Cleveland, Ohio: University Hospitals System and Cleveland Clinic Health System

Our last case profiles two institutions and their collective and individual efforts to integrate anchor institution missions. Linked by a common geography, the flagships of these two health systems are separated by less than two miles. Collectively, University Hospitals and Cleveland Clinic have been important partners, with the Cleveland Foundation and Case Western Reserve University, in working to transform Cleveland’s Greater University Circle.

University Hospitals System

We have done some studies of healthcare disparities [in the surrounding neighborhoods]. It is shocking. It’s absolutely shocking when you look at health disparities with a racial filter, with a socio-economic filter. Our anchor institutions identified a meaningful and sustainable way to help fix the problems through Vision 2010.

— Steve Standley, Chief Administrative Officer, University Hospitals

In 2006, University Hospitals System committed to “Vision 2010: The UH Difference”—a five-year strategic growth plan that would transform the way the hospital system interacted with its community and position it as a national example of a hospital trying to achieve its anchor institution mission. University Hospitals’ $1.2 billion investment is not its only commitment to its anchor mission, but it is a foundational and formative piece and the primary focus of this case study. This vision required a commitment to purchase locally, increase the number of minority- and women-owned suppliers, and aimed to create local supplier capacity where it did not exist before. At the same time, University Hospitals hired an independent organization to hold it accountable and voluntarily entered into a unique Project Labor Agreement (PLA) that obligated it to meet certain targets. University Hospitals’ efforts in this area did not conclude at the end
of this growth process. In fact, Vision 2010 provided the catalyst for these expectations to be applied subsequently to the organization’s entire supply chain. Going forward, University Hospitals has committed to leveraging its resources to maximize its economic impact on Cleveland and Northeast Ohio.\textsuperscript{296}

Consolidated in 1993, the University Hospitals System comprises a major medical academic center and six community hospitals across Northeast Ohio. Together, they employ more than 24,000 people, making the system Northeast Ohio’s second-largest private sector employer and the seventh-largest in the state. The hospital system’s revenues exceed $2 billion annually and it procures approximately $850 million in medical goods and services each year.\textsuperscript{297}

Anchoring the system is University Hospitals Case Medical Center in Cleveland, a 1032-bed medical center. Originally part of Case Western Reserve University, this center was

---

**UNIVERSITY HOSPITALS SYSTEM ANCHOR STRATEGIES**

**Neighborhood Revitalization**

- Greater University Circle Initiative: foundation and anchor institution-led comprehensive neighborhood revitalization effort of surrounding neighborhoods

**Local and Minority Purchasing**

- Vision 2010: $1.2 billion investment with contract goals: 5% women-owned, 15% minority-owned, 20% of workers Cleveland residents, and 80% locally based firms
- Vision 2010: third party oversight and voluntary project labor agreement that prioritized goals

**Community Investment**

- Evergreen Cooperatives: $1.25 million in multi-institutional, business co-development strategy to create jobs for neighborhood residents and allow local sourcing

**Capacity Building**

- NewBridge Cleveland Center for Arts & Technology: job training and skill development in healthcare for adults and the arts for youth

---

University Hospitals Ahuja Medical Center, constructed as part of Vision 2010. Photo: University Hospitals.
first founded in 1896, and contributed to the development in the early 20th century of University Circle, a collection of educational, medical, and cultural institutions. Today the area serves effectively as a second downtown district on Cleveland’s east side. This main campus also includes a dedicated children’s hospital, the region’s only National Cancer Institute-designated Comprehensive Cancer Center, and the state’s only hospital for women.

Since 1950, Cleveland’s population has declined by more than 55 percent. In the first decade of the 21st century, the city suffered the third-largest decline of any major U.S. city (17 percent), only surpassed by Detroit and New Orleans. Today, Cleveland is a majority-black city, increasing by two percentage points to 53 percent between 2000 and 2010 despite a decrease in absolute numbers of African-Americans. The percentage of whites has decreased to 34 percent in the city, while the Latino and Asian populations grew slightly in percentage and absolute terms to 10 percent and two percent, respectively. Despite the city’s diversity, racial segregation of blacks and Latinos remains high, exceeding the average for many large cities, according to the Cleveland City Planning Commission. Additionally, the neighborhoods with the highest concentration of poverty are disproportionately black and Latino.

Furthermore, health disparities between low-income and high-income neighborhoods are extreme. Take, for example, Hough, a neighborhood included in the “Greater University Circle,” a term created by the Cleveland Foundation in 2005 that includes six neighborhoods proximate to University Hospitals and the other anchor institutions as part of an effort to revitalize Cleveland’s east side. According to the Weight of the Nation, an HBO documentary that aired in May 2012 in partnership with Kaiser Permanente, Hough residents have a life expectancy of 64 years. In striking contrast, just eight miles away in the same Cuyahoga County, the suburban town of Lyndhurst boasts a life expectancy of 88.5 years. Of the two dozen cities and counties in which this research has been conducted to date, this 24-year difference in life expectancy is the greatest disparity between any two neighborhoods so close to each other.

On the surface, Vision 2010 was a $1.2 billion investment by University Hospitals in system infrastructure—the most visible of which was $750 million in new construction of five major facilities, in addition to new outpatient health centers and expansions of a number of existing facilities. However, the way this infrastructure investment was coordinated involved a broader cultural change for University Hospitals. Explained Margaret Hewitt, former Vice President of Construction Services, who was hired to oversee this project, “It’s a systems change internally for University Hospitals and externally...
for how we did business.” Prior to the program, University Hospitals had no centralized construction services—each facility handled it independently; now it is systemwide.  

Particularly transformative was the health system’s deliberate decision to target its investment to benefit the local community and regional economy. A variety of different motivations helped trigger this shift. One motivation was the realization that since hospitals have fixed locations and often invest in extensive infrastructures, they should adapt to changes in demographics and local economic conditions, said Steve Standley, Chief Administrative Officer for University Hospitals. By 2005, the situation facing Cleveland was grim. Well before the 2008 financial crisis hit, many large corporations had already migrated out of Cleveland, creating the impression that the situation in the region was growing worse. At the same time, political pressure to benefit the community at a local level increased. Furthermore, the Northeast and Midwestern blackout of 2003, which created power outages for four days, increased the hospital system’s focus on how its supply chain could react to immediate shocks, and bolstered the view that shifting purchases to local suppliers would help build resilience in those situations. All of these themes helped foster the idea of using hospital procurement practices to support the regional economy among the senior leadership.

Furthermore, there were cultural changes in the younger generation of staff and potential hires, who wanted to know how University Hospitals could more positively impact the community and mitigate its environmental impact. Finally, from a mission perspective—both financially and morally—the argument was sound. Noted Standley, it made business sense to help create more sustainable local communities with better employment opportunities since those communities tend to have less need for uncompensated care. Together, these different motivations culminated in a focus shift for University Hospitals.

University Hospitals set the following goals for the project: five percent of contractors were to be women-owned, 15 percent were to be minority-owned business, 20 percent of all project workers were to be residents of the City of Cleveland, and 80 percent of businesses that received contracts were to be regionally based companies in Northeast Ohio. The impetus to make these changes also came from within and outside the hospital system. At the same time that University Hospitals was moving in this direction internally, said Hewitt, “The mayor of the City of Cleveland said: don’t step in a small way. If you’re going to do it, just go for it. Give it everything you’ve got. That’s what we decided to do.” At the completion of the final construction in mid-2011, University Hospitals had met all of these targets except for the residency goal.
Despite this one shortfall, University Hospitals exceeded other targets—92 percent of businesses that participated in Vision 2010 had some element of its operations locally based, defined as within a 50-mile radius. Additionally, as a result of an intensive process of vendor development, University Hospitals developed business relations with more than 100 minority- and female-owned businesses. Said Standley, “We spent $3.6 million on vendor development, outreach, and monitoring; we treated ourselves as though we were a federal coupling project even though we are a private organization.”

Standley added in a separate interview that this sum, which equals less than one half of one percent of just the construction budget, would have likely been spent even with the traditional model. “You’re going to do it anyway, so you might as well build something.”

In order to accomplish these goals, University Hospitals implemented two external checks to keep them on target. First, it hired a third-party private consulting agency, Minority Business Solutions, which maintained a constant presence throughout the entire process and helped provide transparency. Remarked Hewitt, “So with every conversation, they would listen through that filter. They have been very successful in finding opportunities in places where we would have never found them.” This element was especially important because as Vision 2010 commenced, a county corruption scandal regarding diversity targets dominated the political conversation. Standley added, “We knew we were doing some culture bending here. We didn’t want people coming back later, pointing fingers, and saying, ‘the numbers aren’t real,’ saying, ‘these are all fabricated,’ that you didn’t really do this.”

Second, University Hospitals negotiated a Project Labor Agreement (PLA) between itself and the Building Trades Council, the umbrella group of 19 unions working in the construction field. In this case, the agreement went beyond the traditional PLA model, which typically commits the unions not to strike during the life of the construction project as long as union labor is being used. The Vision 2010 PLA also incorporated several notable economic inclusion elements. First, although this contract represented an agreement among private employers, the City of Cleveland was intentionally added as a third-party beneficiary and participated in negotiations over the language of the agreement. Second, University Hospitals’ focus on Northeast Ohio was included in the contract. As a result, union contractors were required to hire at least 20 percent of their workforce from Cleveland. Third, the agreement set targets for diversity hiring and allowed University Hospitals to contract with non-union contractors if the building
trade unions could not meet the targets. Fourth, the agreement recognized partnerships and contracts between union and non-union contractors, enabling increased participation and generating new joint ventures. Finally, the contract required that union contractors, local government officials, the building trade unions, and University Hospitals create diversity-related programs that develop minority- and women-owned business capacity, and increase diversity hiring.\textsuperscript{307}

Capacity building is an important element of University Hospitals’ evolution as an anchor institution. Just as University Hospitals has participated in programs that increased the number of minority- and women-owned business in the supply chain, it was also necessary for those involved in Vision 2010 to increase local capacity in order to reach the benchmarks. Hewitt explained one method of capacity building: “Through the program we found areas where less experienced contractors could put University Hospitals on their resume. We did training; we provided opportunities to say, ‘I have some healthcare experience.’” This incremental approach is important from both the hospital system and contractor perspective. First, for the hospitals, it limits the risk from an inexperienced contractor since federal regulators can inspect at any time. Second, it enables the contractor to participate in a market where healthcare is the largest industry. Without this experience, it might be difficult for these contractors to survive.\textsuperscript{308}

Another method involved incentivizing companies to relocate to Cleveland or the surrounding area. By opening a location or expanding a portion of their business to the Northeast Ohio market, a supplier would satisfy the local requirement and be considered for a contract. This process also works in reverse, incentivizing business to stay in the community. Sarah Kresnye, Community Development Manager at the Center for Health Affairs—the metropolitan hospital association representing 40 hospitals through Northeast Ohio—provided the example of Ben Venue Laboratories, the sterile-injectables manufacturing arm of Bedford Laboratories, which was going to relocate to California. Kresnye added, “Steve Standley basically said if you go, your business from us is going to leave. It made them close their California office and bring those jobs to this region. I think [University Hospitals] recognizes the difference that can be made.”\textsuperscript{309}

Business co-development is a third way to build capacity; one example of this effort is the Evergreen Cooperatives, a network of planned, worker-owned companies that University Hospitals has been instrumental in helping to launch by awarding the cooperatives contracts and providing seed funding to the overall Evergreen Initiative ($1.25 million to date). Evergreen represents the economic inclusion piece of a broader revitalization
strategy of the Greater University Circle Wealth Building Initiative. Addressing gaps in the anchors’ supply chains, these employee-owned, “greenest-in-class” businesses hire from target neighborhoods, providing low-income individuals the opportunity to own part of a business and build wealth.310

At the same time, this effort stabilizes the neighborhoods: employees are provided an opportunity to purchase homes within a target area and since the wealth accumulation is dispersed, the majority of it will remain in the community. As of this writing, eight worker-owners are participating in the employer-assisted housing program. Since housing prices in the target communities are currently so deflated, these employees can expect to own their homes within four to five years by paying their mortgage through a payroll deduction. Additionally, as the businesses become profitable, employees share in the profits through their equity stake; over time, their “capital accounts” can grow into many tens of thousands of dollars. To date, three businesses have been launched: Evergreen Cooperative Laundry, Evergreen Energy Solutions (formerly Ohio Cooperative Solar), and more recently, Green City Growers Cooperative, which opened at the end of 2012.311

University Hospitals is involved in a number of other job creation and wealth building initiatives in the community. For example, it is a partner in the NewBridge Cleveland Center for Arts & Technology, which is developing neighborhood resident skills to support careers in healthcare for adults and provide education and training for youth in a variety of the arts—music engineering, ceramics and digital arts, among others. It is also a participating institution in Health-Tech Corridor, an initiative aimed at promoting the start-up or relocation of biomedical, healthcare, and technology companies into Cleveland’s Midtown section (further detailed in section on Cleveland Clinic Health System). This strategy is another way in which University Hospitals is using its buy local commitment to encourage companies to move into Cleveland and hire locally in order to receive hospital system contracts.

Throughout the process, Vision 2010 faced its share of challenges, providing opportunities for outsiders to benefit from some key lessons. Standley pointed out, “We have learned some good things; we have made some mistakes, but at least we did it. That is what I tell people. Was it perfect? No. Could we have done more? Yes. But at least we did it.” In one respect, the idea of Vision 2010—a five-year planned and timetabled construction project—itself was a challenge. Although Vision 2010 officially began in 2005, many partners did not officially engage until 2007 even though the goals needed to be met by 2010 regardless of when they joined the project.312
Of all the targets that University Hospitals set, the only benchmark Vision 2010 failed to achieve was the hiring of 20 percent of all project workers from Cleveland. When devising these targets, University Hospitals’ leadership decided that the benchmark should be simple and easily understandable; as a result, they adopted the city’s own targets for its projects set forth by the Fannie Lewis Resident Employment Law. According to Standley, when this target was initially accepted, the health system’s leadership did not properly understand how the law set the benchmarks. As time progressed, they realized that the 20 percent did not apply from the owner of the project’s (i.e. University Hospitals) perspective but from each contractor’s perspective and was based on all of the contractor’s projects together on an on-going basis. Standley noted, “So we took a much harder version of [our target], which at the time was pretty unachievable.” It was unachievable because University Hospitals was competing with every federal, county, and city-based project for the same pool of contractors that met this requirement and the capacity simply did not exist to meet the need.313

Another challenge to localization are group purchasing organizations (GPOs), which have increased significantly in scale since the 1990s and serve to minimize hospital costs for medical supplies and related goods by seeking large national contracts. GPOs are not concerned with the geographic location of their suppliers unless their customers (i.e. hospitals) effectively pressure them. However, since hospitals in Northeast Ohio consolidated, becoming in essence three integrated health networks in the 1990s, the dynamic has shifted; they now have the market-share clout to negotiate a similar price to a national contract with a local or regional vendor. Today, University Hospitals can customize a portion of the portfolio at the regional level. Still, this shift toward regionalism required a conscious change in the culture of the organization.314

At the regional level, certain items, such as commodities, are significantly easier to source than physician-preference items, or items that often require technical training to operate. When University Hospitals began this shift in 2006 and 2007, it made the decision to focus on commodity items and on the construction side. This limited the number of bids to national companies that would have historically gone out for a project of this scale. Admitted Standley, “I got big pushback when that happened because culturally up until that time a health system of this size always equated size, scale, and national presence and references with quality. . .[the process was] very challenging. A lot of change management.”315

Another challenge that also presents future opportunities is the limited window of time that exists to reallocate purchasing and resource decisions because of multi-year
contracts. This is more relevant to University Hospitals’ supply-chain decisions going forward than during the execution of Vision 2010. Standley noted the need to be prepared when the “window opens.” These contracts, which range in duration from three to five years, increase the difficulty of reallocating portions of University Hospitals’ $850 million annual purchasing portfolio. Despite this challenge, between 2008 and 2011, University Hospitals was able to double its spending in Cleveland, mostly as a result of the concerted effort of Vice President of Supply Chain, Allen Wild, who actively shifted direct spending under his control. In 2010, University Hospitals purchased more than $300 million (approximately 38 percent) from vendors within Cleveland and more than $500 million (approximately 63 percent) within Northeast Ohio.316

A final obstacle that was identified and addressed early on was achieving diversity goals. According to Hewitt, when she joined the project, she stressed to Standley that University Hospitals needed to establish a position whose sole responsibility was to ensure that diversity remained a priority. It could not be just another item on a “check-list.” Hewitt pushed for third-party oversight, leading to the contract with Minority Business Solutions, because she understood that points exist in construction projects when those in charge—such as project managers—contractors, or construction managers, encounter obstacles or delays, obscuring the importance of diversity relative to completing the project on time and on cost. A third party could focus fully on ensuring that diversity remained an important priority in all phases of the project.317

Cleveland Clinic Health System

We are only as strong as the neighborhoods in which we are located. And I can’t overstate that. That is really critically important: that these neighborhoods be as solid and as stable as they can possibly be.

Oliver C. Henkel, Jr., Chief External Affairs Officer, Cleveland Clinic 318

Cleveland Clinic’s main campus is situated in Cleveland’s University Circle, a vibrant enclave of hospitals, universities, and cultural institutions, surrounded by a ring of severely distressed communities. Cleveland Clinic has historically had a reputation of having “very little regard for what happened outside of our walls,” said Oliver C. Henkel, Jr., Chief External Affairs Officer.319 In recent years, Cleveland Clinic has worked consciously to change the perception of the institution as inward looking by embracing