Cleveland Clinic

It impacts patient safety and quality and no one would argue "It's not the right thing to do." More importantly, effective communication is what we would want for ourselves or our families if we were on the other side.

Patient satisfaction metrics are perception metrics; they are subjective and can be easily biased by several factors. The process is not perfect, and many of the Centers for Medicare & Medicaid Services (CMS) metrics are not well validated. Nevertheless, measuring patient satisfaction and physician communication is part of a new reality that we are all facing as healthcare providers. The measures are publicly reported, so patients can compare providers based on readily accessible information, and these data also will soon play a role in reimbursement as well.

Patient experience is nothing more than service quality, and there are no expensive solutions to high levels of quality service. Providing an excellent patient experience requires functioning processes, and people who care.

Sincerely,

James Merlino, MD
Chief Experience Officer

Why Relationship Centered Communication Matters

Effective communication impacts patient safety, quality and patient satisfaction. In today's healthcare environment, most caregivers face the competing challenges of limited time for patient interaction, variable expectations, and increasing medical complexity. When physicians and advanced clinical care providers are given the support and resources to develop relationship-centered communication skills, they become empowered to handle any communication challenge and can enhance the experience of not only the patient, but also their loved ones and the providers.

Ensuring effective clinician-patient communication is the right thing to do for our patients, and critical to the delivery of safe, high-quality medical care.

How effectively clinicians communicate with patients has emerged as a very important issue in healthcare. In the last three years, Cleveland Clinic has emerged as a leader in the field of patient experience and improving clinician communication. The program outlined below has been instrumental in improving communication scores across the board in HCAHPS and outpatient satisfaction surveys, including CGCAHPS.

This file contains a brief overview and available resources to help you improve how caregivers within an organization can more effectively communicate with patients and families.

Cleveland Clinic

Journey and History

In 2010, Drs. Joseph Hahn and James Merlino asked Dr. Adrienne Boissy to develop a communication curriculum for Cleveland Clinic Health System. Pulling on variable expertise and interest, a Communication Task Force was assembled. The group was made up of Dr. Boissy (Medical Director), Dr. Tim Gilligan (Co-Director), Dr. David Taylor, Dr. Vicente Velez (Director, Advanced Curriculum), Dr. Nurko, Dr. Amy Windover (Director, Faculty Development). The group surveyed what data existed around communication skills and programs, what courses were offered nationally and internally, what other healthcare systems were working on and Cleveland Clinic Lerner College of Medicine curriculum.

In 2011, the task force developed a communication program. Five staff were trained in communication skills, learning theory and group facilitation. A one-day foundational course in Relationship-Centered Patient-Provider Communication (now called the Foundations of Healthcare Communication course) was designed and rolled out in fall 2011. Intentionally, the course welcomed physicians from various specialties in a private, small-group setting. It is peer-led, practical, and the majority of time is spent in skills practice. With feedback from participants, the course was modified such that there is a significant amount of time spent practicing the communication skills and also an opportunity to work through more challenging communication scenarios that the clinicians themselves have encountered.

The feedback has been overwhelmingly positive and powerful. In light of that, the program has expanded and is currently building a healthcare communication track with additional offerings through the Cleveland Clinic Academy (CCA) and also uses the Simulation Center. We also recognized the need to develop our own internal model of communication to continue to build and develop our skills. The team developed the REDE Model of Communication in May 2013 which focuses on relationship-centered communication, techniques which improve physician engagement and satisfaction, as well as improving compliance and decreasing malpractice. This REDE Model has been incorporated into the Foundations of Healthcare Communication course and laid the foundation for our advanced curriculum.

We have recruited and trained 28 facilitators, many of whom are surgeons. More than 1100 physicians have completed the program as of September 2013 and the course is offered over six times a month. Additional courses have been developed within the healthcare communication track for Delivering Bad News, Managing Challenging Communication Scenarios, and Health Behavior Change. In addition, the Foundations of Healthcare Communication course is now mandatory for all on-boarding staff. We also offer the Foundations of Healthcare Communication course to advanced clinical care providers such as physician assistants, nurse practitioners, nurse managers, social workers, and others with significant patient care contact.

Cleveland Clinic

Our Programs

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Customized Site Visit

- Enjoy an opportunity to visit Cleveland Clinic and meet the physician and leadership members supporting our Center for Excellence in Healthcare Communication
- Learn more about our courses (Foundations of Healthcare Communication, Breaking Bad News, Managing Difficult Relationships, Discussing Code Status, etc.), development and implementation process for engaging providers, ongoing research, and educational/data resources
- This visit can be customized to meet the needs of your team. A typical visit would include 4-16 members of your organization and would be scheduled on a date that is mutually convenient

Foundations of Healthcare Communication Course

- Participate in this 8-hour course facilitated by two Cleveland Clinic physicians or advanced clinical care providers
- Experience a course designed to help providers improve their communication with patients through a relationship-centered communication approach
- This course features the Cleveland Clinic REDE model, which provides an evidence-based framework for provider and patient communication
- Course participants learn and practice the skills provided by the REDE model.
- In a small, dynamic setting, participants practice new skills to manage scenarios from their own practice
- **The next class will be offered on January 23, 2014 at the Cleveland Clinic.**

Train the Trainer Program

- An intensive, experiential-based program designed to train physicians and advanced clinical care providers to teach relationship-centered communication skills and to evolve providers who can effectively provide feedback and coaching
- 6-8 day program separated in time which focuses on competencies in learning theory, behavior change, performance assessment, group facilitation skills, and the value/impact of relationship-centered communication skills in healthcare
- Components of the training involve co-facilitating with our peer facilitators, as well as observed facilitation and feedback

Consulting Services

- Our leadership team is available for consultation regarding programmatic development, brainstorming various strategies for provider engagement, and individual coaching.

Cleveland Clinic

Taking place on May 18-20, 2014, in Cleveland, Ohio, the 5th Annual Patient Experience: Empathy + Innovation Summit is a three-day, inter-professional conference devoted to exploring patient experience as a key differentiator essential to the future of healthcare delivery. It brings together patient experience leaders, healthcare CEOs, nursing leaders, policy makers and major stakeholders for presentations, debate and candid discussion of key issues that drive patient experience. Attendees will hear how they strive to deliver the best clinical, physical and emotional experience to patients and families.

The Summit will feature expert panel discussions about the national patient experience movement, providing participants from all disciplines the opportunity to identify shared challenges and inspire innovative solutions to help transform the patient experience and elevate customer satisfaction as a competitive differentiator.

Summit Website

For more information about the Patient Experience: Empathy + Innovation Summit, and to register, please visit empathyandinnovation.com.

James I. Merlino is a colorectal surgeon and the chief experience officer at the Cleveland Clinic.

Ananth Raman is the UPS Foundation Professor of Business Logistics at Harvard Business School.

HEALTH CARE'S SERVICE FANATICS

How the Cleveland Clinic leaped to the top of patient-satisfaction surveys

by James I. Merlino and Ananth Raman

The Cleveland Clinic has long had a reputation for medical excellence and for holding down costs. But in 2009 Delos "Toby" Cosgrove, the CEO, examined its performance relative to that of other hospitals and admitted to himself that inpatients did not think much of their experience at its flagship medical center or its eight community hospitals—and decided something had to be done. Over the next three years the Clinic transformed itself. Its overall ranking in the Centers for Medicare & Medicaid Services (CMS) survey of patient satisfaction jumped from about average to among the top 8% of the roughly 4,600 hospitals included. Hospital executives from all over the world now flock to Cleveland to study the Clinic's practices and to learn how it changed.

The Clinic's journey also holds lessons for organizations outside health care—ones that until now have not had to compete by creating a superior experience for customers. Such enterprises often have workforces that were not hired with customer satisfaction in mind. Can they improve the customer experience without jeopardizing their traditional strengths? The Clinic's success suggests that they can.

The Cleveland Clinic's transformation involved actions any organization can take. Cosgrove made improving the patient experience a strategic priority, ultimately appointing James Merlino, a prominent colorectal surgeon (and a coauthor of this piece), to

PHOTOGRAPHY: MARK HOOPER

lead the effort. By spelling out the problems in a systematic, sustained fashion, Merlino got everyone in the enterprise—including physicians who thought that only medical outcomes mattered—to recognize that patient dissatisfaction was a significant issue and that all employees, even administrators and janitors, were "caregivers" who should play a role in fixing it. By conducting surveys and studies and soliciting patients' input, the Clinic developed a deep understanding of patients' needs. It gave Merlino a dedicated staff and an ample budget with which to change mind-sets, develop and implement processes, create metrics, and monitor performance so that the organization could continuously improve. And it communicated intensively with prospective patients to set realistic expectations for what their time in the hospital would be like.

These steps were not rocket science, but they changed the organization very quickly. What's more, fears expressed by some physicians that the initiative might conflict with efforts to maintain high quality and safety standards and to further reduce costs turned out to be unfounded. During the transformation the Clinic rose dramatically in the University HealthSystem Consortium's rankings of 97 academic medical centers on quality and safety. Its efficiency in delivering care improved as well.

Founded in 1921 with a single site, the Cleveland Clinic has long been one of the most prestigious medical centers in the United States. It has pioneered many procedures (including cardiac catheterization, open-heart bypass, face transplant, and deep-brain stimulation for psychiatric disorders) and made a number of breakthrough discoveries (identifying genes linked to juvenile macular degeneration and to coronary artery disease, for example). It expanded aggressively in the late 1990s and is now one of the largest nonprofit health care providers in the United States. In addition to its 1,200-bed main hospital and its community hospitals, it has 18 family health centers throughout northeastern Ohio; a tertiary-care hospital in Weston, Florida; a brain treatment center in Las Vegas; and operations in Canada, Abu Dhabi, and Saudi Arabia. In 2012 its 43,000 employees treated 1.3 million people, including more than 50,000 inpatients at the main campus.

For most of the Clinic's history, providing patients with an excellent overall experience—in areas such as making appointments, offering a pleasant physical environment, addressing their fears and concerns during their stays, and providing clear discharge instructions—was not a priority. Like most hospitals, especially prestigious ones, the Clinic focused almost solely on medical outcomes. It took great pride that *U.S. News & World Report* repeatedly ranked it among the top five U.S. hospitals for overall quality of care and listed its heart program as number one.

In 2007 the Clinic adopted a new care model in an effort to improve collaboration and thereby increase quality and efficiency and reduce costs. It abandoned the traditional hospital structure, in which a department of medicine supervises specialties such as cardiology, pulmonology, and gastroenterology, while a department of surgery oversees general surgery along with cardiac, transplant, and other specialty procedures. Instead it created institutes in which multidisciplinary teams treat all the conditions affecting a particular organ system. Its heart and vascular institute, for example, includes everything having to do with the heart and circulatory systems (cardiac surgery, cardiology, vascular surgery, and vascular medicine), and cardiologists and surgeons see patients together. The new model had positive effects not only on quality and costs but also on the patient experience.

Certain developments, though, soon led the Clinic's leadership to realize that these changes and accomplishments would not suffice. In 2008, to help consumers make more-informed choices and to encourage hospitals to improve care, the CMS began

From Mediocre to Top Tier

In a U.S. government survey, the proportion of patients who gave the Cleveland Clinic's flagship center the highest possible score for overall satisfaction has jumped in recent years. It now ranks in the 92nd percentile among the roughly 4,600 hospitals surveyed.

OVERALL SATISFACTION
CLEVELAND CLINIC'S PERCENTILE RANKING

2008	2009	2010	2011	2012
55	80	89	90	92
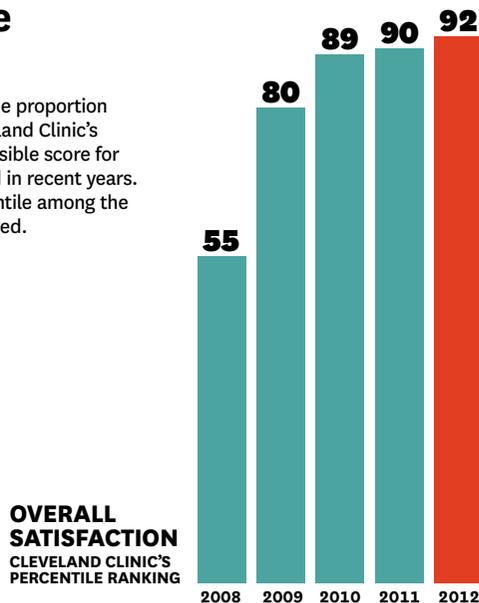
SOURCE CENTERS FOR MEDICARE & MEDICAID SERVICES

Idea in Brief

Organizations that have not had to compete by offering great customer service but suddenly find that they must do so face a challenge: They often have a culture, employees, and processes ill-suited to the task.

But the Cleveland Clinic's success in transforming itself shows that it can be done. In just a few years the Clinic went from having mediocre patient-satisfaction scores to rising to the upper echelons of U.S. hospitals.

Its CEO made improving patients' experiences a strategic priority. He appointed a prominent physician—an insider who commanded the respect of other physicians (a key interest group)—to lead the effort and gave him ample resources: a staff that now numbers 112 people.

The initiative, which is still under way, is having an additional benefit: helping the Clinic improve quality, safety, and efficiency.

making the scores in its satisfaction survey and comparative data on the quality of care publicly available online. It announced that starting in 2013, roughly $1 billion in Medicare payments to hospitals would be contingent on performance in these areas, and the amount at risk would double by 2017.

CMS satisfaction scores are based on randomly selected patients' postdischarge responses to questions about how well doctors and nurses communicated with them, whether caregivers treated them with courtesy and respect, the staff's responsiveness to the call button, how well their pain was controlled, and the cleanliness of the room and bathroom, among other things. Patients are also asked to give the hospital an overall rating and to say whether they would recommend it to friends and family (see the exhibit "From Mediocre to Top Tier").

The Clinic's overall score was just average, and its performance in some areas was downright dismal: It ranked in the bottom 4% for staff responsiveness and room cleanliness, 5% for whether the area near a patient's room was quiet at night, 14% for doctors' communication skills, and 16% for nurses' communication skills. "Patients were coming to us for the clinical excellence, but they did not like us very much," Cosgrove says. And from stories he'd heard from patients and their families and consumer research he had read, he realized that he couldn't count on medical excellence to continue attracting patients—for many people choosing a hospital, the anticipated patient experience trumped medical excellence. He decided to make improving the patient experience an enterprisewide priority.

Leading the Change

Cosgrove understood that to achieve that goal, the Clinic would need to significantly change how it operated. Getting employees to modify their mind-sets and behaviors wouldn't be easy. In recent years cost

pressures had forced hospitals to cut support staff even as medical complexity and regulatory demands increased. Launching an initiative that would add to the burden would be challenging. Obtaining buy-in from physicians would be especially difficult. The Clinic differs from many hospitals in that its physicians are employees, but they wield more power than employees often do. Many are superstars in their specialties; they are a major reason—maybe *the* reason—patients choose the Clinic. Cosgrove couldn't expect to issue an edict and have them salute and obey.

For all those reasons, he decided to create a new position, chief experience officer. He initially appointed an outsider who was not a practicing physician. She left after 24 months. He then decided to call on a senior physician from inside the organization—someone who would fully understand the challenges of delivering a great patient experience while also focusing on medical outcomes and who would have immediate credibility. He chose Merlino.

Merlino had recently moved his practice from the MetroHealth Medical Center, a large county hospital in Cleveland, to the Clinic, where he'd held a fellowship earlier in his career. He was already working on making the digestive disease institute a "patient-centered" organization. Before building his surgical practice, he had worked in government administration and in political public-opinion research and had served on a community hospital's board.

During his interview with Cosgrove, Merlino told a story about his father, who had been a patient at the Clinic several years earlier. That experience had been terrible: Among other things, his father felt that the nurses had been unresponsive, and his physician did not always see him daily. He had died in the hospital thinking it was the worst place in the world. "Nobody else should die here believing that," Merlino said. Both men admitted they didn't know what accomplishing that goal would take. "We will

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ROOM CLEANLINESS

Year	Value
2008	4
2009	20
2010	47
2011	64
2012	71
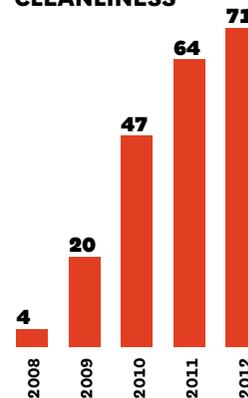
SOURCE CENTERS FOR MEDICARE & MEDICAID SERVICES

need to figure it out together," Merlino told the CEO. Twenty minutes after the interview, Cosgrove's chief of staff called Merlino to offer him the job, asking him to devote 50% of his time to the initiative (he now devotes 80%).

To help carry out the mandate, Cosgrove gave Merlino the Office of Patient Experience, which currently has a $9.2 million annual budget and 112 people, including project managers, data experts, and service excellence trainers. Its responsibilities include conducting and analyzing patient surveys, interpreting patients' complaints, administering "voice of the patient" advisory councils, training employees, and working with units to identify and fix problems.

Publicly Acknowledging the Problem

Getting employees to take the new mandate seriously was a considerable challenge. Doctors and nurses typically focus on performing procedures and treatments and often fail to explain them fully and in terms patients can understand. The Clinic's caregivers were no different.

Ignorance and cost pressures presented two other obstacles. Employees at most hospitals are unaware of CMS scores or don't believe they matter all that much, and they don't understand how to improve the patient experience. Some executives believe incorrectly that amenities like better food and bigger TVs are the key, and others are reluctant to invest scarce funds in a major change program. In these areas, too, the Clinic was no exception.

One of the OPE's first projects under Merlino was to broadly publicize the detailed results of the CMS survey—both for the Clinic as a whole and for individual units. This was Cosgrove's idea. Before becoming CEO, Cosgrove had led the department of cardiothoracic surgery, and he had been tasked with improving the department's surgical outcomes. One method he'd found effective was releasing outcomes data on every surgeon and program so that all could see how their performance compared with that of others. He hoped that publicizing the CMS data would have a similar effect. In one sense, it did: Employees were shocked by the scores and understood that the problem was important. But they were confused about what they could do personally to raise them.

Understanding Patients' Needs

Merlino recognized that to drive meaningful change, he had to create a strategy and a plan for executing it. To measure progress, he decided to rely on the metrics used in the CMS satisfaction surveys—the Hospital Consumer Assessment of Healthcare Providers and Systems. This was an easy choice: The CMS data had credibility, they were available online to consumers, and hospitals' Medicare reimbursements would soon be affected by them. But the industry's understanding of the root causes of *why* patients graded hospitals as they did—of what patients' underlying needs were—was limited.

The Clinic had tried to make itself more appealing to patients by doing things like having greeters at the door, redesigning its gowns, and improving food services. But these amenities were superficial efforts—and shots in the dark. It was unclear which, if any, affected the CMS scores.

Merlino saw that if the patient experience was going to be a strategic priority, employees had to under-

stand exactly what it meant and what each person's responsibility for delivering it entailed. He crafted a broad, holistic definition: The patient experience was everyone and everything people encountered from the time they decided to go to the clinic until they were discharged. The effort to improve it became known as "managing the 360."

Although institutions talk a lot about the importance of empathy in delivering good care, they actually have little knowledge of what patients experience as they navigate health care, except for their interactions with doctors and nurses. So Merlino commissioned two studies. The first involved a randomly selected group of former patients who had taken the CMS survey by phone. Researchers followed up with them, asking why they'd answered each question the way they had. The second was an anthropological examination of a nursing unit that had received some of the Clinic's worst scores in the CMS survey. Researchers observed interactions between patients and employees and questioned both parties about things that happened.

The studies produced a number of findings. Although several problem areas were not especially surprising, it was clear that employees did not always keep them in mind. Patients did not want to be in the hospital. They were afraid, sometimes terrified, often confused, and always anxious. They wanted reassurance that the people taking care of them really understood what it was like to be a patient. Their families felt the same way.

Patients also wanted better communication: They wanted information about what was going on in their environment and about the plan of care; they wanted to be kept up-to-date even on minute activities. And they wanted better coordination of their care. When nurses and doctors did not communicate with one another, patients were left feeling that no one was taking responsibility for their care.

The studies also revealed that patients often used proxies in their ratings: If their room was dirty, for example, they might take it as a sign that the hospital delivered poor care. Another striking finding was the importance of doctors' and nurses' demeanors. Patients tended to be more satisfied when their caregivers were happy. It wasn't that they craved interactions with happy employees; rather, they believed that if their caregivers were unhappy, it meant either that the patient was doing something to make them feel that way or that something was going on that they did not want to reveal.

Making Everyone a Caregiver

At most hospitals the primary relationship is considered to be between the doctor and the patient; the rest of the staff members see themselves in supporting roles. But in the eyes of patients, all their interactions are important.

To understand how many people a patient typically encounters, Merlino asked one patient—a woman undergoing an uncomplicated colorectal surgery—to keep a journal of everyone who cared for her during her five-day stay. It turned out that there were eight doctors, 60 nurses, and so many others (phlebotomists, environmental service workers, transporters, food workers, and house staff) that the patient lost track. Few of her 120 hours at the Clinic were spent with physicians. Moreover, her journal did not even take into account employees in nonclinical areas, such as billing, marketing, parking, and food operations—people who did not interact directly with her but might have had a big impact on her stay. Merlino realized that *all* employees are caregivers, and that the doctor-centric relationship should be replaced by a caregiver-centric one.

To get everyone in the organization to start thinking and acting accordingly, Merlino proposed having all 43,000 employees participate in a half-day exercise. Randomly assembled groups of eight to 10 people would meet around a table with a trained facilitator—a janitor might be seated between a neurosurgeon and a nurse. All would participate as caregivers, sharing stories about what they do—and what they could do better—to put the patient first and to help the Clinic deliver world-class care. They would also be trained in basic behaviors practiced by workers at exemplary service organizations: smiling; telling patients and other staff members their names, roles, and what to expect during the activity in question; actively listening to and assisting patients; building rapport by learning something personal about them; and thanking them. The cost of the half-day program, including the employees' salaries, would be $11 million.

Cosgrove embraced the idea, but some members of the executive team were skeptical. Physicians on the team believed that doctors would never go along with the plan and should not have to take time from their busy schedules. The head of nursing at the time worried about the impact on productivity of taking nurses away from the floor and questioned whether it could be justified without a quantifiable ROI. Cosgrove listened to the discussion in silence and then

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NURSES' COMMUNICATION

2008	2009	2010	2011	2012
16	30	58	74	72

DOCTORS' COMMUNICATION

2008	2009	2010	2011	2012
14	18	29	49	63
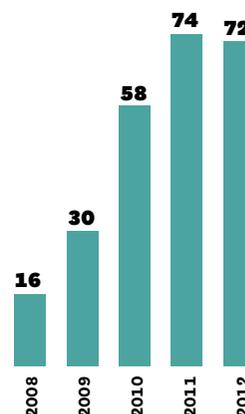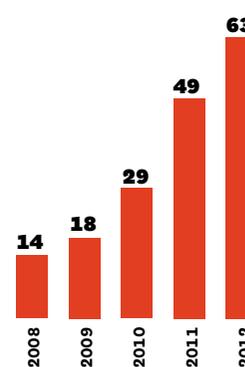
spoke. Making any exceptions, he said, would undermine one of the program's main aims: to eliminate the divide between doctors and the rest of the staff and create a unified culture in which everyone worked together to do what was best for the patients. And yes, the ROI was unclear. "But what will be the cost [for patients and the organization] of *not* proceeding?" he asked. The executive team acquiesced.

The program was launched in late 2010. It took a full year for everyone to go through it. A handful of physicians asked to be excused but were refused. As hoped, the program had a profound impact. Nonphysician employees were amazed by the experience of sitting with doctors and discussing how they, too, were caregivers. Participants shared frustrations about not always being able to provide a nurturing environment. Even doctors who had been skeptical about the exercise felt it was worthwhile.
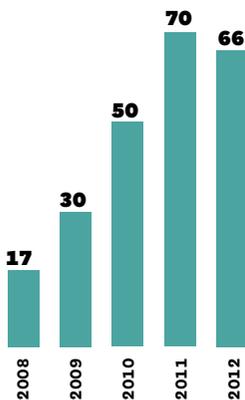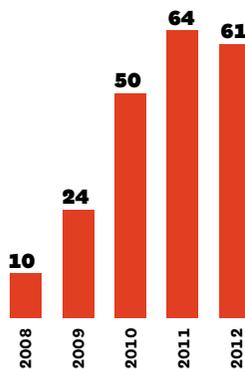
Embedding Changes

To continue to drive change and to permanently alter how people performed their jobs, the Clinic instituted a number of other measures:

Identifying problems. Merlino put in place systems to track and analyze patients' attitudes and complaints and to determine and address the root causes of problems. Like many hospitals, the Clinic had used a similar approach to improve safety. Applying the methodology to issues like dirty rooms, noisy environments, and patient–caregiver communication was not a big leap. In addition, the Clinic's business intelligence department set up electronic dashboards that displayed real-time data available for all managers to view.

Establishing processes and norms. Merlino created a "best practices" department within the OPE to identify, implement, promote, and monitor approaches used by top performers in the CMS survey. In many cases it tested practices in pilot projects before rolling them out broadly.

Some efforts were relatively simple. For example, one program reinforced the basic behaviors taught in the half-day exercise. As part of the program, managers monitored their employees and coached those who were falling short.

A related initiative targeted prospective patients—people deciding where to go for care. A common complaint of potential patients who'd opted to go elsewhere was that the Clinic was too big and was difficult to access; people needed a special connection—"to know someone"—to get an appointment.

So Cosgrove mandated that all patients would have the option of getting an appointment the same day they called, making the Clinic the first major U.S. provider to offer this service. It created a single phone number for booking appointments, and centralized scheduling across the enterprise. When patients called the dedicated number, operators were trained to say, "Thank you for calling the Cleveland Clinic. Would you like to be seen today?" A television and radio advertising campaign, "Today," promoted the new service and sent a clear message that the Clinic would help patients with anything they needed, not just complicated conditions. The campaign was an overnight success: During the first year, visits by new patients increased by 20%. Same-day appointments now account for over one million patient visits a year.

Another common complaint was that despite the creation of the multidisciplinary institutes, caregivers did not communicate or coordinate well with one another. Merlino decided to begin addressing this problem by testing a process to determine the root causes of communication breakdowns in each unit; remedies would then be devised on a case-by-case basis. He commissioned a study of the weekly huddles of critical floor leaders, selecting a floor with one of the hospital's worst scores in the CMS survey for the pilot. A team consisting of the floor's nurse manager; its assistant nurse manager; a physician from the specialty that had the most patients on the floor; the environmental services supervisor (who oversaw housekeeping); the case manager responsible for discharge, insurance, and at-home needs; a social worker; and a representative from the Office of Patient Experience began meeting each week to discuss patient complaints and concerns.

It quickly identified several problems. First, the social worker and the case manager—employees critical to ensuring a smooth discharge process—did not like each other and never talked. The floor, which conducted a large volume of gastroenterology and radiology procedures, constantly ran behind schedule. Patients ordered to have no food or drink before a procedure might go hungry all day if the procedure was delayed; even worse, procedures were sometimes postponed until the next day with nobody informing the patient—leaving him or her not just hungry but confused. Finally, doctors did not always communicate with nurses after rounds, and so nurses were often unaware of the plans for their patients' care that day.

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COMMUNICATION ABOUT MEDICATION

Year	Value
2008	17
2009	30
2010	50
2011	70
2012	66

PAIN MANAGEMENT

Year	Value
2008	10
2009	24
2010	50
2011	64
2012	61

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These problems were not difficult to fix. Most of them were addressed by instituting simple processes to surface issues, get people to work better together, and keep patients informed about what was going on. For example, the weekly huddles forced caregivers to communicate regularly with their colleagues, including ones they did not particularly like. The floor's scores in the CMS survey went from among the lowest in the hospital to the highest in less than a month.

Another area that was hurting the Clinic in the CMS survey was nursing rounds. Rounding on patients hourly is an established best practice that improves safety, quality, and patient satisfaction. But as of 2010 the Clinic did not require hourly rounds; some units conducted them, some didn't. The units that did had higher patient-experience scores, and when the Clinic's leaders learned of the correlation, they decided to launch a pilot project in the heart and vascular institute under the direction of K. Kelly Hancock, who was then its nursing director and is now the Clinic's executive chief nursing officer.

For a period of 90 days, the nurses or nursing assistants on designated floors were required to see patients every hour and to ask them five questions: Do you need anything? Do you have any pain? Do you need to be repositioned? Do you need your personal belongings moved closer to you? Do you need to go to the bathroom? They had to fill out sheets verifying that they had done this. Nurse managers held spot audits, and patients being discharged were asked if the rounds had been performed. Some 4,000 patients in all were involved, and the results were striking. The units that always completed the rounds ranked in the top 10% in the nursing-related parts of the CMS survey; the units that conducted rounds inconsistently scored much lower. The units that never conducted hourly rounds ranked in the bottom 1% of all hospitals. So Cosgrove mandated hourly rounds across the institution.

Engaging and motivating employees. The leaders of the Clinic knew that to improve the patient experience while continuing to drive safety and quality, it would need engaged, satisfied caregivers who understood and identified with its mission: providing exemplary care by excelling in specialized care; developing, applying, evaluating, and sharing new technology; attracting the best staff; excelling in service; and providing efficient access to affordable care. A 2008 Gallup survey of employee engagement at health care organizations highlighted the magnitude of the problem in this regard: The Clinic placed only in the 38th percentile.

One step taken to address this problem was the launching of a "caregiver celebration" program. This

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QUIET AT NIGHT
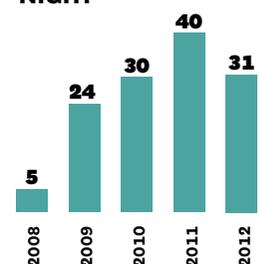
Year	Value
2008	5
2009	24
2010	30
2011	40
2012	31

HOW THE CLEVELAND CLINIC STACKS UP
THE CLINIC'S PERCENTILE RANKING AMONG HOSPITALS SURVEYED FOR THE PROPORTION OF PATIENTS WHO GAVE THE INSTITUTIONS THE HIGHEST POSSIBLE SCORE
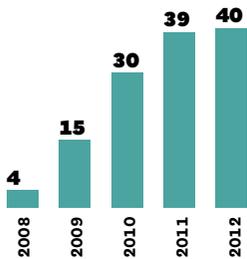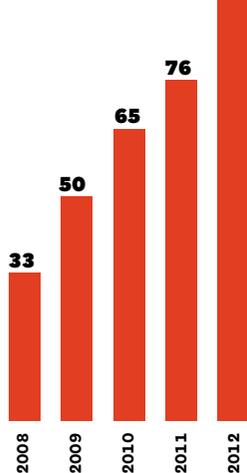
STAFF RESPONSIVENESS

Year	Value
2008	4
2009	15
2010	30
2011	39
2012	40

DISCHARGE INFORMATION

Year	Value
2008	33
2009	50
2010	65
2011	76
2012	97

SOURCE CENTERS FOR MEDICARE & MEDICAID SERVICES

allowed both managers and frontline workers to recognize colleagues who had done something exceptional for patients or for the organization. Recognition made employees eligible for monetary awards of varying amounts, culminating in the $25,000 CEO Award of Excellence, presented to the top caregiver and team members at an annual ceremony.

More broadly, Merlino, Cosgrove, and other members of the executive team recognized that they needed to make a substantial investment in developing and managing the workforce. They saw that the organization's 2,300 managers needed to be educated in how to increase the engagement of members of their teams. All managers are now required to attend a daylong session every three or four months, during which they are trained in such things as emotional intelligence, communicating and implementing change, and enhancing engagement. They must submit annual plans for how they will improve the engagement and satisfaction of the people they manage (actions might include discussing job expectations more frequently, improving communication about activities in the department or the Clinic, and ensuring that employees have the resources needed to perform their jobs). Such steps helped the Clinic move up to the 57th percentile in the Gallup survey. Although this is progress, Clinic leaders recognize that it is not nearly enough.

Setting Patients' Expectations

The patient is not always right: Sometimes patients have desires whose fulfillment would not be in their best interests. Here's a case in point: Patients understandably prefer not to be disturbed at night. But sometimes they must be awakened in order to be given medication, to have a procedure performed, or to have their vital signs checked. Because some patients at the Clinic did not understand the reasons for such disturbances, they were critical when asked in the CMS survey whether their rooms had been quiet at night.

Similarly, the OPE discovered that patients were upset if they used the call system to ask for a nurse's help and did not receive an immediate response—even if their need wasn't pressing. When it probed deeper, it learned that even when patients recognized that their need wasn't urgent, the lack of an immediate response often made them anxious—many feared that if there *were* an emergency, nobody would come. They didn't know that the person answering calls prioritizes them according to the urgency of the request.

The Clinic found it could alleviate such problems by letting patients know *before* they got to the hospital what to expect while they were there. It created printed materials and an interactive online video for incoming patients, describing the hospital environment and procedures and explaining the rationale for them. It also educated them about pain management and how to communicate with providers.

In addition, Merlino realized that the Clinic could enlist patients' help in improving the hospital experience. For instance, it began asking patients in semiprivate rooms to limit nighttime noise. It started to rely more heavily on patients to identify problems and improve processes. It now asks patients to report rooms that have not been cleaned properly and to routinely ask caregivers if they have washed their hands.

Such measures may seem minor, but the effects are important, in terms of cost as well as patient satisfaction. In 2012 salaries, wages, and benefits totaled 56% of the Clinic's operating revenue (supplies accounted for just 10%, pharmaceuticals for 7%). To hold down costs, hospitals will clearly have to increase employee productivity. One approach that has worked well in retailing and service industries is to encourage customers to perform tasks that employees have traditionally done—for example, booking airline tickets, checking out of stores, and answering other customers' questions. If such a process is designed empathically, it can enhance patients' experiences even as it reduces costs.

HOSPITAL LEADERS may believe that they cannot justify the kinds of programs described here. CMS's linking of Medicare reimbursement to patient satisfaction should help convince them otherwise. They should also remember this: Changing culture and processes to improve the patient experience can lead to substantial improvements in safety and quality. To put it bluntly, a patient-centered approach to care, which includes giving patients an outstanding experience, is not an option; it's a necessity.

Despite the Clinic's progress, its leaders know full well that they cannot proclaim victory. Some obvious shortcomings, such as the still-modest degree of employee engagement, remain. And at a fundamental level, operating a truly patient-centered organization isn't a program; it's a way of life. Doing the best by patients means continually analyzing what can be done better and then figuring out how. There will always be something. ▽   **HBR Reprint** R1305J