Embracing Patient-Centered Reforms Ahead of Payment Reform

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Medical Director of Quality

Summit Medical Group, NJ
Summit Health Management

SUMMIT MEDICAL GROUP

SUMMIT HEALTH MANAGEMENT

No speaker disclosures

About Us

- For-profit, physician owned, managed and governed
- C-Suite with physician CEO & Board
- Summit Health Management provides management services to Summit Medical Group
- Growth of 70+ providers/year

About Us

- 390 physicians
- 100+ APNs & PAs
- 210,000 patients
- 14,000 urgent care visits/year
- 11,000 ambulatory surgeries/year

- 70 specialties
- 1,600 employees
- 75,000 visits/mo

Our Population Health Team

Robert W Brenner, MD, MMM

Chief Medical Officer

Jamie L Reedy, MD, MPH

Director, Population Health

Avrim R Eden, MD, MBA

Director, Quality & Utilization

Allen M Khademi, MD

Director, Transitions of Care

Our Vision

To provide patient-centered, outcomes-driven care at lower cost to the sick and well populations for whom we are accountable.

Our Strategy

- Prepare for change from FFS to FFV and full-risk contracts
- **Voluntary front-end investment with no immediate ROI**
- In network with all major payers
- P4P commercial payer & Medicare contracts at **52%** in 2014

- 42 acre main campus
- 32 satellites, 65+ PODS
- 500K SF, another 250K in development

About New Jersey

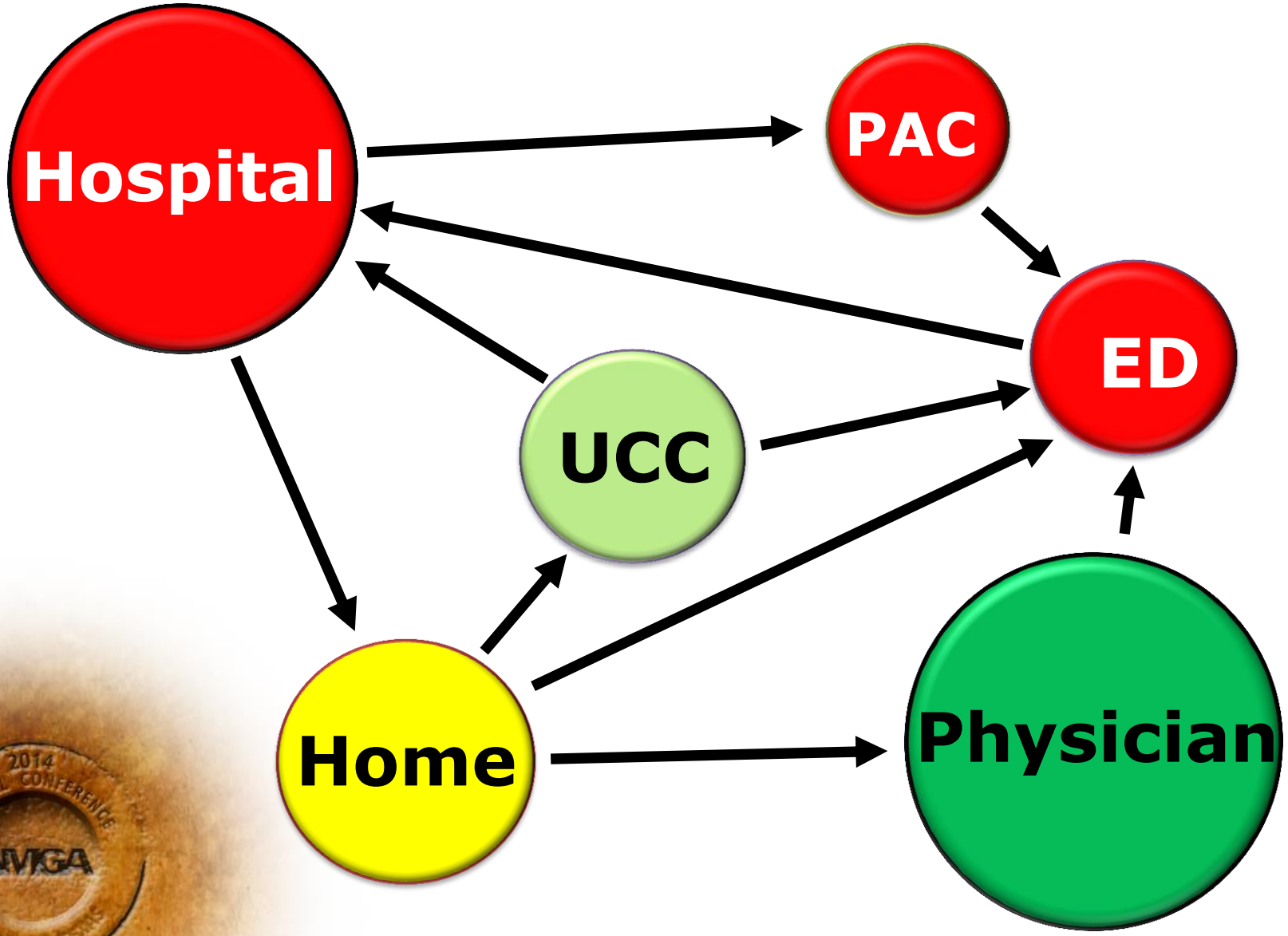
- Most densely populated state
- Highly fragmented
  - **300+** physicians / 100,000 residents
  - High hospital & PAC densities
  - No fully integrated health systems
  - No market-dominant groups
  - 8 medical schools within 1hr drive

Our Patients Have Many Options

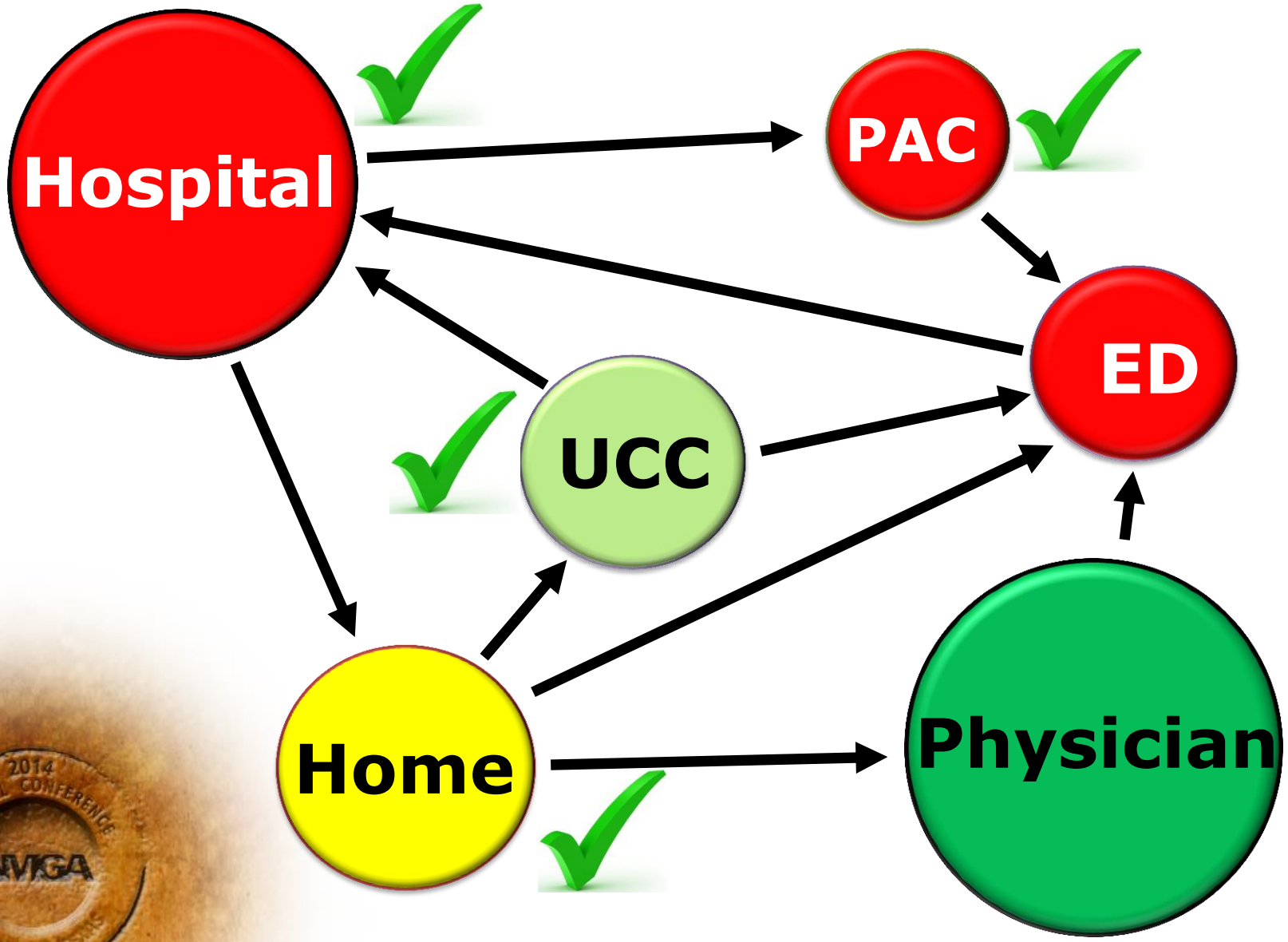
- 11 Hospitals (majority at 4 hosp.)
- 90+ PAC facilities (majority at 17)
- Specialists galore in NJ & NYC
- Not all our PCP patients use our specialists & vice versa
- Many patients winter in the South

Fragmentation of care is our biggest challenge!

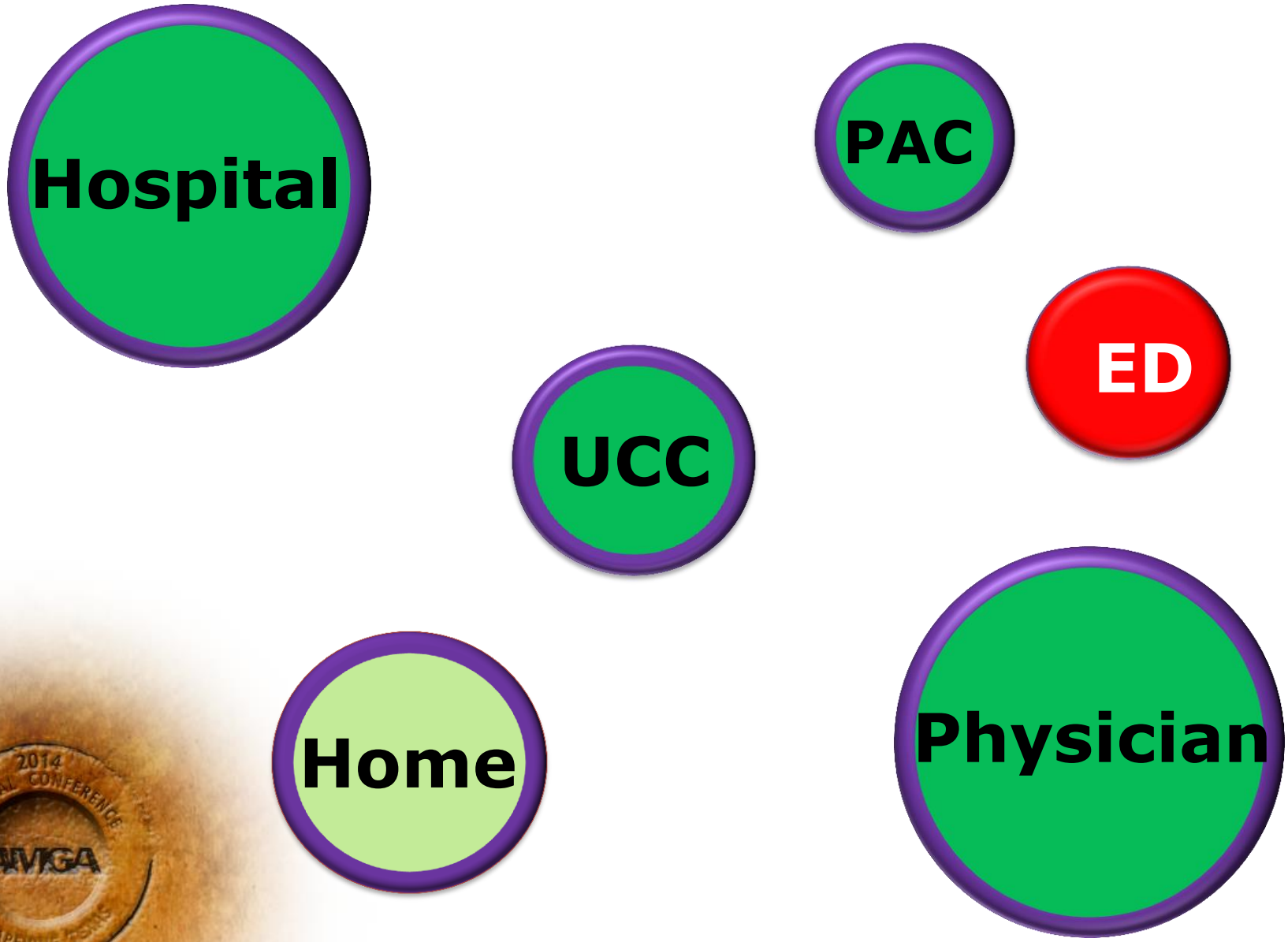
Circles of Unaccountability



Our Interventions Have Saved $77 MM



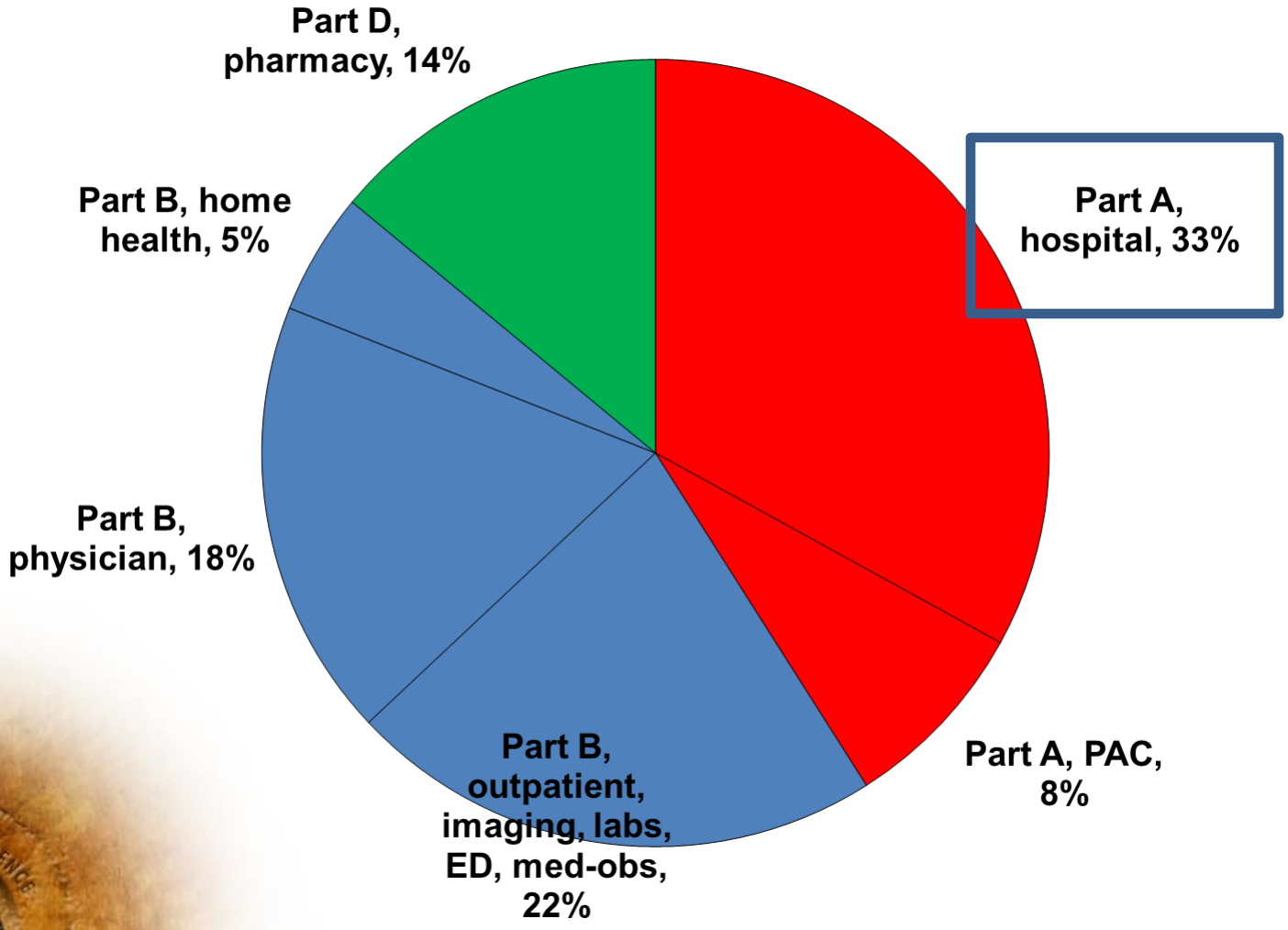
Transitions of Care Strategy



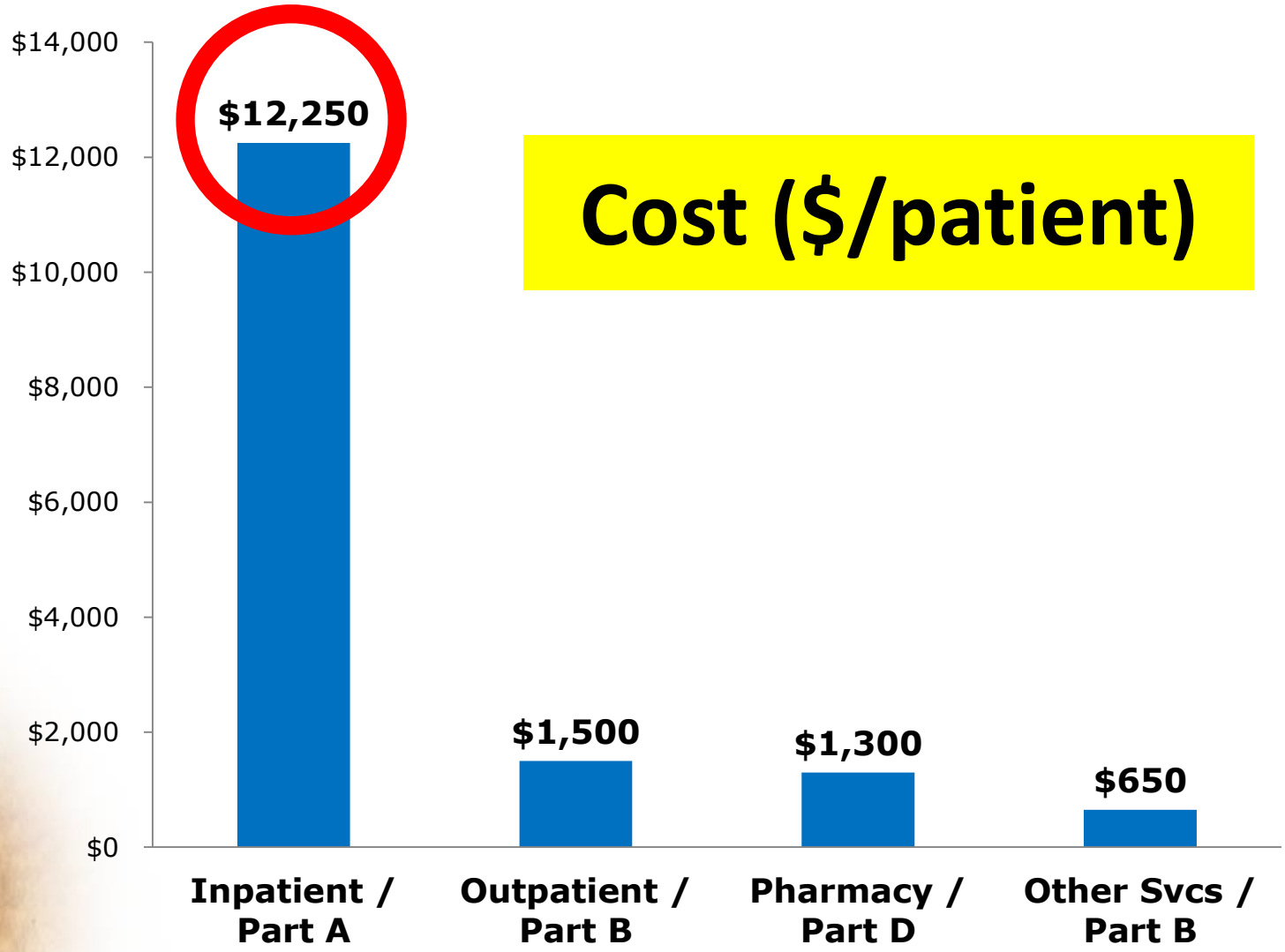
Summary of Outcomes

- **Easier** than expected: reduce hospital utilization & readmits
- **More difficult** than expected: HTN, DM, chronic disease
- **As expected**: preventive & immunizations

Medicare Dollar, 2012



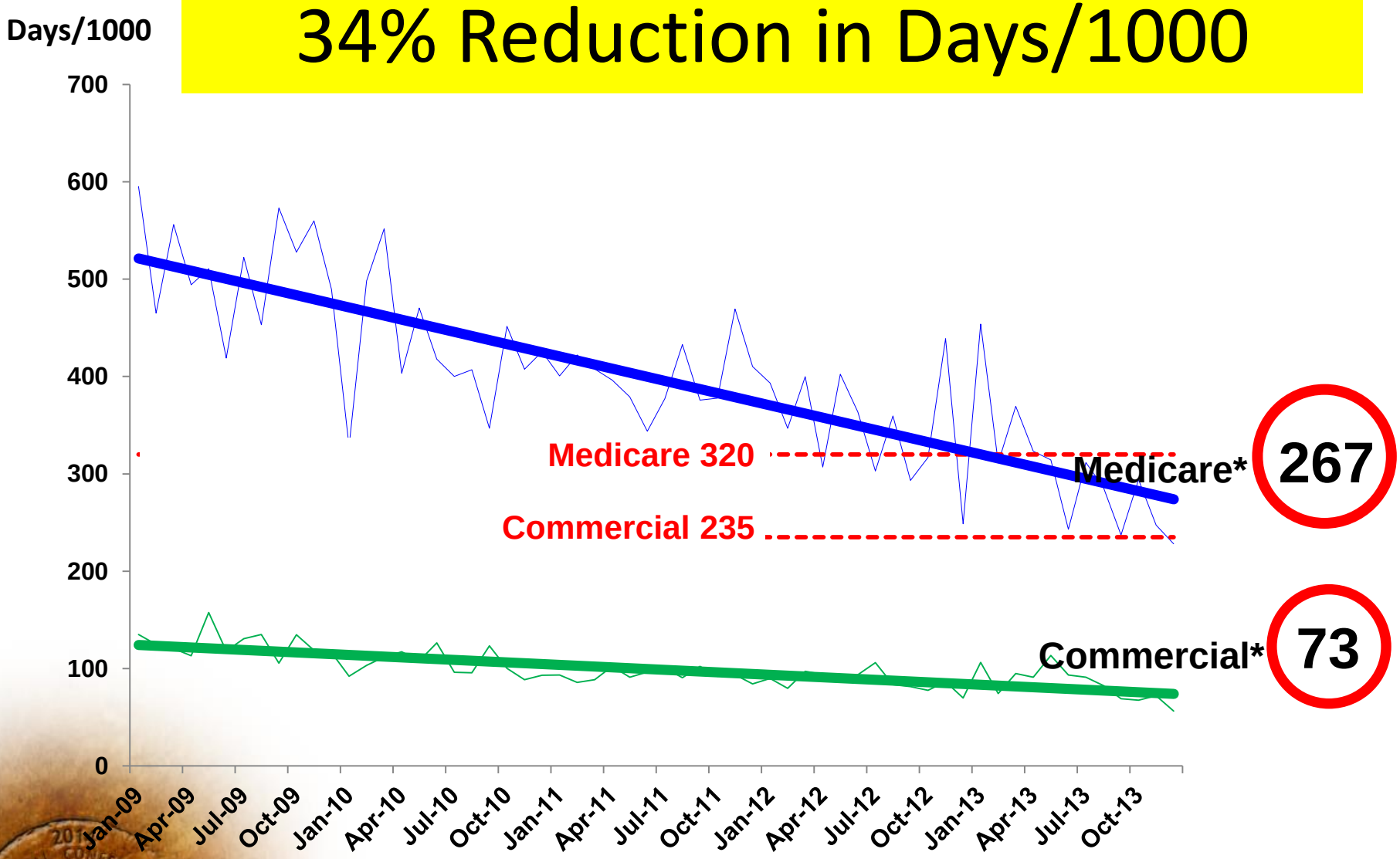
Use Cost To Deploy Scarce Resources



Hospital Utilization KSF

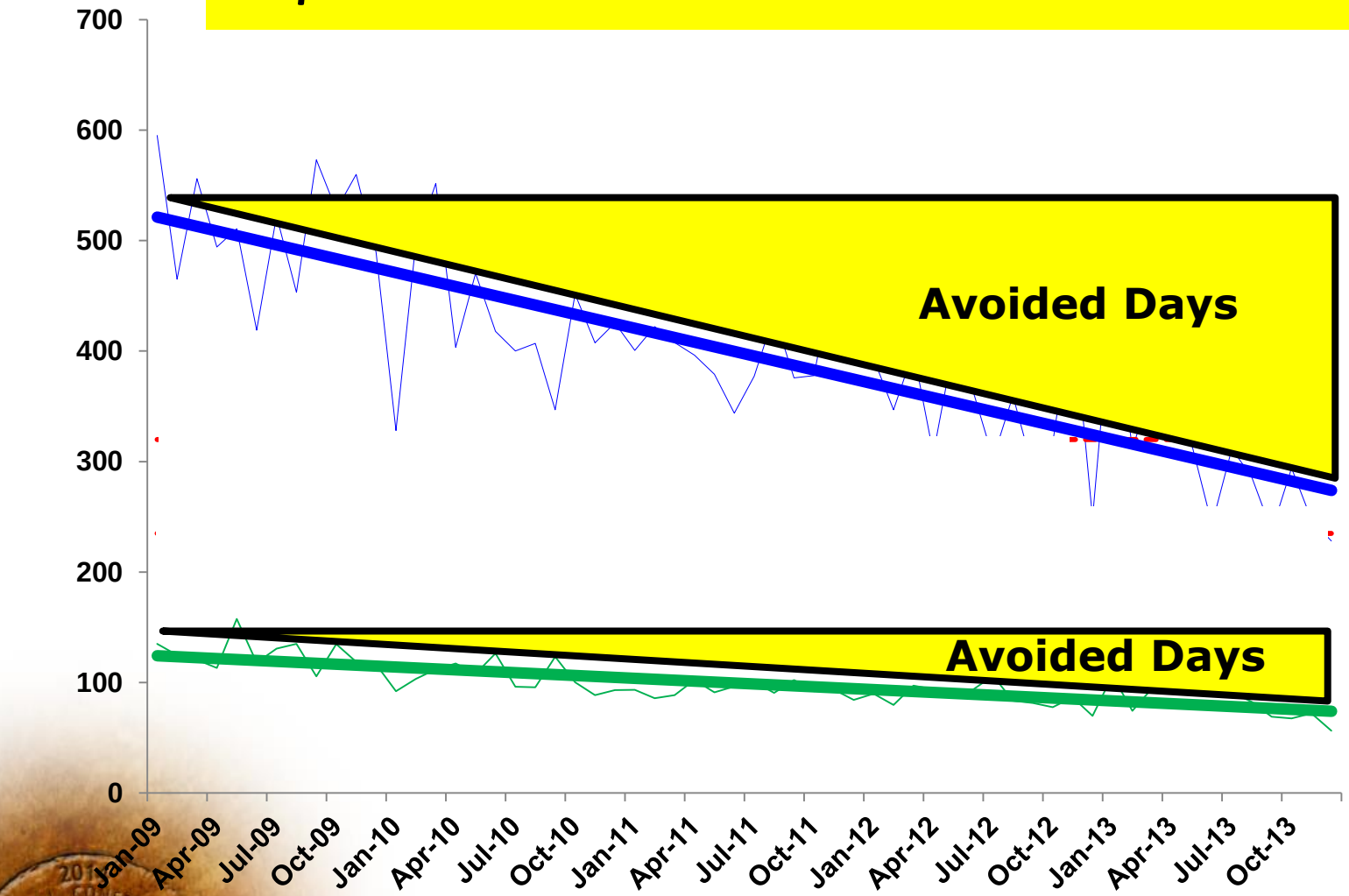
- Our own hospitalists with **100% team-** & **value-**based incentives
- **Continuity-of-Care** vs. Shift model
  - lower patient/physician ratio
  - minimize physician handoffs!
  - early consultations
  - seamless TOC to our PAC teams & care managers

34% Reduction in Days/1000



* 6-month rolling average at our main hospital

$77 MM Saved in Avoided Days



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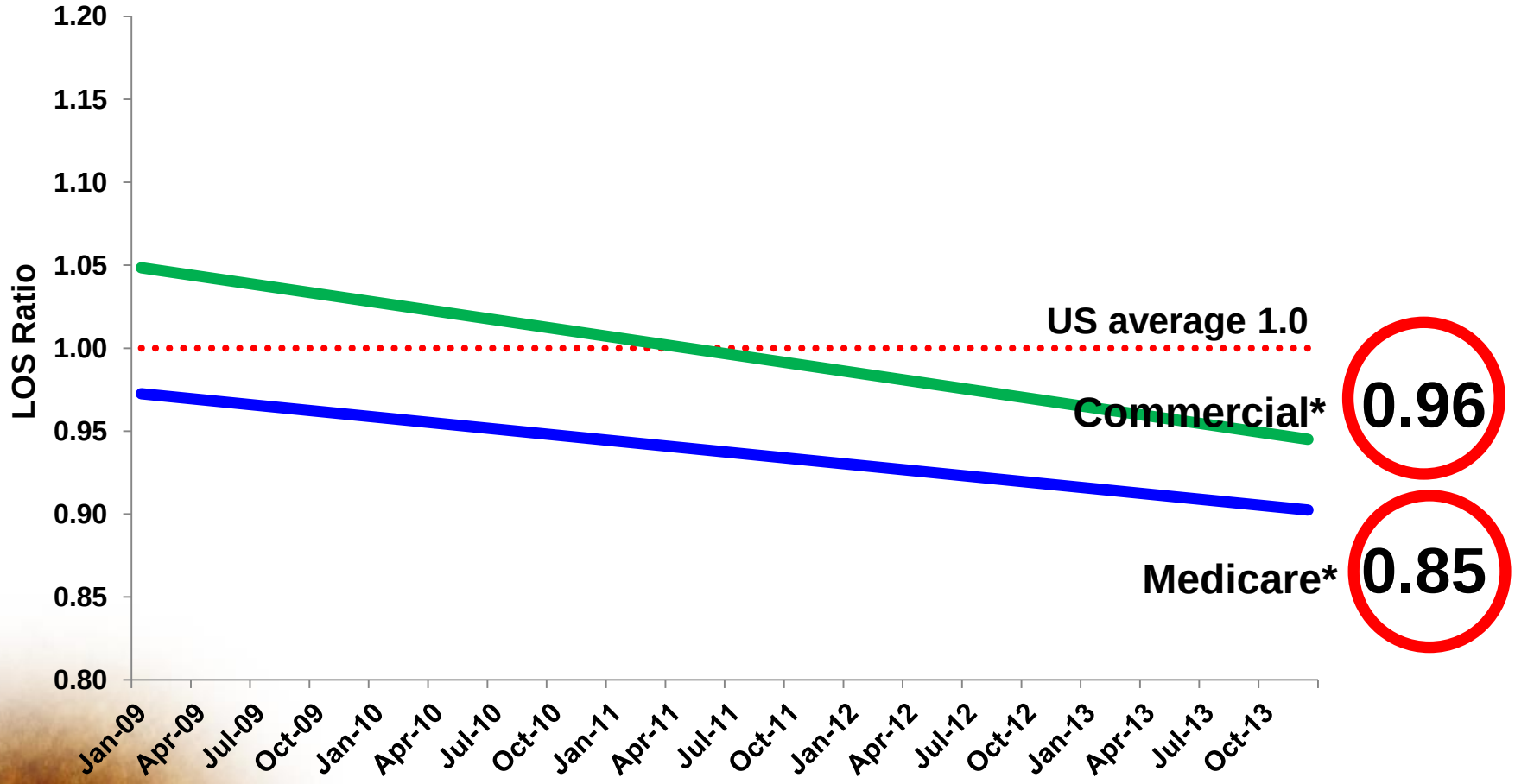
LOS Ratios Are Below US Average



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Hospitalist Chess Analogy

- Enemy are outliers & re-admissions
- **Opening gambit by physician is KSF!**
- Middlegame with PAs
- Endgame is seamless TOC home/PAC

Use Predictive Models

1. Predict outliers (LOS >2SD)
   - **10%** outliers = **30%** hospital days
   - 90% admits = 70% days
2. Identify High-Risk-For-Readmissions
3. Alert TOC team re HRR discharges

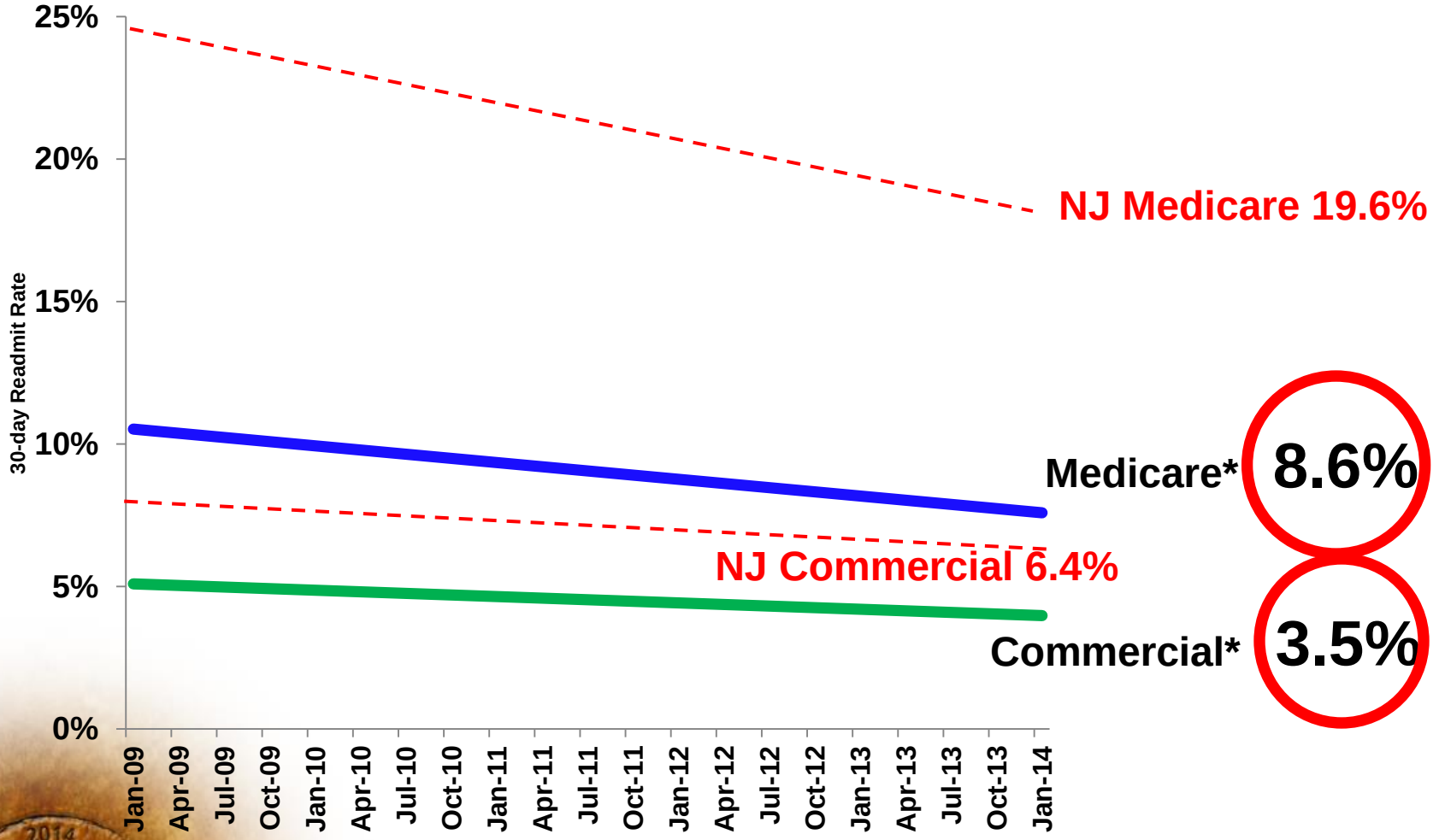
Predictive Model for Readmissions

- Day 2: identify high-risk-for-readmit
- Keep them an extra day!

Example: 100 patients

20 high-risk patients	**+20 days**
80 patients ½ day early	**-40 days**
NET DAYS	**-20 days**

30-Day Readmissions Below Benchmark



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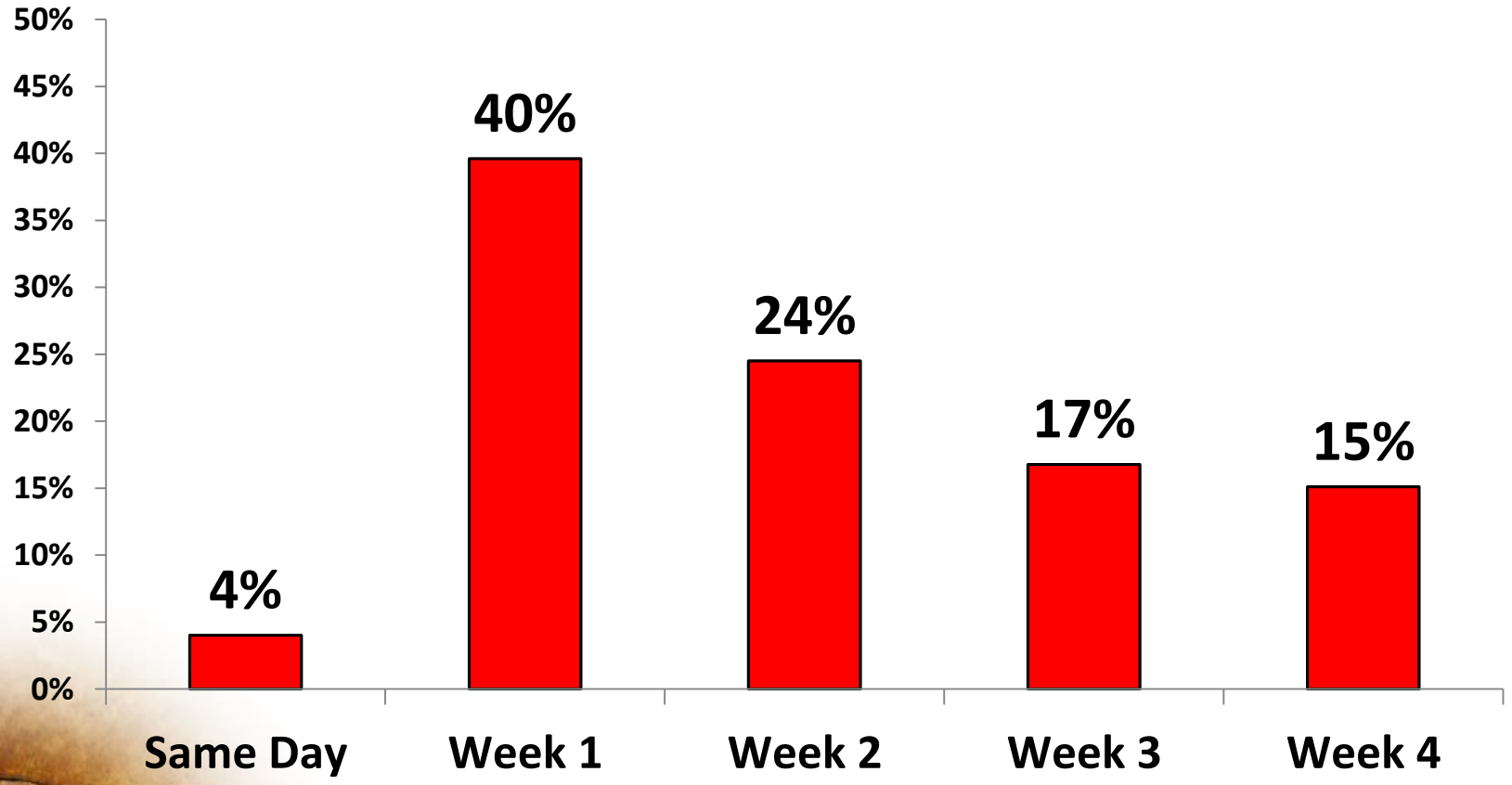
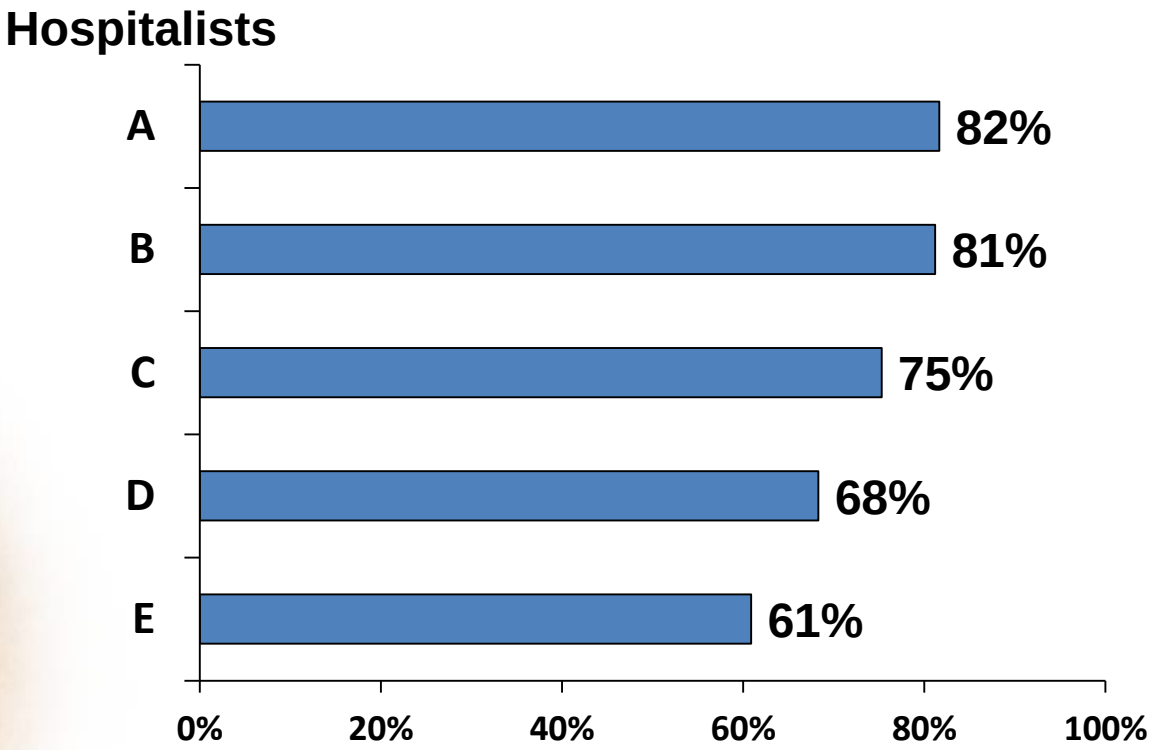
30-Day Readmits, Time to Readmit
N=298



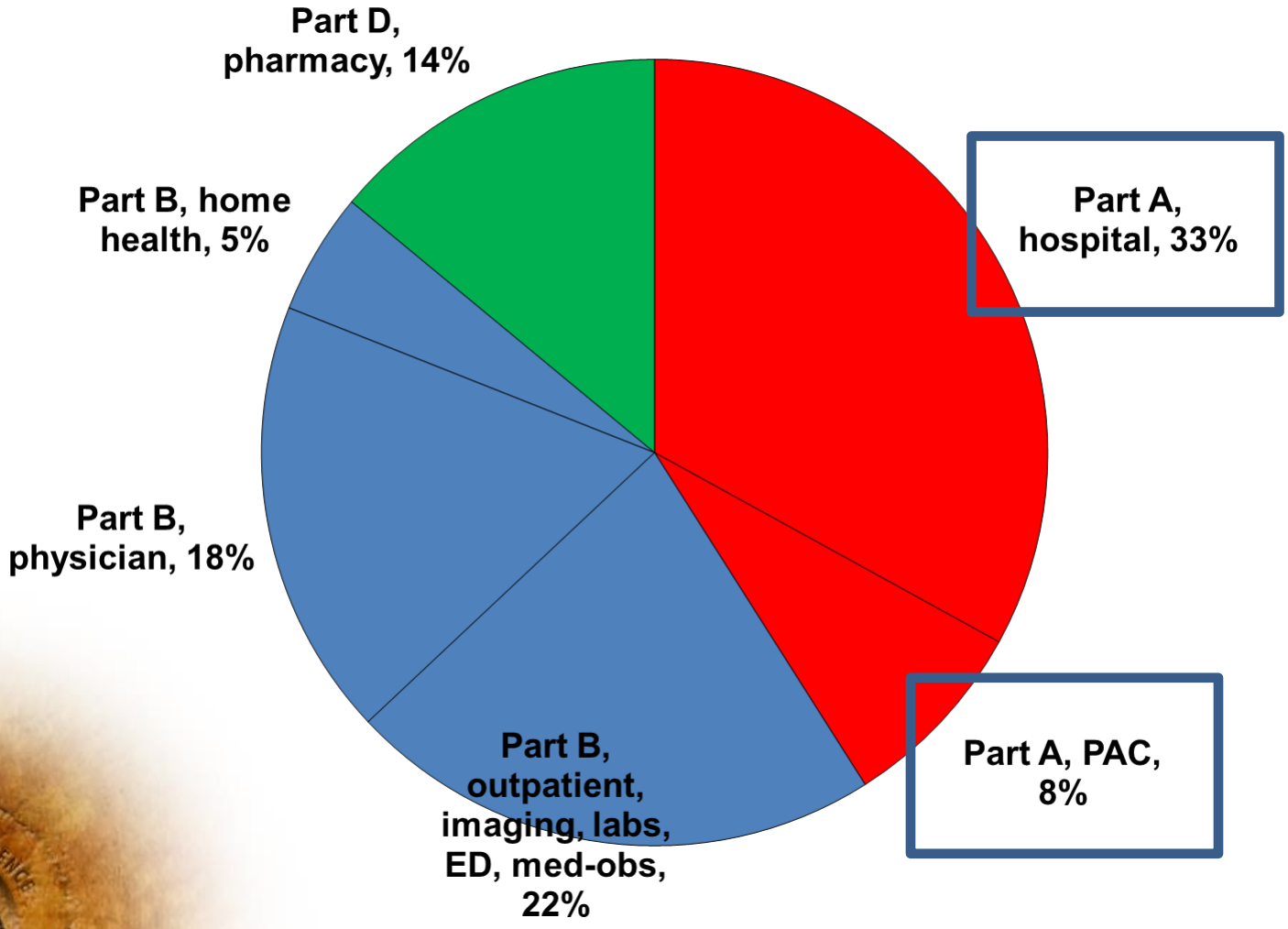
	Week 1	Week 2	Week 3	Week 4
Cmltv	44%	68%	85%	100%

Hospitalist Performance Index

Weight	25%		20%		20%		20%		15%
	Adjusted Workload N	+	Scaled SOI	+	Scaled LOS Ratio	+	Scaled Readmit Rate	+	Scaled Mortality Index

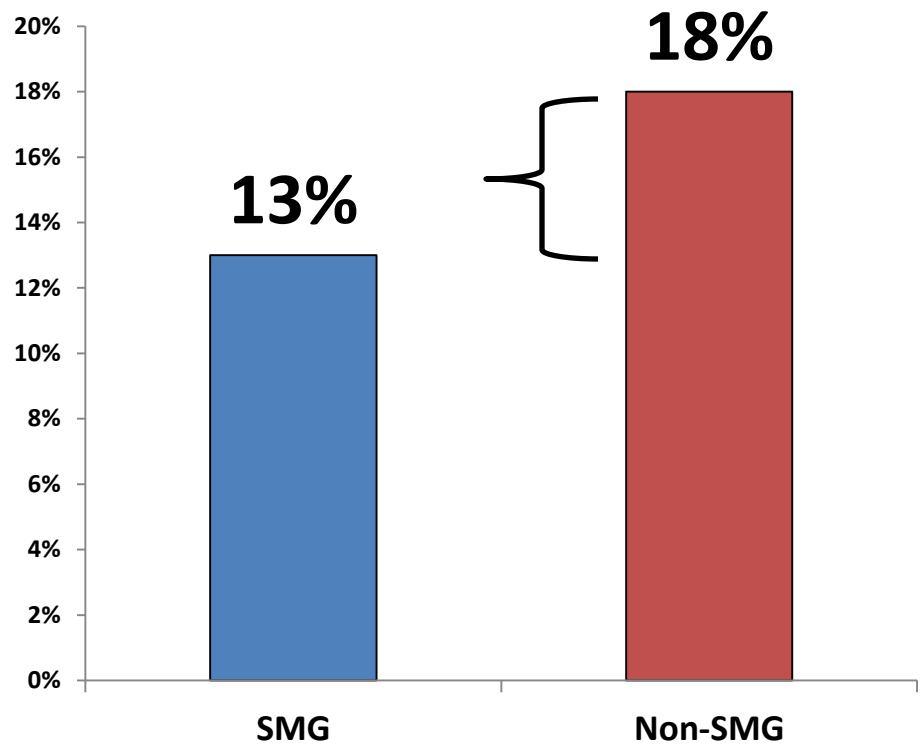


Medicare Dollar, 2012



Geriatric PAC Pilot, N=311

Readmissions



Annualized Avoided Readmissions		
Avoided readmits	Avoided days	Avoided cost
65	300	$800,000

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Takeaways!

- **Team-based continuity-of-care**
- Inpatient registry for hosp & PAC
- Use predictive models, think chess!
- Seamless handoffs & TOC
- **Unblinded reports!**
- Avoid individual FFS for IP & PAC

Summary of Outcomes

- **Easier** than expected: reduce hospital utilization & readmits
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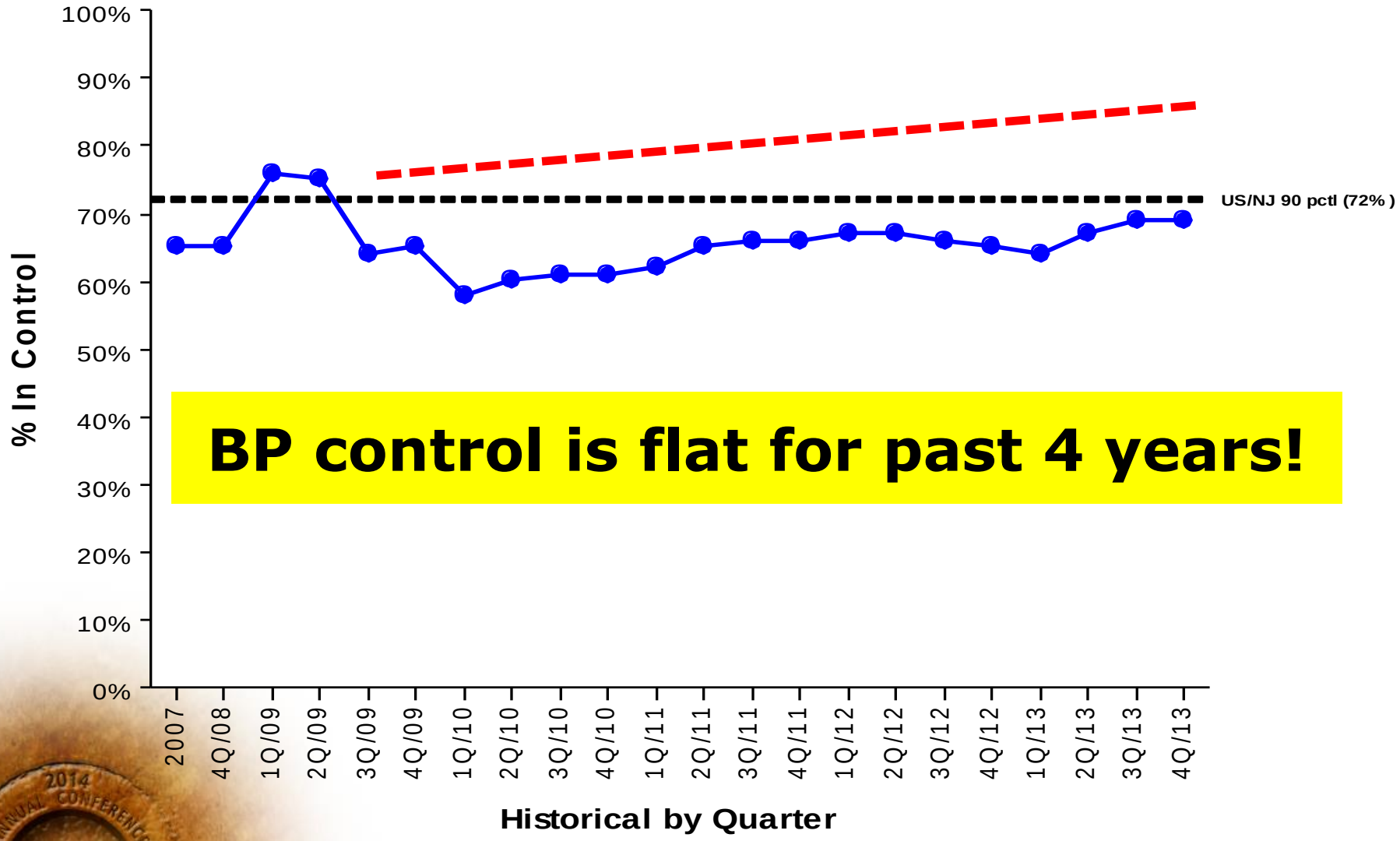
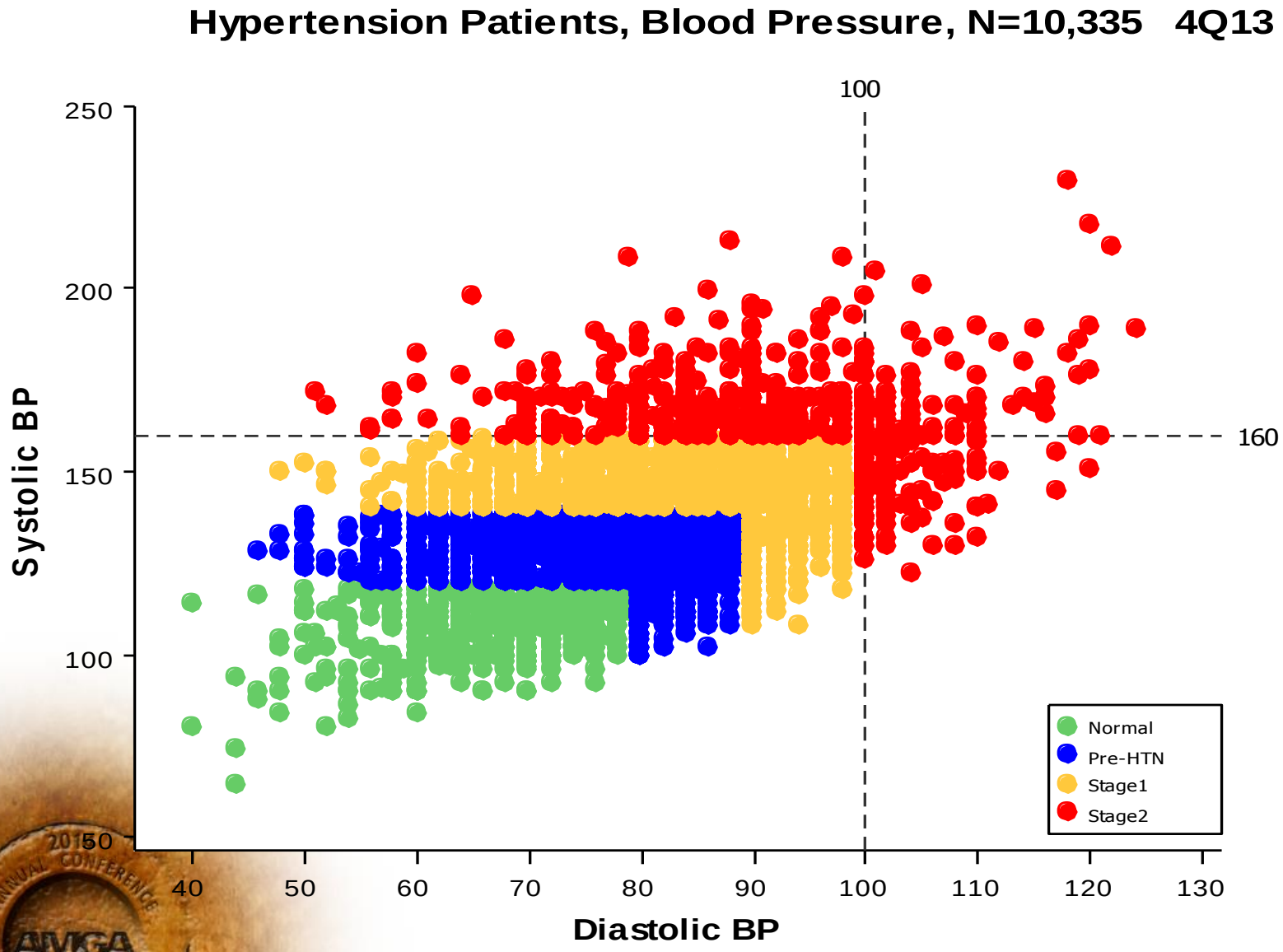
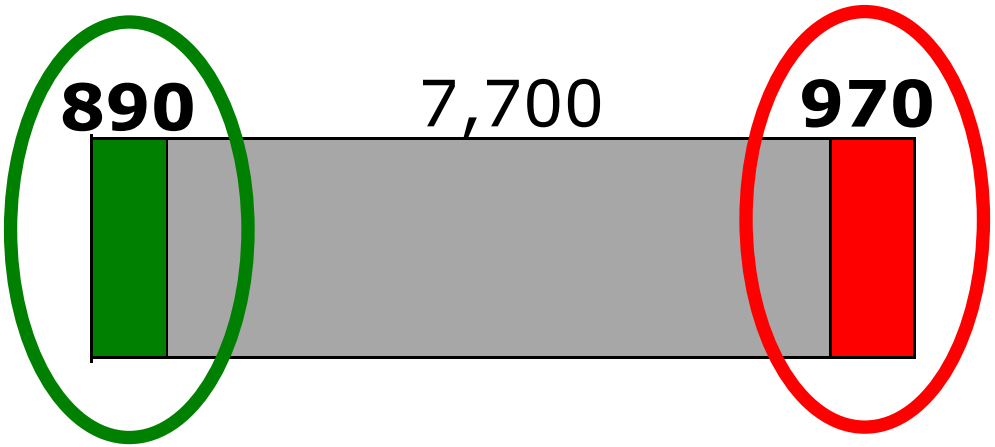
Controlling High Blood Pressure (CBP), N=10,335



BP control is flat for past 4 years!


Hypertension Patients, Blood Pressure, N=10,335 4Q13
100
160
250
200
150
100
Systolic BP
40
50
60
70
80
90
100
110
120
130
Diastolic BP
Normal
Pre-HTN
Stage1
Stage2

Δ-Better and Δ-Worse Groups



- Two BP readings w 20 point change

Plank 1

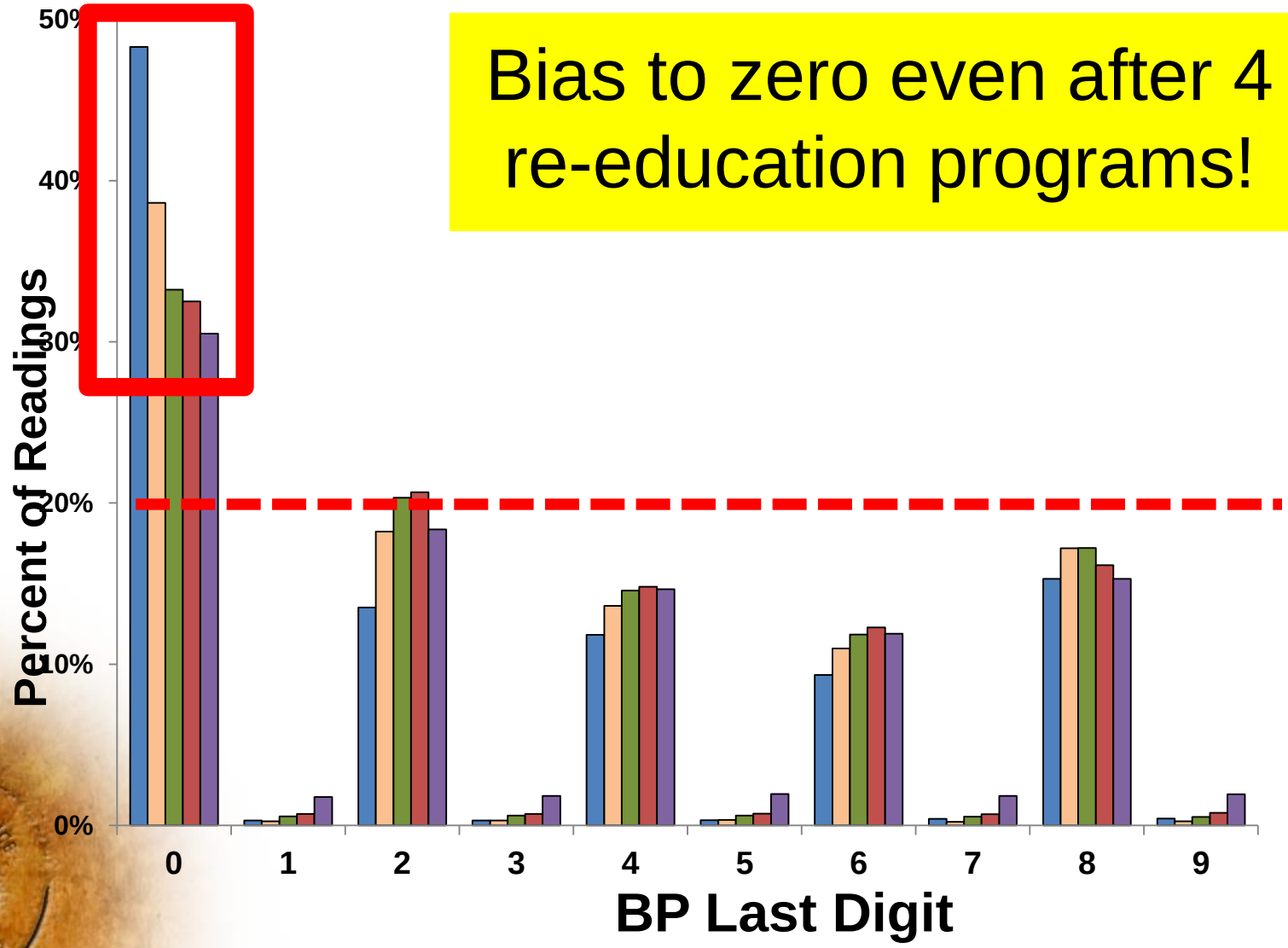
BP in Control, N = 9,550

- **Average 64%** BP in control
- **80%** of **Δ-Better** patients
- **27%** of **Δ-Worse** patients

Averages can deceive you

Plank 1

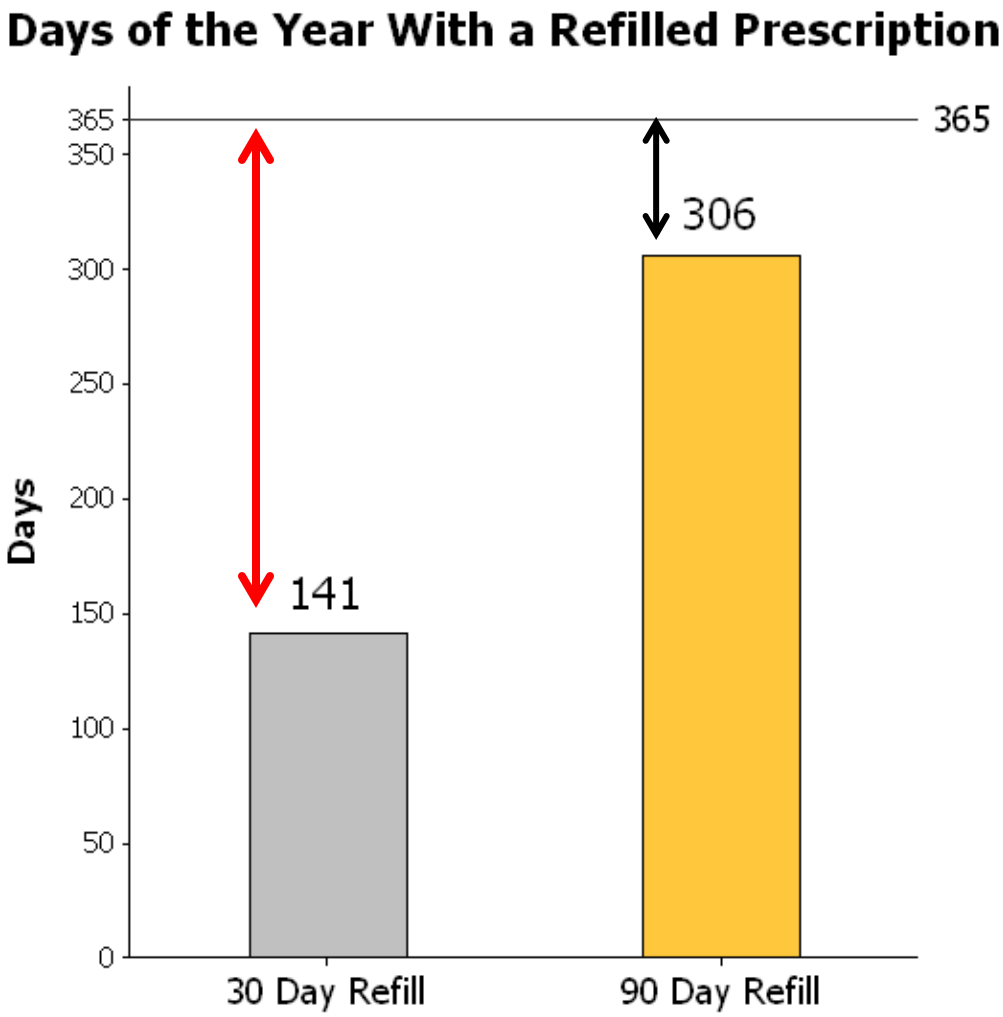
Accurate BP Measurement, N=398,000



Bias to zero even after 4 re-education programs!

Plank 2

Stronger Adherence For 90-Day Refills



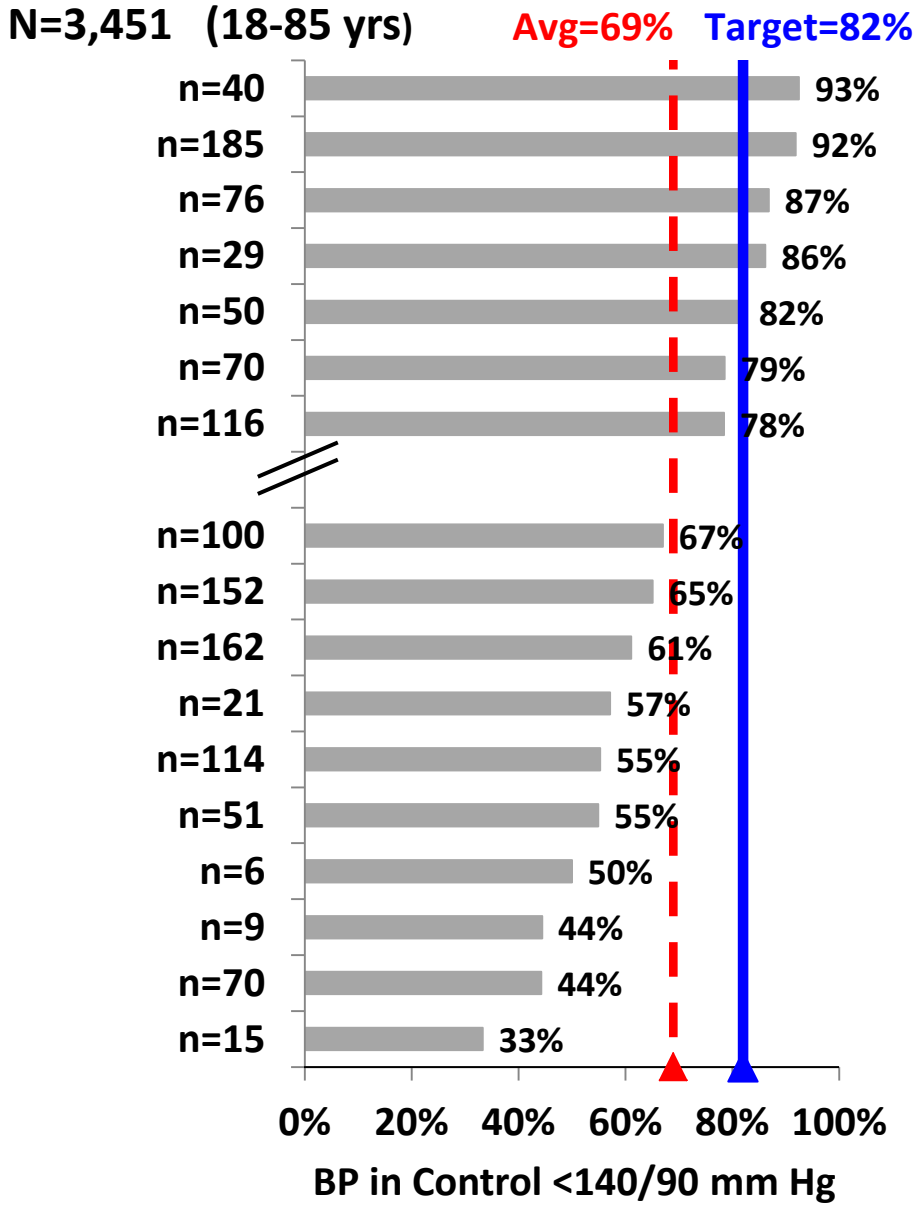
Takeaways!

Measure Up Pressure Down

American Medical Group Foundation

- Re-engage physicians, staff, mgmt
- Adopt medication algorithm
- 2-week follow-up BP
- Patient engagement
- **Transparent monthly reports!**

Jan 2014: Unblinded report after 1st month



Process	→	Outcomes	→	**Outcomes that matter to patients!**
• A1c done		• A1c <8		• **strokes**/1000 diabetics • **AMI**/1000 • **blindness**/1000 • **amputations**/1000
• Spirometry		• FEV1<70%		• **fewer & shorter admits for COPD**

Use NNT to Guide Priorities

Number needed to treat: for every patient with BP in control we avoid 1 event (AMI and stroke) in the next 5 years!

	Hypertension			
	Male	**Female**	**TOTAL**	**WELL VISITS**
Example Population	10,000	10,000	**20,000**	**20,000**
80% BP in control	8,000	8,000		
NNT	18	38		1,000
AMI/Strokes avoided	444	210	**654**	**20**

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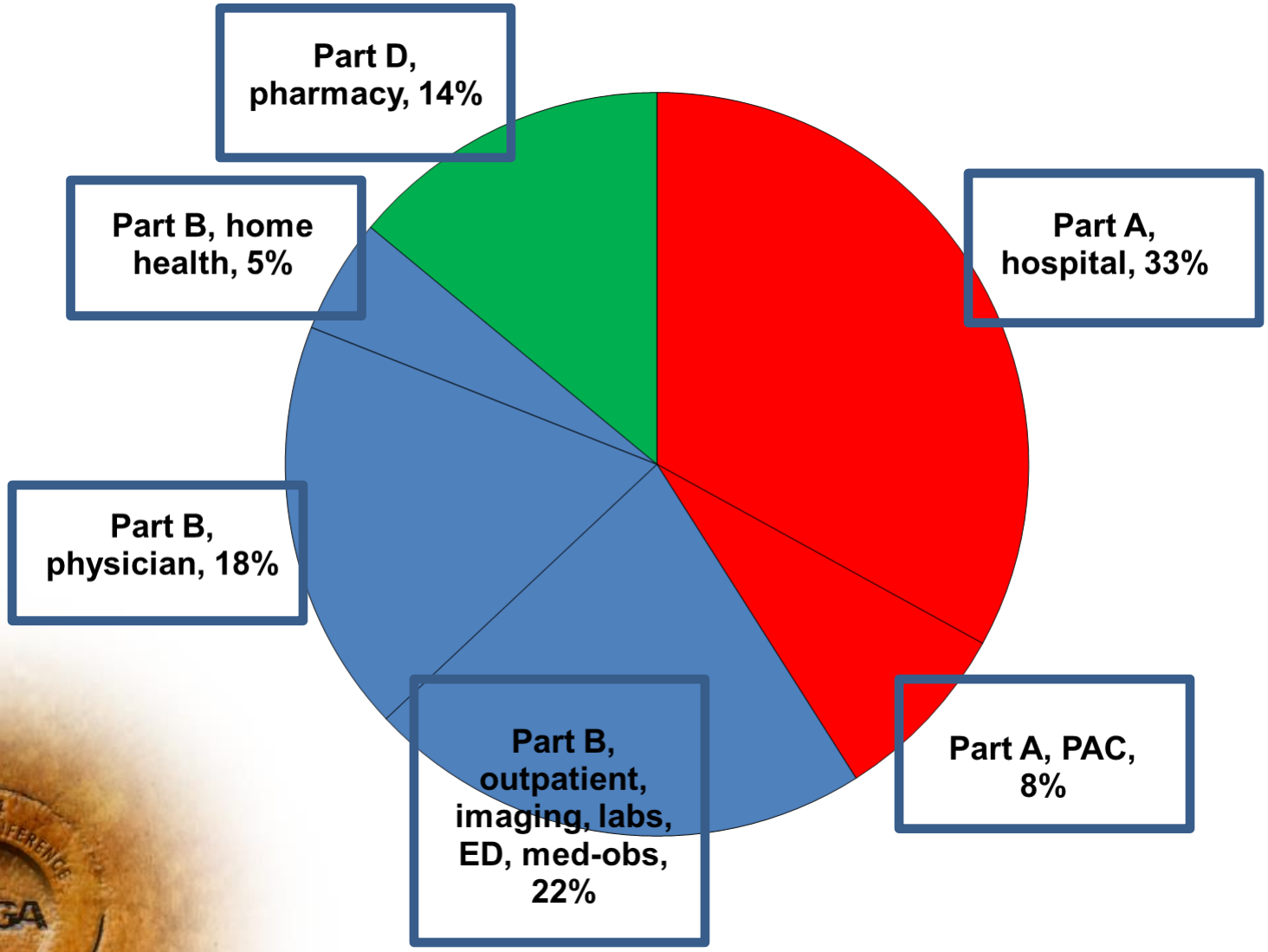

Use “What if” to Prioritize Resources

1. **Value to patient? Outcomes that matter!**
2. Value to healthcare? Quality/Cost
3. Economically sustainable?
4. Scalable?

Scarcest resource is physician forbearance for more QI initiatives!

Metrics Are Not People!

The **greatest danger** is a decline in empathy for our patients, and becoming a *computer*-centric medical home.

"The doctor will *see* you now."

Significance of Our Story

If we can successfully improve quality and value of care in our most *unfavorable* fragmented environment, that is good news for groups in similar situations.

Contact Info

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