Clinical Integration of Medical Groups and Hospitals
Sutter Health

Don Wreden MD
Chief Medical Group Transformation Officer
Sutter Health
Don Wreden MD

Relevant background

Since 1984
General Internal Medicine practice
Sutter Medical Group

1996-2005
Board of Directors
Sutter Health

2001-2013
President and CEO
Sutter Medical Group

2013-2014
Chief Medical Group Transformation Officer
Sutter Health
Sutter Medical Group

1983 Independent multispecialty medical group

1992 Affiliated with Sutter Health (Hospital company) through Medical Foundation model

2011 SMG merged with 3 other medical groups

2014 ~600 physicians (55/45 Specialty/PCP)
My invitation to do this talk

“Please discuss the challenges of integration as hospitals acquire medical groups.”

“Physician leadership and medical groups must be at the core of clinical integration. Hospitals are an essential component of Integrated Healthcare Delivery Systems collaborating with medical groups, but no longer the center or the acquirer.”

“Collaboration for Clinical Integration and Value”
Sutter Health

Serving more than 100 communities with:

• 5,000 physicians
  ➢ 8 medical groups with 5 medical foundations
  ➢ 4 IPAs
• 24 hospitals
• 48,000 employees
• $10 billion revenues
• Home health & hospice, and long-term care services throughout Northern CA
• Health research and medical education/training
• 24 fundraising organizations
Sutter Health

Integrating Health Care Delivery System
Our Organizational Evolution (7 years)

**Yesterday**
- 50-plus Boards
- Disparate admin. services
- Local training and development
- 30-plus affiliate brands

**Today**
- **Five** regions/boards
- **Shared** admin. services
- **System** leadership development
- Stronger **system brand**
Our Cultural Evolution

**Yesterday**
- Affiliation benefit measured in dollars
- Minimal physician integration
- Physicians as key customer
- Local performance indicators
- Clinical variation

**Today**
- Affiliation benefit measured in better care
- Sutter Medical Network
- Physicians as key partners/leader
- Common dashboard
- Evidence-based guidelines/EPI
## What Hasn’t Changed

<table>
<thead>
<tr>
<th>Yesterday</th>
<th>Today</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Mission-driven</td>
<td>• Mission-driven</td>
</tr>
<tr>
<td>• Patient-centered</td>
<td>• Patient-centered</td>
</tr>
<tr>
<td>• Embrace change from a</td>
<td>• Embrace change from a</td>
</tr>
<tr>
<td>position of strength</td>
<td>position of strength</td>
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</table>
Triple Aim

Population Health

Experience of Care

Per Capita Cost
So what happened to facilitate “Collaboration for Clinical Integration and Value”?
Some Examples:

1. Combined explorations of learning and innovation  
   (*Blue Ribbon Teams I and II*)

2. Bring physicians together around clinical integration  
   (*Sutter Medical Network*)

3. Design and implement new models of care together  
   (*Advanced Illness Management*)
1. Combined explorations of learning and innovation

Blue Ribbon Teams

Blue Ribbon Team I
Acute Care Facilities

Blue Ribbon Team II
Ambulatory Facilities
Blue Ribbon Team I
Acute Care facilities

Multidisciplinary team looking at top performing hospitals in the country
Blue Ribbon Team I – “Six in 06”

# 1 Eliminate Non-Dashboard Priorities
# 2 Immediately Deploy Physician Portal for All Medical Staff
# 3 Real Time Quality Data, Broadly Used
# 4 Nurse Led multidisciplinary model for Concurrent Care Intervention
# 5 VPMA at Each Facility
# 6 Communicate Patient Centered Perfect Care Focus Frequently Across All Levels
# 7 ICU process & outcome measures
  - Ventilator Associated Pneumonia (VAP)
  - Stress Ulcer Prevention (SUP)
  - Deep Vein Thrombosis Prophylaxis (VTE)
  - Sepsis (Central Line Blood Stream Infection--CLBSI)
  - ICU Mortality
Blue Ribbon Team I

Overarching Themes

- Quality & Patient Safety Culture
- Leadership Commitment
- Clarity & Focus
- Physician Engagement
- Use of Data
Ambulatory Care
Blue Ribbon Team

Multidisciplinary team looking at top performing medical groups in the country
Blue Ribbon Team II

Overview

**Midwest**
- Luther Midelfort – Mayo Clinic
- Park-Nicollet

**Northwest**
- The Everett Clinic
- Virginia Mason

**Southern California**
- HealthCare Partners
- Sharp Medical Groups

**Internal**
- Palo Alto Medical Foundation - Camino Region
- Palo Alto Medical Foundation – Palo Alto Region
- Mills-Peninsula Medical Group
How Others Define “Patient-Centered”

- Facility Design and Planning
- Disease Mgmt Program Planning
- Improvement Teams
Blue Ribbon Team II

First Surprising Finding

- Originally named *Ambulatory Blue Ribbon Team*
- Luther Midelfort and Park Nicollet had *dissolved organizational boundaries* between inpatient and outpatient services
  - Focus belongs *on the patient*
  - This led to improved overall performance

**Immediate action:**

Changed the team name to

*Blue Ribbon Team II*
Blue Ribbon Team II
Patient Centered Care at the Core of Observed Best Practices

Patient-Centered
Standard Improvement Methodology
Strategic Partnerships
Focus
Integrated Services
Operational Tactics
Financial Alignment
Phys-Admin Teams
Cultural Characteristics
Execution
Blue Ribbon Team II

Team Recommendation

1. Create an Organizational Compact to deliver patient-focused care.

2. Create a disease management registry to identify patients with specific needs:
   – Congestive Heart Failure (CHF)
   – Diabetes
   – Those needing end-of-life (palliative) care.
3. Coordinate Patient Care Services

4. Establish Paired Administrative/Physician Leadership teams
   Identify and proactively train appropriate physicians and administrators for management and leadership roles using the concepts of team accountability and paired leadership
5. “Liberate” our organization from siloed decision making by integrating Financial reporting in a way that supports integrated patient care.
6. Evolve to efficient patient-centered care processes by embracing Lean principles.

7. Reduce patient cost by patient-centered Hospitalist programs in all affiliates that are integrated with ambulatory services.
BRT I and BRT II

• Common Observations/Themes
  – Patient-centeredness
  – Combination of vision and catalyzing event led to culture change
  – Focus and accountability
  – Effort on breaking down and eliminating organizational silos
  – Use of common language and approach to improvement
Building a System of Coordinated Care

[Diagram with various locations such as In Transit, In the Patient, Away from the Patient, and Around the Patient, connected by images and labels like Decision Support Tools & Data Mining, The Patient, Hospital A, Surgery Center, Practice, Clinic, Hospital B, Clinical Lab, Patient’s House.]
2. Bring physicians together around clinical integration

Sutter Medical Network
History of the SMN

• Sutter Health committed to a strong physician relationship strategy in the early 1990’s and has stayed committed.
• The SMN was formalized in 2006 and a new Sr. VP position created in 2008.
• SMN Participation Standards created in 2009 and performance improvement plans processed since 2010.
The Purpose of the Sutter Medical Network

Our Mission
The Sutter Medical Network provides a leadership role in the development of a physician and provider network, coordinating patient care and creating a culture of quality, service and affordability throughout the Sutter Health system.

Our Goals
• Be a demonstrated nationally recognized quality, affordability and outcomes leader.
• Lead Ideal Care Model development, partnering with other parts of the delivery system to coordinate care across the entire network.
• Lead the development of Sutter Health’s Clinically Integrated Physician Network of 5,000+ doctors serving Northern California.
SMN Provider Organizations

- Brown & Toland Physicians
- Central Valley Medical Group
- Mills Peninsula Medical Group
- Palo Alto Medical Foundation
  - Palo Alto Foundation Medical Group
  - Peninsula Medical Clinic
- Sutter East Bay Medical Foundation
  - East Bay Physicians Medical Group
- Sutter Gould Medical Foundation
  - Gould Medical Group
- Sutter Independent Physicians
- Sutter Medical Foundation
  - Sutter Medical Group
  - Sutter North Medical Group
- Sutter Pacific Medical Foundation
  - Sutter Medical Group of the Redwoods
  - Physician Foundation Medical Associates
The SMN brings **common standards** and coordinated approaches to care around the patient and **measures performance** on those standards.
Why We Must Develop a Clinically Integrated Network

• We are not **consistently superb** across the Sutter network
  – We are inconsistent in the **quality** of care delivered
  – We are inconsistent in the **service** we deliver
  – We are inconsistent in the **cost** of care delivered and too expensive

• We lack **accountability** to deliver superbly consistent health care across our the Sutter Network

• We are losing **patients** to organizations that are more clinically integrated
How a Clinically Integrated Network Can Maximize Success

• **Improves quality** by setting performance standards for patient satisfaction, quality, care coordination and utilization across the Sutter network.

• **Lowers cost** through the use of shared services that provide IT infrastructure, credentialing, quality improvement and utilization management.
In a Clinically Integrated Network, Patients…

### Give
- **Some Choice**
  - Patients will be asked to see physicians within the Sutter network to ensure that they receive consistent high quality and low cost care

### Get
- **Consistent Value**
  - Providers who perform at the top deciles in quality, service and utilization

- **Transparency**
  - Access to information about the quality, service and utilization of their providers

- **Coordinated, Patient Centered Care**
  - New and innovative models of care
  - Coordinated care management
  - Integrated medical record information and educational materials to support decision making
  - Seamless, timely referrals
In a Clinically Integrated Network, Provider Organizations…

<table>
<thead>
<tr>
<th>Give</th>
<th>Get</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Transparency</strong></td>
<td>• Venue to Participate in Payment Reforms (ACO, Bundled Payments)</td>
</tr>
<tr>
<td>– Data submission on quality and utilization</td>
<td>– Compete on value of care</td>
</tr>
<tr>
<td><strong>Control</strong></td>
<td>– Population management</td>
</tr>
<tr>
<td>– Meet SMN Participation Standards</td>
<td><strong>A Preferred Provider for Patients and Consumers</strong></td>
</tr>
<tr>
<td>– Refer within the SMN</td>
<td>– Demonstrate market leading quality, coordination and value through increased focus on expanded clinical measurement and initiatives</td>
</tr>
<tr>
<td>– Physician credentialing aligned with network credentialing activities</td>
<td>– Higher patient satisfaction and quality outcomes</td>
</tr>
<tr>
<td>– Participate in quality improvement and care management programs</td>
<td><strong>Access to Information and Resources</strong></td>
</tr>
<tr>
<td>– Collaborate on some contracting elements</td>
<td>– SMN staff to support improvement on the quality and cost of care</td>
</tr>
<tr>
<td><strong>Time</strong></td>
<td>– Resources to manage patients with complex health needs</td>
</tr>
<tr>
<td>– SMN governance committee participation</td>
<td>– More information about patients</td>
</tr>
<tr>
<td></td>
<td><strong>Achieve Economies of Scale and Alignment Across the Sutter Network</strong></td>
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</table>


In a Clinically Integrated Network, Sutter Health…

**Give**

- **Support Services: Capital and Operating Costs**
  - IS, Data Analytics and Decision Support resources and support
  - Quality Improvement resources and support to implement best practices (tool kits, etc.)
  - Staff resources and support dedicated to each medical foundation

- **Control**
  - Collaborate on some contracting elements
  - Required to include physician input into program development and initiatives

**Get**

- **Bridge to the Future of Health Care Delivery and Sustainable Growth**
  - Position the organization for alternative reimbursement models (ACO, Bundled Payments)
  - Compete on Value of Care
  - Population Management

- **A Preferred Provider for Patients and Consumers**
  - Demonstrate market leading quality, coordination and value through increased focus on expanded clinical measurement and initiatives
  - Higher patient satisfaction and quality outcomes

- **Achieve Economies of Scale and Alignment Across the Sutter Network**

- **A Preferred Partner for Physicians**
  - Physicians can remain independent and be part of the Sutter network
A Clinically Integrated Network
Supports Our Total Care Accountability and Health Plan Strategies

• A CI program is a **foundational building block** for a Total Care Accountability Strategy and a Sutter Health Plan. Without being clinically integrated, a network cannot be accountable for the total care nor perform at the levels necessary for a successful health plan.

• This involves **working with the Sutter family AND** Sutter partners such as IPAs and other physicians in independent practice.

• Responsibility for a population requires **clear accountability for the patient** regardless the setting of care.
Physician leaders agreed to **raise the bar** on our commitment to common standards and performance—to further seamless care around the patient.

1. Broadening quality measurement.
2. Focusing on appropriate utilization and referrals.
3. Furthering physician connectivity.
4. Sharing relevant encounter, clinical and claims data.
5. Expanding SMN Participation Standards.
Physicians will play key a role in **committees** developing the **standards** to which we will all agree to further **clinical integration**.

<table>
<thead>
<tr>
<th>Committee</th>
<th>Role</th>
</tr>
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</table>
| Utilization Management | • Oversees utilization management activities across the network  
                        | • Helps patients access the most appropriate, cost efficient health services |
| Quality              | • Oversees network quality improvement and management activities  
                        | • Ensures the highest standards of quality care are met across the network |
| Standards            | • Ensures that all SMN providers have appropriate and current credentials and board certification  
                        | • Maintains the official list of SMN providers  
                        | • Oversees performance on SMN Participation Standards  
                        | • Coordinates SMN Participation Standard recommendations |
| Patient Experience    | • Oversees patient experience activities across the network  
                        | • Helps ensure patients receive exceptional, patient centered care |
| Connectivity         | • Serves to connect SMN physicians so that they can share patients as well as deliver information to the network necessary for operations and performance monitoring.  
                        | • Promotes and supports the use and implementation of SMN-approved applications and establish network standards for physician connectivity |
Clinical Quality - Physician Organizations (P4P)
Q113 vs. Q213 Scores
Q113 scores compared to the 2012MY (prelim) P90 and P50 values (33 measures)*
Q213 scores compared to the 2012MY (final) P90 and P50 values (33 measures)
Bonus measures, if met, are included in green portion of bar

* Note: Brown & Toland data (including Alta Bates) were not reported Q1 2013 due to data system issues. Except for 1 generic Rx measure and the 4 Shared "bonus measures", (sorted by current quarter # of measures in best decile)

- Measures Below 50th Percentile
- Measures Between P50 and P90
- Measures in Best Decile

(Zero bars indicate no measures reported for quality in that quarter.)
IHA Top Performers, 2013

Top Overall Performer Award Winners

• Sutter Gould Medical Foundation
• Palo Alto Medical Foundation
• Palo Alto Medical Foundation - Mills-Peninsula Division/Mills-Peninsula Medical Group
• Sutter Pacific Medical Foundation - Sutter Medical Group of the Redwoods
• Sutter Medical Foundation - Sutter Medical Group
• Sutter East Bay Medical Foundation

Most Improved Award Winner

• Sutter Gould Medical Foundation
Connectivity: Patient Adoption My Health Online
(SH/SMN Dashboard Measure)

Nov-13 MHO Patient Adoption Rate Across SMN

- 79.8%
- 67.7%
- 58.7%
- 49.7%
- 43.1%
- 35.1%
- 0.0%
- 10.0%
- 20.0%
- 30.0%
- 40.0%
- 50.0%
- 60.0%
- 70.0%
- 80.0%
- 90.0%

Percentage

Medical Foundations

<table>
<thead>
<tr>
<th>Medical Foundations</th>
<th>PAMF*</th>
<th>SGMF</th>
<th>SMN</th>
<th>SEBMF</th>
<th>SMF**</th>
<th>SPMF</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Adoption</td>
<td>79.8%</td>
<td>67.7%</td>
<td>58.7%</td>
<td>49.7%</td>
<td>43.1%</td>
<td>35.1%</td>
</tr>
<tr>
<td>Activated Patients</td>
<td>472,966</td>
<td>105,414</td>
<td>941,578</td>
<td>62,704</td>
<td>237,465</td>
<td>63,029</td>
</tr>
<tr>
<td>Total # of Adult Patients</td>
<td>592,323</td>
<td>155,677</td>
<td>1,604,689</td>
<td>126,205</td>
<td>550,739</td>
<td>179,745</td>
</tr>
</tbody>
</table>

* PAMF is PAMF-AD, PAMF-CD, PAMF-MPD (but excluding MPMG), PAMF-PAD and PAMF-SCD.
** SMF is SMF-CD (SMG, SNSMG, and SWMG but excluding SIP), SMF-WD, and SMF-ND.
Source: Epic/Clarity and the SHEW for Patient Adoption Metrics. Epic/Clarity and TheDoctorForYou Database for Physician Adoption Metric.
3. Design and implement new models of care together

Advanced Illness Management (AIM®)
An Operational and Clinical Approach to Complex Care
living in two worlds at the same time is challenging
The Second Curve

First Curve

Second Curve
First-Curve to Second-Curve Markets

How will hospitals successfully navigate the shift from first-curve to second-curve economics?

**Volume-Based First Curve**
- Fee-for-service reimbursement
- High quality not rewarded
- No shared financial risk
- Acute inpatient hospital focus
- IT investment incentives not seen by hospital
- Stand-alone care systems can thrive
- Regulatory actions impede hospital-physician collaboration

**Value-Based Second Curve**
- Payment rewards population value: quality and efficiency
- Quality impacts reimbursement
- Partnerships with shared risk
- Increased patient severity
- IT utilization essential for population health management
- Scale increases in importance
- Realigned incentives, encouraged coordination

The Gap
Advanced Illness Management (AIM®)

Currently operating in 14 out of 19 planned counties within Sutter Health’s Service Area

Center for Medicare & Medicaid Innovations Challenge Grant Targets:
• Serve 10,800 persons
• Capture $29 M in Medicare Savings

• More than 4,500 persons enrolled since initiation of pilot in 2009.
• Over 2,600 enrolled since CMMI Grant
• Current daily average census is nearly 1,300
The AIM Journey

- Imperative for AIM
- From Fragmented to Integrated
- AIM Program Model Characteristics
- From Pilot to CMMI Grant
- Scaling AIM Across the System
- Successes & Challenges, Opportunities
- Our Path Forward

AIM Program Model:
- Better Health
- Better Care
- Lower Cost

Initial AIM Program
Home Health Based
2002

Decision more was needed
Design Team Formed
2008

Conducted Pilot in Sacramento, Roseville, and Davis Areas of Northern California
2009-2011

Awarded CMMI Innovations Challenge Grant 2012

Decision to expand system wide & seek outside funding
2011-2012

Completed Pilot Program Evaluation demonstrated highly positive outcomes
2011-2012

Launch readiness planning
2012

Site implementation
Currently serving 15 counties
Nov 2012-Mar 2014
4 counties to go

Infrastructure development
2012-2015

AIM Program Model:
- Better Health
- Better Care
- Lower Cost

Program evaluation-patient, healthcare provider and payer perspective

Continuous program development, improvement, maturing
When I have Advanced Illness, this is how I'll spend the last year of my life:

I'll spend 17 days in the hospital; 12 in the ICU

I'll have a 25% chance of receiving hospice care where I'll spend 8 days on service before I die. More likely though, I'll die in the hospital (where I didn’t want to be).

Medicare will spend 28% of all their payments on me in the last year of life.

Medicare will spend $213, 840,000 per year for 5000 other Sutter patients like me

I represent 5% of the population that spend the highest amount of Medicare dollars and take the most time and resources from the providers who care for me
Total Medicare Spending

28% in Last Year of Life
8% in Last Month of Life

Variation = Overtreatment:
- Hospitalization
  - Readmissions
  - ICU days
  - LOS
- ER Visits
- Specialty consults
- Tests, procedures

Dartmouth Atlas 2008

US Dept. of Health & Human Services 2003
The AIM Journey

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healthcare provider and payer
perspective

AIM Program Model:
Better Health
Better Care
Lower Cost
# AIM® Model Design Characteristics

## 5 Descriptors of AIM Enrollees

1. > 2 Chronic Illnesses; >1 illness
   - Advancing
2. Poly-pharmacy
3. Clinical, Functional, and/or Nutritional Decline
4. High Symptom Burden leading to repeat utilization
5. MD ‘Surprise Question’ 12 Months

## 5 Principles of Model

1. Personal Goals, Not Clinical Goals
2. Person & their Lead Physician Relationship Central
3. Dual Therapeutic Approach Curative + Palliative
4. Evidenced Based Clinical Care and Care Management
5. Simplify and Drive Communication to MDs Make Right Thing, the Easy Thing To Do
## AIM® Model Design Characteristics

### 5 Pillars of Care

1. Advanced Care Plans
2. Self Mgt plan of Red Flags Symptoms
3. Medication Management
4. Ongoing Follow Up Visits
5. Engagement & Self Management Support

### Dual Care Approach: Curative + Palliative Care

### 5 Drivers of Outcomes

1. Aware and skilled in Health Literacy & Patient Engagement
2. Consistency Across All Care Settings
3. In Sickness and In Health
4. Frequent & Predictable MD Communication
5. Teams Without Borders
Closer Look at Integration

AIM® – At a Glance

(1) Referral
(5) AIM Inpatient Admission

HOSPITAL
AIM Care Liaison (RN)

AIM Intake RN

Physician Office

(2) Home Based Visits

AIM Home Health
AIM RN Care Coordinator & AIM MSW

(3) Phone Visits

Physician Office

IF

AIM Telesupport & Office Based Case Management
AIM RN Care Coordinator & AIM MSW

· Acute exacerbation
· Pain crisis
· Family Anxiety

(4) Critical Event

≤6 months

12-18 months

Post AIM

End of Life Care

Other
What’s Different About Clinician & Patient/Family Person-Centered Approaches?

Clinician

- Teach Back
- Chunk and Check
- Motivational Interviewing
- Evidence based care management
- Evidence based palliative care

Patient/Family

- Bubble Diagrams
- Stop Light Forms
- SMART Goals
- Medication Management
- POLST
- Mock Runs
- Personal Health Record
Early Indicators of Success

<table>
<thead>
<tr>
<th>Internal Analysis of Pilot Results</th>
<th>Independent Evaluation of Pilot Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIM Patients Pre/Post</td>
<td>AIM Patients Pre/Post</td>
</tr>
<tr>
<td>AIM n=</td>
<td>245</td>
</tr>
<tr>
<td>Matched Compare Group n=</td>
<td>44,741</td>
</tr>
<tr>
<td>Percent of Inpatient Admissions</td>
<td>-53%</td>
</tr>
<tr>
<td>Percent of ED Visits</td>
<td>-16%</td>
</tr>
<tr>
<td>Percent ICU Days</td>
<td>-75%</td>
</tr>
<tr>
<td>Change in LOS</td>
<td>-1.6</td>
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</tbody>
</table>

* Matched Compare Group Medicare FFS
** Risk Adjusted Controls Compare Group Medicare FFS

**Consistent results of AIM enrollment (the “AIM Effect”)**

- **Substantial reduction in inpatient & ED utilization**
- **Significant savings to Medicare over a 6-month period**
- **Avalere also noted AIM had stronger impact on patients within 6 months of death**
- **Avalere also tested results using 1:1 matched sample: lower but still substantial AIM effect**
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perspective

AIM Program Model:
Better Health
Better Care
Lower Cost
Grant Summary

- July 2012-Jun 2015
- $13 million from CMMI;
- SH $21.4 M
- Key High Level Priorities
  - Geographic Expansion
  - 10,800 enrollees
  - $29M Medicare Savings

Where are we now?

- Expansion to date: 14 counties out of 19 counties
- Over 3000 persons enrolled since July 2012; 4700 since inception
- Serving over 1500 persons daily
“AIM” & CMMI’s Triple AIM

**Better Health Goals**
- Hand Off Structure and Advanced Care Planning; Filling the gaps
- Reduce # and ALOS of hospitalizations; Reduce ICU days; over 90 days
- Reduce ED visits by 20% over 90 days
- Improve quality of life of patients with advanced chronic illness
- Provide high patient, caregiver, and physician satisfaction

**Better Care Goals**
- Train 90 employees on AIM techniques over 270 days
- AIM enrollees with documented advanced care plans w/in 30 days of enrollment
- Increase access and LOS for pt/family with comprehensive end of life care
- Reduce skilled nursing facility stays

**Lower Cost Goals**
- *Medicare and other payer cost savings (aggregate and per enrollee)*
- *Cost of providing care overall*
**90 Day Pre/Post Utilization and Cost Analysis**

**12 Months Rolling Q4 2012- Q3 2013**

**6 Out of 9 Sites Reporting**

*At this time data is not available for East Bay Region (EBR) due to a recent electronic medical record system conversion and for Central Valley Region (CVR) due to insufficient pre/post data. Both should be available for the quarter ending 12/31/13.*

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**Change in Hospital Utilization Post AIM Enrollment**

6 Out of 9 Sites Reporting (Q4-2012 to Q3-2013)

**Change in ED Visits Post AIM Enrollment**

6 Out of 9 Sites Reporting (Q4-2012 to Q3-2013)

**Change in ICU Encounters Post AIM Enrollment**

6 Out of 9 Sites Reporting (Q4-2012 to Q3-2013)
Challenges

- Time required to adopt and hardwire new clinical and care management skills
- Regulatory & legal environment not aligned with health care reform innovation
- Immediate demand for clinical, operation, and financial integration outpaced IS infrastructure
- Resources and skills to perform specialty analytics in timely, consistent and reliable manner

Speed of implementation required by CMMI – rapid deployment required
Opportunities

- Investment in infrastructure for broader complex care management
- Design new national model of care for persons with advanced illness
- Develop new national payment model to serve this complex growing population of patients
So what happened to facilitate “Collaboration for Clinical Integration and Value”? Some Examples:

1. Combined explorations of learning and innovation (*Blue Ribbon Teams I and II*)

2. Bring physicians together around clinical integration (*Sutter Medical Network*)

3. Design and implement new models of care together (*Advanced Illness Management*)