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9-612-031

REV: FEBRUARY 4, 2013

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Cleveland Clinic: Improving the Patient Experience

The patient is not only an illness . . . he has a soul.[1]

— Dr. René Favaloro, Cleveland Clinic surgeon, who performed the world's first coronary bypass, 1967

In September 2011, Dr. James Merlino, a colorectal surgeon and chief experience officer for the Office of Patient Experience (OPE) at Cleveland Clinic (CC) in Cleveland, Ohio, was with patients when he received an urgent page from his assistant:

"There is an irate man in the main lobby screaming about his poor treatment at the CC!"

Merlino rushed to the lobby, where five police officers and a CC senior executive were trying to subdue a middle-aged patient. The hysterical man was yelling that CC was mistreating and neglecting him, and, that if CC's inaction continued, he would die.

The patient, Bob Jones,[2] had several concomitant comorbidities including morbid obesity and some struggles with mental illness. Jones was right about one thing: he needed surgery within the next few weeks to save him from a potentially life-threatening condition. CC had been trying for months to address Jones's progressively worsening health. In return, he had been verbally abusive to the medical staff, missed appointments, and aggressively made unreasonable demands of nurses and physicians. That particular day, Jones had arrived unexpectedly at CC and demanded to immediately see his surgeon. He was asked to schedule an appointment for a few days later: his surgeon was not in the hospital that day, and Jones had failed to show up to his scheduled appointment earlier in the week. This had set off his profanity-laced tirade. Although Merlino knew the patient was not acting rationally, he recalled: "Not caring, failing, refusing, neglecting—these are tough words for those of us who swear an oath to do everything necessary to help our fellow human beings."

A few days after the lobby incident, Jones's surgeon and Merlino had a difficult conversation. Should they "fire" Jones as a patient, which would discharge CC of all obligations and leave Jones to find medical care elsewhere? Treating Jones, they knew, would be challenging and thankless. The surgeon, angry and shaken, expressed his concerns: "He doesn't follow our directions. What if something goes wrong? I will be responsible."

Professors Ananth Raman and Anita L. Tucker prepared this case. Research Associates Rhea Ghosh and Rachel Gordon provided assistance. HBS cases are developed solely as the basis for class discussion. Cases are not intended to serve as endorsements, sources of primary data, or illustrations of effective or ineffective management.

For Merlino, this was an unfortunately common dilemma he faced as chief experience officer. He had to constantly consider customer perspectives and perceptions even if they were unreasonable or one-sided. In a best-case scenario, Jones's surgery would go well. Yet his obesity and noncompliance presented clinical risk. Furthermore, his unreasonable expectations made it likely that Jones would perceive his experience at CC highly unfavorably, potentially inaccurately reflecting the quality of care he had received. If Jones was randomly selected to fill out a patient satisfaction survey required by the government, his responses would likely lower CC's score. Maintaining high patient satisfaction scores was essential in attracting patients to the hospital, and would soon be tied to federal financial reimbursement—both critical at a time of significant financial hardship for the healthcare industry. CC, and the OPE in particular, was effectively punished for every Bob Jones it treated. By all rational measures, Merlino knew that firing Jones would maximize CC's performance. He also knew that if they did, Jones could possibly die very quickly. Perhaps smart business and patient-centered care were not as compatible as he had always believed.

Cleveland Clinic: Performance through Innovation

Founded in 1921, CC was a non-profit academic medical center that had grown into one of the largest and best-regarded private healthcare facilities in the world. In the past year, 54,038 patients had been admitted and 27,142 inpatient and 53,757 outpatient surgeries had been performed.[3] The main hospital had just over 1,200 beds and employed over 1,700 physicians and dentists and almost 3,400 registered nurses full-time. The salaries, wages, and benefits for CC's 40,000 employees totaled $2.9 billion in 2009, which included the salaries for 2,700 physicians and 11,000 nurses. (See **Exhibits 1** and **2** for selected CC 2009 financial statements.) CC also sponsored large-scale research and academic programs. CC's Lerner Research Institute was one of the largest private research facilities in the nation, with an annual budget of $258 million in 2008. Its graduate medical education program was also among the nation's largest, with over 800 residents and fellows. In 2004, CC opened the Cleveland Clinic Lerner College of Medicine of Case Western University, one of the few medical schools in the country that did not charge tuition.

CC had consistently been listed by *U.S. News and World Report* as one of the country's top hospitals. In the magazine's "2010–2011 Best Hospitals Honor Roll," CC had been ranked as the fourth best hospital in U.S.,[4] and CC's heart and surgery program had been ranked number one for 16 consecutive years.[5] Fourteen other adult specialties had also placed in the top 10.[6] Patients came from the local area and also from across the country and more than 100 nations to access CC's world-class care.[7] To make its expertise broadly available to patients who did not live close to Cleveland, in addition to 10 community hospitals and 16 family health centers across Ohio, CC had recently opened centers in different states (Florida and Nevada) and internationally. In the United Arab Emirates, for example, CC planned to open a $2.5 billion, 360-bed facility in Abu Dhabi in 2012.

CC attributed its success to a long history of innovation. It had been the site of many important medical breakthroughs, including the first isolation of the neurotransmitter serotonin and the first coronary artery bypass surgery. (See **Exhibit 3** for a partial list of other CC medical firsts.) Additionally, CC was an innovator in business processes. A 2009 *Newsweek* magazine article described CC as "a hospital trying to be a Toyota factory" for its emphasis on continuous cycle improvement and lean operations.[8] In one example, CC cut a standard visit for patients receiving blood thinning drugs from 30 minutes to 15 minutes by mapping each part of the visit and even creating a DVD for patients to watch instead of having doctors deliver the same introductory talk to every patient that came to the clinic. Moreover, to keep tabs on wait times, CC had invested in an electronic dashboard that displayed real-time wait times in assorted departments throughout the

hospital and updated the information every half-hour so that patients always knew when they could expect to be seen. The 2008 Dartmouth Atlas of Health Care reported that, of the five top-ranked medical centers in the country, Cleveland Clinic delivered the most cost-efficient care.[9]

CC had also implemented a nontraditional organizational structure designed to make the hospital more patient-friendly. CC president and CEO Dr. Delos M. Cosgrove described the change:

> [In 2006] we changed our organizational structure from the typical profession-oriented organization designed around physician competencies, such as surgery, to a patient needs-oriented approach, such as the Heart and Vascular Institute. We are the only hospital to be completely organized around patient needs. Each institute is based around a single organ system or disease. Medical and surgical services are combined under single leadership in a common location. Our Heart and Vascular Institute includes cardiac surgeons, cardiologists, and vascular surgeons, all co-located.

This initiative was part of a wider and highly unconventional ethos at CC that stressed hospital-wide collaboration and coordinated patient care. Unlike most American hospitals, where doctors worked as independent practitioners paid on a fee-for-service basis, CC operated as a group practice. Physicians were all on one-year salaried contracts and received no bonuses or financial incentives for procedures performed or patients seen. Explained Cosgrove at a 2009 Senate hearing, "There is no incentive for our doctors to order expensive devices, or unnecessary tests or procedures . . . Money should not factor into the decision whether to operate or not."[10] Each physician was instead subject to a detailed annual performance review that determined his or her salary adjustment. The group practice model also eased systemic change, facilitating the cutting-edge care delivery improvements CC was known for. A professor at the University of Maryland's medical school explained: "It's a lot more difficult for a community hospital to tell 100 private practitioners it wants them all to start using computers for electronic record-keeping. Physicians don't like others to tell them what to do."[11] But there seemed to be clear and measurable benefits to CC's approach. Cleveland Clinic's COO noted, "The Dartmouth Atlas shows there is a relationship between our group practice model and lower costs—not just for the Cleveland Clinic but for other group-model organizations as well. Accountable health organizations, which tightly integrate a hospital with physicians and other caregivers, can bridge the gaps between them and erase redundancies." Indeed, as part of his campaign to reform healthcare, in June 2009 President Obama pointed to CC as providing "the highest quality care at costs well below the national norm."[12]

A Transformational Experience

The idea for emphasizing patient experience, creating the OPE, and hiring a chief experience officer at CC crystallized for Cosgrove after he attended a class at Harvard Business School in Boston, Massachusetts, in the fall of 2006. Cosgrove recalled, "I attended two classes. The first class was good. In the second class, a student raised her hand and asked, 'Dr. Cosgrove, what are you doing to teach your doctors empathy?'"

The young woman, Kara Medoff Barnett (MBA 2007), went on to tell Cosgrove that her father—a physician in North Carolina—had needed a mitral valve repair[a] in 2000. She explained, "As a

[a] The mitral valve is the inflow valve for the left side of the heart. The mitral valve opens to allow blood to flow to the heart and closes to make sure that the lungs do not fill with blood. A mitral valve repair is an open heart procedure that treats either the narrowing or leakage of the mitral valve. Adapted from Encyclopedia of Surgery, www.surgeryencyclopedia.com, and Society of Thoracic Surgeons, www.sts.org, both accessed October 2010.

physician and father of six children, my father cared deeply about outcomes and technical skill in selecting a hospital and a surgeon, but there were other factors impacting his decision. My parents, who would be traveling far from home in pursuit of the best care, expected meaningful communication before and after open heart surgery. They had heard that this was not always the case at Cleveland." Ultimately Barnett's father had decided to have his surgery at the Mayo Clinic (Mayo) in Minnesota even though the Mayo heart program was not as highly ranked as the CC program. Barnett recalled, "My father made his decision based on reputation and anecdotal evidence." Barnett's father's surgery was a success and the family was extremely pleased with the care he received while recovering at the Mayo.

Although Cosgrove had adopted the slogan of "Patients First" in 2004 when he took over as CEO,[13] Barnett's story left Cosgrove speechless. A highly regarded heart surgeon himself, Cosgrove had long assumed that what distinguished hospitals were their clinical outcomes. Yet Barnett's father had chosen a hospital with a slightly *higher* mortality rate for his procedure based on an entirely different set of criteria. (For a graph of mitral valve mortality rates at CC, the Mayo, and nationally, see **Exhibit 4.**) Reflecting on the incident later in an article for *Cleveland Clinic Magazine,* Cosgrove wrote:

> Here at Cleveland Clinic, we always positioned quality in terms of outcome. But I have come to understand that there is more to quality healthcare than great outcomes. There is the entire experience that patients have, from the moment they call for an appointment to the moment they arrive at the hospital—fearful and concerned—to the moment they get in their cars and drive away.
>
> The patient experience encompasses many aspects of care, from the physical environment to the emotional. . . . It is about communication and the expression of care and concern at times when they are most needed. . . . It is our duty to remember that empathy lies at the very heart of the healthcare profession.[14]

Patient Experience in the Broader Healthcare Context

In 2007, prioritizing patient experience was a still a relatively novel idea. The general assumption was that because patients came to the hospital out of necessity rather than choice, healthcare providers could ignore customer service. Operating models typically focused on two improvement measures: cost containment and positive clinical outcomes. In fact, the major advances of the healthcare industry—cutting-edge treatments, technologically sophisticated delivery methods, high-efficiency protocols—often came at the expense of patient experience, making care delivery increasingly impersonal and mechanized.

By 2010, however, improving patient experience had become a part of the mainstream healthcare agenda, particularly at leading facilities like Cleveland Clinic and the Mayo Clinic. In fact, a 2010 survey of healthcare executives found that 37% ranked "patient experience/patient satisfaction" a top three priority, the second-most frequent answer just after cost reduction (40%).[15] Merlino observed, "Fortunately, among top hospitals, it's not often the medical care that goes wrong. Instead there are little indiscretions, such as patients not getting their questions answered." As competition between healthcare providers increased, nonclinical factors that before may have seemed trivial—for example, staff courtesy or ease of registration—became important competitive differentiators. For example, Merlino noticed that his colorectal surgical patients spent only a few hours of a five-day stay with physicians, and instead spent the majority of their time with other hospital staff or alone.

Consumers also had access to more comparative data on providers, allowing them to make better-informed choices about their care. The main source of consumer information about patient satisfaction was the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey. Introduced in October 2006 by the federal Centers for Medicare and Medicaid Services (CMS) and the Agency for Healthcare Research and Quality (AHRQ),[b] HCAHPS was a 27-question survey administered to recently discharged patients that was designed to provide the first national, standardized measure of patient experience. Hospitals were rated on ten dimensions of care, including room cleanliness and staff responsiveness. (For a complete list of HCAHPS survey questions and categories, see **Exhibit 5.)** In July 2007, collecting and submitting HCAHPS data became, for all intents and purposes, mandatory for hospitals receiving Medicare and Medicaid funding;[16] if hospitals did not report their HCAHPS data, they risked losing up to 2% of their annual medical payments from CMS.[c] In March 2008, each participating hospital's HCAHPS scores became publicly available online. (See **Exhibit 6** for 2008–2009 HCAHPS data for CC, the Mayo Clinic in Rochester—which CC considered a competitor—as well as the U.S. average.) The heightened transparency convinced the many hospitals that had put little effort into managing patient experience to quickly shift resources and priorities.

At the same time that there was a renewed emphasis on understanding the patient experience and perspective, hospitals across the U.S. faced major economic challenges as healthcare costs continued to rise,[d] while undercompensated care provided by hospitals also rose. Cosgrove, in an August 2010 speech to the City Club of Cleveland, stated, "The recent healthcare debate has highlighted the skyrocketing cost of healthcare in the United States. Healthcare costs were more than seventeen percent of the GDP in 2010." The number of patients covered by Medicare or Medicaid also grew to more than 60 percent of all admissions, further stretching hospital resources; Medicare reimbursed just 90.1 percent of the cost of care, and Medicaid reimbursed 89 percent.[17]

To further complicate the matter, successful quality improvement initiatives could sometimes hurt hospitals' bottom lines. A 2010 *Businessweek* article observed, "The crazy world of hospital economics does not offer a lot of incentives to change. Both Medicare and private insurers reimburse on a piecework basis—known as fee-for-service—that encourages hospitals to treat more, prescribe more, and test more . . . Consequently, hospitals have no financial motivation to invest in productivity-enhancing computer technology, management experts, or efficiency research—and, by and large, they don't."[18]

This was illustrated in an example from a 2010 *New Yorker* article:

> Recently, clinicians at Children's Hospital Boston adopted a more systematic approach for managing inner-city children who suffer severe asthma attacks, by introducing a bundle of preventive measures. Insurance would cover just one: prescribing an inhaler. The hospital agreed to pay for the rest, which included nurses who would visit parents after discharge and make sure that they had their child's medicine, knew how to administer it, and had a follow-up appointment with a pediatrician; home inspections for mold and pests; and vacuum cleaners for families without one (which is cheaper than medication). After a year, the hospital readmission rate for these patients dropped by more than eighty per cent, and costs plunged. But an empty hospital bed is a revenue loss, and asthma is Children's Hospital's leading

[b] Both CMS and the AHRQ were run by the federal Department of Health and Human Services.

[c] The technical term for these payments was Inpatient Prospective Patient System (IPPS).

[d] The cost of providing hospital care rose 55% between 1997 and 2007, after adjusting for inflation. (Source: http://www.hcup-us.ahrq.gov/reports/factsandfigures/2007/highlightsV2.jsp, accessed February 2013.)

source of admissions. Under the current system, this sensible program could threaten to bankrupt it.[19]

The scenario described in the article was all too familiar to most healthcare providers. But despite the challenges, there was continued pressure to move toward more patient-centered care. In May 2010, Donald M. Berwick, the newly appointed CMS administrator, delivered a Yale Medical School graduation address that emphasized the importance of patient experience. He told the class about an e-mail he had received from a stranger describing the care her husband, a former psychiatrist, had received at the end of his life. Berwick quoted from the e-mail:

> My husband was Dr. William Paul Gruzenski, a psychiatrist for 39 years. He was admitted to (a hospital she names in Pennsylvania) after developing a cerebral bleed with a hypertensive crisis. My issue is that I was denied access to my husband except for very strict visiting, four times a day for 30 minutes, and that my husband was hospitalized behind a locked door. My husband and I were rarely separated except for work . . . He wanted me present in the ICU, and he challenged the ICU nurse and MD saying, "She is not a visitor, she is my wife." But, it made no difference. My husband was in the ICU for 8 days out of his last 16 days alive, and there were a lot of missed opportunities for us.

Mrs. Gruzenski continued: "I am advocating to the hospital administration that visiting hours have to be open especially for spouses . . . I do not feel that his care was individualized to meet his needs; he wanted me there more than I was allowed. I feel it was a very cruel thing that was done to us."[20]

After reading the e-mail, Berwick reminded the newly minted doctors, "What is at stake here may seem a small thing in the face of the enormous healthcare world you have joined. It is as a nickel to the $2.6 trillion industry. But that small thing is what matters. I will tell you: it is *all* [emphasis in the original] that matters. All that matters is the person. The person."[21]

The Cleveland Clinic Approach

Cleveland Clinic was the first major academic medical center to make patient experience a strategic objective, and one of the first to establish an Office of Patient Experience (OPE). The OPE worked across departments at CC to promote and systematize high-quality care. They were responsible for ensuring the physical comfort of CC patients. In addition, OPE were responsible for guaranteeing that CC's patients' educational, emotional, and spiritual needs were met. (**Exhibit 7** lists the OPE's major programs.) By 2010, the OPE office managed 12 different programs and had 14 staff members who served in a variety of roles. (For an organization chart, see **Exhibit 8**.) The OPE had a 2010 budget of $6.4 million.

Merlino was appointed chief experience officer in July 2009, and co-led the OPE with the executive chief nursing officer and Nursing Institute chair, Sarah Sinclair. Deeply committed on a personal level to improving patient experience, Merlino estimated that he devoted roughly 80% of his time to the OPE and the remaining 20% to performing surgeries.

Integrated Patient Experience

Overall, Merlino's goal was to show how patient experience could fit into CC's larger organizational objective of delivering high-quality care at a lower cost. Merlino had observed during his tenure that many of the most effective initiatives were simple and low-cost measures to make

employees feel that they had a stake in patient experience. For example, in her first month as chief nursing officer, Sinclair realized that CC nurses had heard very little about HCAHPS scores; some didn't realize that CC measured patient satisfaction scores, or that "communication with nurses" was one of the major categories. Merlino explained, "Our HCAHPS scores were not posted anywhere or even talked about, so one of [Sinclair]'s first projects was to post our scores and educate the nurses. Almost immediately after she began that basic program we saw a positive jump in scores for nursing communication and concomitant increase in reputation."

Merlino also believed that improving patient experience was not just the right thing to do, but a business necessity. He cited a 2007 McKinsey study in which, to the question "What factors are the influence on your choice of hospitals?" 41% of respondents said "Patient Experience"—the most popular answer, ahead of location, reputation of hospital, and physician's decision.[22] Patient experience was particularly important in attracting the internationals, corporations, and other high-paying patients necessary for CC to offset losses from Medicare and Medicaid patients. Merlino explained how quality of experience could drive patient volumes:

> This level of caring especially makes a difference when dealing with insurers and private payers. We can go to Lowe's, the retail giant with which Cleveland Clinic has a publicly reported contract, and assure them that we will do more than just provide high-quality health-care to their employees. We can ensure that their employees are going to be cared for better. Additionally, our focus on the patient experience creates a return in new and more patients.

A New Initiative

The OPE ran many patient experience improvement programs focused on improving operations, services, or facilities to meet and exceed patient expectations. Some improvements were amenity-related; for example, the OPE enlisted famous designer Diane von Furstenberg to redesign its hospital gown, and added pull-out beds for family members to many inpatient rooms. Others were designed to strengthen the relationship between employees and patients. For example, in a culture-changing exercise, all 42,000 employees received education about Cleveland Clinic's mission, vision, values, service standards, and service recovery, as well as the importance of the patient experience. The training, led by a facilitator, used a learning map to drive the discussion among a randomly selected group of 8 to 10 employees. The OPE also created joint patient-employee hospital advisory councils.

But there were still patient complaints, reflected in HCAHPS scores, that care delivery improvements and patient panels were powerless to fix. Merlino described one such situation:

> Take quiet-at-night, for instance. If you look at the national data from hospitals around the country, most hospitals don't do well in that area. And when you think about it, and ask the question "why?" and then you go around in the hospital at night, you realize very quickly that they're not doing well because they're not quiet places. A lot of patient complaints about quiet-at-night are driven by the activities with the patient at night, not necessarily that it's noisy. For example, [the VIP Floor] is where the sheikhs and the kings and the billionaires stay. And so you expect that if that's the VIP floor and you're delivering [the highest] level of care, that floor's quiet-at-night scores would be very high. And in reality they're not. They're low. And when you drill down with the patients and ask them why, what they tell you is, "Well, I was trying to get some sleep and the nurse came in at three in the morning to take my vital signs." Or, "I couldn't get much sleep because every time my heart raced, the heart monitor went off and the nurse came in to wake me up." They have this expectation that when they're up there, it's like the Ritz Carlton.

Merlino had found that when he was frank with patients, their understanding changed. He recalls telling them, "Look, you're in a hospital. The nurse is supposed to come in at three in the morning and wake you up to make sure you're still alive. Don't expect that you're coming here because it's a hotel and you're going to sleep."

Merlino decided to create a program based on the same principle of expectation modification. He knew that other industries, such as the retail industry—supermarkets in particular—had managed to meet consumers' needs by putting them in charge of some functions. Self-service checkout at the grocery store intrigued him. He explained, "Here's an industry that has managed to keep costs down by shifting the expectations of its customers. It has been able to figure out what people value and deliver that value to them without increasing costs. What can we learn from such industries?"

A new program, "What to Expect During Your Hospital Stay," educated patients about what their stay at CC would entail. Specifically, the program educated patients in six areas—communicating with their healthcare team, managing their pain, medications in the hospital, hospital environment, concerns about their care, and going home. Merlino hypothesized that patients' satisfaction would increase once they had a better understanding of what to expect during their hospital visit. To implement the program, the OPE developed a pamphlet and a web-based video that explained to patients what their experience might look and feel like. (**Exhibit 9** shows an excerpt of the pamphlet.)

OPE conducted a small experiment in early 2011 by offering some colorectal surgical patients the pamphlet and link to the video, and giving the others no such information. They compared the HCAHPS scores of the two groups. (**Exhibit 10** displays the HCAHPS scores for the two groups.) Merlino was encouraged by the results. He commented, "Even as we have fewer resources, patients are demanding more from us. We need patients to understand what to expect when they arrive." He posited that the program could be "revolutionary" as he knew of no other hospitals proactively shaping patients' expectations.

HCAHPS Revisited

Recently, the economic rationale for improving patient experience had become even stronger. CMS announced that beginning in 2012, it would move from a "pay for reporting" to a "pay for performance" requirement. Healthcare providers would be financially rewarded or penalized based on their performance on several quality measures, including HCAHPS scores. And, apart from direct HCAHPS-related incentives, patient experience correlated with many other quality measures included in the plan. For example, the CMS would penalize hospitals for "excess readmissions" compared to expected 30-day readmissions for heart failure, pneumonia, and heart attack patients. Improving discharge information and nurse communication—two central components of patient experience—would likely keep readmissions to a minimum.

Merlino had mixed feelings about elevating HCAHPS scores to that level of importance. On the one hand, the OPE had used HCAHPS extensively, not only to assess its own impact, but to help practitioners and management assess theirs on an ongoing basis. The office had developed a Patient Experience Dashboard, as shown in **Exhibit 11**, which indicated patient feedback on a monthly basis and highlighted trends.[e] Moreover, HCAHPS data was used to prioritize improvement initiatives and continuously monitor new programs. Merlino had quickly learned through his work at the OPE that just because something sounded like a good idea didn't mean it would be successful. HCAHPS scores helped the OPE determine whether interventions were having the intended results. For

[e] Governmental regulation only required that hospitals collect and report HCAHPS scores on an annual basis.

example, in 2007 the OPE launched the Patient Service Navigator (PSN) program. Patient Service Navigators worked directly with patients, providing guidance and assistance throughout the care process to improve the patient's experience. PSNs often had a background in customer service and were then trained on CC's care delivery process. Merlino stated, "The PSN was really the patient's advocate who provided personalized guidance and care both to the patient and the patient's family." Although the program worked well in a pilot test at one clinic, when CC increased the program to 16 PSNs throughout the main campus, patient improvement scores did not significantly improve. Fortunately, real-time HCAHPS scores quickly surfaced the lack of results and CC postponed scaling up the expensive program until they were able to assess why it wasn't working as planned.

But while the OPE had success using HCAHPS measurement as a tool to drive improvement, Merlino was increasingly concerned that the "perception metrics" collected through HCAHPS unfairly penalized certain hospitals—CC included—for variables outside of their control. In 2010, CC used data from over 100,000 patients to assess whether several clinical variables would have an impact on HCAHPS scores. Merlino reported:

> When HCAHPS scores were adjusted by severity of illness, there was a statistically significant decline in key HCAHPS domains as severity of illness worsened. The decline was greater than 10 percentage points for top-box responses (percentage of patients who respond in the most positive manner—"always" responses) in these critical domains: nurse and doctor communication, responsiveness, quiet at night, and pain management. A 10% decline in HCAHPS scores is a significant reduction for any domain, as this can correspond to a 20- to 30-point drop in overall percentile ranking.

This was worrying news for the OPE; Cleveland Clinic had a 2010 Case Mix Index (CMI)[f] of 2.34, one of the highest in the country, indicating a large proportion of severely ill patients. By comparison, the national average CMI was 1.42,[g] while at the Mayo Clinic – St. Marys it was 1.96 and at the Mayo Clinic – Rochester Methodist it was 1.87.[23] Moreover, CC's analysis showed that increased length of stay and level of depression—both highly correlated with severity of illness—had a significant negative impact on self-reported satisfaction. Finally, CC determined that large hospitals performed more poorly on HCAHPS than did small hospitals. The results, which suggested that CC's HCAHPS scores were artificially weighed down, were not entirely surprising to Merlino, but with CC's reputation and soon its Medicare reimbursements tied to HCAHPS performance, he felt that CC was being misrepresented at best, or at worst punished for helping those who needed care the most—the severely ill, the depressed, and long-term patients. It was enough to make him wonder: "Improving the patient experience is the right thing to do for our patients, but at what point does the burden of improvement exceed the responsibility of hospitals?"

Returning to Bob Jones

Merlino pondered what he should do with Bob Jones. After consulting legal counsel, Merlino decided that CC was well within its rights to "fire" Jones as a patient, even though it would probably mean that Jones would deteriorate rapidly. He called Jones's surgeon, Dr. Smith, to discuss the options.

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[f] The CMI was a measure of the relative cost of resources needed to treat all cases in a healthcare facility. It was commonly used as a proxy to measure the severity of illness of patients in a facility. Higher CMI indicates higher patient severity.

[g] Min: 0.59; max: 3.77; SD: 0.33. Data for hospital with ≥ 10 beds.

Merlino recalled, "I informed the surgeon of our plan and was met with silence and finally disagreement. He told me, 'We can't fire this guy—he will die.'" Merlino was proud of his colleague's decision to do what was right for the patient: "There it was: the oath to do no harm. The promise to always be there for the patient, to always be committed to doing what was right, to help a fellow human being in need."

Merlino believed that his colleague was right to insist that the hospital act in the patient's, rather than the hospital's, best interest. They had an obligation to treat him with the respect that all human life deserves, even if doing so imposed considerable costs on the caregivers and the hospital. At the same time, Merlino knew that even with surgery, Jones's prognosis was poor. Furthermore, despite their efforts on his behalf, Jones would likely never feel that the physicians and others at CC treated him with "courtesy and respect"—a key component to a successful HCAHPS outcome.

Merlino wondered if it was fair for the government to hold CC responsible for HCAHPS outcomes under these circumstances. However, given that CC had to publicly report their HCAHPS scores, should he hold departments within CC responsible for these metrics?

Exhibit 1 Consolidated Balance Sheet (US$ '000, Year-end December 31)

Assets	**2009**	**2008 (adjusted)**
Current Assets		
Cash and cash equivalents	**$3,450**	$134,881
Patient receivables, net of allowances for uncollectible accounts of $125,273 and $128,209 in 2008	**678,820**	592,904
Investment for current use	**153,228**	91,186
Other current assets	**233,039**	235,363
Total Current Assets	**1,068,537**	1,054,334
Investments		
Long-term investments	**2,891,472**	2,116,718
Funds held by trustees	**354,008**	249,098
Assets held by captive insurance subsidiary	**192,504**	158,125
Donor restricted assets	**271,484**	252,295
	3,709,468	2,776,236
Property, plant, and equipment, net	**2,938,607**	2,776,236
Other Assets:		
Pledges receivable, net	**173,652**	143,432
Trusts and beneficial interests in foundations	**114,063**	98,048
Other non-current assets	**105,509**	63,499
	393,224	304,979
Total assets	**$8,109,836**	$6,990,730

Liabilities and net assets	**2009**	**2008 (adjusted)**
Current liabilities:		
Accounts payable	**$283,609**	$376,220
Compensation and amounts withheld from payroll	**188,001**	190,981
Estimated amounts due to third-party payors	**59,086**	32,067
Short-term borrowings	**--**	2,866
Current portion of long-term debt	**12,618**	17,689
Variable rate debt classified as current	**495,815**	797,840
Other current liabilities	**332,531**	321,386
Total current liabilities	**1,371,660**	1,739,049
Long term debt:		
Hospital revenue bonds	**2,050,386**	1,247,139
Notes payable and capital leases	**38,190**	43,935
	2,088,576	1,291,074
Other liabilities:		
Professional and general insurance liability reserves	**158,161**	224,318
Accrued retirement benefits	**581,342**	717,587
Other noncurrent liabilities	**249,500**	303,233
	989,003	1,245,138
Total Liabilities	**4,449,239**	4,275,261
Net assets:		
Unrestricted	**3,037,411**	2,1650,893

Liabilities and net assets	2009	2008 (adjusted)
Temporarily restricted	**417,457**	359,898
Permanently restricted	**205,729**	194,678
Total net assets	**3,660,597**	2,715,469
Total liabilities and net assets	**$8,109,836**	$6,990,730

Source: Company documents.

Exhibit 2 Consolidated Income Statement (US$ '000, Year-end December 31)

Operations	2009	2008 (adjusted)
Unrestricted revenues		
Net patient service revenue	**$5,056,265**	$4,687,777
Other	**524,344**	494,094
Total unrestricted revenues	**5,589,609**	5,181,871
Expenses		
Salaries, wages, and benefits	**2,935,898**	2,737,190
Supplies	**601,958**	583,052
Pharmaceuticals	**311,907**	282,892
Purchased services	**327,026**	285,945
Administrative services	**145,257**	177,887
Facilities	**320,562**	284,667
Insurance	**7,354**	84,065
Provision for uncollectible accounts	**194,020**	187,011
	4,843,982	4,622,709
Operating income before interest, depreciation, and amortization expenses	**745,627**	559,162
	71,237	61,117
Interest	**315,023**	255,328
Depreciation and amortization	**359,367**	242,717
Operating income		
Nonoperating gains and losses		
Investment return (loss)	**291,057**	(506,834)
Derivative gains (losses)	**69,044**	(132,198)
Other, net	**291**	(19,524)
Net nonoperating gains and losses	**360,392**	(658,556)
Excess (deficiency) of revenues over expenses	**719,759**	(415,839)

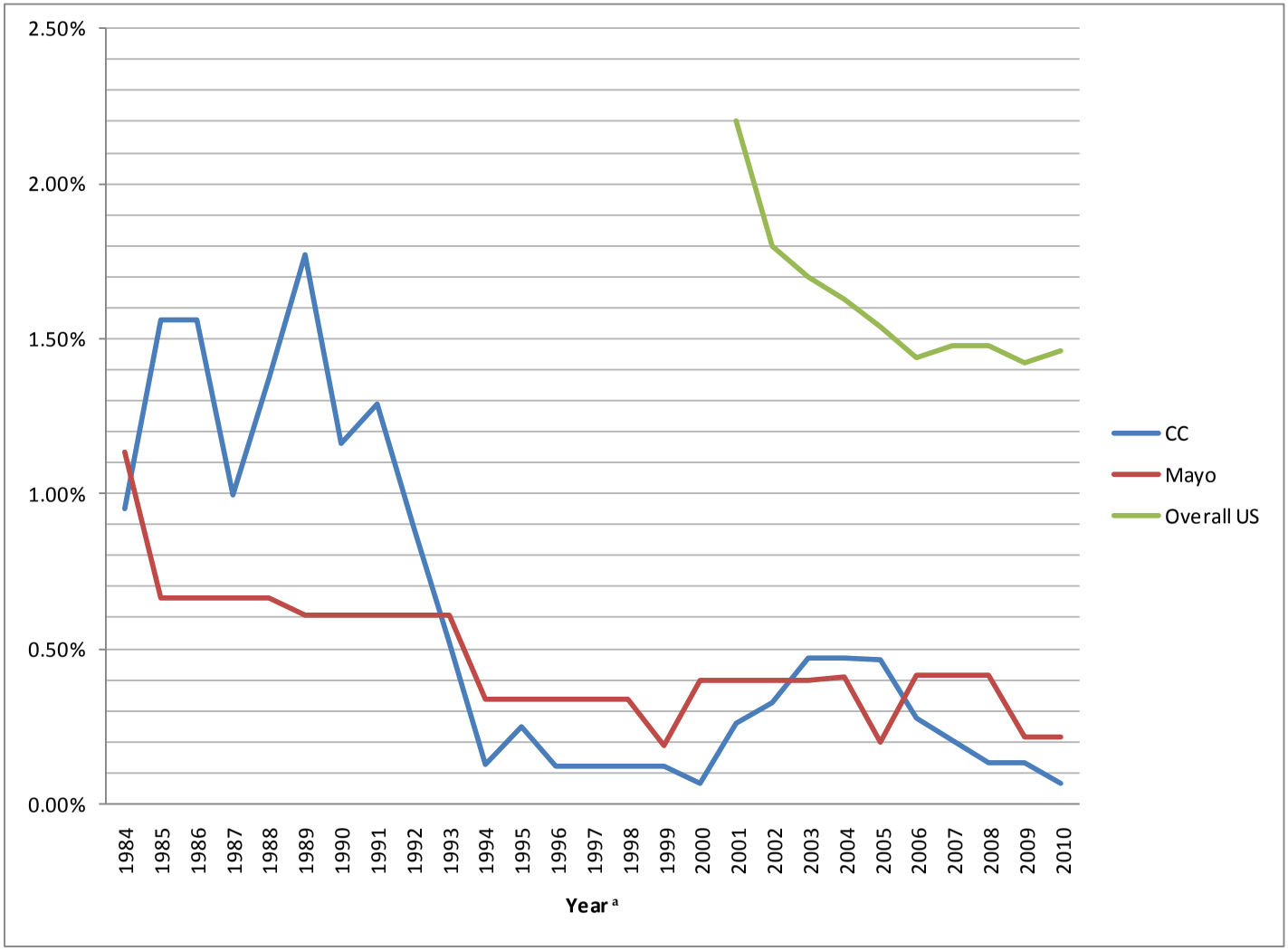
Source: Company documents.

Exhibit 3 Partial List of Medical Breakthroughs at CC (1940–2009)

- Isolation of serotonin, a key factor in hypertension (1948)
- First successful "stopped-heart" surgery, in which the heart is stopped so it can undergo surgical repair (1951)
- First coronary angiography (1958)
- Development and refinement of coronary bypass surgery (1967)
- First minimally invasive aortic heart valve surgery (1996)
- First successful larynx transplant (1998)
- Discovery of first gene linked to juvenile macular degeneration (2000)
- Discovery of first gene linked to coronary artery disease (2003)
- Pioneering success in deep brain stimulation for psychiatric disorders and minimally conscious state (2006)
- First kidney surgery performed through patient's navel (2007)
- Nation's first near-total face transplant (2008)
- World's first heart/liver transplant in patient with total artificial heart (2009)

Source: Cleveland Clinic, "Facts & Figures," http://my.clevelandclinic.org/Documents/Patients/facts_figures_08.pdf, accessed September 2010

Exhibit 4 Isolated Mitral Valve Repair Mortality (Five-Year Moving Average)



Source: Data from Cleveland Clinic, the Mayo Clinic, and the Society of Thoracic Surgeons.

[a] Five-year moving average, calculated as the average mortality rate from selected year and previous four years; e.g., "2005" data point is the average mortality rate for 2001, 2002, 2003, 2004, and 2005.

Exhibit 5 HCAHPS Survey Questions

YOUR CARE FROM NURSES

1. During this hospital stay, how often did nurses treat you with courtesy and respect?
   - Never
   - Sometimes
   - Usually
   - Always

2. During this hospital stay, how often did nurses listen carefully to you?
   - Never
   - Sometimes
   - Usually
   - Always

3. During this hospital stay, how often did nurses explain things in a way you could understand?
   - Never
   - Sometimes
   - Usually
   - Always

4. During this hospital stay, after you pressed the call button how often did you get help as soon as you wanted it?
   - Never
   - Sometimes
   - Usually
   - Always

YOUR CARE FROM DOCTORS

5. During this hospital stay, how often did doctors treat you with courtesy and respect?
   - Never
   - Sometimes
   - Usually
   - Always

6. During this hospital stay, how often did doctors listen carefully to you?
   - Never
   - Sometimes
   - Usually
   - Always

7. During this hospital stay, how often did doctors explain things in a way you could understand?
   - Never
   - Sometimes
   - Usually
   - Always

HOSPITAL ENVIRONMENT

8. During this hospital stay, how often were your room and bathroom kept clean?
   - Never
   - Sometimes
   - Usually
   - Always

9. During this hospital stay, how often was the area around your room quiet at night?
   - Never
   - Sometimes
   - Usually
   - Always

YOUR EXPERIENCES IN THIS HOSPITAL

10. During this hospital stay, did you need help from nurses or other hospital staff in getting to the bathroom or in using a bedpan?
    - Yes
    - No → *If No, Go to Question 12*

11. How often did you get help in getting to the bathroom or in using a bedpan as soon as you wanted?
    - Never
    - Sometimes
    - Usually
    - Always

12. During this hospital stay, did you need medicine for pain?
    - Yes
    - No → *If No, Go to Question 15*

13. During this hospital stay, how often was your pain well controlled?
    - Never
    - Sometimes
    - Usually
    - Always

14. During this hospital stay, how often did the hospital staff do everything they could to help you with your pain?
    - Never
    - Sometimes
    - Usually
    - Always

15. During this hospital stay, were you given any medicine that you had not taken before?
    - Yes
    - No → *If No, Go to Question 18*

16. Before giving you any new medicine, how often did hospital staff tell you what the medicine was for?
    - Never
    - Sometimes
    - Usually
    - Always

17. Before giving you any new medicine, how often did hospital staff describe possible side effects in a way you could understand?
    - Never
    - Sometimes
    - Usually
    - Always

WHEN YOU LEFT THE HOSPITAL

18. After you left the hospital, did you go directly to your own home, to someone else's home, or to another health facility?
    - Own home
    - Someone else's home
    - Another health facility → *If Another, Go to Question 21*

19. During this hospital stay, did doctors, nurses, or other hospital staff talk with you about whether you would have the help you needed when you left the hospital?
    - Yes
    - No

20. During this hospital stay, did you get information in writing about what symptoms or health problems to look out for after you left the hospital?
    - Yes
    - No

OVERALL RATING OF HOSPITAL

21. Using any number from 0 to 10, where 0 is the worst hospital possible and 10 is the best hospital possible, what number would you use to rate this hospital during your stay?

22. Would you recommend this hospital to your friends and family?
    - Definitely no
    - Probably no
    - Probably yes
    - Definitely yes

ABOUT YOU

There are only a few remaining items left.

23. In general, how would you rate your overall health?
    - Excellent
    - Very good
    - Good
    - Fair
    - Poor
24. What is the highest grade or level of school that you have completed?
    - 8th grade or less
    - Some high school, but did not graduate
    - High school graduate or GED
    - Some college or 2-year degree
    - 4-year college graduate
    - More than 4-year college degree
25. Are you of Spanish, Hispanic or Latino origin or descent?
    - No, not Spanish/ Hispanic/ Latino
    - Yes, Puerto Rican
    - Yes, Mexican, Mexican American, Chicano
    - Yes, Cuban
    - Yes, other Spanish/ Hispanic/ Latino
26. What is your race? Please choose one or more.
    - White
    - Black or African American
    - Asian
    - Native Hawaiian or other Pacific Islander
    - American Indian or Alaska Native
27. What language do you mainly speak at home?
    - English
    - Spanish
    - Chinese
    - Russian
    - Vietnamese
    - Some other language (please print):_____
      _____

Source: HCAHPS Online website, http://www.hcahpsonline.org/surveyinstrument.aspx, accessed July 2011.

Exhibit 6 HCAHPS 2008-2010 Data for CC, the Rochester Mayo Clinic, and U.S. Average

	Cleveland Clinic		Mayo Clinic - St. Marys		Mayo Clinic - Methodist		U.S. Average	
	08-09	09-10	08-09	09-10	08-09	09-10	08-09	09-10
1. Nurse communicated well with patient (Q1, Q2, Q3)	71	75	80	79	78	81	75	76
2. Doctors communicated well with patient (Q5, Q6, Q7)	76	76	81	82	83	83	80	80
3. Staff responsiveness (Q4, Q11)	53	58	66	70	64	68	63	64
4. Patient's pain was well-controlled (Q13, Q14)	64	68	73	73	69	69	69	69
5. Staff explained medicines before giving them to patient (Q16, Q17)	56	59	70	67	63	65	59	60
6. Hospital room and bathroom kept clean (Q8)	62	68	74	74	67	68	70	71
7. Quiet at night (Q9)	48	51	64	62	55	58	57	58
8. Given information about what to do during recovery at home (Q19, Q20)	81	83	86	84	90	88	81	81
9. Rate hospital favorably (Q21)	72	76	79	81	72	80	66	67
10. Would recommend hospital to friends and family (Q22)	79	82	85	85	83	83	68	69

Source: U.S. Department of Health & Human Services, http://www.hospitalcompare.hhs.gov, accessed August 2010, modified by casewriter.

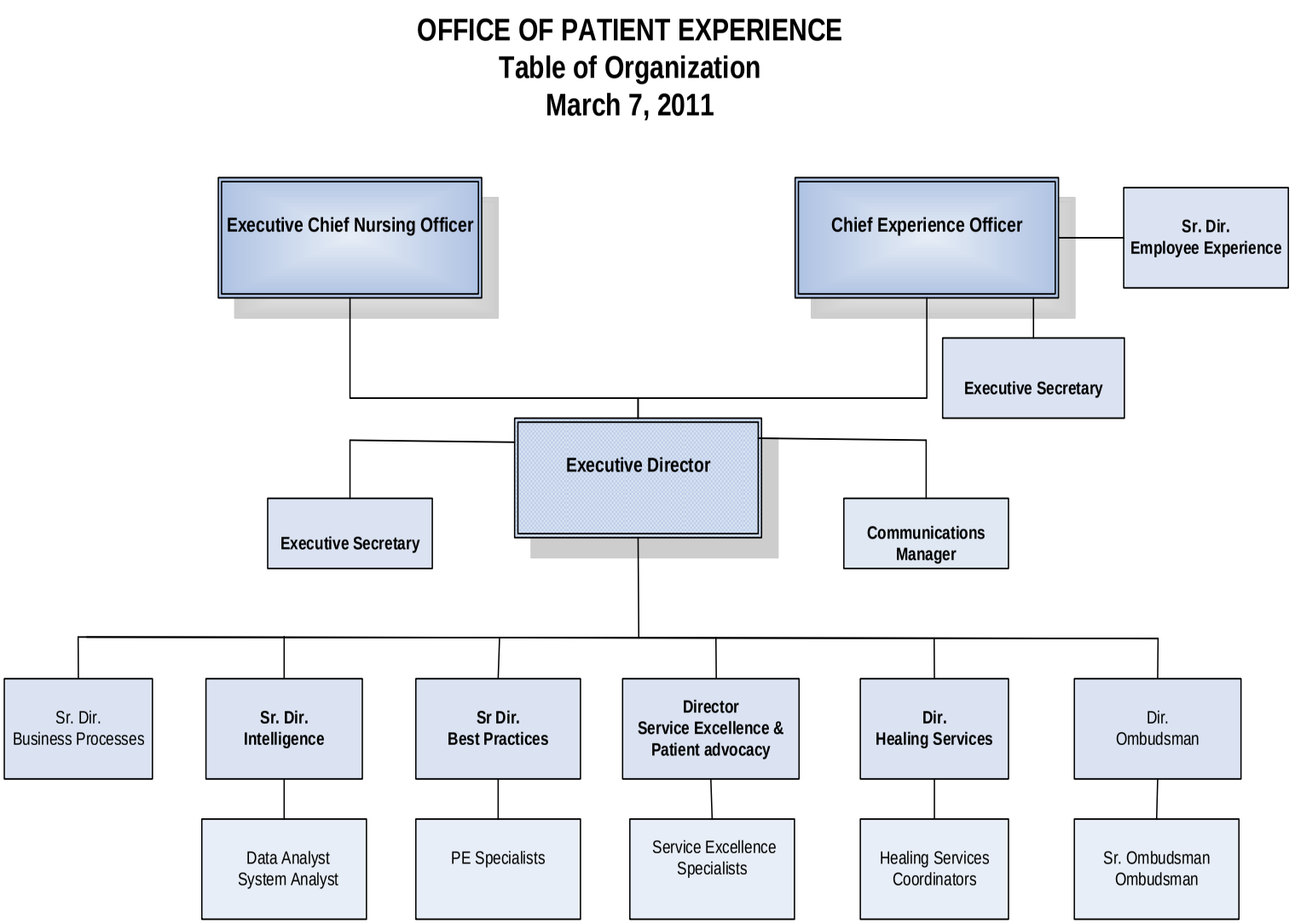
Notes: For questions 1–7, % of patients answering "Always." For question 8, % of patients answering "Yes." For question 9, % of patients answering "9" or "10" (0=worst, 10=best). For question 10, % of patients answering "Definitely Yes."

Exhibit 7 OPE Programs and Services

Program/Service	Description
Best Practices	The Best Practices Department monitors national and local HCAHPS trends to identify how the top performing hospitals identify and maintain success. They consult with Cleveland Clinic institutes and community hospitals to identify, implement, and promote best practices. They may also perform unit observations to sustain best practices.
Patient Survey Administration and Data Analysis	The OPE collects and analyzes patient feedback from several sources to provide greater insight about how patients perceive their experience. It maintains a Patient Experience Dashboard for hospital leaders to monitor real-time survey results and feedback trends specific to their areas, and to help prioritize improvement initiatives.
Ombudsman	The Ombudsman Office is the liaison between Cleveland Clinic and the patient in resolving problems that may arise during the course of treatment. An Ombudsman has the authority to investigate complaints independent of the departments involved and the administration. They work proactively with doctors and nurses to make improvements. Each CC community hospital has one or more Ombudsmen.
Patient Experience Forums	Patient Experience Forums allow all Cleveland Clinic employees to participate in deeper discussions about key patient experience issues. A November 2010 event attracted more than 300 participants. Attendees from several clinical and nonclinical areas participate, including representatives from every Cleveland Clinic community hospital, the outpatient family health centers, and the main campus.
Patient Experience Teams	Patient Experience Teams are multidisciplinary, collaborative teams of unit-based caregivers who meet regularly to review patient comments from the patient satisfaction surveys in order to celebrate successes and identify opportunities for improvement. Action plans are developed to address negative comments as necessary.
Exceptional Healing Partners	Exceptional Healing Partners is an employee recognition program that celebrates employees who consistently anticipate and exceed patient and family expectations and embody the Cleveland Clinic values. Every year, 12 employees are selected, based on nominations from their peers and patients, and are honored at a special reception and during the year.
Health Literacy Education and Solutions	The OPE provides health literacy information and education to patients, helping them better understand how to make appropriate health decisions. Health literacy includes both written and verbal health instructions.
Communicate with H.E.A.R.T.	The OPE runs two customer service training programs for employees, together known as Communicate with H.E.A.R.T. S.T.A.R.T. with Heart focuses on five components as standards of behavior for all patient, family, and caregiver interactions. They are: **S**mile and greet warmly; **T**ell your name, role, and what to expect; **A**ctive listening and assist; **R**apport and relationship building; **T**hank the person. Respond with H.E.A.R.T. helps employees address patient and family concerns and questions at the point of service. The critical components are: **H**ear the Story; **E**mpathize; **A**pologize; **R**espond to the Problem; **T**hank Them.
Voice of the Patient Advisory Councils	CC has more than 15 Voice of the Patient Advisory Councils (VPACs) that meet regularly to discuss and to have a positive impact on a variety of issues and challenges affecting patients and family members. VPACs include employees and patients and give staff an opportunity to hear directly from the people they serve. VPACs have reviewed several hospital policies, including patient visitation and discharge information, helped define the expected service behaviors of all employees, renovated family areas, and developed educational materials.
Cleveland Clinic Experience	The Cleveland Clinic Experience is an organization-wide initiative designed to integrate exceptional employee and patient experiences. Cleveland Clinic Experience consists of three interactive learning sessions, in which caregivers from all disciplines and locations discuss the Clinic's mission, values, expected service behaviors, service recovery, and supporting each other.
Healing Services Program	The Healing Services Program provides holistic care for patients, families and employees. Healing Services are offered free of charge to patients, families, and employees, and include Reiki, Healing Touch, personal aromatherapy, guided imagery, and spiritual practices.
Code Lavender	Code Lavender is a personalized, rapid-response holistic care service provided by the Healing Services and Spiritual Care teams. Code Lavender is called when a patient, family member, employee, or employee team would benefit from immediate well-being support. The Code Lavender Team provides holistic healing services to help individuals who are experiencing a stressful or extreme event.

Source: Company documents.

Exhibit 8 OPE Organization Chart



Source: Company documents.

Exhibit 9 Excerpt from "What to Expect During Your Hospital Stay" Pamphlet

Medications in the Hospital

Your healthcare team will talk to you about new medications you are given in the hospital.

They will explain each new medication, including:

- What it is for
- How and when to take it
- Possible side effects it may cause

Please ask for information about your medications in writing, much like you receive a side effects leaflet stapled to your medication at the pharmacy.

If you brought your medicines from home, please ask a family member or friend to take them home. You will be given the medications you need while you are in the hospital.

Hospital Environment

Quiet Environment

Many of our rooms are semi-private, with two patients in each room. Each patient has a phone, television and separate closet. There is a curtain that can be pulled for privacy.

There can be a lot of hustle and bustle in the hospital, and it can be noisy. Your team will try to limit noise as much as they can while you recover, especially at night.

Let them know if it's too loud for you, and they'll do what they can to minimize the noise.

We follow "HUSH" (Help Us Support Healing) guidelines between 9 p.m. and 7 a.m. to help you rest in a quiet environment. An overhead announcement will let you know when the quiet hours begin. Lights will be dimmed, your door will be closed with your permission, and we ask that you try not to play music too loud or watch TV too late at night, especially if you have a roommate. Ask if headphones are available for the TV.

Remind friends or family who visit to keep the noise level down, since others may be sleeping. Please avoid late-night conversations or phone calls. Thank you for helping us make sure you and all other patients can get the rest they need.

We will limit nighttime interruptions as much as possible, but please understand that we will be checking on you during the night to make sure you are ok. In addition, it's sometimes necessary to wake you up during the early morning for a blood test so your doctor has the test results early enough. That way, changes can be made to your treatment if needed.

Clean Environment

All caregivers wash their hands or use waterless hand cleanser between patients and in between during different tasks for patients. We encourage you to ask your caregivers if they have washed their hands.

A clean environment helps keep you safe as you recover. Your room and bathroom will be cleaned regularly, but the housekeeping staff will try not to disturb you. If you need anything cleaned up (for instance, if you spilled something), ask them to come back in.

Source: Company documents.

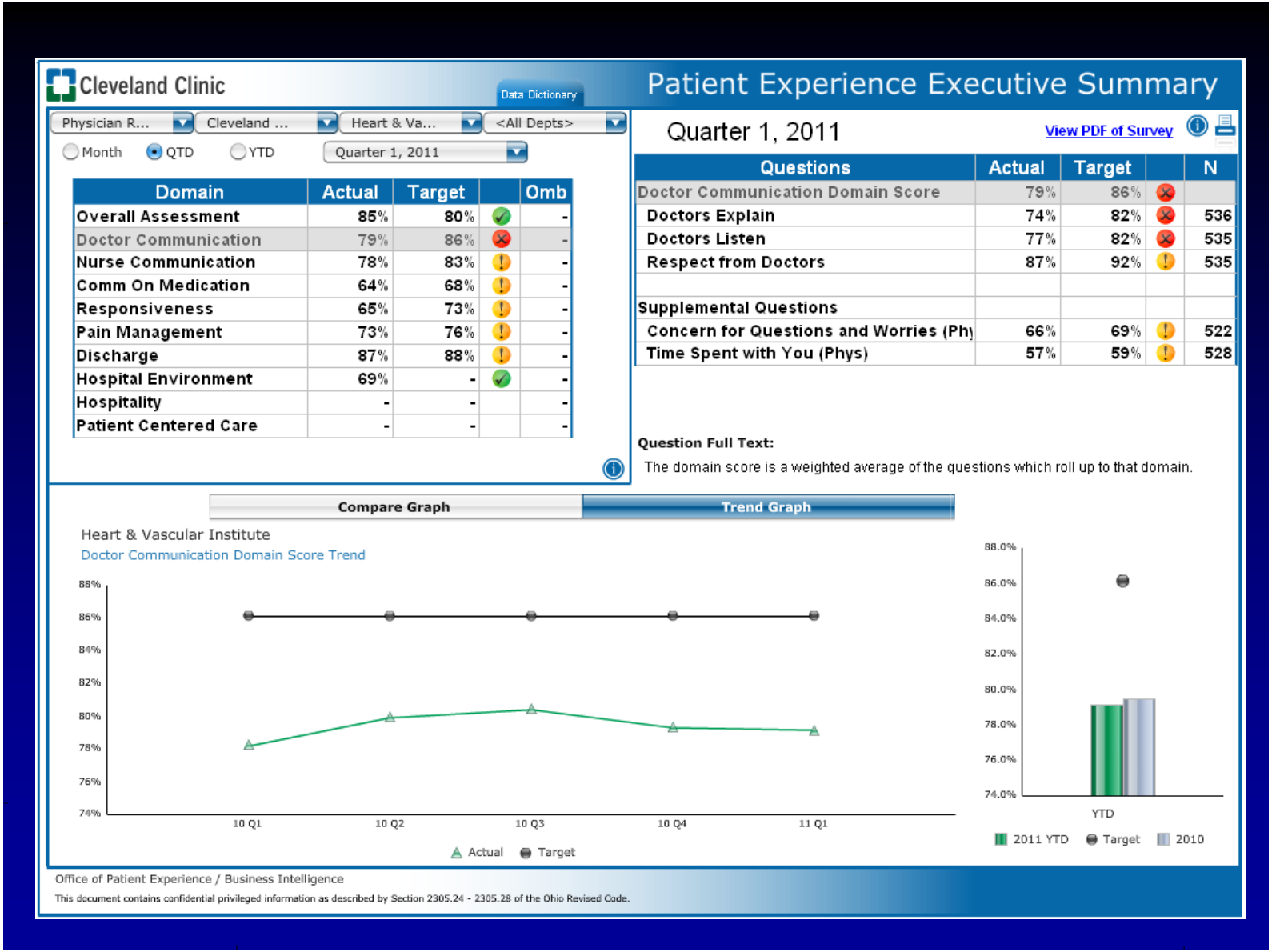
Exhibit 10 Percentage of Patients Reporting Highest Scores on HCAHPS Questions Analyzed by Whether They Received or Did Not Receive Education on What to Expect During Their Hospital Stay

	Patients who viewed expectation modification materials	Patients who did not view the materials
	Early 2011	Early 2011
Number of patients	71	316
1. Nurse communicated well with patient (Q1, Q2, Q3)	85	82
2. Doctors communicated well with patient (Q5, Q6, Q7)	81	75
3. Staff responsiveness (Q4, Q11)	67	56
4. Patient's pain was well-controlled (Q13, Q14)	72	72
5. Staff explained medicines before giving them to patient (Q16, Q17)	74	63
6. Hospital room and bathroom kept clean (Q8)	78	64
7. Quiet at night (Q9)	45	42
8. Given information about what to do during recovery at home (Q19, Q20)	92	92
9. Rate hospital favorably (Q21)	80	82
10. Would recommend hospital to friends and family (Q22)	92	85

Source: Company documents.

Notes: For questions 1–7, % of patients answering "Always." For question 8, % of patients answering "Yes." For question 9, % of patients answering "9" or "10" (0=worst, 10=best). For question 10, % of patients answering "Definitely Yes."

Exhibit 11 Patient Experience Dashboard



Source: Company documents.

Endnotes

[1] Cleveland Clinic, 2008 Annual Report.

[2] The patient's real name has not been used and some details have been changed to protect his or her privacy.

[3] "Cleveland Clinic Details," *U.S. News and World Report*, http://health.usnews.com/besthospitals/cleveland-clinic-foundation-6410670/details, accessed September 2010.

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[5] Cleveland Clinic Overview, http://my.clevelandclinic.org/about/overview/default.aspx, accessed September 2010.

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[7] Cleveland Clinic Overview, http://my.clevelandclinic.org/about/overview/default.aspx, accessed September 2010.

[8] Jerry Adler, "The Hospital That Could Cure Health Care," *Newsweek*, November 26, 2009, http://www.newsweek.com/2009/11/26/the-hospital-that-could-cure-health-care.html, accessed August 2010.

[9] At CC, expenses during a person's last two year of life averaged $31,252. This amount was about half of expenses during the same time period at the most expensive hospital. Source: Adler, "The Hospital That Could Cure Health Care."

[10] Statement of Dr. Delos M. Cosgrove to the Senate Committee on Health, Education, Labor, and Pensions, June 11, 2009, http://help.senate.gov/imo/media/doc/Cosgrove.pdf, accessed March 2011.

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[12] President Obama as quoted in Mark Maymik and Sarah Jane Tribble, "President Obama will be at the Cleveland Clinic on Thursday on a campaign to reform the nation's health-care system," *The Cleveland Plain Dealer*, July 21, 2009, http://www.cleveland.com/news/plaindealer/index.ssf?/base/news/124816515990620.xml&coll=2, accessed August 2010.

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[14] "A Better Patient Experience: A Letter to Our Readers from Delos M. Cosgrove, M.D., CEO and President," Cleveland Clinic, August 2007, http://cchealth.clevelandclinic.org/first-word/better-patient-experience, accessed October 2010.

[15] HealthLeaders Media Council, Industry Survey 2011, http://www.healthleadersmedia.com/pdf/survey_project/2011/Mkt_press.pdf, accessed March 2011.

[16] Information for this section taken from "HCAHPS: Patients' Perspectives of Care Survey," Center for Medicare and Medicaid Services, https://www.cms.gov/HospitalQualityInits/30_HospitalHCAHPS.asp, accessed September 2010.

[17] American Hospital Association, "Assessment of Cost Trends and Price Differences for U.S. Hospitals," March 2011, http://www.aha.org/aha/content/2011/pdf/11costtrendspricediffreport.pdf, accessed March 2011.

[18] Catherine Arnst, "Hospitals: Radical Cost Surgery," *Businessweek,* January 7, 2010, http://www.businessweek.com/magazine/content/10_03/b4163040943750.htm, accessed January 2011.

[19] Atul Gawande, "Now What?" *The New Yorker* 86, no. 7 (April 5, 2010), p.21.

[20] Donald M. Berwick, "2010 Yale Medical School Graduation Address," May 24, 2010, New Haven, CT, http://www.ihi.org/NR/rdonlyres/0B7E1957-A466-4134-907D-F9E2B0F9BDE0/0/BerwickYaleMedicalSchool GraduationAddressMay10.pdf, accessed September 2010.

[21] Berwick, "2010 Yale Medical School Graduation Address."

[22] Kurt D. Grote, John R.S. Newman, and Saumya S. Sutaria, "A Better Hospital Experience," *McKinsey Quarterly*, November 2007, https://www.mckinseyquarterly.com/Health_Care/Hospitals/A_better_hospital_experience_2081, accessed February 2011.

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