Innovation in health care:

An interview with the CEO of the Cleveland Clinic

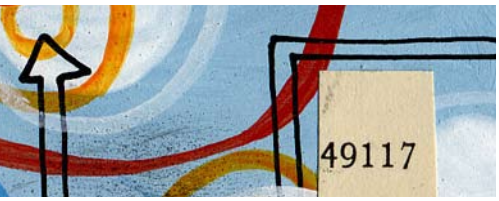
Delos "Toby" Cosgrove discusses innovation in health care—including a key role for top executives to play in reducing the nation's health care burden.

Brendan C. Buescher and Paul D. Mango

As a leading medical institution in the United States, the Cleveland Clinic operates at the center of the country's raging debate over health care. Like many peers, the clinic finds itself fighting to hold the line on costs while maintaining quality, attracting the most qualified staff, and providing access to affordable health care. But its efforts don't stop there. Established in 1921 as a nonprofit group practice with a mission that links patient care, research, and education, the clinic has long been a crucible for experimentation and innovation.

And innovate it has, though not always without controversy. With more than 37,000 employees and annual revenues in excess of $4.4 billion, the Cleveland Clinic is leading a charge to lower the burden of disease on the country's health care system while improving quality and patient experience. Cafeterias in the clinic's many facilities no longer serve foods containing trans fats. Cleaning supplies have been replaced with nontoxic alternatives. What's more, starting last September new employees aren't allowed to smoke. Applicants are tested for nicotine, and those who test positive are provided with free smoking-cessation assistance but are not offered employment. Clinic physicians excel at technological, biomedical, and pharmacological innovation—its heart and vascular institute has been number one in the field for more than a decade. However, some observers believe that a number of these physicians have a conflict of interest.

The clinic's CEO, Delos "Toby" Cosgrove, whose own research has produced more than 30 patents, recently sat down with McKinsey's Brendan Buescher and Paul Mango to discuss health care in the



United States, the importance of innovation as the industry globalizes, and the delicate balance among competing interests in the field. Cosgrove is not your usual executive; he spent 30 years at the clinic as a cardiac surgeon before being promoted to CEO, in 2004. Since then, he has immersed himself in the details of his new role, seeking to improve not just the clinic and the health of its patients but also their hospital experience and the future of the health care industry overall.

The *Quarterly:* *Where do you think the US health care system is heading—and what needs to be done?*

Toby Cosgrove: If you look at health care in the United States, what has caught the attention of most citizens is the cost, at around $2 trillion annually, or 16 percent of GDP. At that level, costs already affect competitiveness, so there's a lot of concern about what will happen as those costs increase. That has led to three seismic shifts in health care.

The first is prevention. The only thing we can do to reduce costs, while still improving quality, is to reduce the burden of disease. Forty percent of the premature deaths in the United States are caused by obesity, inactivity, and smoking, all of which ought to be preventable. Two-thirds of the country is overweight and a third is obese. Over the decades I have operated on a lot of patients with lung cancer, and every one of them was a smoker. So a natural starting point is to help people stop smoking and help them lose weight.

Delos "Toby" Cosgrove

Education

Graduated with BA in history in 1962 from Williams College, Williamstown, Massachusetts

Earned MD in 1966 from the University of Virginia School of Medicine in Charlottesville

Career highlights

Cleveland Clinic (1975–present)

- President and CEO (2004–present)

Fast facts

Serves on several editorial boards, including those for *American Heart Journal* and *Circulation*

Member of 16 scientific societies, including the American College of Surgeons, the American Heart Association, and the American Association for Thoracic Surgery (for which he served as president in 2000)

Holds more than 30 patents for developing medical and clinical products used in surgical environments

Has published nearly 400 journal articles and book chapters, one book, and 17 films on training and continuing medical education

The *Quarterly:* *Practically speaking, what has the Cleveland Clinic done in the area of prevention?*

Toby Cosgrove: We feel that if we're going to be a health care organization, we really ought to walk the talk. We decided that a hospital should be an organization with employees who don't smoke, so we stopped hiring smokers. Although there are 6,000 companies across the country that don't hire smokers, very few of them are health care providers. We took some criticism from the press for initiating this practice, and employees were worried that the next steps might be attempts to regulate their sexual habits or their eating habits at home. That is not our intention. Criticism has died away, and the policy hasn't affected the number of job applicants. People still want to work here.

Obesity, on the other hand, will require the education of a whole generation of people, and it has to start by addressing childhood obesity. That means asking obstetricians to educate women prenatally, because that's when they really have the mother's attention. As far as inactivity is concerned, people have to understand that they need to get up and move around more or their whole body will start to deteriorate.

Competition in this sector has been driven very much by cost and by being the lowest-cost provider. But low costs don't necessarily equate with great outcomes or great quality. Instead, maybe what we really ought to be driving for is value for the health care dollar. This is the second of the seismic shifts in health care.

The *Quarterly:* *How do you get more value for the money that's spent at the Cleveland Clinic?*

Toby Cosgrove: Value for your dollar has a lot to do with quality and outcomes and transparency. It turns out that in health care, there is very little information about what quality is. To improve value, you still have to measure costs, but you also have to measure quality, in terms of outcomes. At the Cleveland Clinic, we've had a long history of measuring outcomes in cardiac surgery. So we asked all the other departments to do the same sort of thing—to figure out what they want to measure, measure it, and then become transparent about it, because patients should know the expected outcomes. We ought to be able to say not just that we're great doctors but also here's how we actually do—and put metrics to it. If nobody has ever come up with any metrics for dermatology, we'll do it. And if someday somebody says there's a better way, then we'll adopt whichever approach is better.

We now have 29 books on outcomes. Some of them just track volume, some of them measure quality, but each year they get a little more sophisticated. As we measure these things we find problems, and as we find the problems then we can go back and start to address them. That exercise is now pretty much adopted and a part of the culture at the clinic, and three years into this program the measures are getting more sophisticated; results can be found on our Web site. Interestingly, other institutions are starting to do the same thing. For example, Brigham and Women's Hospital and the University of Pennsylvania both produced their own cardiac surgical-outcome books that were identical to the ones we put out—the same size, the same format, the same graphs—and that's great. Now we're starting to talk about quality, not about perception and reputation.

In the same spirit of transparency, as of the first of January we opened our medical records—what's often called "the chart"—to patients anytime they want to see their own charts. The charts really aren't the hospital's; they belong to the patients, and we think it's their right to have that information. This transparency has an effect on care, because now, when the nurses review charts during shift changes, they do it bedside instead of at the nursing station. So when they say, "Well, Mrs. Smith went for a walk this morning," Mrs. Smith can jump in, if she needs to, to say, "Oh, no, nobody got me up."

The *Quarterly:* *Does that level of transparency also change how you think about competition?*

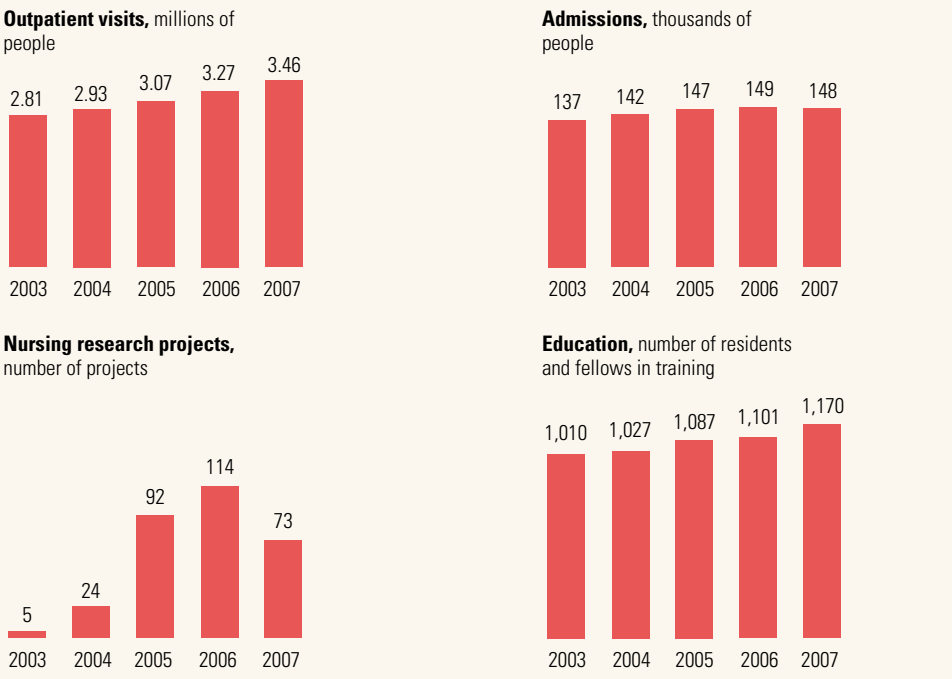
Toby Cosgrove: Yes, and that brings us to the third seismic shift in health care. When I first started as a cardiac surgeon, 20 percent of the patients died. Success and quality were judged by whether the patient walked out or got carried out. Now, it's quite different—nearly everyone survives. Now patients judge us in the same way they would judge a restaurant or a hotel: on the experience they have here. That experience has a physical, clinical, and emotional component. They'll form their opinions and they will talk to people. I think we really have to address the quality of the experience because patients expect it, and it is an opportunity to improve their emotional well being, which clearly has an influence on the speed of their recovery.

Exhibit

An innovative approach

The Cleveland Clinic's mission links patient care, research, and education.

Vital statistics for Cleveland Clinic Health Systems



Source: Cleveland Clinic

We've started to try to address those things. The physical aspect includes the cleanliness and the convenience and the small physical things that you do. For example, those gowns that tie up the back are probably the most dehumanizing clothing that you can possibly put on. So we redesigned it to be more like a bathrobe. We began to look at things we could put in the rooms so if family members wanted to stay with the patient, they could. In fact, we designed and are now installing in rooms a couch that is both comfortable to sit on and pulls out at night into a bed for family members.

We looked at the experience of patients, particularly how the clinic's staff members interact with them. People learn from an early age how to size others up—whether they look at you, smile when they talk, how they touch you. These are all interactive, physical, emotional activities that impart a message of care, and ensuring that everyone heeds this requires a huge training process. To lead the effort, we hired a chief experience officer, whose entire responsibility is to look at the hospital experience from the eyes of the patient and to translate that message back to the caregivers.

The *Quarterly:* *Let's change gears a bit. You've talked about some of the things that the clinic is doing, but what can other CEOs or leaders do—either at the individual or systemic level—to reform the health care system?*

Toby Cosgrove: They can do a lot. The preventative health steps are pretty clear: they can do things that encourage people to take care of themselves, stop smoking, and increase activity. They can provide the stimulus, they can provide the facilities, and they can drive these ideas home. I was thrilled, for example, when Disney CEO Bob Iger decided that there would no longer be people smoking in films made by Disney. That's huge, and I'd encourage him to get with other film producers to do the same.

Systemic health care reform is a huge issue, obviously, and it's emotionally loaded because every single individual in the United States is a stakeholder. One way or another, all of us will one day be involved in the health care system. So there are 300 million people that are involved in this discussion, and we have to begin to understand where we are going and to develop some consensus about what to do. This isn't going to be a quick fix; it's going to take years.

Right now, there are all kinds of experiments under way, all over the country, to try and figure out how we can do this. It's happening on a state-by-state basis, and frankly I'm pleased about that, because with a lot of little experiments going on, some of them will be successful and some of them will fail. There will be lessons learned that will ultimately help us form a national health care policy. That's going to be a step-by-step process.

The *Quarterly:* *Let's talk about the Cleveland Clinic as a business. How did it develop such a global presence?*

Toby Cosgrove: The clinic has a long history of seeing patients from all over the world, going back to the 1950s, when coronary angiography originated here. That was the defining procedure for coronary artery disease, so people came from all over the world to learn

about it. Then they'd go back home and refer patients, and we saw as many as 5,000 patients a year from overseas. After September 11 all that changed, because people were unwilling or unable to come to the United States.

So we began to look at various opportunities to meet our global patients halfway—and we were getting a lot of invitations to collaborate. We spent a lot of air miles and shoe leather figuring out what we could do, where we could do it, and if it was reasonable. We came to a couple of conclusions. First, we could not expect Cleveland Clinic doctors from the United States to practice in countries like China. These physicians didn't speak Chinese, they weren't licensed in China, and they didn't want to live there. As we probed deeper, we realized that other countries wanted to have us involved because they realized we had an operational model that provided doctors with the necessary facilities, technology, and support.

The second thing we realized was that we did not want to be involved for the short term. We didn't want to just put the Cleveland Clinic name on something and expect the brand to stick. Finally, we didn't want to put our capital at risk. I didn't think I could go to the people of northeast Ohio and say, "We're not investing here, we're going to invest somewhere else."

The *Quarterly:* *So how involved are you overseas?*

Toby Cosgrove: We eventually settled on a couple of opportunities. The first was in Abu Dhabi, where we signed a 15-year contract to build and select the staff and manage a hospital for a fixed fee.[1] Recently, we signed a similar arrangement with a hospital outside of Vienna for heart surgery. We also opened a limited facility in Toronto, and we have relationships with hospitals in Saudi Arabia and Egypt. We see these partnerships as an opportunity to monetize our intellectual capital—the things we've learned about running a hospital for a long period of time—and do well by doing good.

Now, sooner or later, every country is going to want to develop its own expertise, and so the flow of patients coming to the United States to visit the Cleveland Clinic is probably not going to increase. For example, we used to have a lot of patients come from South America, and we've also trained a large number of residents from that region. Now, the leading heart surgeon in every country in South America was trained at the Cleveland Clinic. Guess what? We don't see any patients from South America anymore.

The *Quarterly:* *So how will you draw patients to Cleveland as other regions step up to serve themselves?*

Toby Cosgrove: Our value proposition to the world is technology leadership. In an environment where the ability to distribute medical knowledge is compressing very quickly, we need to be able to continue to innovate in the way we practice and dispense medicine. Part of the success of this organization has always been its willingness to lead in innovative ways. We have a long history of innovation, including things like a lumpectomy rather than a radical mastectomy for breast cancer, coronary angiography, and coronary bypass. If this institution doesn't innovate, there will be nothing to differentiate it from others.

[1] For more on the involvement of foreign hospitals in the Gulf Cooperation Council (GCC) states, see Viktor Hediger, Toby M. H. Lambert, and Mona Mourshed, "Private solutions for health care in the Gulf," mckinseyquarterly.com, March 2007.

We've done everything we can to foster that spirit of innovation, including asking each one of our 1,800 doctors to take a trip once a year to go someplace new and learn something. It doesn't matter where. A lot of the new things that I've done resulted from a glimmer of an idea I discovered out in the world—from France, Germany, England, and Stanford. So if we have all these doctors out there scouting for new ideas, we're bound to get better because there's always somebody doing something better than we are. We just have to go find it.

The *Quarterly:* *And what about concerns regarding conflicts between the physician's interests and those of the patients?*

Toby Cosgrove: This area may be different in medicine than in most other fields because medicine is looked at as a charitable activity. Think of this: kidney dialysis was developed by a doctor here at the Cleveland Clinic after World War II, and no patents resulted from that. We received no financial returns for this breakthrough, even though we paid for all of the research that went into developing it. Companies picked up this innovation, manufactured dialysis machines, and made a bundle of money—which all flowed away from the clinic.

Recognizing this dynamic, we argued that it would be at least fair if the clinic were to benefit from the research it invested in—whether in time, effort, intellect, or cash. Institutions and researchers started asking product developers to share the profits. The same discussion has gone on in universities.

Then the laws changed, and research institutions were encouraged to patent and commercialize their developments. That really opened the floodgates. Up went the number of patents, up went the number of developments and disclosures. And that's where the conflict of interest question came up. People began to ask, "Are you doing this simply to make money or are you doing it to help mankind?" The answer is that we need to do both—to maintain the emphasis on patients' interests while rewarding innovation.

The *Quarterly:* *How have you kept that balance at the clinic?*

Toby Cosgrove: We did a couple of things. About seven years ago, we formed a venture capital company and used our expertise to help it vet proposals for new products. For that we receive a portion of returns for anything it developed.

Then we formed Cleveland Clinic Innovations, which is the development arm for the intellectual property of our employees. So all of the patents and developments and the returns on them are the property of the Cleveland Clinic and are shared with the inventor. I was named CEO as that process was happening, and I became the focal point for this question about conflict of interest and disclosures. This is an evolving area. What are our obligations to the physician innovator, to the hospital regarding public disclosure, and to patients?

We have put a lot of thought into establishing a policy that protects the patient while not discouraging innovation, and that requires doctors to disclose their commercial and consulting arrangements. We developed a registry. We want to make sure that commercial interests do not inappropriately influence clinical decision

making. That's taken a lot of thought. We don't want to make the rules so restrictive that we say to doctors, "We don't want you talking to any company," because that will inhibit the development of new techniques and new products and stop the innovation process—and ultimately endanger patients.

The *Quarterly:* *To wrap up, what challenges keep you up at night?*

Toby Cosgrove: Well, there are things you can control and things you can't. I can't really consider it a challenge if there's nothing I can do about it. For example, I don't have much capacity to deal with reimbursement from the government, so I don't lose a lot of sleep over it. The things that I do have control over—the culture of the organization, a few strategic decisions, and probably most important, the selection of people—I do worry about. It's not very hard to decide if people are bright enough to fill a role, but if they don't have the cultural fit or the work ethic, they just won't last here.

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