Session 4 – How Cleveland Clinic Uses Data to Transform the Patient Experience

[Moderator]
We will now welcome and introduce Dr. James Merlino. So Dr. James Merlino is the Chief Experience Officer and Associate Chief of Staff of the Cleveland Clinic Health System, as well as a practicing staff colorectal surgeon in the Digestive Disease Institute. He is the founder and current president of the Association for Patient Experience. As a member of the Clinic's executive team, Dr. Merlino leads initiatives to improve the patient experience across the Cleveland Clinic Health System. In addition, he also leads effort to improve physician-patient communication, patient access, and referring physician relations. Partnering with key members of the Clinic leadership team, he helps to improve communication with physicians and employees and to drive the employee engagement strategies. Dr. Merlino was named to HealthLeaders magazine's 2013 list of 20 people who make healthcare better. He is also a recognized world leader in the emerging field of patient experience. And may I just add I just had a great opportunity to visit a bit more with Dr. Merlino about the way that he has operationalized the patient experience and as he described for me the kind of responsibility that he has, the scope of the responsibility in managing a nearly 700-person contact center, for example, as just one of the many areas of responsibility that he has, it is truly an incredible structure and an incredible vision that he has implemented over the last 5 years as Cleveland Clinic's Chief Experience Officer.

So please join me in welcoming Dr. Merlino.

[Applause]

[Dr. James Merlino]
It's really an honor to be here. This is an amazing conference and as Dan had been telling me about the company, I think the ability of what Health Catalyst does to really take hospital data and make it into a meaningful product for us to improve is amazing. So it's truly an honor. I think I'm the pitch hitter. I am like the last speaker before the panel discussion and have early tough act to follow. But a couple things about me. So why is a colorectal surgeon in charge of patient experience at the Cleveland Clinic? Well, nobody ever asked me that. So the reality is I think that my CEO thought that as a pathologist couldn't make the experience better, that it probably was not going to happen. So that is the answer. And by the way, that is the best joke that I have. And one of the most interesting parts of my job is the contact center, they're down at the back stage. And for those of you that work in organizations, with contact centers, or for those of you that have the honor of actually managing one, I can tell you that of the 700 people, it's about 699, too many, prefer to have much less but nevertheless it's an amazing program.

So, I have to give some advertising first or somewhat say narcissistic. But we did write a book about our experience, called *Service Statistics*, which is coming out on December. And what I am fascinated by the most of what we found is we're very honest about what has worked and what hasn't worked. And I think that as we look at patient experience today at the Cleveland

Clinic, it is the net result of a lot of good and a lot of bad, and I think that we learn by really hearing about the bad as much as we talk about our successes. Our guiding principle has been this, patients first, and my CEO, Dr. Cosgrove, claimed this term when he took over the clinic 10 years ago. And what he was trying to do was pretty simple. He wanted to create an alignment or a model that people would recognize early what defines us. And when I talk about this, people really think, well that's kind of insignificant because we're in healthcare and we're all about patients. But the reality is we're not. And in fact, there's emerging evidence and a great study that's done every year by Forrester Research in concert with a company out of Boston called Watermark Consulting that looks at service industries that are publicly traded and the S&P 500. And they have been doing this study for the last 6 years where they've broken companies into what they call service excellence leaders and service excellence laggards. And consistently, year over year, the service excellence leaders perform on average 30% higher in the market than the laggards. And when they look at what defines those companies versus the ones that are the laggards, the leaders are the ones that have an absolute focus on their customer. They are the ones that build strategies around it, they're the ones that build tactics to support it. It is alignment around what you do. It's getting everybody in your organization to understand that they are there to serve the customer.

Now, whenever I talk to patient advocacy groups about this, they always kind of yell at me because, well, patients are not customers. Well, I got news for you. In an organization like mine where 50% of the patients to my number one service line, which is worth about a billion dollars a year to us, come from outside the state of Ohio. Those are customers before they become our patients. And everybody, including my colleagues, who spoke before me want to get those customers. So, we have to think about this as really alignment around your customer. So, it's very, very important really to think about this from a strategic standpoint and also to build tactics around it.

The other thing that this is important is it talks about this ecosystem. So we are all in this healthcare ecosystem. I think it's especially true for people in this room because most of you I think are in the healthcare space, to some degree. But even if you're not, think about this. This is the only business in the world where it touches everybody. So, whether you work directly in healthcare to serve patients or whether you work around healthcare to support what providers do, someday you'll still be in this environment because you will be a patient. Nobody escapes that. So, we want to think about really what we do everyday and how we hope the providers organize what they do everyday to make sure that they're really focused on this idea of putting patients at the center of everything we do.

So I'm not going to brag a lot about us but I want to show you some data because everybody always wants to see the data. So I'm going to zip through this. So this is one way we benchmark our organization. It is the USA Today's report on top 5 hospitals and we look at this because we're in it, and I'd like to see what our friends are doing. And what you see on the Y axis is percentiles. And so, when we started this, our HCAHPS nurse communication score was at the 17^{th} percentile, so they were at the 80^{th}. And I don't show this to say, oh look how great we are, although sometimes I like to say that we're really great. I show this to say, look where we were

and look where we are today. And this is actually a better benchmark for us because this is the top 15 largest hospitals by single site in the United States. So I see this is our true peer group. Very similar in demographics and peer mix, etc. The top 5 is really more of a beauty contest. But when we started this, we were the lowest. And even in what I think is our true peer group, we've excelled. But one that I'm most proud of is this one, which is how patients rate our communication scores with physicians. And I have to tell you, when I took this job back in 2009, I thought this is a metric that is not going to improve. And today, we're not where we need to be, we're at the 67th percentile of all hospitals reporting, but compared to where we started, we made amazing progress. And again, if you look at the top 15 hospitals, we were down here and today we're there. So again, it's not to say, look how great we are. It is to say, you can improve these metrics. And I can tell you with certainty that there's a lot of healthcare leaders out there in the United States today that think you cannot.

So getting into the presentation, my first poll question is, healthcare providers understanding what their customers, the patients, really want. True or False?

[Male Facilitator]
Alright. Ladies and gentlemen, this is session 4 poll question #1. Healthcare providers understand what their customers, the patients, want. Choose 1 for True, 2 for False.

Alright. We have our results. Let's go ahead and share those. We have 8% that thinks it's true and 92% that thinks that's false. Back to you Dr. Merlino.

[Dr. James Merlino]
So that's pretty good. I congratulate you because I agree, we don't. But this is our scenario. We are very good at standing up in front of patients and telling them exactly what we think they need to know. And we are good at this because we're the professionals. We must know what patients want. We train for years to do it, right? And by the way, we're not only the professionals but we're also patients. So therefore we definitely know what the other side wants. But the reality is we don't really spend a lot of time understanding it and this is demonstrated by a great study that was published by health leaders two years ago when they asked CEOs, CNOs and chief operating officers of major healthcare organizations across the United States tell us one of the priorities for fixing the patient experience. And they said things like new facilities, ensure quiet time, give private rooms, and this is my favorite because 65% of the hospitals in the United States are semi-private. So we're certainly not going to wreck all the hospitals and build new ones, provide food and demand, give the patients interactive bedside computers, and my favorite was eliminate the visiting hours. The problem was that no one asked the patients what was important to them. And when you ask patients, and I mean really do hardcore research analytics trying to understand what's important to patients, you get something very different.

So we noticed that our scores a couple of years ago were starting to plateau. We were doing a lot of improvement but we weren't getting the trajectory in the metrics that we really wanted. So we hired two companies, one out of New York, administered the government-mandated

inpatient survey, the HCAHPS survey to a thousand patients, and then we have the researchers go back and ask the patients why they answered the way they did to each question. And then we hired a company out of Chicago to do what's called ethnographic research. So a team of four researchers were planted on one of our worst floors for six weeks. They followed patients around, they talked to staff, and they observed interactions. And then we brought the data together. So, if you're following me and you guys are data experts, I'm sure you are, it's a robust quantitative study and a robust qualitative study, and it was done by outside big firms because in healthcare we're very good at doing study that tells exactly what we want to know. So we wanted to avoid that. We get to the executive debriefing, Kelly Hancock, who is our chief nursing officer, my partner in crime around the patient experience, and we're watching the slides and the first things the researchers put up was respect. Patients want more respect. And I went to Kelly and I said, that's it. We're fired. Okay, we just spent $250,000 to have these companies tell us patients want more respect. Always going to find out and we're so screwed.

But what was fascinating is after they left, so that's not really what it's about. What it is about is individual identity. Patients want us to treat them like individuals. They want us to remember that they're people, that they have a spouse, they have families, they have hobbies, they want us to engage with them personally. Now, this goes against everything we teach healthcare providers, you know, objective, don't be emotional, detachments. But patients want this because they believe that when we have a personal connection, we will care more, we will be less likely to make mistakes, well, the reverse, safer and higher quality care. So, I would have never been able to tell you that.

Another thing they told us is they wanted us to communicate better and they didn't just want me to communicate better. They wanted me and the nurse to communicate with each other better. And this started to develop this concept that a lot of us talk about but we really don't understand – is that patients use proxy measures to understand what's going on in their environment. So patients are unsophisticated healthcare consumers. And again, when I talked to the patient advocates, they said, no, patients are really smart. Yes, patients can be very smart, but they're unsophisticated. I can quickly take you down a conversation about a colorectal disease to a point where you can't understand it, even if you studied it for two weeks. You just can't be sophisticated. But what they do is they pick things they understand to measure our effectiveness.

So if I walk in at 7 o'clock in the morning and the tell the patient something and then I leave and the nurse comes in at 9 and the patient asks the nurse what did Dr. Merlino just say, and the nurse doesn't know, they think, well how can the hospital deliver high quality when in fact the doctor and the nurse aren't even talking to each other? That's a proxy measure.

The other thing they wanted was happy people and this was kind of interesting because I look at it and said, there it is, the soft side of patient experience, it is about making people happy. And they looked at me and said, not really. What it's about is consistency. And where this comes out is because if you think about being a patient, if you've ever been in the hospital, and by the way it's true for the ambulatory care as well, all you think about if you're in the hospital

is what's going on around you. So everything you interact with, you're looking for visual and verbal cues to better understand your environment. So if I walk in to a patient's room and I'm rushed, patients are going to ask me less questions because they don't want to contribute to the problem or whatever they think I am dealing with. If the nurse walks into the room, and it goes the doctor as well, and appears angry, the patient will be less likely to engage because they will be thinking, oh I'm going to make her or him more angry. Alternatively, patients are also thinking, did I do something to make them angry? I've been here for four days. So it is about being consistent because patients are looking at us and they're listening to us and they're using visual and verbal cues to better relate to their environment.

We also look very closely at emotions. So being the patient is stressful, there's incredible anxiety, fear and terror. There is uncertainty and confusion and I think one of the things that surprise us the most, although it should not have, is that every emotion that the patient experiences, the family experiences. So these are our customers and we spent a lot of time trying to drill down to understand what our customer wants, what's important to our customer. Now, they want high quality healthcare, that's kind of a given, but this is critical to them. And when you think about the space of patient-reported experience of care, understanding this information is critical because you're going to drive strategies and tactics to support this. So this is nothing more than data derived to help you focus on your customer experience strategies.

And here's a great example. So when we look at the problems we had in the emergency department, and so we asked all the leaders in the emergency department, what do they think the biggest problem is? What do you think it is? People always say it's the wait times. So we've used the data, we drilled into what patients were saying in verbatims, and then we did focus groups. And in fact, what you see is the wait time issues are lower on the left and things like concern for me as a patient, as a person, communication were much higher. And we had terrible wait times and we're taking a big hit on the patient experience scores because we thought people were just not happy with waiting. But we did this pilot where we actually went around and taught everybody in the emergency department to keep the patient informed as to what's going on. So you're the janitor and you're sweeping the hallway and you see a patient, you should say, "I know you've probably been here a long time. Is there anything I can get you? I know they're working on things, it just takes time to sort stuff out." Everybody engages around keeping people informed. Suddenly the patient experience scores went up because that was the most important thing to the patient. So, the answer to the poll question, it's true. We think we know but until we start using data, we truly don't know.

So poll question #2, what is the most important factor today driving improvement in healthcare delivery? And your options are data transparency, financial incentive for performance, improved leadership and management skills, both 1 and 2, I would say both 2 and 3.

[Male Facilitator]
Alright. Ladies and gentleman, let's go to poll question #2. Again, what is the most important factor driving improvement in healthcare delivery? A) Data transparency; B) Financial

incentives for performance; C) Improved leadership and management skills; Both A & B; or Both B. and C. Take your poll.

Alright. We have the results. Let's go ahead and show it. And the answer is both C and D, improved financial incentives for performance and improved leadership and management skills. Back to you Dr. Merlino.

[Dr. James Merlino]
Alright. So you're wrong. It's actually transparency and probably a little bit of financial incentive. What is fascinating about what's going on in the healthcare environment today is how we're using transparency of data and linking it to financial reimbursement. So that's been probably the greatest help that I've got in improving the patient experience. Now, I'd like to think it's because I'm a great leader, and I am, just ask me, but the point is that I'm having a lot of help from what's going on in the environment today. You know, if you think about what's different about healthcare reform today versus 10 years ago or 20 years ago, and it's fascinating because for those of you that have been in healthcare a long time, you know about every decade or so there's a new "healthcare reform movement."

But this is the first time in the history of American healthcare where we've taken the two things that doctors and hospitals care about the most outside of course of taking care of patients, we always accept that that's a primary motive, but the two things that people in healthcare care about the most, which is reputation and money, and the government has linked them together to transparency of data and reimbursement. And why this is so different today is because it's being done by the largest payer in the United States, which is Medicare. And by the way, that largest payer is also the regulator. So it's not just that's happening to hospitals because they accept Medicare but it's happening to all delivery if they're working in an environment where there are Medicare patients. So the idea of taking data and linking it to performance is what's driving incredibly powerful change in healthcare today. And what's fascinating about this is it's not just about buildings and systems anymore, that it's becoming about individual performance. And Patrick Conway, he is the Chief Medical Officer of Medicare, he is from Ohio by the way, will tell you that his goal, Medicare's goal is to take as much physician and provider specific information as possible and put it online so that people can access it. It's never been done before. And it's fascinating, when I first started talking about patient experience improvement 5 years ago, all the private practice doctors would look at me and say, "I don't care about the HCAHPS. That's your problem. It's a hospital thing." And what can I say? But today, when I talk to private practice doctors, my line is a little different because what I tell them is that unless you want to practice outside the American Healthcare System, you probably need to pay attention to this because you won't be practicing in a hospital that accepts Medicare.

And we're seeing the power of this to commercial entities. So Healthgrades is a great example of that, and you can see that there's three patients I thought I at first, which is always nice to see, but what's different now for companies like Healthgrades, and there's a lot of commercial scorecards like this, is think about where they get most of their data from. It's the things down

on the right-hand corner. It's information that's publicly reported. So you have this proliferation of data availability, which is touching providers individually, which will be picked up by all these sites and use to commercialize.

And then there's interesting things like this, that when I'm in Massachusetts. So I'm sure people have heard of this kind of no name magazine called Consumer Reports, right? Well, what they recognized is that nobody was using the publicly reported data because I'm sure we don't spend our Friday nights going online to want to see how our doctors are doing. So the Massachusetts Health Authority partnered with Consumer Reports to produce a special report in the July edition, the July 2012 edition, and what they did was they did group surveys of physicians. And just like they rank commercial products, they used little circles. And look at the things that they ask patients and then put in the publication, how well do your doctors communicate? How well do your doctors coordinate care? And it's pretty impressive. But what was more impressive was the recourse that the physicians in Massachusetts had against consumer reports and the MHA, which was nothing, because it's transparent data that's publicly available and sanctioned by the state. So they weren't happy about this but they could do nothing to stop it. And in fact, that Act alone has improved access in other things like physician communication in the states.

And the link to reimbursement is fascinating as well, and I think it's the second driver of change. I think the most important driver is transparency, especially with physician behavior because if you're a physician and your data is out there for everybody to see and you're ranked, who wants to be on the bottom of the list, right? You're going to go with the colorectal surgeon that has the worst outcomes? Wrong. But what the government is doing is they're increasing what's at risk for reimbursement. And this is a list that's a little bit of an eyesore but you can see all the percentages for all of the initiatives that are out there. And if you just look at the second one, value-based purchasing, which is where the experience of care falls in line, 2% is at risk to the hospital if they don't achieve metrics, time metrics, around value-based purchasing experience of care. And what's fascinating is when you think about that in relation to hospital operations today, Moody has just published their annual survey of hospital clients and they demonstrate that the average hospital bottom line in the United States today is 2.2%. So you can quickly see how this becomes a financial dilemma for hospitals that don't perform well. And in fact, Medicare care has also said publicly that because of the increasing transparency of data and reimbursement that they expect about 800 hospitals in the United States to close. Nobody knows which ones because it's a constantly moving number, because a lot of the data and a lot of the performance is judged based on percentiles, like I showed you earlier with the patient experience data. So, it is about transparency and it is about reimbursement.

My next question. Every caregiver in an organization must be held accountable to organizational metrics. True or False?

[Male Facilitator]
Alright. Ladies and gentlemen, poll question #3. Every caregiver in an organization must be held accountable to organizational metrics. 1) True; 2) False. Go ahead and vote.

Alright. We have the results. Here we go. How do you like that? 99% said True. Will the one person raise their hand that said false?

[Dr. James Merlino]
Yeah, I want to see the one person.

[Male Facilitator]
Back to you, Dr. Merlino.

[Dr. James Merlino]
See, I'm giving you easy questions, right? And it's supposed to be fun. So think about this. So everybody looks at my job and says, oh you're in charge of patient experience. That's such a great job. And then everybody says, oh and that's so important. Who can disagree that the patient experience is really, really important? Right? Nobody. But then they look at me and say, well, how do you fix that? And isn't it kind of soft and isn't it the kind of touchy feely stuff? And I look at them and I say, it is and that's what makes it great because when you really improve something, people look at you and think you're a really great leader. But I go back to something my mentor at Harvard told me. He said, "Look, Jim. Nobody will disagree with the importance of the issue. The question is how do you execute?" If you can't execute, you can't fix it. And hospitals are all about execution process. And what's wrapped around execution? It's data.

So when we think about the patient experience, our responsibility is to manage this 360. It's not just about the interaction with the provider at the episode. It is about everything that person thinks about us before they become our patient, the customer experience. It's about how they get access to your organization. And think about it. If the access is clunky, or they get angry at the access, that's the first impression often. It's everything you do at the episode and it's what you do to get them back to where they started. That's the 360 of the patient experience.

And when you think about the inpatient journey alone, there are a bunch of touch points, a bunch of process touch points that really impact how we deal with those patients. And so, as we think about executing, we have to understand what are the critical touch points and how do we get data to tell us how we're doing and how do we use that holistically to drive our strategy and ultimately develop tactics where we can be successful. So it's fascinating because you can look at that red line and you can actually map the real journey. So this is an example of an experience map.

Now, we didn't use the fly by night patient experience consultant to do patient experience mapping. We worked with Forrester Research to really do process mapping. And this is a critical function because what it does is it allows you to see how people move through your system and there's a great example from business. I was telling somebody earlier today when

they asked me where we got the idea to improve the patient experience, I said, about a third we stole from other healthcare systems, a third we stole from business, and a third I pulled out of my butt. But Federal Express did this to look at how they mail packages and Federal Express used to be the #1 overnight delivery company. And for a couple of years, they were hemorrhaging market share and it couldn't figure out why. And one day, the CEO got so pissed, he went home, he tried to do a package, mail package from home, and what he discovered was there are all these ways to mail packages and there needed to be one. So they mapped up their entire process and they consolidated and they learned where the pain points were for their customers and they recaptured their market share. So this is a real toll. And when you look along the patient journey, you can decide based on data, focus groups and quantitative data, where the critical points are and that's where you want to measure. And that's data along the continuum. And to be successful at driving process improvement specifically for the patient experience, and by the way this is something that's critically important to drive improvements and safety and quality as well. You look at and determine from a patient's perspective what's important and where you need to measure. And then you take that continuum and you figure out how you drive that data across the organization.

So I talked about the strategy of wanting to improve the patient experience and there's a variety of tactics that go into that. And as I said earlier, our success is the net result of the things that worked over the things that didn't work. But all of those tactics have to have data to support them, because if they don't, first of all, you have no idea from a process standpoint if people are actually doing what you want them to do. And #2, you have no idea if you're investing on something that's actually making a difference. Well my biggest challenge is when I took over this job 5 years ago was taming what I call the elephant problem. If you remember there's this old fable of the 7 blind men touching the elephant and every blind men describes the elephant slightly different but nobody has the big picture of what the elephant looks like because nobody has the perspective. Well patient experience is like that and it's the same for safety and quality. Everybody has an idea of how to improve it. For patient experience, let's put flowers on the tray, let's smile more. Let me tell you something. If the transporter is consistently late to take the patient to the procedure after they've been fasting all day, you can lay all the smiling you want on that and it's not going to make the patient happy. So you have to control the elephant and you have to pick out best practices that truly make a difference, that have been demonstrated to make a difference, and you have to pick out best practices where you can put a process metric in front of it to see if it's actually being done and an outcome metric behind it to see if actually it's making a difference.

So once you collect data along that continuum, you have to think about how you want to drive it down from the enterprise, all the way down to the individual. And as you heard me talk earlier about transparency, I want to give you an example of how this can be very powerful in changing behavior, especially with a very difficult stakeholder group like physicians. And we think about the data differently. So at the enterprise level, it's very strategic. As you start to move down, it becomes tactical and then ultimately at the individual manager or individual provider level, it's very operational but it's all about driving that data across the organization

because this is how people change in healthcare. And you heard earlier from Dr. Steele, it's about getting people the data.

So this is an example of what we use at the Cleveland Clinic Dashboard and I'm very fortunate because we have an incredibly robust BI group, that they will take all of the data that I think is important and put it on the computer so that all of our managers have access to it. And we're able to look at things from an enterprise perspective. So this is the HCAHPS scores that the Medicare mandated inpatient satisfaction for the entire enterprise. And then what I can do is I can look at it by institutes and we keep it simple. Green means you're at the 90th percentile, yellow means you're within 2 points of being at the 90th percentile, and I think everybody can figure out what red means. And we're able to take this down to an institute. This is our heart and vascular institute. And this is the entire enterprise of heart and vascular that supports the Cleveland Clinic. Same scheme. And we can take it down to a much more granular level. So within the heart and vascular, this is thoracic and cardiovascular surgery. And that's physician communication scores because that's the primary metric that we drive to them. And then we can take it to a unit view. So JE3 is one of our cardiac units that actually happens to be the VIP unit. And again, the ability to take data from a global strategic perspective and scale it so managers can understand it and then wrap your tactics around it is very critical to driving change. And we can also trend it so that people can see how they're performing over time, obviously another critical tactic.

Now, one of the things I am very proud of is we have really pushed individual physician accountability. And what we do specifically for physicians as it relates to patient satisfaction is we've defined it for them. If you think about basic change management around anything you're doing, there's three elements. You have to have a burning platform. And so, our burning platform was when we started this overall we were in the 10th percentile of all hospitals in the United States. So that's a pretty big burning platform and I threw a lot of gas on that to say, really? You guys, top hospital, best heart center in the world, lowest 10th percentile? So because you used to give talks in front of groups like this and say yeah, people come to us for high quality but they don't like us very much. So that's a burning platform.

The second thing you need to do is you need to define it, what is it that you want people to understand. And the third thing is you need to tell them what you want them to do. So for our doctors as it relates to patient satisfaction and patient experience, it's all about communication, because we know that when physicians communicate better with patients, patients are happier. When physicians communicate with nurses and other healthcare providers, coordination of care improves. So every quarter, each one of our physicians gets a report like this which labels all their communication scores in the ambulatory environment, the inpatient environment, and how many complaints they have, and it's completely unblinded.

Now, I took the names off of this to protect the guilty, but complete data transparency around how our physicians communicate. And we ranked them. We showed them where they fall against their peers in their department. So we give them a lot of data to understand their performance relative to each other.

My final poll question is patient comment, anecdotes and verbatims alone can drive improvement. True or False?

[Male Facilitator]
Alright. Ladies and gentlemen, our last question. Number 4 Patient comment, anecdotes and verbatims alone can drive improvement. 1) True; 2) False. Go ahead and vote.

Alright. Let's show the results. That was an easy one. Although the decision is pretty split. Look at that. 52% said true and 48% said false. Back to you Dr. Merlino.

[Dr. James Merlino]
So this is an example of one physician who had seven patient complaints over 90 days. Now, when I showed this to the particular surgeon, I'll say the surgeon, he says that, "you know, Jim, the plural of verbatim is not data" and I would get him, "I said, I never was very good in English, so I'm not really sure, but I think we know what the problem is, right?" So this isn't just a satisfaction problem. This is a safety problem and it's a quality problem. And this person is better today. But anecdotes can be very powerful drivers of change.

And here's another example. So when we started driving improved physician communication skills, there's been a ton of literature that's been published saying that doctors don't communicate well, but nobody would believe it because of course I'm the greatest communicator in the world, just ask me. So we took 90 days of patient reported comments about physicians, about 540. And you can see that 50% of those were negative. And when you broke them down, and this is our group practice, 3000 doctors, when you broke them down, what you found was 72% related to communication. Now, I unblinded all that data. So I know who the doctors were and I know who the patients were and I went back to the doctors and i asked them, how do you think your relationship was with patient A? And they'd say something like this. "Well, I have a great relationship with Mr. Jones. Mr. Jones is a fly fisherman and I look like fisherman. Every time I see him, we talk about fly fishermen. He is a great patient." And then you'd go talk to him, Mr. Jones, and say, how is your relationship with Dr. Merlino? And the conversation would go something like this, "Well, Dr. Merlino is a fly fisherman and I'm a fly fisherman. So every time we get together in his office, we talk about fly fishing. But every time I see him in his office, he addressed my blood pressure medication and you know, I never quite understand what that means or how I should take it."

So why is there a disconnect? The disconnect is because Mr. Jones in front of Dr. Merlino will never challenge me because of the submissive relationship that patients have. But in the comfort and convenience but more important anonymity of their own home, they tell the truth. And the truth is they don't feel like they understand the healthcare interaction. So data like this, and this is all verbatims, when you take it back to the providers, it demonstrates to them that in fact there's something that's disconnected. So verbatim information in healthcare I think is extremely powerful. You have to be careful because you don't want to fascinate

somebody based on one patient complaint. But trending an anecdote verbatims around buckets is really very important and very powerful.

So finally, creating the patient's first culture and improving the patient experience requires as to create a purpose. That idea of patients first in itself can be transformational but you should get people to realize why they come to work. You need to understand your customer. We're very good at telling ourselves we do but we really don't. And I would argue that that's Cleveland Clinic data. And so you might say, well maybe that's not my patients. But I would say it's your patients. We need to understand because what's important to patients is often very different than what we think. And that can be powerful. Using transparency as a tool in itself can drive improvement. We've seen it. Our biggest jump in enterprise physician communication scores, 20 percentile points, 20 percentile points came when we unblinded the data. Amazing change.

I think it's necessary that we wrap everything we do around data across the continuum and then drive it down the organization. I think that goes about saying in a group like this. And the soft stuff, the patient comments, the verbatims, they really count. And when I a talk to hospitals across the country, I ask them, "do you push out your verbatims to managers and doctors?" And most of them say, "I'm not even sure we collect verbatims." But the point is they should and they should push that out as well as how they push out the quantitative data.

Thank you very much.

[Applause]

[Moderator]
Thank you, Dr. Merlino. Terrific. Alright. Gentlemen, have a seat.

[Dr. James Merlino]
Thank you very much.

Q&A with Dr. Glenn Steele (Session 3) and Dr. James Merlino (Session 4)

[Moderator]
Well my goodness. During these two sessions, we received 120 questions. So, I'm not quite sure what the cost of that is. Hopefully it's all that's terrific content that there's a lot of interest and maybe a part of it is there is an incredible competition under way and I see the leader board changing a lot in terms of the point total. So that's terrific as well.

Yeah, you're doing great. Both doing great. Okay. So I've tried to look for patterns and we only have a little less than 10 minutes. Dr. Steele needs to catch his plane. We don't want him to miss that. So one set of questions that I think is fascinating to hear from both Dr. Merlino and Dr. Steele is this question post, does the health system need to have a health plan to succeed?

And we have two national, very, very strong health systems with different strategies. So why don't we start with Dr. Steele and then Dr. Merlino.

[Dr. Glenn Steele]
First of all, I think we have some data in our interactions with Eastern Maine Health System to a large system which has pretty much the same demography as we have in Maine. We have data with Meridian Health System in central New Jersey which has quite different demography essentially now. That's early data. We have data with Christiana in Delaware. We have data with West Virginia University in Morgantown showing that we can accomplish pretty much the same results and they, as their dominant payers, did not have a sweet spot. I can tell you that. So I do not think you need to have a functionally vertically integrated system like we have in order to achieve these results.

[Dr. James Merlino]
So we don't have one, so I guess the answer, you know, I don't think we need one? As I've seen backstage to Dan earlier, it's something that we look at as part of our strategic plan off for three years and it used to be very transparent. So we set said publicly. The reason we didn't pursue it is because we didn't think we have the competency to pursue it, and it's extremely complicated. We are constantly looking at other systems and we are great admirers of the work at Geisinger, especially when Dr. Steele showed a slide before about how the health system and the payer system and the healthcare overlap. We think that is a critical relationship to driving cost benefit, to drive safety and quality. And so, if you don't have that and I think when you own one it's probably the easiest way to manage it, you have to have great relationships with the people that are your payer partners – because we can't achieve the changes that I think we need to achieve in today's environment without really working that team part together very closely.

[Moderator]
So that's right. Makes sense. This next question was asked, in one form or another, almost a dozen times. So you both referenced in the presentations that you made the importance of a data foundation, a data warehouse or a data platform that said many of the insights that led you to action. Could you each just spend a few moments discussing how each of your organizations approach the data foundation and have found ways to leverage that foundation for success? Let me start with Dr. Merlino.

[Dr. James Merlino]
I think data is critical in everything we do in healthcare. Healthcare is very complicated. There's lots of processes. It's highly regulated. We can't fix every little problem. We have to zero in on the things that really matter and the only way that you know how to zero in what matters is to look at the data, certainly outcomes data. I think that issue starts to drive improvement across the organization. As I said in my talk, without data as your guide to help you drive those improvements, you're not going to be successful. I think the biggest challenge we have today or healthcare in general is this cost of the big data – what does it mean, how do

we start to use data more effectively, there's so much of it today, but it is absolutely a critical question that we have to better understand.

[Dr. Glenn Steele]
Yeah, there's two answers to the question. One is the architecture. We basically have created skunk works that is a series of very, very bright people who like Math in school, and they don't have P&L operational responsibility. And we have a series of requests to go to them from the men and women who are either involved in the P&L or are running a P&L. And then they have to prioritize what to do, but that's an essential architectural part of how we organize this. Because we don't think people who are dealing with the day-to-day responsibilities of the P&L and in an increasingly stringent market have the same innovative capabilities quite frankly but they have to connect, they have to connect.

The second thing which is very important is we do have this ability to look at payer and provider data as an aggregation and that's built into certainly version 2 and will be built into version 3 of our data warehouse. I'd like to get outside data as well and only the small portion of what we are going to be using to change behavior of these folks that were responsible for actually in the health system, a lot of is outside the health system. So we're always looking at different ways to design how the interactions work.

I was intrigued with Jim's slide. Our strategy with innovation and quality to top translates to each individual P&L having a significant amount of their financial affirmation, as well as credibility determined by whether they hit their innovation or not. And in order for them to hit their innovation, they are dependent upon our skunk works. So that's kind of how the connection goes back and forth there.

[Moderator]
Interesting. Let me ask to follow on the question which was also asked a number of times within the app. It's an organizational question, and, essentially the question is who should manage the analytics function? Is it the business function? Is it an IT function? Is it a P&L function? Is it a staff function? What are your thoughts?

[Dr. James Merlino]
So we've actually struggled with that question recently. It was primarily in our medical operations organization and what we've done now is we've created a separate entity that falls out to IT and medical operations with a regular reporting to what we call a newly created clinical enterprise management council – because we think that as we look to the future of how we're going to manage patients in this rapidly changing environment, we need to collect better data and integrate it into our operations faster and more effectively. So we've really reorganized how we look at it in our organization because you need the EMR platform to collect a lot of it because there's certainly increasing number of patient-related data points that you need to integrate. But you have to make sure that that gets tightly integrated with the people that are actually driving the operations of the organization. And if there isn't strategic

oversight, you know, the CEO or the clinical leadership council constantly pounding on these leaders that it's a priority, I think it will just, it will fall to the dust pile of it, it's just another priority we have to worry about.

[Dr. Glenn Steele]
Yeah, I mean obviously the answer, is it's a matrix and it's a very complex and dynamic matrix. I think we are always trying to think, if I could make a decision with my colleagues that 10 years from now was thought to be as farsighted as a decision in 1995 to go with Epic and do our ambulatory electronic first, I would consider that a great legacy and essentially I don't know what that decision is but I'm pushing for distributed data, I'm pushing for more functionality amongst those that we serve, whether they're members or whether they're patients. I'm pushing for utilizing data that's available already in the outside world that we're not thinking about integrating in terms of behavior change, I'm thinking about not competing so much for pipe and for fragilely designed EHR, but I'm thinking about function applications where we could really create a hell of a market, like in every other industry. So I'm kind of the (95:40) guy out there and then I get kind of toned down by all the people who actually, you know, like Math when they were in school. And so, it's a complex matrix. And we'll often go in the direction, we don't spend a lot of time talking about governance at Geisinger. The system is driven by clinical leadership and that's that profession (96:06) a purpose. When people see the results that I've presented to you and understand that they're sustainable and maybe scalable, that's what really drives us. And whoever can help us drive quicker, generally gets moved up in our concept of a matrix governance.

[Moderator]
Fantastic. Well please join with me in thanking Dr. Merlino and Dr. Steele. It's great insights. Thank you so much.