities, Cleveland Clinic initiated three pilots, which included 20% of Cleveland Clinic providers and 60,000 patient lives.

Team-Based Care Model

This model of care tested the theory that if a physician had assistance with documenting a patient’s visit, the visit would be more thorough and interactions between the physician and the patient would be more satisfying. The team that participated in this pilot included six family practice physicians, three nurses, ten medical assistants, one care coordinator, and a pharmacist.

Responsibilities were delegated and shared between two medical assistants and the physician. The medical assistant gathered and documented the...
data, took a competent history, remained in the room with the physician, completed all visit documentation, supported the treatment plan, and closed the visit by providing written patient education materials and instructions. During the patient visit with the medical assistant in the room, the physician confirmed the patient’s history, performed the physical exam, made medical management decisions, and articulated the treatment plan. Each individual in the patient care chain was empowered to function to the highest level associated with his or her qualifications.

**Macro Model (MD/APN/MA)**

This model optimized the care team by emphasizing the role of the advanced practice provider and adding a medical assistant to do pre- and post-visit planning. The team included three internal medicine physicians, one advanced practice provider, four medical assistants, and one nurse coordinator.

In this model, the advanced nurse practitioner’s role was enhanced and focused on access and leveraging clinical expertise. In terms of access, the advanced nurse practitioner partnered with the physician to increase accessibility to the practice by seeing patients that needed same-day and urgent appointments, routine follow-up, and routine healthy patient physicals. In addition, the advanced nurse practitioner served as an expert in disease management, assisting patients with chronic diseases.

Medical assistants assumed roles in pre- and post-visit planning. For pre-visit work, two weeks prior to a visit, a medical assistant would pre-order labs, review health maintenance information, and conduct a pre-visit call with patients to assess concerns and complete a medication review. Post-visit, a medical assistant would conduct phone calls and send letters to follow up on appointment scheduling, review studies, and medication adherence; obtain follow-up on blood glucose and blood pressure readings; and work with the nurse care coordinators.

**Integrated Care Model (MD/RN)**

This model focused on building an effective team around the patient. The team included one registered nurse care coordinator per physician, eight medical assistants (for pre-visit planning), a clinical pharmacist, and a diabetes educator when applicable.

There were three major components to this pilot: patient-centered teams, pre-visit planning, and top-of-license training. A smaller coverage team allowed patients to know their care team, including consistent support staff. Team continuity-enhanced communication, trust, and teamwork were key components of this model. The closed team allowed for task realignment, workflow improvements, and retraining, and prompted the implementation of daily huddles to increase collaboration.

These three pilots were a foray into primary care coordination, pre-visit planning, pharmacist inclusion on the care team, and overall caregiver engagement in changing the care model. The measures that were used to assess success were:

- Quality improvement
- Decreased emergency department visits, hospital admits, and readmits
- Increased access and continuity
- Increased provider and patient satisfaction
- Increased practice efficiency
- Decreased annual cost per life
- Documentation for all ACO measures

Overarching guiding principles emerged: the commitment to “patients first,” the criticality of developing relationships with patients, standardizing practice, shared expectations and accountability, working to top of license, and interdisciplinary partnerships. These principles have endured through time.

With the completion of the pilots and after incorporating lessons learned, an all-site roll-out was planned. The key components of the roll-out included: care coordination for high-risk patients, embedded pharmacy support, team care integration, medical assistant pre-visit planning, mid-level support to improve access, and top of license scope training and education. Recognizing that one size did not fit all, a process was established to address:

1. Preparation/planning
2. Change management
3. Care coordination
4. Evaluation of practices
5. Team care
6. Pharmacy
7. Pre-visit planning
8. Workforce planning

Process gap analyses were completed to determine what critical needs existed per practice. Collaboration with all key stakeholders occurred, and change management sessions were conducted to ensure caregivers knew what was going to change and why. Processes and workflows were redesigned and tested through patient
assessment, individualized care planning, empowerment of patients and families, and engagement of the entire care team.

Great strides have been made and continue to be made to ensure that patients are coordinated across the continuum. The primary care coordinator has emerged as the coordination quarterback and ensures patients who need to be in a medical home, regardless of where they are in their care process, are coordinated back to that home. The primary care coordinator is a part of the primary care team and focuses on identified high-risk patients. Key functions include targeted outreach, partnering with the patient on health goals, and providing education to the patient and their family (see Table 1 and Figure 1).

Data and Analytics

Actionable data are critical for managing patient populations. Cleveland Clinic has the ability to risk-stratify patients and identify gaps in care. They have the capability to understand patients from a holistic standpoint through a coordinated view of their medical, functional, social, and cognitive/behavioral data. They can reach out to patients who have missed visits.

All of this leads to better and more timely care for patients. They have seen the impact of these efforts and transparency of data through improved ACO quality results (see Figure 2).

Education and Training

As an academic/medical institution, Cleveland Clinic devotes substantial resources to fellowship, residency, and physician education programs, and to their renowned college of medicine. In 2016, they trained more than 1,800 residents and fellows throughout the health system. Training future physicians is vital for success in a value-based world.

They have partnered with another medical school on an exciting demonstration project that focuses on both medical school and residency training for future primary care in Ohio. It includes the integration of three inter-linked components: education, the patient-centered medical home care model, and a community based component. This paradigm will produce future caregivers who understand what makes a high-performing health system.

Targeted Clinical Interventions

The health system’s “16K in 2016” initiative included a targeted focus on screening patients for hypertension, an essential ACO metric. This effort included the following components: educating patients about the importance of blood pressure monitoring; educating caregivers about the importance of obtaining accurate blood pressure readings at every visit; following up 30 days after the reading of high blood pressure; and engaging in proactive outreach. Results have brought 5,100 new patients with blood pressure under control (see Figure 3).
simulation. Information technology readiness was completed. Patient and caregiver education occurred, and metrics were established by site.

This significant undertaking was a pivotal step in the transformation of Cleveland Clinic’s primary care practices. Today:

- 47 primary care coordinators work with primary care teams to manage high-risk patients.
- 35 pre-visit medical assistants ensure that patients are appropriately prepared for their visits.
- 25 physicians have added a medical assistant and practice using the team-based model.
- Pharmacists are an integral part of the primary care team, assisting with medication reconciliation and providing consultative services as needed.
- Advanced practice providers partner with physicians directly in the practice not only to improve access and panel management, but also to offer urgent access for patients in a new model that is staffed solely by advanced practice providers.

The journey continues. In early 2013, the organization began a pilot process with The Joint Commission (TJC) to test their primary care medical home certification criteria. By fall 2013, Cleveland Clinic became the first organization to achieve Primary Care Medical Home (PCMH) Certification for Hospitals from TJC. TJC program goals are: coordinate high-risk patients’ care; top-of-license work for all individuals; reduce all-cause readmissions; close gaps in care; build competency in risk contracting; build teams around the patient; prevention and health maintenance; enhance patient access; reduce cost per unit of service; and improve provider productivity.

In January 2015, the organization started their first year in the Medicare Shared Savings Program. They continue to advance capabilities to best manage patient populations, not only in primary care practices, but as attributed patients move along the continuum of care. Their goal is to “flip the exam room” by identifying and engaging patients who have not recently sought care.

Population management has emerged as a priority for the enterprise. Medicine takes center stage in advancing the work that they have already done and the work that is still underway.

**Care Coordination**

The care coordination function continues to mature and is grounded in patient-centricity with these core components: patient advocacy, holistic
Care Redesign

Cleveland Clinic has embarked on two parallel design efforts to continue to improve primary care. The areas of focus for the current efforts are the same: reduce provider burnout; reduce preventable utilization; improve the percent of patients with control over their chronic diseases; reduce care and coding gaps; increase non-traditional encounters (e.g., telehealth, home visits); and ensure high-risk patients are in a collaborative primary care-specialty care management model.

The methods are different. The culture of improvement has been implemented at one practice and they are instituting a learning collaborative approach with eight other practices.

Change Management

A challenge throughout each phase of this work is the change in culture that is required at the level of the individual, practice, and enterprise. To implement and sustain change requires investment, support, and patience. Prioritization of these efforts is imperative to ensure that the teams have the required resource—both human and technical—to ensure success. Providing flexibility to try new workflows, modify the original plan or budget, and measure things differently contributes to the team’s opportunity to find success. Finally, providing the teams with the time to create and test demonstrates the commitment to this work and its value to the organization.

Lessons Learned

Cleveland Clinic has learned several things over the course of their journey and anticipates that their learning will continue as they go forward:

- The path to change is not always clear or direct; their organization is large, with multiple simultaneous initiatives.
- Basics that are core and foundational to good healthcare delivery have been their focus. However, patient expectations have changed, making some basics more challenging than in the past.
- Change is hard; change management support is crucial.
- They do know that they need to engage their teams in the work and in the change process. The front line must help design what the future state looks like in order for them to buy into and execute the change. Patients also need to be involved in the design and change process.
- Finally, Cleveland Clinic knows that their work will never be done. They will continue to iterate over time and evolve processes and their care delivery system to better meet patients’ and caregivers’ needs.

Adapted from Cleveland Clinic’s Acclaim Award application, submitted by Anthony J. Warmuth, M.P.A., FACHE, CPHQ, CPPS, administrator, enterprise quality.

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