Whether you're in primary or specialty care, a free app now available from Cleveland Clinic's Referring Physician Center will simplify your referral process and make communication with our specialists more efficient.

THE FEATURES YOU NEED
Our Physician Referral App will give you the ability to:

- Browse an alphabetical directory of Cleveland Clinic physicians by specialty, department and location
- Bookmark physician profiles
- Tap on email addresses or phone numbers to easily refer or transfer a patient or make an inquiry
- Quickly write and save notes from physician profiles

The Physician Referral App is available for iPhone®, iPad®, Android™ phone and tablet.

CONTINUED ON BACK COVER
Services for Physicians

REFERRING PHYSICIAN CENTER AND HOTLINE
Cleveland Clinic’s Referring Physician Center has established a 24/7 hotline — 855.REFER.123 (855.733.3712) — to streamline access to our array of medical services. Contact the Referring Physician Hotline for information on our clinical specialties and services, to schedule and confirm patient appointments, for assistance in resolving service-related issues, and to connect with Cleveland Clinic specialists.

PHYSICIAN DIRECTORY
View all Cleveland Clinic staff online at clevelandclinic.org/staff.

TRACK YOUR PATIENT’S CARE ONLINE
DrConnect is a secure online service providing real-time information about the treatment your patient receives at Cleveland Clinic. Establish a DrConnect account at clevelandclinic.org/drconnect.

CRITICAL CARE TRANSPORT WORLDWIDE
Cleveland Clinic’s critical care transport teams and fleet of vehicles are available to serve patients across the globe.

- To arrange for a critical care transfer, please call 216.448.7000 or 866.547.1467 (see also clevelandclinic.org/criticalcaretransport).
- For STEMI (ST elevated myocardial infarction), acute stroke, ICH (intracerebral hemorrhage), SAH (subarachnoid hemorrhage) or aortic syndrome transfers, call 877.379.CODE (2633).

OUTCOMES DATA
View clinical Outcomes books from all Cleveland Clinic institutes at clevelandclinic.org/outcomes.

CLINICAL TRIALS
At any given time, we offer thousands of clinical trials for qualifying patients. Visit clevelandclinic.org/clinicaltrials.

CME OPPORTUNITIES: LIVE AND ONLINE
Cleveland Clinic’s Center for Continuing Education’s website offers convenient, complimentary learning opportunities. Physicians can manage CME credits using the myCME.com web portal. Visit ccfcme.org.

EXECUTIVE EDUCATION
Cleveland Clinic has two education programs for healthcare executive leaders — the three-day Executive Visitors’ Program and the two-week Samson Global Leadership Academy immersion program. Visit clevelandclinic.org/executiveeducation.

SAME-DAY APPOINTMENTS
Cleveland Clinic offers same-day appointments to help your patients get the care they need, right away. Have your patients call our same-day appointment line, 216.444.CARE (2273).
Patients have always had opinions about their experience in the doctor’s office, but these opinions were largely shared among family and friends. With the advent of accountable care organizations (ACOs) and value-based purchasing, however, these opinions are now being made public. The intention is to ensure that patients are treated equally, respectfully and well — goals reinforced by tying patient response to reimbursement by the Centers for Medicare & Medicaid Services (CMS).

ACOs and health systems that contract with CMS are now required to use the Clinician and Group Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS) survey to measure how Medicare and Medicaid patients perceive the care they receive in providers’ offices. A similar measurement tool, termed HCAHPS, is utilized in inpatient settings.

CG-CAHPS questions address 12 areas of interest:

- Timeliness of care, appointments and information
- How well providers communicate
- How the provider rates
- Access to specialty care
- Health promotion and education
- Shared decision-making
- Health status and functional status
- Attitude of office staff
- Care coordination
- Between-visit communication
- Education about medication adherence
- Cost of medications

Providers never see the individual responses, but the results are tallied and mailed to ACOs and health systems, which must then decide how to use the information to improve the care they provide, or risk losing reimbursement dollars.

While it’s natural for many providers to focus on the potential of the survey results to increase or decrease reimbursement, the questions actually reflect the health of the doctor-patient relationship. In this respect, they reinforce the value of good communication, timely access and courtesy in fostering relationships that result in better patient care.

At Cleveland Clinic, we have arranged for 1 in every 7 patients to receive a CG-CAHPS survey. We consider the results invaluable and use them for ongoing improvement of the patient experience systemwide. Over time, recurring themes have helped us determine what aspects of office care patients consider most important:

- The doctor listens to them.
- The doctor spends an adequate amount of time with them.
- The doctor carefully explains what they need to know.
- They understand the information the doctor gives them.
- The doctor prepares by reading their medical history before entering the exam room.
- The doctor discusses disease prevention.
- The doctor answers their questions.
- The doctor provides test results in a timely manner.
- They know how to reach the doctor after hours.
- They participate in shared medical decision-making.

While there is no doubt these surveys will play a central role in your financial future, we urge you to think of the broader impact of your patients’ opinions on the care you provide. By using the results to focus on providing more patient-centered care, patient satisfaction will be reflected in the survey results, and that will help secure the health of your financial future.

Dr. Longworth can be reached at 216.445.9085 or longwod@ccf.org.
New guidelines issued by the American Heart Association and American College of Cardiology may potentially expand the number of patients using statins as a first-line therapy in hyperlipidemia management. Yet, some patients cannot tolerate the drugs due to muscle aches and weakness, gastrointestinal symptoms, liver enzyme abnormalities or other issues. This poses a challenge to reducing patients’ low-density lipoprotein cholesterol (LDL-C), considering statins’ demonstrated benefits in primary and secondary prevention of cardiovascular morbidity and mortality.

A major observational study by Cleveland Clinic offers some good news for these patients and their doctors: The majority of patients with previous intolerance can tolerate a subsequent statin trial. In addition, intermittent statin dosing can be effective in some patients and may result in the reduction of LDL-C levels and even the attainment of LDL-C goals.

Co-author Michael Rocco, MD, Medical Director of Cardiac Rehabilitation and Stress Testing, Section of Preventive Cardiology, explains: “Even though statins work by similar mechanisms, intolerance to one does not predict a poor response to another.”

ONCE STATIN-INTOLERANT DOESN’T MEAN ALWAYS
During a median follow-up of 31 months, 72.5 percent of patients previously identified as “statin-intolerant” remained on regular statin therapy — including 63.2 percent on a daily regimen and 9.3 percent on intermittent dosing (ranging from once weekly to six days a week). Statins were completely discontinued in only 27.5 percent of patients.

“Even if patients cannot tolerate a daily dose of a statin, it’s possible to see a significant reduction in cholesterol levels from taking the drug less often, even as infrequently as once a week,” Dr. Cho says.
“Even though statins work by similar mechanisms, intolerance to one does not predict a poor response to another.”

Patients on intermittent statin dosing had significantly less LDL-C reduction compared with those on daily dosing (21.3% ± 4% vs. 27.7% ± 1.4%; \( P < .001 \)); but compared with patients who discontinued statins, those on intermittent dosing had significantly greater LDL-C reduction (21.3% ± 4% vs. 8.3% ± 2.2%; \( P < .001 \)). Also, a significantly higher portion of patients on intermittent dosing vs. those who discontinued statin therapy achieved Adult Treatment Panel III LDL-C goals (61% vs. 44%; \( P < .05 \)).

HIGHER DOSES NOT ALWAYS NEEDED

Some studies with atorvastatin, fluvastatin and rosuvastatin have suggested that every-other-day dosing regimens need to be nearly twice the daily dose to result in comparable LDL-C lowering, but Cleveland Clinic’s analysis found that reasonable reduction can be achieved with the same or even low doses in both daily and intermittent dosing strategies.

Also, Dr. Rocco says: “Starting at a low dose of a potent statin with intermittent dosing and gradually increasing the dose and frequency over time can promote better tolerance.”

To refer a patient to any of our heart specialists at the Sydell and Arnold Miller Family Heart & Vascular Institute, call 855.REFER.123.

DEALING WITH Statin Intolerance

Fortunately, many patients are able to tolerate statins without side effects, but it is not uncommon for some patients to complain of symptoms they believe are caused by their lipid-lowering medication. These guidelines can help you respond:

Patient history. Headaches, gastrointestinal complaints, muscle toxicity (weakness and/or pain) and elevated hepatic enzymes have been shown to be related to statin usage. Since those symptoms also may result from factors unrelated to statin intake — increased physical activity, hypothyroidism, heavy alcohol use, acute viral disease or drug interactions, for example — it’s important to first conduct a thorough history of your patient to rule out other causes.

Rechallenge. Discontinuing the statin to determine if adverse muscle or hepatic events resolve, and rechallenging with the previous or lower dosage to determine if symptoms return, can help confirm whether intolerance is the root cause.

Dosage or drug changes. If symptoms resume on rechallenge, consider reducing the dosage amount or administration frequency of the existing statin, or prescribing a different one. Statins with alternative metabolic pathways may provide symptom relief. Those with longer-acting formulas may enable intermittent — i.e., every-other-day or weekly — dosing while still helping reduce low-density lipoprotein cholesterol (LDL-C). However, it remains unclear whether such intermittent statin dosing results in the same cardiac risk reduction as daily administration.

Other alternatives. If statin-related symptoms still persist, LDL-C-reducing options alone or in combination include non-statin drugs such as ezetimibe, bile acid sequestrants and niacin. It is important to emphasize the role of physical exercise and dietary additions such as soy, viscous fiber (found in whole grains, beans, nuts), plant sterols and stanols (from fruits, vegetables, nuts, seeds, cereals and legumes). Caution is advised, because clinical trials have not compared the long-term outcomes of various statin intolerance-management strategies.
A HIDDEN “GEM”:
When Your Patients Might Benefit from a Geriatric Evaluation

When an older person’s care requires in-depth investigation beyond the limits of a typical office visit, a geriatric consult at Cleveland Clinic can lend a hand.

Patients age 65 or older are eligible, and the average age of referrals for geriatric evaluation and management (GEM) is 85. The consult seeks to address geriatric syndromes such as:

- Memory problems or confusion
- Balance and walking problems
- Falls
- Medication issues such as nonadherence, interactions or adverse effects
- Unexplained weight loss
- Behavioral changes such as sadness, apathy, depression, anxiety or withdrawal

“We work in collaboration with the primary care physician, allowing you to focus on managing the patient’s medical conditions, such as hypertension, diabetes or heart failure,” explains Barbara Messinger-Rapport, MD, PhD, Director of the Center for Geriatric Medicine. “A mood disorder, recurrent falls or urinary incontinence in an older adult is unlikely to resolve unless multiple aspects of aging are acknowledged and addressed.”

Assessments typically are done at Cleveland Clinic’s main campus, although house calls are possible through the Home Care Department. Dr. Messinger-Rapport strongly recommends that a family member accompany a patient to the one- to two-hour appointment.

The evaluation includes medication review, cognitive testing and depression screening. A geriatrician reviews the patient’s medical history, performs an examination, and interviews the family and patient about their goals and concerns.

“At the end, we discuss what our assessment shows and what our recommendations are,” says geriatrician Ronan Factora, MD. Recommendations may include further testing, therapy evaluations, subspecialty referrals or resources to help the family deal with associated issues, such as a dementia diagnosis. The patient and family often leave the initial visit with a summary of the recommendations, which also are sent to the primary care physician. Sometimes additional information needs to be obtained, and the diagnosis and recommendations will come later.

Information from a geriatric consult can help individualize medical decisions, says Dr. Factora. Goals of the recommended interventions are to:

- Support the patient’s efforts to remain independent and age well at home
- Avoid complications related to medications
- Reduce unnecessary hospitalizations
- Ensure that medical, cognitive and psychological conditions are managed appropriately
- Develop a care plan in line with each patient’s quality-of-life goals and life expectation.

In a follow-up visit four to six weeks later, a nurse practitioner helps the patient and family understand the diagnosis and reviews new information, including laboratory or imaging results and counseling from resources such as the Alzheimer’s Association. “We determine if they are following our recommendations, address concerns and evaluate for changes,” says Dr. Factora. Further visits may occur as needed.

Medicare Part B and most private insurers cover GEM physician and nurse practitioner visits, plus diagnostic testing and brain imaging when medically indicated. Referrals — such as for social work, physical therapy or occupational therapy — also are covered. Costs of specialist visits or additional services are discussed before scheduling.

To refer a patient for a GEM assessment, call 855.REFER.123.
ADDRESSING THE ATTACK:
When (and Why) to Refer Kidney Stone Patients to a Specialist

Most patients suffering from a kidney stone attack visit their primary care physician (PCP) or the emergency department for immediate treatment of the pain. While preventive efforts to decrease the risk for future attacks is a good first step, many patients may benefit from seeing a specialist to determine both the cause of their stones and proper therapies.

“Since kidney stones are very common and widespread in the general population, most of those patients are seen by their PCPs,” says Cleveland Clinic nephrologist Juan C. Calle, MD.

“General instructions about diet and fluid intake for prevention of kidney stones are often sufficient if a patient has had only one stone formed (depending on the size and any associated comorbidities) with no complications.”

WHEN EXTRA HELP IS NEEDED
However, more than 40 to 50 percent of patients will have a recurrence of the disease within five years. For that reason, Dr. Calle says, this patient population would potentially benefit from seeing a specialist (either nephrology or urology) at least once.

A urologist and/or nephrologist will determine the exact cause of the kidney stones. Because there are several types of kidney stones and the causes for each vary, knowing this information is critical in determining the best course of treatment and prevention, including medical management of the condition on an ongoing basis.

“Our work as nephrologists is mainly to focus on prevention of the stone and to make sure no other associated diseases are the cause for them or a worsening factor,” Dr. Calle explains. “I believe almost all patients with multiple kidney stones or large kidney stones and associated diseases should have a referral to nephrology for prevention and management of those associated conditions.”

OUR IMAGING TOOLKIT
Typically, a urologist or nephrologist will conduct some sort of imaging during the appointment, whether that be a CT scan, X-ray or ultrasound.

Typically, Dr. Calle says, there should be a urine analysis and basic blood work. In cases involving more than one kidney stone or when other associated diseases are possible causes, a 24-hour urine collection may provide useful information.

“While the main focus is on diet and fluids, there are some conditions that require special treatments to handle the risk factors that promote the formation of kidney stones,” Dr. Calle adds. “Most definitely, patients who may have genetic abnormalities causing the stones should be treated by a specialist in the area.”

A COMPREHENSIVE TREATMENT SYSTEM
Once the cause and type have been determined, there are now highly successful minimally invasive treatments, Dr. Calle says.

At Cleveland Clinic, most patients with stones have the potential to be seen by either specialist (preferably urology in the acute setting or nephrology to begin the workup). Treatment options include ureteroscopy, shock wave lithotripsy (SWL), SWL under conscious sedation and percutaneous nephrolithotomy.

These and other solutions are available to relieve your patients’ kidney stones and return them — pain-free — to your care.

To refer a patient to the Glickman Urological & Kidney Institute, please call 855.REFER.123.
Cancer Genomic Testing
IN A REAL-WORLD SETTING

Davendra Sohal, MD, MPH, staff physician in the Department of Solid Tumor Oncology
Nearly every major hospital or cancer treatment practice performs specific genomic testing on every cancer patient’s tumor sample — such as K-ras oncogene analysis for those with colorectal cancer or HER2 analysis in breast cancer. These standard-of-care tests detect a single genetic mutation associated with a patient’s tumor type. Since August, oncologists at Cleveland Clinic’s Taussig Cancer Institute have been enrolling patients in an expanded genomic testing clinical study in which 250 patients with 15 different tumor types will be analyzed over the next year for 236 cancer-related genes.

The genes tested have been implicated in cancer, with implications for cancer therapeutics. They are all included in the FoundationOne™ genomics assessment test. For this clinical investigation, Cleveland Clinic has partnered with FoundationOne’s developer, Foundation Medicine, a molecular information company specializing in comprehensive genomic analysis of tumors.

In the study, each patient’s tumor sample is tested with the FoundationOne genomics profile, which detects several types of DNA alterations — base substitutions, small insertions/deletions, copy number alterations and gene rearrangements. The test includes those genes that show a high frequency of common alterations but also those on a tail on the curve, such as those mutations occurring at low frequency but across many different tumor types. This type of approach provides a strong rationale for looking broadly rather than just looking with disease-specific genes.

“We have chosen a variety of cancers that include the most common cancers,” says Davendra Sohal, MD, MPH, staff physician in the Department of Solid Tumor Oncology and principal investigator of the study. “The goal is to see if this type of expanded genomic testing can impact clinical outcomes in a meaningful way.”

“We understand the importance of genomic testing in a broad fashion and are investing heavily in this,” adds Brian J. Bolwell, MD, FACP, Chairman of the Taussig Cancer Institute. The target population for the study includes patients lacking good treatment options, such as those with metastatic disease or whose cancer has progressed despite one or two rounds of standard chemotherapy. “There is opportunity to make a difference for these people if we can apply the existing knowledge about cancer mutations to making useful treatment decisions.”

FEASIBILITY AND UTILITY

One of the trial’s goals is to study the feasibility of doing genomic analyses in a real-world setting. “We want to see how well tests like FoundationOne can be performed in a real-world setting in a variety of tumors,” comments Dr. Sohal. Questions to be answered include: How long does it take for a patient to be consented to receive this testing? How long does it take to process the test and for doctors at Cleveland Clinic to get the result? How long does it take for the patient to learn the result and recommendations for treatment?

The ultimate goal is to probe the clinical usefulness of expanded genomic testing. Every test result includes molecular details about a patient’s tumor along with supporting data suggesting a particular targeted therapy. This information is provided to a panel of oncologists within the Taussig Cancer Institute. This Genomics Tumor Board meets weekly to review each result independently and make recommendations for treatment — whether with approved drugs or as part of clinical trials in and around Cleveland. These recommendations are transmitted to the primary oncologist, who makes final personalized recommendations to the patient. “If many patients can get to useful treatments — whether FDA-approved or off-label, or under a clinical trial of a targeted therapy — then it can make a real difference,” says Dr. Sohal.

Because the science behind genomic testing is evolving rapidly, new genetic mutations are rapidly emerging. Cleveland Clinic has chosen to partner with Foundation Medicine as the company continually updates its testing panel to keep current with the latest research in cancer-related genetics.

For more information, call 216.444.7923 or 866.223.8100.
Chances are good that you’ll encounter essential tremor (ET) in your primary care practice. It’s the most common movement disorder, affecting all age ranges and as many as 6 to 9 percent of people 60 and older according to prevalence studies.

But due to embarrassment, fear or normalization, your patients may not volunteer that they’re having problems. That means you’ll have to rely more on observational and interview skills to uncover what’s going on and begin the diagnostic and treatment process, says Cleveland Clinic neurologist Michal Gostkowski, DO. Some advice on how to proceed:

**Initial signs.** ET involuntary movements most often involve the hands and occur during action, in contrast to Parkinson disease (PD) tremors, which occur at rest. ET patients may try to mask or hide their shaking. So Dr. Gostkowski watches their hands when they’re distracted and listens for vocal tremors, another distinctive ET symptom. He also asks if their activities have changed. ET patients may stop socializing or discontinue hobbies that are affected by their tremors. Those restrictions, in turn, may trigger depression, another indicator to watch for. Also, since alcohol can temporarily dampen ET tremors, sufferers may be vulnerable to alcohol overuse or addiction.

**Other diagnostic aids.** Though ET has its own complications, your patient’s biggest early concern may be that his or her tremors result from PD. A neurologist can make the definitive diagnosis, but for reassurance’s sake, some simple tests in your office — handwriting and water-pouring ability — can help differentiate ET from PD. ET patients’ handwriting is large and scratchy-looking, while PD patients’ rigidity results in smaller and smaller printing (a condition called micrographia). ET patients also have trouble pouring water from one cup to another, a task that PD patients execute without spills because their tremors occur at rest.

**Patient questions.** Your patients likely will ask what caused their ET and what course their disease will take. Though ET clearly has a strong genetic component, no ET-linked genes have been identified so far, and it is likely that some as-yet unknown environmental cofactors are involved. Tremors tend to become more severe as patients age, with some association between age of ET onset and how quickly ET progresses. Older-onset patients have a faster rate of progression.

**Medical treatment.** Unfortunately, medications are only modestly effective at reducing ET tremors. The beta-blocker propranolol and the anti-seizure drug primidone are the most studied and seemingly the most beneficial, but each lessens tremor in about half of ET patients. Other ET medications include benzodiazepines and anticholinergics, which should be used cautiously in older patients.

**Surgery.** Deep brain stimulation (DBS) of the thalamus has shown good results in ET. “It’s a very viable option,” Dr. Gostkowski says. “We expect 70 percent to 80 percent improvement in the tremor in about 90 percent of patients,” with minimal side effects. ET patients and their physicians should consider DBS when tremors begin to impair daily living activities.

To refer a patient for evaluation for essential tremor, call 855.REFER.123.
When to Refer Patients for Hearing Tests

In a noisy world and with an aging population, hearing loss is an increasing concern. Early intervention is important. Here’s how to help your patients get the care they need.

Almost half of American adults 75 or older have impaired hearing, according to the National Institutes of Health. But hearing loss isn’t just a concern for geriatric patients. Fifteen percent of Americans aged 20 to 69 also suffer high-frequency hearing loss due to noise exposure at work or play. Yet the National Institute on Deafness and Other Communication Disorders estimates that only 1 in 5 people who could be helped by a hearing aid actually wears one.

“The emphasis for primary care physicians (PCPs) hopefully can be to prompt patients to have hearing evaluations sooner,” says Sarah Sydlowski, AuD, PhD, Audiology Director of the Hearing Implant Program in Cleveland Clinic’s Head & Neck Institute. “The earlier we can diagnose and manage the hearing loss, the better the outcome and the easier the transition to using amplification.” Some key points to consider:

**Symptoms** — Your patients may complain that people are mumbling or that they frequently ask speakers to repeat themselves. They may report the roaring, buzzing or ringing sensations of tinnitus, which can accompany hearing loss. They may avoid noisy rooms or social situations where many people talk at once. Family members may notice TV or radio volumes set unusually high, or may feel the person is withdrawing from activities they used to enjoy.

**Other risk factors** — Certain chemotherapeutic agents and some drug classes, such as aminoglycosides and aspirin in high doses, can cause hearing loss. Baseline hearing evaluations, as well as monitoring after treatment begins, are important. Loud concerts and extended use of headphones and earbuds at high volume can degrade hearing at an early age. Your younger patients and their parents should be aware of the risks of amplified audio at volume settings greater than 50 percent of maximum, or for long duration, Dr. Sydlowski says, and of post-exposure warning signs such as tinnitus or muffled hearing. Headphones with volume limits and parental controls are available. Hunters, musicians and patients with occupational noise exposure are all at risk for noise-induced hearing loss. An audiologist can assist with customized earplugs.

**Where to refer** — Audiologists are master’s- or doctoral-level professionals trained in the assessment and management of hearing loss. They administer comprehensive evaluations, make recommendations for appropriate intervention such as hearing aids, and will make recommendations for further medical or surgical evaluation if needed.

What patients should expect — Initial evaluation involves listening to tones through headphones at various intensities and frequencies to determine hearing thresholds, as well as tests to assess the patient’s ability to understand speech. More comprehensive evaluation, if needed, employs specialized tests to assess middle ear function, such as tympanometry or acoustic reflex testing. Behavioral evaluation can be tailored for children as young as 7 to 8 months; for babies younger than 6 months, electrophysiologic testing can indicate hearing sensitivity. If a hearing loss is identified, a hearing needs assessment will be scheduled.

Addressing concerns — Your patients may resist scheduling an evaluation or follow-up care because of the social stigma of hearing loss. They also may have outdated perceptions about assistive devices. “They think they’re going to have big, clunky hearing aids like their grandfather wore,” Dr. Sydlowski says. In fact, hearing aids have shrunk drastically while improving technologically. They are now more sophisticated while also simpler to use. They can selectively amplify missing sounds, detect and adjust to different acoustic environments, and wirelessly connect with cellphones, iPads and other devices for listening.

“The biggest obstacle to obtaining appropriate hearing care is often the patient’s hesitation to admit they have difficulty hearing,” Dr. Sydlowski says. “In fact, patients typically wait seven years on average before seeking management for their hearing loss. Primary care physicians are in a perfect position to advocate making hearing health and associated quality of life a priority for their patients.”

To refer a patient for a hearing evaluation, call 855.REFER.123.
When Alan Birnbaum fractured his hip, he underwent surgery at Cleveland Clinic and was discharged to a skilled nursing facility (SNF) for subacute care.

“We were given a list of facilities to choose from, and we chose Montefiore (in Beachwood, Ohio) because it was close to home,” says his wife, Anne. “Proximity was important to us, as was the fact that we knew Alan could still connect with Cleveland Clinic staff.”

COORDINATED SYSTEM ELIMINATES BARRIERS

That connection is virtually seamless at nine partnered SNFs, where Cleveland Clinic physicians and nurse practitioners provide post-hospital care in Northeast Ohio. Eiran Z. Gorodeski, MD, MPH, Director of the Center for Connected Care, says Cleveland Clinic is “very actively” developing coordinated systems to remove barriers between the hospital, SNFs, hospice, rehabilitation therapy and home care. The center brings together Cleveland Clinic’s post-acute care operations under one umbrella.

A full-time staff of 540 physicians, nurse practitioners, nurses, therapists and others cares for 2,000 to 2,100 home care patients, 300 hospice patients, and 150 to 200 SNF patients per day, according to Dr. Gorodeski.

“The home care program alone sees more patients on a daily basis than there are beds in the entire Cleveland Clinic health system,” he explains.
HEALTH CARE REFORM DRIVES INTEGRATION
The Affordable Care Act’s focus on rewarding value-based care (specifically, quality and outcomes) is one factor driving U.S. hospitals toward integrated systems. In the post-hospital arena, expected benefits include:

- Smoother hospital discharges and transitions
- Improved communication among medical professionals across points of care
- Increased focus on helping patients receive care where they prefer — at home and in their community
- Better outcomes for patients
- Cost savings resulting from fewer hospitalizations, tests and medical procedures

HOSPITAL READMISSION RATES ARE LOW
Preliminary data collected by Cleveland Clinic supports its efforts toward providing value-based care. Hospital readmission rates for patients at its partner SNFs are approximately 10 percent lower on average than rates at nonaffiliated SNFs, Dr. Gorodeski reports. “Data from insurance partners indicate that patients entering our SNF programs are costing less because of lower readmissions and appropriately shorter stays,” he says.

Hospital readmission rates and patient satisfaction scores for Cleveland Clinic’s home care services are as good as or better than those of comparable home care agencies. Home care services through the Center for Connected Care include home-based nursing and therapy care, mobile physician care (primary and palliative care at home), infusion therapy, specialized wound and ostomy care, behavioral health care, respiratory care, and home-based hospice care, among others.

Primary care physicians can use Cleveland Clinic’s DrConnect web portal to view electronic medical records (EMRs), enabling them to follow their patients in the hospital or an affiliated SNF. By mid-2014, Cleveland Clinic is on track to extend EMRs to its home care programs as well.

“You will always have a Cleveland Clinic colleague to email or talk to when your patient makes the transition from hospital to SNF and then back home,” Dr. Gorodeski says.

For more information on Center for Connected Care services, call 1.888.REFER.123.

VIRTUAL VISITS
Cleveland Clinic’s Center for Connected Care is piloting the use of “virtual video visits” using video conferencing technology to improve the care we deliver in our patients’ homes. This technology has the potential to give patients convenient access to their caregivers.

What's covered in a virtual visit?

- Clinical status assessment
- Encouragement and motivation to manage health conditions
- Psychosocial support, for example, discussing preferences, culture and worries
- Health education
- Assisting patients and families with administrative issues related to care, including access to follow-up care
- Promoting patient satisfaction with care

For more information on our virtual visit pilot program, please call 216.636.8982.
Joining Forces for Efficient, Effective Care

A pilot program offers new opportunities for community-based primary care physicians (PCPs) and Cleveland Clinic orthopaedic specialists to collaborate to provide coordinated, high quality patient care.

“This partnership supports the creation of a complete care plan for each patient, and gives us the chance to work closely with the PCP to be certain we get the best possible patient outcomes,” says Mark Froimson, MD, MBA, President of Euclid Hospital and staff physician in the Department of Orthopaedic Surgery.

The pilot program was created by the Centers for Medicare & Medicaid Services under the Affordable Care Act. Using a system of bundled payments, it establishes both performance and financial accountability for episodes of patient care.

Cleveland Clinic’s participation includes hip and knee replacements at Euclid Hospital. The hospital receives one predetermined Medicare payment for all services related to these procedures, and it must meet quality-of-care targets.

ENHANCED PATIENT CARE

“Patients typically express concern about transitions of care and fragmented care,” explains Dr. Froimson. “Close collaboration with PCPs in this new program improves quality and enhances the patient experience. It means better care delivered more efficiently.”

The development of a complete care plan begins when a PCP refers a patient for joint replacement. The orthopaedic surgery team works with the PCP to optimize the patient prior to surgery, getting him or her in the best possible shape to avoid the risk of complications or readmission. Six areas are addressed:

- Smoking
- Diabetes
- Obesity
- Chronic anemia
- Poor dental hygiene
- Malnutrition

If any of these problems exists, Cleveland Clinic staff assists the PCP to get them under control. “This can really act as a motivator for patients and help PCPs gain compliance,” notes Dr. Froimson.

Under the pilot program, there is greater flexibility with post-operative care. This allows participating providers to bend some Medicare rules, which ultimately benefits the patient, Dr. Froimson says. “For example, we can discharge a patient to a post-acute care facility without first keeping them in the hospital for three days. And, we can waive the typical strict requirements for home care and provide services that allow more patients to recover where they’re most comfortable — at home.”

Much of this flexibility stems from the financial risk that Cleveland Clinic assumes with the bundled payment approach. “We are willing to take on that risk,” Dr. Froimson explains, “because we have such confidence in the care we deliver.”

Although the PCP’s relationship with Medicare remains the same for now, Dr. Froimson believes there will be opportunities for gain-sharing in the future. He also is confident that the program will expand to other medical conditions and Cleveland Clinic sites. “We think this is the future of healthcare, and we are excited to be leading the way and learning what is most successful for our patients,” he says.

For more information about the complete care program for joint replacement patients, contact Maryann Horrigan, RN, at horrigm@ccf.org or 216.692.9130.
Coming Events

CME Opportunities: Live and Online — Cleveland Clinic’s Center for Continuing Education’s website, ccfcmee.org, offers convenient, complimentary learning opportunities, from a virtual textbook of medicine (Disease Management Project) and a medical newsfeed refreshed daily to myCME, a system for physicians to manage their CME portfolios. Many live CME courses are hosted in Cleveland, providing an economical option for business travel.

Executive Visitor’s Program

March 26-28, 2014
InterContinental Hotel
Cleveland, Ohio
Register at clevelandclinic.org/ExecEd

Healthcare Innovation:
Shared Medical Appointments:
The Intersection of Quality and Value

April 24-25, 2014
The Ritz-Carlton Hotel
Cleveland, Ohio
Register at ccfcmee.org/SMA14

Primary Care Evidence-Based Medicine

May 2-3, 2014
Cleveland Clinic Administrative Campus
Beachwood, OH
Register at ccfcmee.org/primarycare

Perspectives in Pediatrics:
From Theory to Practice

May 18-10, 2013
Global Center for Health Innovation
Cleveland, Ohio
Register at ccfcmee.org/pediatrics

The Cleveland Clinic Way: Order Your Copy Now!

New book by Cleveland Clinic CEO and President Dr. Toby Cosgrove gives you the good news about American healthcare. Learn how Cleveland Clinic and its unique model of medicine are able to deliver higher quality healthcare at a lower cost; hear how Cleveland Clinic experts are leveraging big data, air transport and teamwork to build a healthcare system that really works.

Order your copy at clevelandclinic.org/ClevelandClinicWay
A Streamlined Referral Experience? We’ve Got an App for That! continued from cover

SIGN UP FOR DR CONNECT OR ORDER A PRINT GUIDE

The app’s two main features are accessible with one click of a button or one phone call:

The “Find a Doc” tool available on clevelandclinic.org — This online search tool can now be accessed on a portable device with this app. “A referring physician is able to search for a doctor by location, specialty, last name, gender, or whether they need a surgeon or pediatric specialist,” explains Michelle Medina, MD, Medical Director of Cleveland Clinic’s Provider Relations Center. “Cleveland Clinic doctor profiles can be bookmarked, or notes about a doctor can be added and saved. A referring physician can also contact a Cleveland Clinic doctor directly.”

The patient referral tool — This streamlines referrals and hospital transfers by allowing one-click access to the Referring Physician Hotline and the Hospital Transfer Line. It also allows referring physicians to sign up for DrConnect to follow their patients’ progress online and request a print copy of the Cleveland Clinic Guide for Referring Physicians.

A FULL-SERVICE CENTER HERE FOR YOU

Our new app is just one new tool at your disposal. Our dedicated Referring Physician Center team is available 24/7 and committed to serving you and your patients.

One call is all it takes. Simply contact the Referring Physician Hotline at 855.REFER.123 for personal help obtaining information or connecting with our clinical specialists and services, scheduling and confirming patient appointments, or resolving any service-related issues.

For more information, call 855.REFER.123 or visit clevelandclinic.org/referringphysician.
We want your opinion on how Rounds can be improved to better serve you in your practice. Please take a minute to complete this short survey to let us know how you feel about Rounds, and what you feel can be improved about the publication.

As a thank you for completing this survey, please accept the $1 bill that was mailed with this edition of Rounds.

We ask that you return this survey by March 3, 2014.
Thank you for completing this short survey!
Please fold, secure the open end with tape (do not staple), and place in the mail.
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   - Yes
   - No
   - Unsure

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