

section three

SYSTEM AND CONSOLIDATION

10. THE LOOP YEARS

(PART II), 1995-2004

BY JOHN CLOUGH

Leadership is action, not position.

—Donald H. MacGannon

BEGINNING IN THE MID-1990S, THE PACE OF GROWTH IN SIZE AND complexity of the organization accelerated dramatically. These developments, though they occurred simultaneously, followed pathways that are best understood when considered separately. They included (a) acquisition of nine hospitals in the northeast Ohio region, the assembly of the Cleveland Clinic Health System, and the formation of the Physician Organization (PO); (b) building integrated clinics and hospitals in Naples and Fort Lauderdale, Florida (see Chapter 21); (c) creation of fourteen family health centers; (d) construction of a research and education institute, an eye institute, and a cancer center on the Cleveland campus; (e) establishing new and expanded emergency services at a site that included twenty-four new operating rooms (see Chapter 9); (f) establishment of The Cleveland Clinic Lerner College of Medicine of Case Western Reserve University; (g) strengthening of information technology and implementation of the ambulatory electronic medical record; (h) reorganization and strengthening of clinical and administrative management; (i) initiating a comprehensive leadership program called World Class Service; and (j) reorganization of the academic enterprise toward programmatic research, i.e., “investigation of their problems.”

ASSEMBLY OF THE CLEVELAND CLINIC HEALTH SYSTEM

Over a three-year period beginning in 1995, nine hospitals in Cleveland and the surrounding suburbs came together and merged with The Cleveland Clinic Hospital to form the core of the Cleveland Clinic Health System. These hospitals included Marymount, Lakewood, Fairview, Lutheran, Meridia Hillcrest, Meridia Huron, Meridia Euclid, Meridia South Pointe, and Health Hill. In the process, the Meridia name was dropped in favor of the original individual hospital names, and Health Hill became the Cleveland Clinic Children's Hospital for Rehabilitation.

At the same time, two additional systems formed in Cleveland, the University Hospitals Health System, and the ill-fated Mt. Sinai Health System. By the time the dust died down, only a handful of Cleveland's hospitals remained independent: Deaconess, Parma Community Hospital, MetroHealth Hospital, and the Veteran's Administration hospitals. With the exception of Deaconess, these facilities were governmentally owned.

In 1996, Mt. Sinai's economic problems led that organization to sell their system, which included Mt. Sinai Hospital, Mt. Sinai Hospital East (the former Richmond General Osteopathic Hospital), and the Integrated Medical Campus in Beachwood to the for-profit Primary Health System, creating at the same time the Mt. Sinai Foundation, another conversion foundation. They also sold Laurelwood Hospital to the University Hospitals Health System. In separate transactions, Primary Health System also acquired St. Alexis Hospital and Deaconess Hospital, converting them to for-profit entities. The former deal also resulted in a name change of St. Alexis Hospital to St. Michael Hospital.

During these years, Mt. Sinai and St. Luke's Hospitals closed.

Several factors led to the sudden emergence of hospital merger activity. These included (a) the aggressive rise of the for-profit hospital systems (especially Columbia-HCA, which was at the height of its strength) and their targeting of the Cleveland market at that time, (b) the repeal of Ohio's certificate-of-need law in 1995, (c) the failure of the Clinton health care reform initiative in 1994, (d) the concentration of market power in the insurance companies and their dominance in the health care marketplace, and (e) the threat of a merger between

Blue Cross of Ohio and Columbia-HCA.

Columbia-HCA entered the market by acquiring a half-interest in several area hospitals, the other half held by the Sisters of Charity. The hospitals were St. Luke's (having just been cast loose by MetroHealth after a brief merger), St. Vincent Charity, St. John West Shore, and Timken Mercy (Canton, Ohio). The resulting organization was called Caritas, and its formation generated the St. Luke's Foundation, a so-called conversion foundation, resulting from the conversion of a nonprofit to a for-profit entity. The conversion foundations had the purpose of making sure that the endowments were used for community benefit.

Jack Burry, then president of Blue Cross of Ohio, concluded a deal with Rick Scott, chief executive of Columbia-HCA, which would have made the insurance company a part of Columbia-HCA. The Ohio Attorney General struck this deal down, and in the process the Blue Cross-Blue Shield Association canceled the membership of Blue Cross of Ohio, which since then has been known by its original name, Medical Mutual of Ohio. All of these factors combined to convince the community hospitals' executives and boards to seek refuge under the protective wings of the better managed and economically strong Cleveland Clinic.

For The Cleveland Clinic, the process began when, during discussions between Cleveland Clinic leadership and Marymount Hospital's CEO Thomas Trudell in 1995 about Marymount's joining the Cleveland Health Network (see Chapter 9), Trudell suggested consideration of a merger instead. Convinced that merger was the relationship they wanted, they quickly concluded a handshake agreement with The Cleveland Clinic, which was formalized in December 1995. Among other things, the agreement recognized and supported Marymount's Catholic mission and protected the interests of the retired nuns who had staffed Marymount for many years. At the time, no one recognized the importance of this event or predicted what was to follow over the next two years. Although Trudell lived to see the formation of the Cleveland Clinic Health System, initiated by the merger of Marymount with The Cleveland Clinic, he died suddenly in 2002, while at the peak of his career.

In May 1996, Lakewood Hospital, with 295 beds and a level-2 trauma center, became part of the emerging Cleveland Clinic Health System through a three-way agreement of The Cleveland Clinic with

the City of Lakewood and the non-profit Lakewood Hospital Association. Lakewood, previously affiliated with University Hospitals, had been looking for a new partner and had explored joining the Columbia-HCA system, but their board ultimately preferred to remain nonprofit. It is the only municipal hospital in the system. The City of Lakewood owns the building and leases it to the Lakewood Hospital Association, which is now part of the Cleveland Clinic Health System.

A few months later, in the fall of 1996, Fairview Health System and The Cleveland Clinic agreed to merge, bringing Fairview General Hospital (469 beds) and Lutheran General Hospital (204 beds) into the fold. Fairview Health System and Meridia had been engaged in merger discussions, but Fairview decided to join The Cleveland Clinic. Fairview Health System, previously known as Health Cleveland, was a two-hospital system consisting of Fairview General and Lutheran General Hospitals. Together with Lakewood Hospital, these hospitals became the Western Region of the Cleveland Clinic Health System. A search committee selected Louis Caravella, M.D., a prominent and widely respected ophthalmologist, to lead the region. When Caravella stepped down in 2003, the Clinic selected Fred DeGrandis, then the chief executive officer of St. John West Shore Hospital, to succeed him.

Meridia had continued to look for a partner, weighing the pros and cons of joining The Cleveland Clinic vs. University Hospitals. For Meridia this was a prolonged process, involving the use of a national consultant (Goldman Sachs Group) to evaluate the opportunities that remained. One important factor in the ultimate choice was support for the Clinic from the Meridia trustees.

In March 1997, the Meridia Hospital System, having failed to conclude its merger with Fairview, agreed to merge with The Cleveland Clinic. This merger brought Hillcrest (347 beds and a level-2 trauma center), Huron Road (387 beds and a level-2 trauma center), Euclid General (371 beds, including a 48-bed rehabilitation unit), and South Pointe (166 beds, formed from the 1994 merger of Suburban and Brentwood Osteopathic) Hospitals into the Cleveland Clinic Health System. The former Meridia Health System became the Eastern Region of the Cleveland Clinic Health System, under the leadership of Charles Miner. When Miner announced his intention to leave the Cleveland Clinic Health System in 2003, the Clinic chose Tom Selden, long-time chief executive officer of Parma Community



Aerial view of The Cleveland Clinic, 2003

Hospital, to replace him.

In July 1998, the Cleveland Clinic Health System admitted Health Hill, a 52-bed children's rehabilitation hospital, and shortly thereafter, the name was changed to the Cleveland Clinic Children's Hospital for Rehabilitation. It became a part of Children's Hospital at The Cleveland Clinic for administrative purposes.

Along with Loop, the key Cleveland Clinic executive most intimately involved in assembling the Cleveland Clinic Health System was Frank Lordeman, the Clinic's chief operating officer. Originally from California, Lordeman had come to Cleveland to serve as president and chief operating officer of Meridia Hillcrest Hospital. Lordeman was no stranger to hospital consolidation, having served as president of Health Ventures, Inc., a for-profit hospital system based in Oakland, California. The Meridia system, led at that time by Richard McCann, had formed from the merger of five hospitals (Hillcrest, Euclid General, Huron Road, Suburban, and Brentwood) in the mid-1980s. The latter two hospitals, located adjacent to each other on Warrensville Center Road, soon merged all their operations to form

South Pointe Hospital. Brentwood was an osteopathic hospital with strong academic ties to Ohio's only osteopathic medical school at Ohio University in Athens, Ohio.

Shortly after Lordeman left Hillcrest to join The Cleveland Clinic in 1992, Blue Cross of Ohio attempted a merger with the Meridia system, which was looking for a partner. Charles Miner, formerly an executive with Figgie International, succeeded Lordeman at Hillcrest. This merger went forward, and McCann became an employee of Blue Cross, but the union dissolved soon thereafter because of the Meridia board's cultural differences with Burry, president of Blue Cross of Ohio. When McCann moved to Blue Cross, Miner became the chief executive of the Meridia System.

Blue Cross then went on to an ill-fated attempt to merge with Columbia-HCA, which was hungrily eyeing the Cleveland marketplace. However, about that time, Columbia-HCA ran afoul of the Justice Department and began to downsize, eventually giving up on the idea of entering the Cleveland marketplace. Almost no one thought this merger was a good idea, anyway. Ohio Attorney General Betty Montgomery refused to allow it, and the Blue Cross-Blue Shield Association dismissed Blue Cross of Ohio from membership. Since then the company has been known as Medical Mutual. It is still one of the strongest health insurers in the region.

Several other organizations have affiliated with the Cleveland Clinic Health System, although they are not formally merged with The Cleveland Clinic. These include the Ashtabula Medical Center, with its 226-bed hospital, the Ashtabula Clinic, and seven satellite locations in Ashtabula, Ohio; the Summa Health System, comprising Akron City Hospital and St. Thomas Hospital in Akron, Ohio; and Grace Hospital, an 87-bed, long-term acute care hospital in Cleveland.

While all this was going on, University Hospitals also assembled a system that included the following hospitals: University Hospitals, Bedford Medical Center, Geauga Regional Hospital, Memorial Hospital of Geneva, and Brown Memorial Hospital (in Conneaut, Ohio). When Columbia-HCA abandoned Northeast Ohio, University Hospitals bought their half interest in Caritas, a group of Catholic hospitals including St. Vincent Charity, St. John West Shore, St. Luke's, and Timken Mercy in Canton, Ohio. University Hospitals ultimately closed St. Luke's Hospital, long a Cleveland icon, after a brief attempt to make it succeed as a psychiatric hospital. After Primary Health System

referred to previously, the Cleveland Clinic Health System was divided into three regions: Eastern, Western, and Central (the latter including the main campus and Marymount). The Cleveland Clinic's Board of Trustees, with a few additions from the member hospitals' boards, functioned also as the board for the system. There was no organization comparable to the Clinic's Board of Governors at the system level, because physicians had a much more limited role in the System hospitals than on the Clinic's main campus. However, under the managed care arm of system management, a system-wide Physicians' Organization was established to deal with physician-specific issues.

The establishment of the Cleveland Clinic Health System also had another significant result. It made The Cleveland Clinic, now with approximately 25,000 employees, the fourth largest employer in the state, behind General Motors, Delphi Automotive, and Kroger Company, and one of only two health care organizations in the top twenty-five. The other health care organization in the top 25 private-sector employers in Ohio was University Hospitals of Cleveland, which ranked ninth based on the *2000 Harris Ohio Industrial Directory*. The Cleveland Clinic had truly joined the ranks of big business.

THE CLEVELAND CLINIC HEALTH SYSTEM'S PHYSICIANS' ORGANIZATION

Associated with the hospitals that joined the Cleveland Clinic Health System were four physician hospital organizations (PHOs). On the east side of Cleveland were the Meridia PHO (the largest of the four), which was linked to the four Meridia hospitals (Hillcrest, Euclid, Huron, and South Pointe), and the Marymount Hospital PHO. On the west side of the city were the PHOs of Lakewood Hospital and the Fairview Hospital System (Fairview and Lutheran Hospitals). The purpose of these PHOs was to allow the hospitals and their associated physicians to act as combined entities in contracting with payers for the delivery of managed care. Altogether, approximately 2,000 physicians were members of these PHOs. As the Cleveland Clinic Health System came together, it became necessary to decide the direction in which the relationship of the new hospital system to the physicians in the PHOs would evolve.

The need to contract with payers for managed care still existed,

and the PHO physicians were used to the idea of working with their respective hospitals. There was, nevertheless, some unease among the physicians about having the same sort of relationship with a large hospital system anchored by The Cleveland Clinic. Many were concerned that The Cleveland Clinic would force them into an employed, salaried relationship, like that in The Cleveland Clinic's staff model. Some, on the other hand, had actively campaigned against their hospitals' joining The Cleveland Clinic, because they wanted a relationship with a system that would buy their practices. There was also fear that The Cleveland Clinic would impose controls on their freedom to practice as they chose. It fell to Dr. Alan London, The Cleveland Clinic's dynamic, young Executive Director of Managed Care, to resolve these issues and work out a satisfactory working relationship with the PHO physicians.

As noted in the previous chapter, London had come to the Clinic in 1995 from Tenet Healthcare Corporation in California. He grew up in Cleveland and got his medical degree from the Medical College of Ohio in Toledo. He received his training in family practice at the University of California, Irvine. At Tenet, then known as National Medical Enterprises, he was executive vice president and national medical director. He had developed and directed a broad spectrum of managed care and healthcare delivery programs within the Tenet network both in the United States and abroad. Thus, he was well suited to the difficult task that now confronted the institution.

The first assignment was to develop a strategic plan to bring the groups together. All this work was completed by November 1998, and the Physician Organization (PO) Board, chaired by London, began to meet then to hammer out a physician participation agreement. The PO Board's 15 members consisted of four physician-elected trustees, six regional hospital-nominated trustees, and five member (CCF) trustees. The physician members were half specialists and half primary care physicians. Elected Board members served for terms of two years. Although for all intents and purposes, the agreement was finished by May 1999, it was not agreed to until September of that year. The Board also established the following committees: risk pool, medical management, finance and contracting, and membership and credentialing. All but about 200 of the original PHO members chose to stay in the merged organization, and the size of the PO has remained constant at about 2,000 (22% primary care).

DEPLOYMENT OF FAMILY HEALTH CENTERS AND AMBULATORY SURGERY CENTERS

The Cleveland Clinic established its first off-site medical practice in the nearby community of Independence, just south of Cleveland. The original idea for this arose in the sports medicine section of the Department of Orthopaedic Surgery, and orthopedists Dr. John Bergfeld, team physician of the Cleveland Browns, and Dr. Ken Marks, head of the department, pushed hard for its establishment. Bergfeld and Marks saw an opportunity to take the Clinic's elite sports medicine program out into the community where it could be more accessible to scholastic sports participants. They were anxious to more fully develop the concept in a Clinic-owned facility.

Thus, the first Cleveland Clinic Family Health Center opened in leased space in Crown Centre, a large new office building near the intersection of I-77 and Rockside Road in Independence, under the direction of internist Cynthia Deyling in September 1993. It was an immediate success. The original sports medicine concept was successfully implemented there as well. Within a couple of years, the practice had outgrown its original quarters, and The Cleveland Clinic constructed a new building, Crown Centre II, adjacent to the first site. The physicians working in this facility were all employees of The Cleveland Clinic and were included in a new Division of Regional Medical Practice headed by David L. Bronson, M.D.

Bronson had been recruited from the University of Vermont to head the Clinic's department of general internal medicine in 1992. Originally from Maine, Bronson received his M.D. degree from the University of Maine and trained in internal medicine at the University of Wisconsin. After finishing his training, he returned to New England and joined the faculty of the University of Vermont. While in Vermont, as a faculty member and later as associate chairman of the department of internal medicine at the University of Vermont, he had become interested in innovative delivery of medical care. Subsequent to his arrival in Cleveland, it quickly became apparent that he would make an outstanding leader for the formation and management of a group of strategically placed, primary care-oriented practices that could function as access points to the main campus's subspecialty-oriented physicians. Bronson assumed the leadership of the new division in 1995.

In the early 1990s, the time was clearly right for this initiative, and several factors were important in creating a favorable setting for establishment of satellites. Managed care appeared to be replacing traditional fee-for-service indemnity health care insurance coverage, and for physicians this favored banding together “to act as a unit” in contracting with the payers. Furthermore, it appeared then that primary care physicians would finally assume their long sought-after role as gatekeepers and that Cleveland Clinic-style specialists would have a less central role in care management.

The Clinton administration was pushing for a modified version of the “managed competition” care delivery model envisioned by the Jackson Hole Group, led by Alain Enthoven and his colleagues. This model encouraged the formation of groups of primary care physicians with strong administrative capabilities (“Accountable Health Plans”) that could contract directly with employers and other payers and manage the health of “populations” of patients through careful attention to prevention. Capitated payment was the order of the day. This, so the story went, would keep the patients out of the hospitals and away from the expensive subspecialists, save money, and result in great outcomes. Although capitated HMO-type managed care never really caught on in Cleveland, the primary care satellite concept worked very well for The Cleveland Clinic and its widely distributed patient population.

Dr. Cynthia Deyling continued to lead the first family health center at Independence, which moved to the new adjacent building in 2000. The three other original family health centers opened in Willoughby Hills to the east, Westlake to the west, and Solon to the southeast. Primary care physicians led all of them. Dr. Thomas Morledge (internist) was the director of the Willoughby Hills facility, Dr. Mary Walborn (internist) led the Westlake center, and Dr. Ruth Imrie (pediatrician) was in charge of the Solon location. As had occurred in Independence, these practices also grew rapidly. An “inner ring” strategy began to take shape.

Over the next five years, several additional Family Health Centers came into being. In 1998, The Cleveland Clinic acquired the Wooster Clinic, a highly-regarded group practice in Wooster, Ohio, headed by Dr. James Murphy. Many of The Cleveland Clinic’s physicians had close referral relationships with the doctors at the Wooster Clinic, so the association was natural. In fact, this relationship brought the

Clinic back to its roots, in a sense, because George Crile, Sr., had graduated from Wooster College's long defunct medical school in the nineteenth century. This acquisition also turned out to be the first of the "outer ring" facilities.

Also in 1998, the Lorain Ambulatory Surgery Center was added. John Costin, M.D., an irrepressible and entrepreneurial Cleveland Clinic-trained ophthalmologist, and Michael Kolczun, M.D., a prominent alumnus of The Cleveland Clinic's orthopedic surgery program, played important roles in getting the project started. A number of successful Lorain County physicians joined in this endeavor, and it has become one of the leading medical facilities in the region.

The following year, The Cleveland Clinic opened its Strongsville facility, under the leadership of internist Dr. Howard Graman. This was the first of the Family Health Centers built using the pyramid-like Crile Building as its architectural model. Subsequent newly constructed Family Health Centers follow the same design. In addition to primary care, the Strongsville Family Health Center has an ambulatory surgery component.

In 2000, The Cleveland Clinic opened its Beachwood facility in the same building that had housed Mt. Sinai's Integrated Medical Campus. The Clinic purchased this building from the bankrupt Primary Health System. Interestingly, the original plan was for The Cleveland Clinic to purchase the Integrated Medical Campus along with two hospital buildings (St. Michael and Mt. Sinai East) that were to have been closed by Primary Health Systems. However, the proposed closure of these two hospitals, though they were both losing money and suffered from chronic low occupancy (less than 30% in both cases), precipitated community protests that were fanned by local politicians. Ultimately, University Hospitals bought the hospitals for \$12 million and promised to keep them open as full-service hospitals. Since Mt. Sinai East had the same Medicaid provider number as the already closed Mt. Sinai Hospital in University Circle, University Hospitals reaped the federal and state monies that Mt. Sinai, if it had remained open, would have received through Ohio's Hospital Care Assurance Program (HCAP) for indigent care in 1998 and 1999. It is probably not coincidental that the amount of these payments was approximately \$12 million. In September 2003, University Hospitals Health System announced the impending closure of St. Michael Hospital after having lost \$33 million trying to keep it run-

ning, and it closed at the end of the year. Like Strongsville, the Beachwood Family Health Center also had ambulatory surgery and a fairly broad range of subspecialists.

In addition to the eight major facilities described above, several smaller centers (Brunswick, Lakewood, Chagrin Falls [formerly Curtis Clinic], Elyria, Chardon Road/Willoughby Hills, and Creston, as well as a sports health center at the Jewish Community Center in Beachwood) also opened. In all, by 2002 the Family Health Centers, some with ambulatory surgery centers, employed over 250 physicians and accounted for about half of the outpatient visits to The Cleveland Clinic. Eighty-nine primary care residents and 99 medical students received part of their training at the Family Health Centers in 2001. The Family Health and Ambulatory Surgery Centers filled an extremely important role for The Cleveland Clinic's delivery system.

NEW BUILDINGS: ACQUISITIONS AND NEW CONSTRUCTION

After the Century Project was completed in 1986, there was a brief lull in new building construction and expansion. Nevertheless, the staff continued to grow at its exponential rate (see Epilogue) and, by the early 1990s, it was clear that this could not continue without the addition of space for clinical and research activities. Some of the existing facilities, moreover, were showing the effects of age and changes in design requirements for the Clinic's growing and increasingly complex needs. For example, all the organization's computing facilities were at that time located in a basement under the East 90th Street employee garage. With the institution's increasing dependence on technology to support its voracious appetite for information, this was clearly a vulnerable point in the system.

Lack of adequate laboratory space had become an obstacle to recruiting first-class scientists to the Research Institute. Besides the research facilities in the FF Building, which had been constructed in 1974, there was some very old space in a loading dock area abutting the south side of the L Building, which at that time housed the artificial organs program. The Sherwin Building, which had opened in 1991, funded by a \$30 million campaign led by Bernadine Healy, M.D., chairwoman of the Research Institute, and Arthur B. Modell,

president (1991-1996) of The Cleveland Clinic Foundation, relieved the pressure temporarily. The Sherwin Building represented the first phase in a grander design (see Chapter 9).

Lerner Research Institute

The realization of this grand design was the Lerner Research Institute, funding for the construction of which was the major purpose of the campaign called "Securing the 21st Century." This campaign, led by trustee Joseph Callahan and managed by William Grimberg, the director of Institutional Advancement, provided about \$190 million toward the building of the Lerner Research Institute, of which \$16 million was a gift from Mr. and Mrs. Alfred Lerner. Lerner was, at the time, president (1996-2002) of The Cleveland Clinic Foundation.

The Lerner Research Institute is a five-story, U-shaped building designed by Cesar Pelli and located on the south side of Carnegie Avenue between East 97th and 100th Streets. The western limb of the U houses the Department of Biomedical Engineering. It contains a fully equipped machine shop as well as an array of laboratories, supporting, among other things, The Cleveland Clinic's artificial heart development program.

The base of the U contains traditional laboratories for biomedical research, housing the Clinic's extensive programs in molecular biology as well as other basic research programs. On the first floor of this part of the building is the Reinberger Commons, a rotunda area designed to promote collaborative interaction among the scientists and named for the philanthropic Reinberger brothers, distinguished fellows of The Cleveland Clinic Foundation.

The eastern limb of the U provides a home for the Division of Education and the Cleveland Clinic Educational Foundation. A prominent feature of this part of the building is the Alumni Library, which occupies most of the third and fourth floors of the east wing. The north ends of the limbs of the U are connected by a skyway at the third-floor level, and short bridges connect the west end of the Lerner Research Institute to the laboratory medicine building at the second level and the east end to the East 100th Street garage and the skyway to the Crile Building at the third level.

Occupancy of the Lerner Research Institute began early in 1999, and the building was formally opened and dedicated in May of that year, with a week-long series of celebrations. Although the original intent was to occupy floors one through four initially and later build out and open the top floor, by the end of 1999 the building was full, and the Research Institute was already looking for additional space.

Cole Eye Institute

The establishment of the Cleveland Clinic Eye Institute and recruitment of Hilel Lewis, M.D., in 1992 had signaled the Clinic's intent to support this activity with the construction of new facilities for ophthalmology and eye research. An important part of this process was the success of the previously mentioned Securing the 21st Century campaign in raising \$30 million, anchored by a \$10-million gift from Jeffrey Cole, needed to fund the construction of the building to house the Institute. The Cole Eye Institute, which opened in 1999, is located on the south side of Euclid Avenue between East 100th and 105th Streets, just east of the Crile Building and connected to it by a skyway. An important feature of this building, designed by Lewis, is the radial design of the examining rooms, which are long and narrow, and arrayed in a semicircle. This design permits the examining-room entrances to be closer together than they would be with traditional design, thus facilitating access and promoting efficiency. It is also responsible for the distinctive curved appearance of the north face of the building.

Taussig Cancer Center

Although not part of the original program for Securing the 21st Century, a significant gift from the Taussig family enabled the Clinic to accelerate plans for a new building to house the Cancer Center. Once again, Cesar Pelli's considerable talents were employed to develop the dramatic S-curved appearance of the \$49-million Taussig Cancer Center, which opened in 2000. It occupies the south side of Euclid Avenue between East 89th and 90th Streets. It hous-

es clinical examining and treatment rooms on the first and second floors and research laboratories on the upper floors. It is connected to the radiation oncology department of the Cancer Center (in the T Building) through a second-level bridge across East 90th Street.

W.O. Walker Center

In the mid-1980s, the State of Ohio began construction of a \$72-million, 15-story building occupying the land bounded on the west by East 105th Street, on the north by Euclid Avenue, on the east by Stokes Boulevard, and on the south by the Ohio School of Podiatry. This building, named after William O. Walker, the founder and longtime publisher of the *Call and Post* newspaper, was intended to house a state-of-the-art residential rehabilitation center to be operated by the Ohio Bureau of Workers' Compensation. It was similar to, but bigger than, a similar facility in Columbus, the Leonard Camera Center. Despite valiant attempts, neither of these operations was successful. In Columbus, Ohio State University took over operation of the Camera Center, using it primarily for sports medicine services. In Cleveland, after a prolonged negotiation, the state sold the Walker Center to The Cleveland Clinic and University Hospitals late in 1996 for \$44 million. The two organizations each paid half of the purchase price, occupied alternating floors, and shared certain common facilities.

The Cleveland Clinic had several clinical services in the Walker Center, including the Spine Institute, Pain Management, outpatient rehabilitation facilities, and the histocompatibility laboratory. Management of the facility required ongoing cooperation between The Cleveland Clinic and University Hospitals, something that few would have predicted possible. Nonetheless, the project went forward smoothly.

Parker Hannifin Building

In September 1997, the Parker Hannifin Company, a well-established Cleveland equipment manufacturer, moved its corporate headquarters to a new building in suburban Mayfield Heights, Ohio.

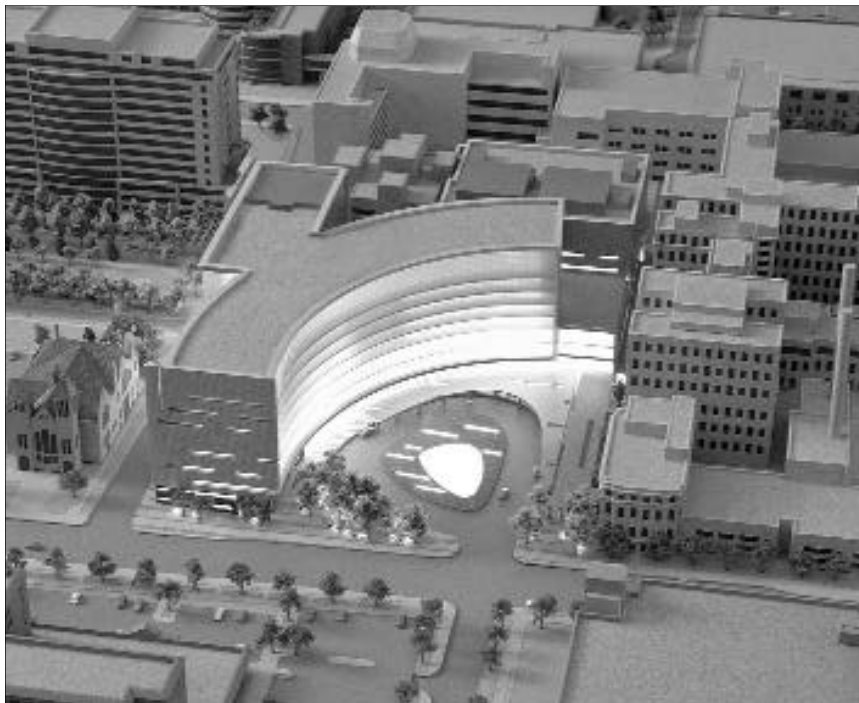
They donated their old corporate headquarters building at 17325 Euclid Avenue (between Ivanhoe and London Streets) to The Cleveland Clinic. This structure, with more than 500,000 square feet of usable space, housed the Cleveland Clinic Health System's Information Technology Division, as well as several other administrative functions.

TRW Building

Following its acquisition by Northrop Grumman, TRW's aerospace division was moved to California and its automotive division to Livonia, Michigan. Thus, in December 2002, TRW donated its corporate headquarters in suburban Lyndhurst, Ohio, to The Cleveland Clinic. This 300,000-square-foot facility is situated on a 58-acre wooded parcel of land on the west side of Richmond Road between Legacy Village Mall on the south and Hawken Lower School on the north. This is a portion of the old Bolton Estate. Besides the land and office complex, which contains a large auditorium and a spectacular atrium, TRW's gift included a 300,000-square-foot garage that accommodates 577 cars, a 5,000 square-foot repair facility, and the Bolton House. The latter is a 21,836-square-foot mansion built in 1917 and completely renovated by TRW in the mid-1980s to provide housing for corporate visitors and conferences. The house has 12 bedrooms, each with a private bath.

Heart Center

Plans for a new Heart Center, to be funded mostly by philanthropy, had been incubating since the successful completion of the Securing the 21st Century campaign. As these plans took shape, the concept emerged of a nearly one million square-foot building to house the new center, including 288 hospital beds, laboratories, and outpatient facilities. Replacement of the parking garage on the south side of Euclid Avenue at East 93rd Street with a new parking and office structure on the north side of Euclid made space for the new building. A tunnel under Euclid Avenue eased access to the new facility.



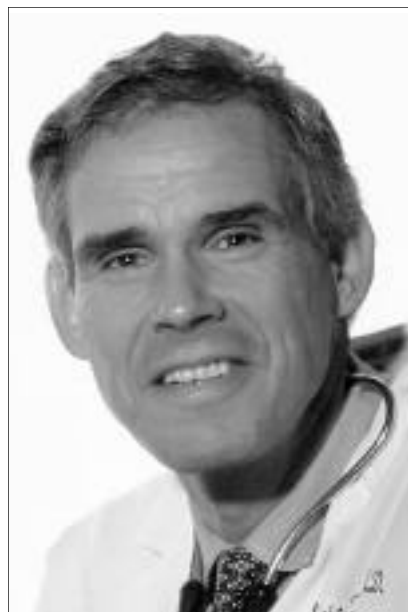
Heart Center, architect's model, 2003

THE ACADEMIC ENTERPRISE AND THE MEDICAL SCHOOL

In March 2001, Loop announced the reorganization of The Cleveland Clinic's academic enterprise. The Board of Governors appointed Dr. Eric Topol, a distinguished clinical investigator and head of the Clinic's cardiology department, as Chief Academic Officer. His team consisted of Dr. Andrew Fishleder, who would continue to head the Clinic's postgraduate education programs, Dr. Richard Rudick, head of the newly created Office of Clinical Research, and Dr. Paul DiCorleto, head of the Lerner Research Institute, the Clinic's basic research program. Brian Williams, Ph.D., Edward Plow, Ph.D., Andrew Novick, M.D., and Joseph Iannotti, M.D., Ph.D. filled the remaining seats on the Academic Council.

Just over a year later, in May 2002, through a formal agreement with Case Western Reserve University supported by the University's new president, Dr. Edward Hundert, and a generous gift from Alfred

Lerner, the president of The Cleveland Clinic Foundation, The Cleveland Clinic Lerner College of Medicine of Case Western Reserve University was born. This event greatly pleased many of Cleveland's traditional leaders, who had long sought to bring The Cleveland Clinic and Case Western Reserve University together. This process was difficult because of competition between The Cleveland Clinic and University Hospitals, but it was greatly eased by changes in leadership at University Hospitals and the resolution of conflict between University Hospitals and the University itself. The purpose of the new medical school was to produce physician investigators, an increasingly rare breed of medical graduates. The first class of 32 students was scheduled to enroll in July 2004.



*Eric J. Topol, M.D.,
Chief Academic Officer, 2001-*

INFORMATION TECHNOLOGY AND THE ELECTRONIC MEDICAL RECORD

Computers had appeared at The Cleveland Clinic in a big way during the early 1980s. The idea of managing as many functions as possible, including patient care, with the help of computers led to several ill-fated, institution-wide projects, but the technology then simply wasn't up to the task. Instead, many different systems and networks serving various functions (billing, scheduling, laboratory management and reporting, radiology, pathology, and a proliferating gaggle of clinical registries) sprang up, Babel-like in their inability to communicate with each other. The ideal of an institution-wide electronic medical record seemed as though it should be achievable but had always been just out of reach. Commercially available prod-



*C. Martin Harris, M.D.,
Chief Information Officer, 1999-*

ucts were unable to cope with the sheer size and complexity of The Cleveland Clinic, although they were capable of serving small medical offices. Some institutions developed home-grown electronic medical records (e.g., Harvard Community Health Plan, Kaiser Permanente, and others), but attempts to do this at The Cleveland Clinic were unsuccessful and costly. Part of the problem was that the Clinic's early computer experts did not understand the needs of medicine, and the Clinic's medical experts were unsophisticated in the realm of digital technology.

In 1996, Dr. C. Martin Harris was recruited from the University of Pennsylvania to fill the role of the Clinic's first Chief Information Officer. Harris is a nearly unique individual in that he is a highly skilled internist as well as a computer expert with a degree from the Wharton School of Business. Thus, he understands the needs of medicine, but he also clearly understands the capabilities of the technology and its cost implications. His communication skills are such that he can talk the languages of the key players and bring all the pieces together in a way that none of his predecessors had been able to do. He has a methodical business approach that enables him accurately to evaluate existing products and make choices that do not lead to unpleasant surprises after implementation begins.

Harris's first task, however, was to develop a plan that would get the Clinic through a looming problem that few people could accurately evaluate, i.e., "Y2K." In 1998, concern began to grow about what would happen on January 1, 2000, to the computer-based infrastructure upon which U.S. business (including hospitals) and government had become increasingly reliant. This concern stemmed from the fact that much of the software serving major date-

sensitive functions, written over the previous 25 years, recognized only the last two digits of the year, assuming “19” for the first two digits. Nobody knew what would happen to scheduling systems or equipment programmed to require service on certain dates (such as pacemakers, etc.) when “99” flipped over to “00” at the turn of the century. Articles predicted that airplanes would fall out of the sky, that the world monetary system would collapse, and that disastrous events killing many patients would occur in hospitals. Lawyers were salivating at the prospect.

Harris devised a plan in which all computer-based functions at the Clinic would be classified into (a) those that had to be fixed because they were likely to fail with significant bad results, (b) those that were likely to fail but could be discarded and replaced, and (c) those that would not be affected by the arrival of Y2K—the year 2000. Millions of lines of code in the scheduling, admission, and billing systems had to be examined and corrected. Every computer in the Clinic had to be checked for date-sensitive software, and every piece of equipment with a microprocessor in it also had to be tested. Then each piece of equipment and software had to be classified into one of the three categories listed above and certified as Y2K-ready or discarded and replaced. Amazingly, despite a certain level of hysteria that prevailed both inside and outside the institution, Harris and his team accomplished all this six months ahead of schedule, and Y2K came and went uneventfully at the Clinic.

For his next task, Harris and his colleagues in the Information Technology Division (ITD) addressed the previously unsolved issue of the electronic medical record. By this time, several departments had begun experimenting with one or another of the commercial products that were becoming available. Harris organized the evaluation scheme, piloted several of the products, and concluded that the Epic system, with EpiCare as the front end, had the capacity, flexibility, and user-friendliness required to meet the needs of patient care at The Cleveland Clinic. Introduction of this system to clinical practice began in 2001 and was essentially complete in the outpatient clinics by the end of 2002. The next hurdle will be implementation of an electronic medical record in the hospital, including computerized physician order entry (CPOE).

While all this was taking place, the Internet had developed from a curiosity, mainly frequented by computer “nerds,” into a poten-

tially important tool for dissemination of information and for marketing. The Cleveland Clinic's presence on the World Wide Web began, somewhat primitively, in 1994. By 1996, there was an organized web site (www.ccf.org) providing much information about the Clinic and its departments (including the entire third edition of *To Act As a Unit*), but very limited capability for interaction. This was solved in 2002 with the introduction of *e-ClevelandClinic.com*, the commercial arm of the Clinic's web site. *e-ClevelandClinic.com* grew out of an idea conceived by Dr. Eric Topol, head of the Clinic's cardiology department. The purpose was to make on-line, second-opinion consultation with Cleveland Clinic specialists available to the public in a secure, protected web environment. The Clinic's partnership with WebMD, a popular health care portal to the Internet, provided greater ease of access to the Clinic's web site.

The ITD division, under Harris's leadership, has truly brought the organization into the 21st century by providing the nervous system for the widely disseminated components of the Cleveland Clinic Health System. With the sophisticated connectivity that now exists, the Clinic is poised for whatever the future may bring.

STRENGTHENING OF MANAGEMENT

While all of this was going on, several significant changes took place in the executive management of The Cleveland Clinic.

After 18 years of dedicated service, Daniel Harrington, the Clinic's Chief Financial Officer, retired in 1999. Michael O'Boyle was eventually recruited to fill the role of Chief Financial Officer for the Cleveland Clinic Health System. He came to the Clinic from his position as Executive Vice President and Chief Financial Officer of MedStar Health, Inc., of Columbia, Maryland. MedStar was the largest healthcare network in the Baltimore-Washington metropolitan area. He had 18 years experience as chief financial officer for medical organizations.

Also in 1999, Ralph Straffon, M.D., the Clinic's Chief of Staff, retired and was replaced by Robert Kay, M.D., a pediatric urologist. Straffon died after a prolonged illness on January 22, 2004. Kay had most recently served, as previously mentioned, in the role of Director of Medical Operations. He was a lifelong Californian prior



*Michael O'Boyle,
Chief Financial Officer, 2001-*



*Robert Kay, M.D.,
Chief of Staff, 1999-*

to his recruitment by Straffon to join the Clinic's staff in 1980 as head of the Section of Pediatric Urology. He obtained his M.D. from the University of California Los Angeles in 1971. Since joining the Clinic, he has had a distinguished medical career, including his service as chairman of the Section on Urology of the American Academy of Pediatrics. He has held numerous administrative positions at the Clinic, including service on the Board of Governors and the Board of Trustees. He has received much recognition for excellence as a physician and is consistently listed among America's best doctors. He also obtained an M.B.A. degree from Case Western Reserve University in 1990.

Melinda Estes, M.D., returned to The Cleveland Clinic in 2000 after a three-year stint as Executive Vice President and Chief of Staff at MetroHealth Medical Center to serve as Executive Director of a newly created Division of Business Development. Loop soon prevailed on her to assume the reins at Cleveland Clinic Florida, where she became CEO in 2001, replacing Dr. Harry Moon. Estes received her M.D. degree from the University of Texas, Galveston. After joining the medical staff at The Cleveland Clinic in 1982, she



*James Blazar,
Chief Marketing Officer, 1999-*

was appointed head of the section of neuropathology, a position she held until moving to MetroHealth in 1997. In addition, she served on the Clinic's Board of Governors from 1990 to 1995 and as Associate Chief of Staff from 1990 to 1997. Estes resigned in 2003 to accept a hospital CEO position in Vermont.

Following the departure of Chief Marketing Officer Peter Brumleve, James Blazar was recruited from the Henry Ford Health System to fill this position in 1999. Blazar had 24 years of experience in marketing, mostly in health care. He had received his undergraduate education at the University of

Cincinnati and an M.B.A. degree from the University of Chicago. He worked at Henry Ford Health System for eight years, where he began as Vice President of Marketing and Product Development, later moving to the Vice Presidency of Primary Care and Clinical Services for Henry Ford's medical group.

Finally, when William Grimberg, head of Institutional Advancement, left the Clinic in 2001, Bruce Loessin moved over from Case Western Reserve University, where he had served as Vice President for Development and Alumni Affairs, to take the helm of the fundraising department, now known as Institutional Relations and Development. Since completing his education at the University of Michigan in 1972, Loessin had gained experience at several institutions, encompassing teaching and research, fund-raising, capital support, broadcasting, special events, continuing education, international studies, and federal relations. His successes at Case Western Reserve University made him the ideal candidate to succeed Grimberg.

By 2003, the Administrative Council had expanded to 12 members, but dropped back to 11 members with Estes's departure.

Chaired by Loop, the group now included Altus, O'Boyle, Kay, Lordeman, Blazar, Harris, London, Ivancic, Bronson, and Clough. The Board of Governors and the Medical Executive Committee remained constituted as before, although the personnel changed from time to time.

Professional divisional and especially departmental management also underwent some significant changes during this period.

At the divisional level, Paul DiCorleto, Ph.D., replaced George Stark, Ph.D., as chairman of the Lerner Research Institute in 2002. DiCorleto, also a molecular biologist, has worked extensively with cytokines. He has served on the Board of Governors, the Medical Executive Committee, and the Academic Council and is an able successor to Stark, who remains active in research. In 2003, Michael Levine, M.D., a pediatric endocrinologist from Johns Hopkins University, replaced Moodie as chairman of the Division of Pediatrics and head of The Children's Hospital at The Cleveland Clinic. In October 2003, three other significant divisional leadership changes occurred. Claire Young, R.N., replaced Shawn Ulreich as Chief Nursing Officer. Kenneth Ouriel, M.D., head of the Department of Vascular Surgery, replaced Hahn as chairman of the Division of Surgery, and James B. Young, M.D., co-chair of the Heart Failure Center, replaced Ahmad as chairman of the Division of Medicine.

At the departmental level, numerous changes have taken place since the last edition of this book. In 2003, Dr. Charles Emerman headed the Clinic's Emergency Department, which operates jointly with the emergency department at MetroHealth Medical Center. Tommaso Falcone, M.D., became the chairman of Obstetrics and Gynecology, having succeeded Jerome Belinson, M.D. After Bronson moved to the Division of Regional Medical Practice, Joseph Cash, M.D., briefly headed the Department of General Internal Medicine until his untimely death in 1999. Dr. Richard Lang replaced him. Sethu Reddy, M.D., succeeded Charles Faiman, M.D., as the head of Endocrinology. Joseph Iannotti, M.D., Ph.D., became chair of Orthopaedics, following Kenneth Marks, M.D. Both Anatomic Pathology and Clinical Pathology received new chairmen, with John Goldblum, M.D., now in charge of the former and Raymond Tubbs, D.O., the latter. The Department of Vascular Medicine was merged into Cardiovascular Medicine and no longer has a

department chair. As the result of the departure of David Longworth, M.D., a search for his successor in Infectious Disease is under way. Finally, in November 2003, Derek Raghavan, M.D., Ph.D., from the University of Southern California, was appointed the new chairman of the Taussig Cancer Center, succeeding Maurie Markman, M.D.

TAKING STOCK: A PROGRESS REPORT

As Loop prepares to retire after nearly 15 years as chief executive officer, it is instructive to consider how far the organization has advanced during that time. We have been looking at the trees in the last two chapters; now it is time to look at the forest.

In 1990, the organization had annual revenues of \$572 million and equity of \$301 million with debt of \$365 million. In 2003 the debt had approximately tripled to \$1 billion, but the annual revenues had risen sixfold to \$3.5 billion, and equity had grown to \$1.3 billion, a fourfold increase. In Cleveland, there were 650 thousand outpatient visits to the main campus in 1990, but by 2003 this total had increased to 2.1 million visits to the Clinic's facilities, now supplemented by 14 family health centers and four ambulatory surgery centers. On the hospital side, the organization has grown from one hospital in Cleveland and one in Florida in 1990 to 10 hospitals in Cleveland and two new hospitals on two new unified campuses in Florida (Weston and Naples) in 2003.

Accompanying these physical and financial changes, the Clinic's culture has changed as well. A sense of proactive urgency has replaced the relaxed camaraderie of past years. Although there is still a marked emphasis on leadership, teamwork, active practice, and academic achievement, we now require excellence in more than one endeavor, and we recognize a stronger need for intellectual growth, practice building, communication, and service excellence. This is Loop's "New Professionalism," and it is reflected further in the shift of the Clinic's university affiliation from Ohio State University to Case Western Reserve University. Research has metamorphosed from a small and unfocused sideline to a highly sophisticated, programmatic enterprise. Fund raising, which was negligible in the past, is now well organized and productive, and the endowment has

increased from \$150 million to \$800 million. The Annual Professional Review has progressed from a predominantly subjective to a more objective exercise, and this progression continues.

Finally, on June 2, 2004, Board of Trustees Chairman A. Malachi Mixon III announced the election of Delos M. “Toby” Cosgrove as the Clinic’s next chief executive officer. Cosgrove had succeeded Loop as chairman of cardiovascular surgery, and would now succeed him again as CEO. This would be the Clinic’s smoothest succession at the top leadership position, and the staff enthusiastically welcomed the transition.

The combination of new divisional and departmental leadership as well as dynamic leadership at the top has kept the organization’s energy level at high intensity. Coupled with the World Class Service leadership development initiative that began in 2003, these changes promise to catapult The Cleveland Clinic and the Cleveland Clinic Health System to new heights of accomplishment in the decades to come.



*Delos M. Cosgrove, M.D.,
Chairman of the Board of Governors
and Chief Executive Officer, 2004-*