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	Today
- Affiliation benefit measured in dollars	- Affiliation benefit measured in **better care**
- Minimal physician integration	- Sutter Medical **Network**
- Physicians as key customer	- Physicians as key **partners/leader**
- Local performance indicators	- **Common** dashboard
- Clinical variation	- **Evidence-based** guidelines/EPI

What Hasn't Changed

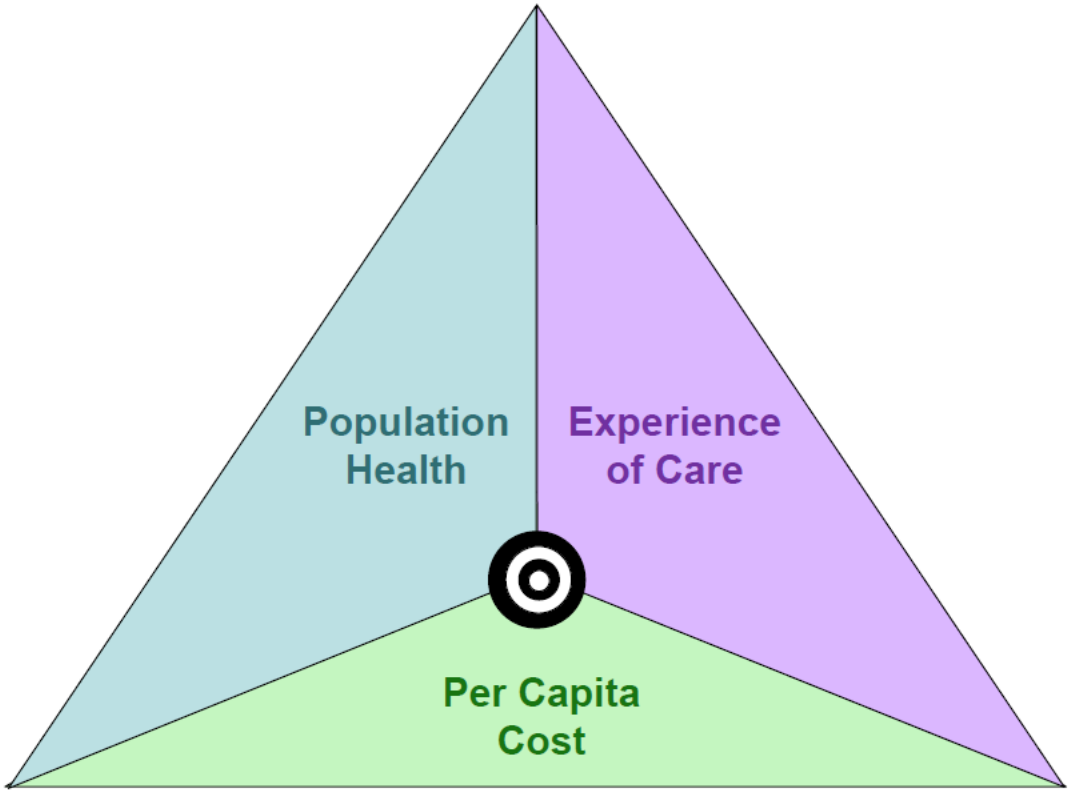
Yesterday

- Mission-driven
- Patient-centered
- Embrace change from a position of strength

Today

- Mission-driven
- Patient-centered
- Embrace change from a position of strength

Triple Aim



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

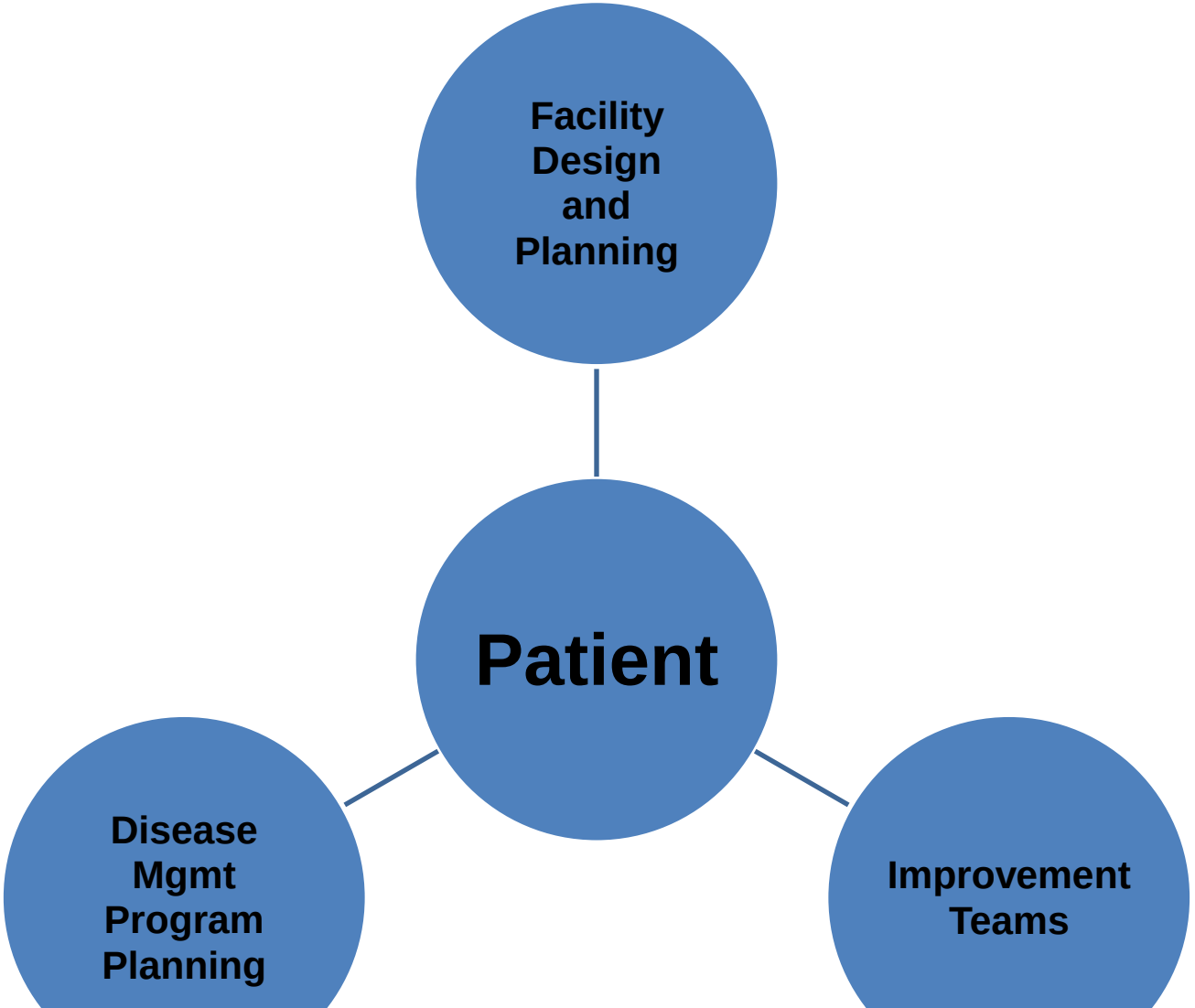
Southern California

- 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”



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

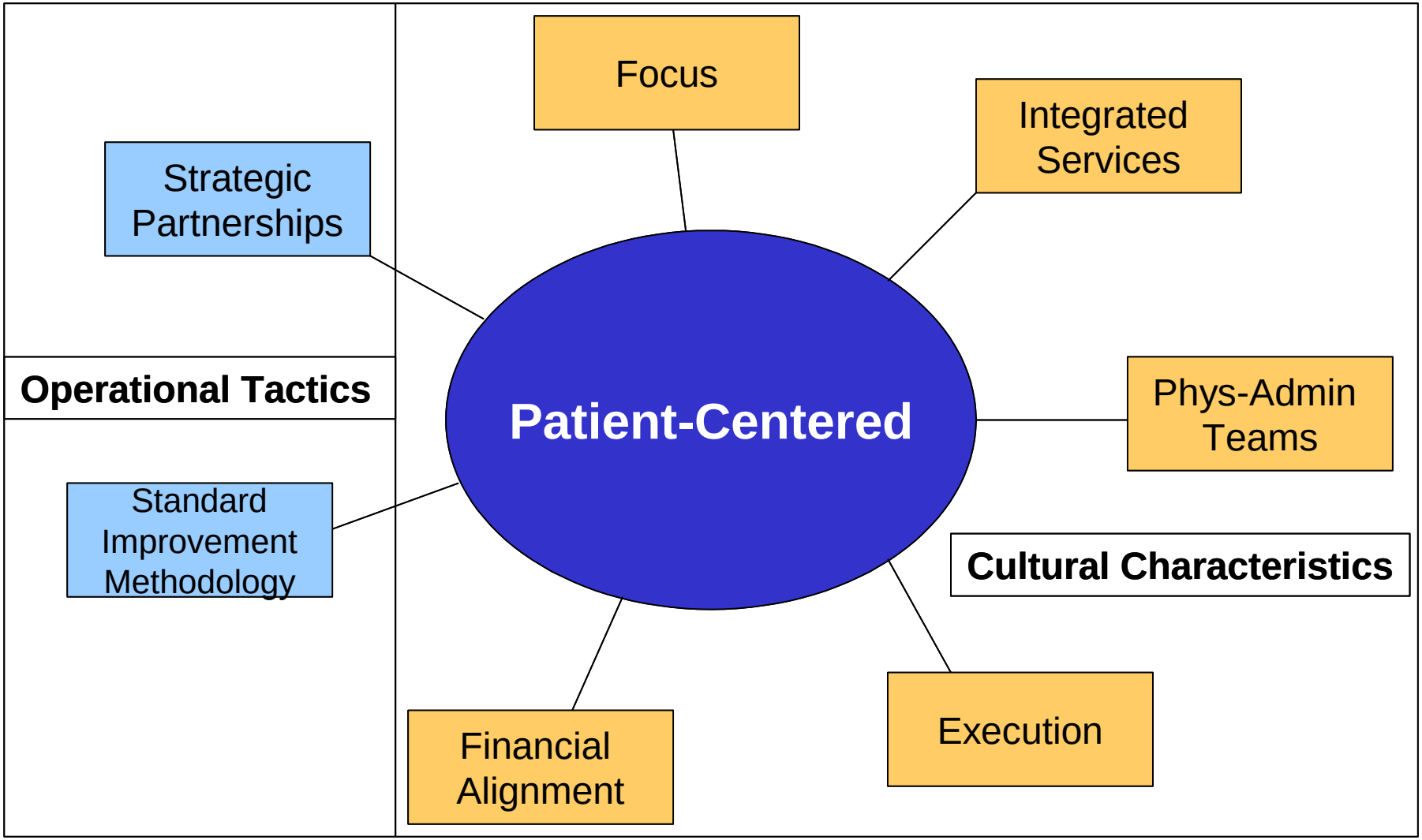
Immediate action:

Changed the team name to

Blue Ribbon Team II

Blue Ribbon Team II

Patient Centered Care at the Core of Observed Best Practices



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.

Blue Ribbon Team II

Team Recommendation

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

Blue Ribbon Team II

Team Recommendation

5. “Liberate” our organization from siloed decision making **by integrating Financial reporting** in a way that supports integrated patient care.

Blue Ribbon Team II

Team Recommendation

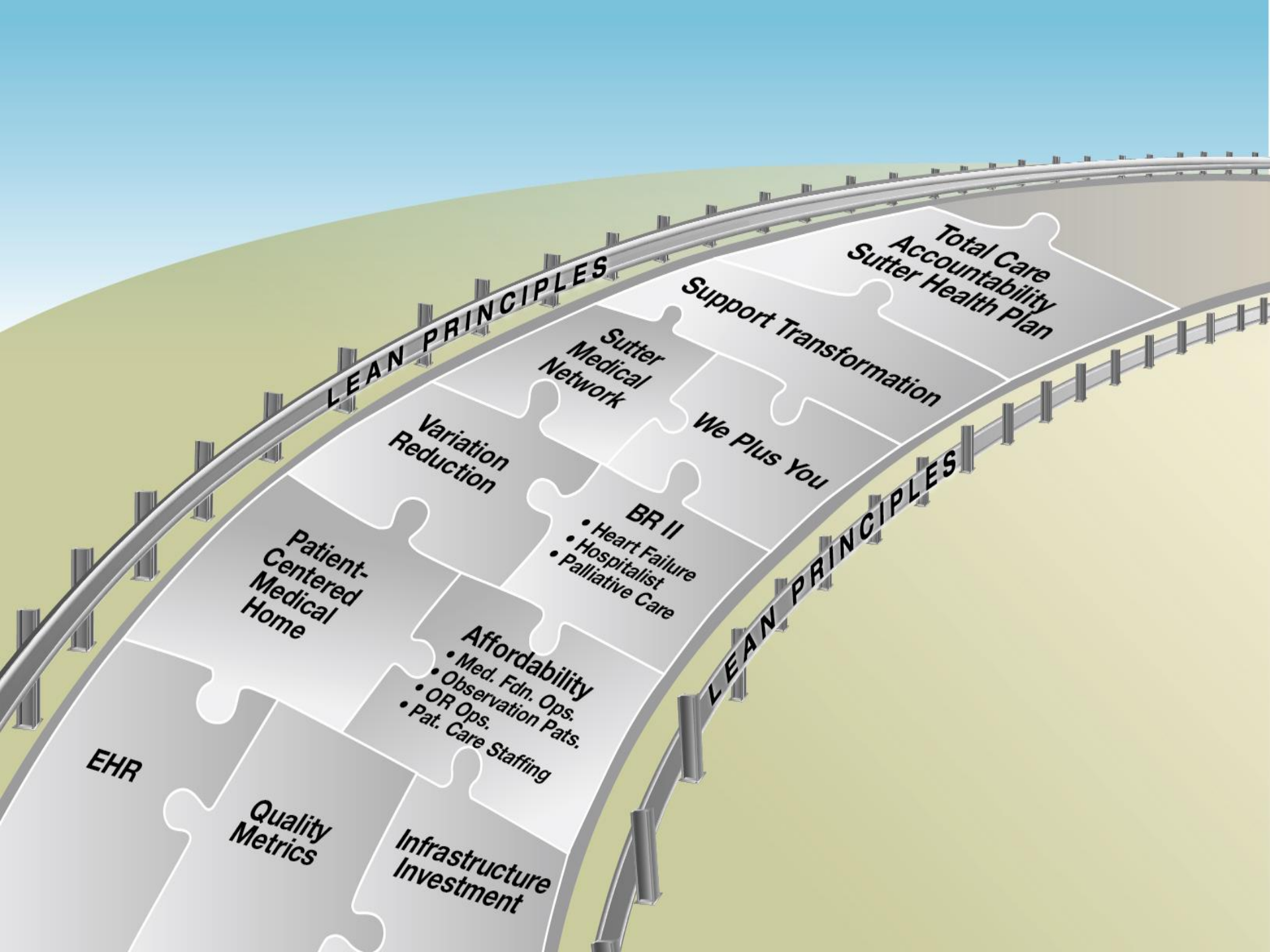
6. Evolve to efficient patient-centered care processes by embracing Lean principles**.**

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


LEAN PRINCIPLES
LEAN PRINCIPLES
Total Care Accountability Sutter Health Plan
Support Transformation
Sutter Medical Network
We Plus You
Variation Reduction
BR II
• Heart Failure
• Hospitalist
• Palliative Care
Patient-Centered Medical Home
Affordability
• Med. Fdn. Ops.
• Observation Pats.
• OR Ops.
• Pat. Care Staffing
EHR
Quality Metrics
Infrastructure Investment

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…

Give

- **Transparency**
  - Data submission on quality and utilization
- **Control**
  - Meet SMN Participation Standards
  - Refer within the SMN
  - Physician credentialing aligned with network credentialing activities
  - Participate in quality improvement and care management programs
  - Collaborate on some contracting elements
- **Time**
  - SMN governance committee participation

Get

- **Venue to Participate in Payment Reforms (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
- **Access to Information and Resources**
  - SMN staff to support improvement on the quality and cost of care
  - Resources to manage patients with complex health needs
  - More information about patients
- **Achieve Economies of Scale and Alignment Across the Sutter Network**

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

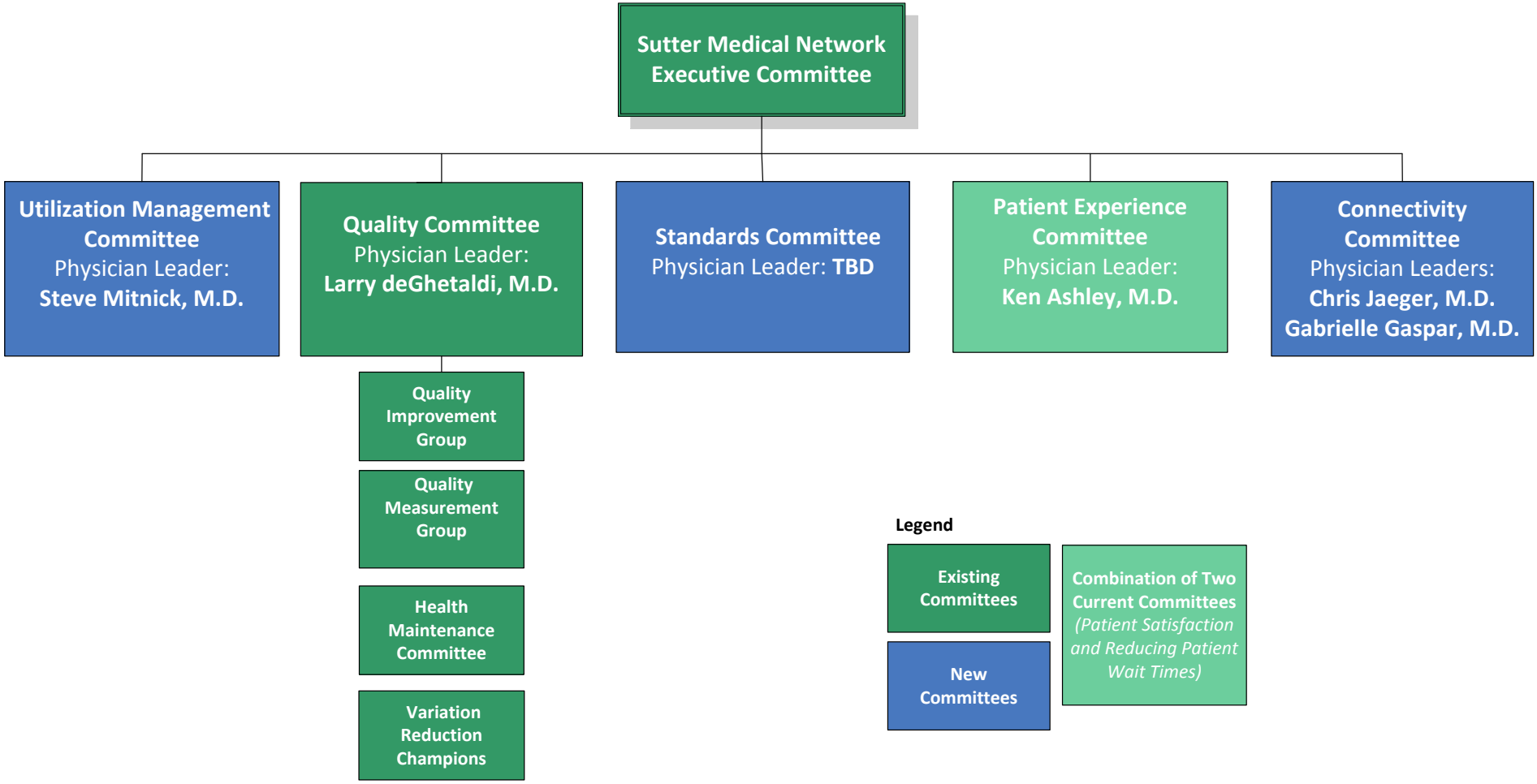
Physician leaders agreed to raise the bar on our commitment to common standards and performance—to further seamless care around the patient.

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.

Committee	Role
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

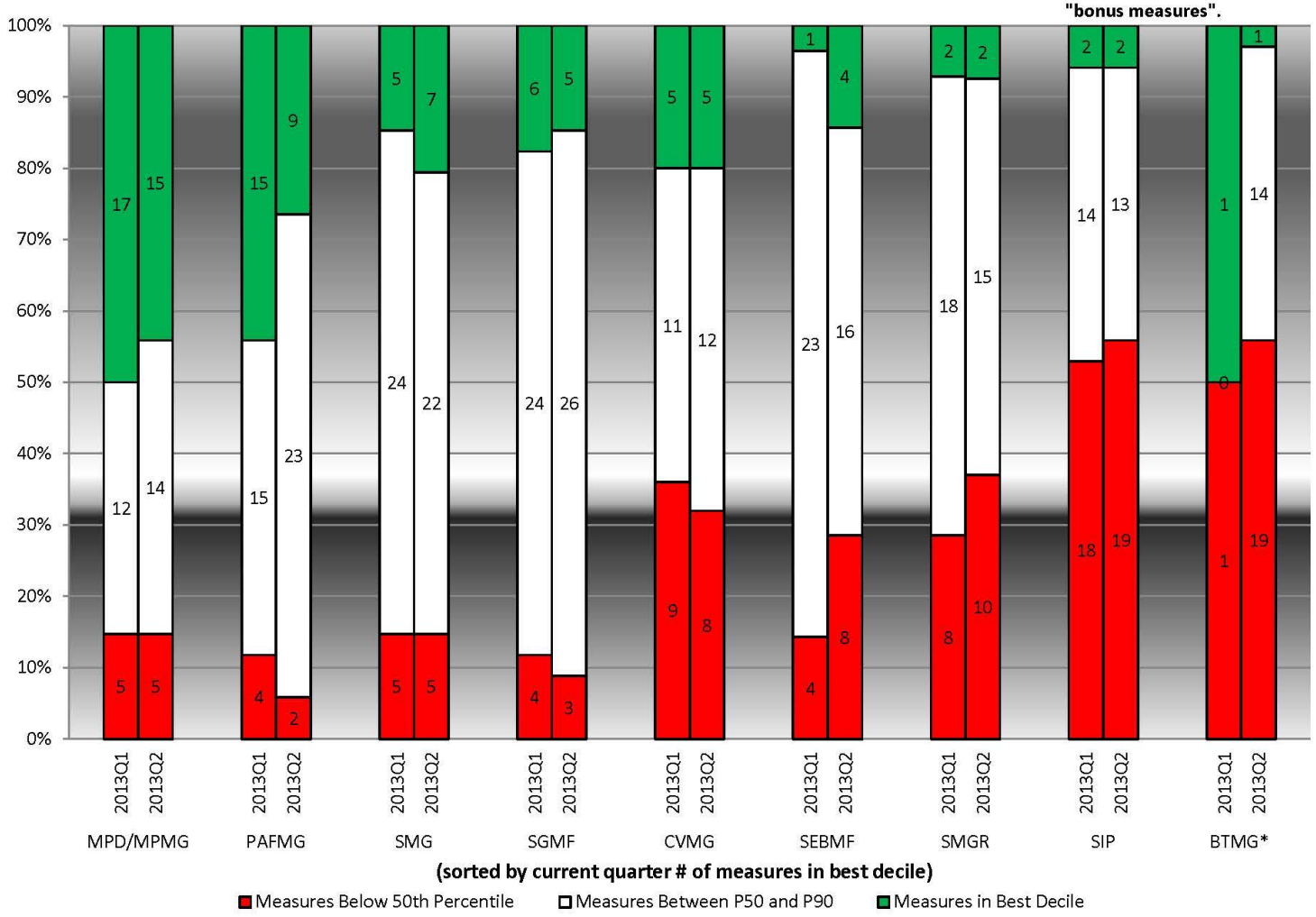
Sutter Medical Network Committee Formation



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".**



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

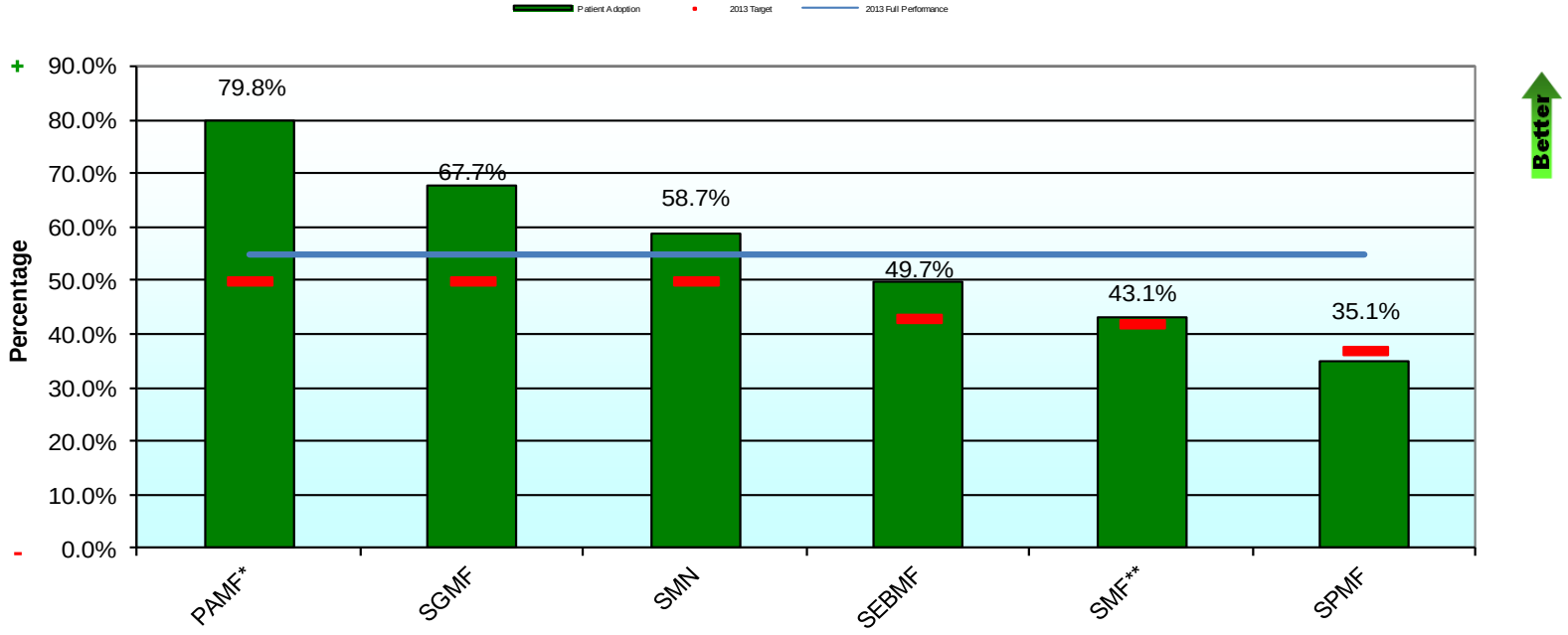
Most Improved Award Winner

- Sutter Gould Medical Foundation

Connectivity: Patient Adoption My Health Online

(SH/SMN Dashboard Measure)

Nov-13 MHO Patient Adoption Rate Across SMN



Medical Foundations

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

* 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.

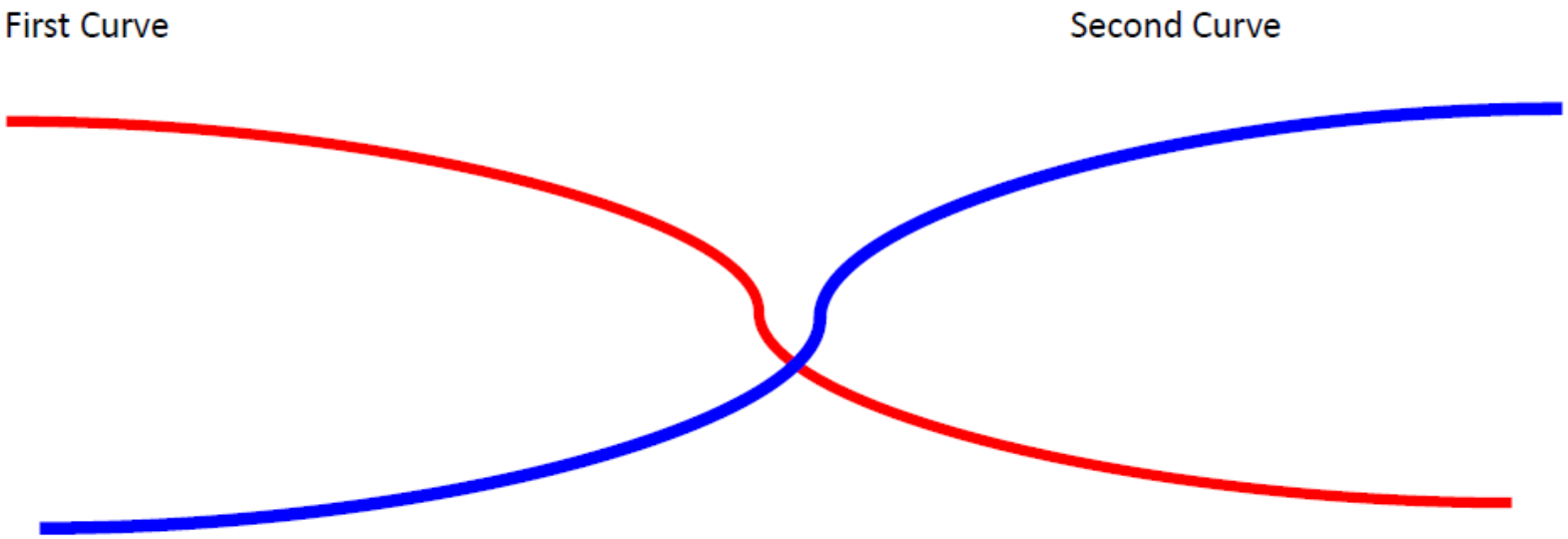
Source: Epic/Clarity and the SHEW for Patient Adoption Metrics. Epic/Clarity and TheDoctorForYou Database for Physician Adoption Metric.

3. Design and implement new models of care together

Advanced Illness Management (AIM®)
An Operational and Clinical Approach to Complex Care

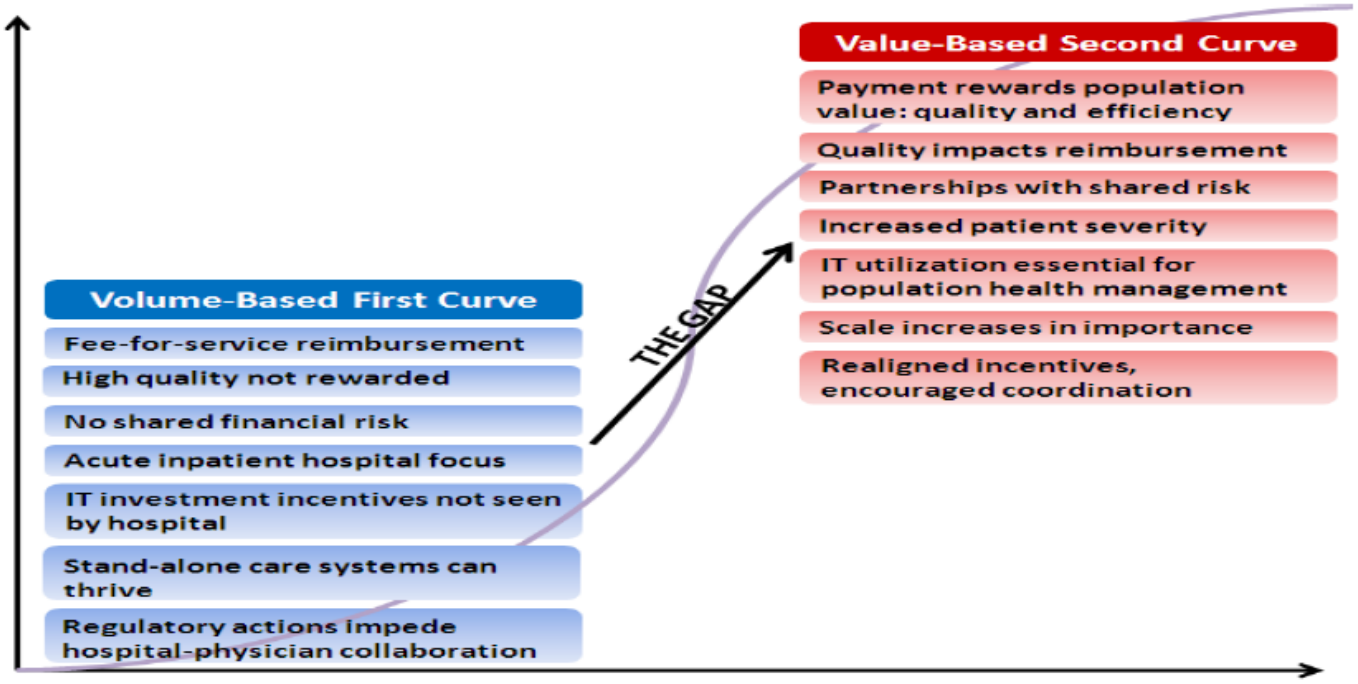
living **in two worlds** at the same time
is **challenging**

The Second Curve



First-Curve to Second-Curve Markets

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



Advanced Illness Management (AIM®)

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

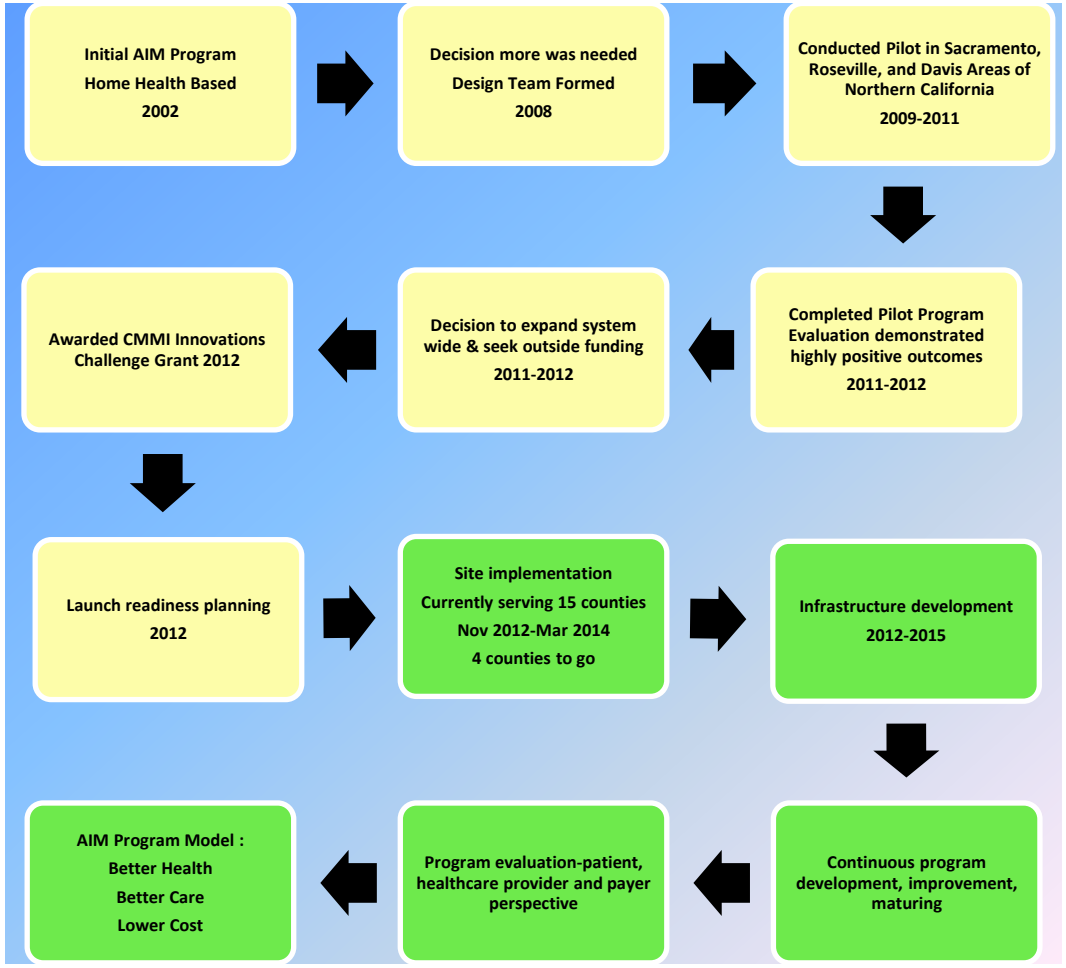
Center for Medicare & Medicaid Innovations Challenge Grant Targets:

- 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

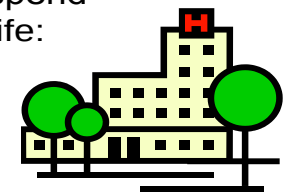
The AIM Journey

- 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



When I have advanced illness…

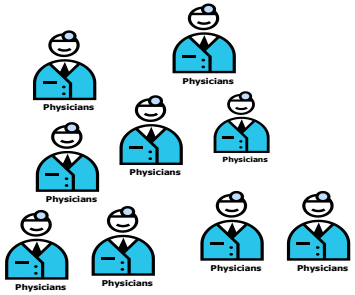
When I have Advanced Illness, this is how I'll spend the last year of my life:



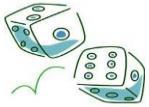
Hospital

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

I'll take 18-30 medications; several times a day



I'll make 54 trips to 9 different doctors and still not know who decides what



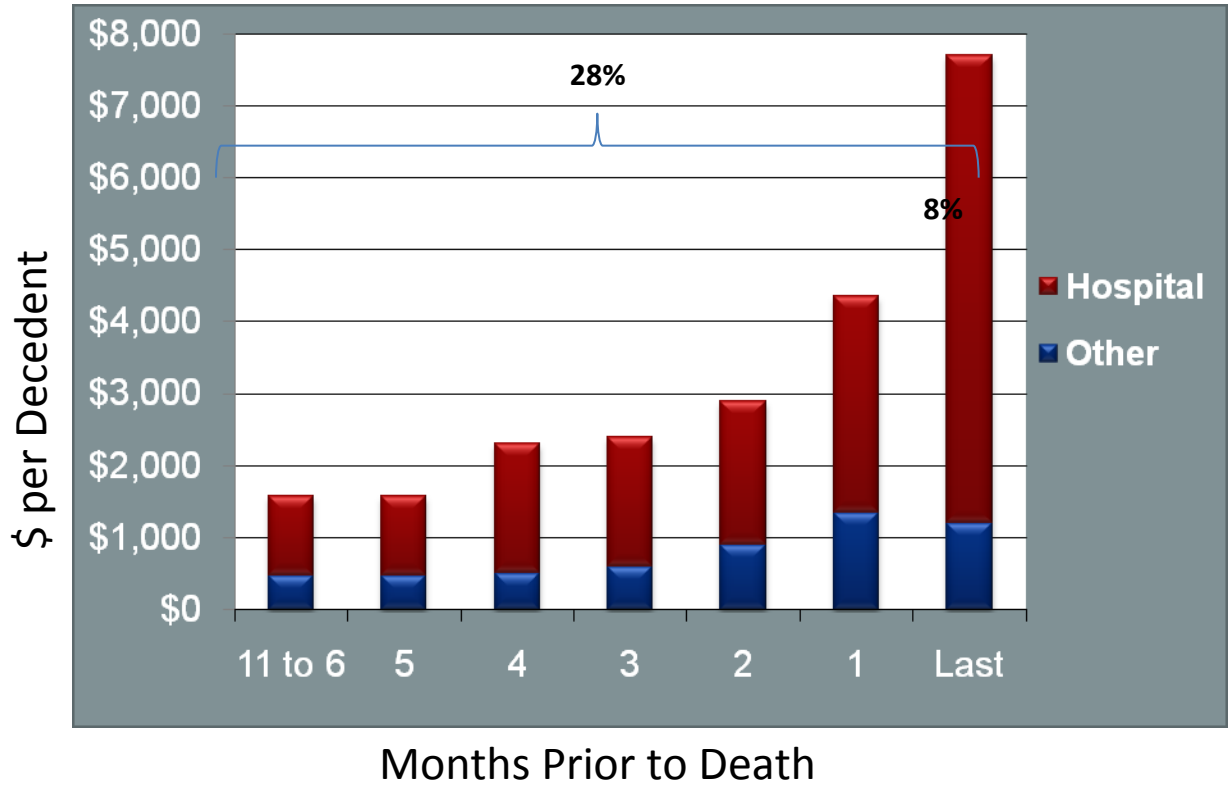
I'll have a 25% chance of receiving hospice care where I'll spend 8 days on service before I die. More likely though, I'll die in the hospital (*where I didn't want to be).*

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



US Dept. of Health & Human Services 2003

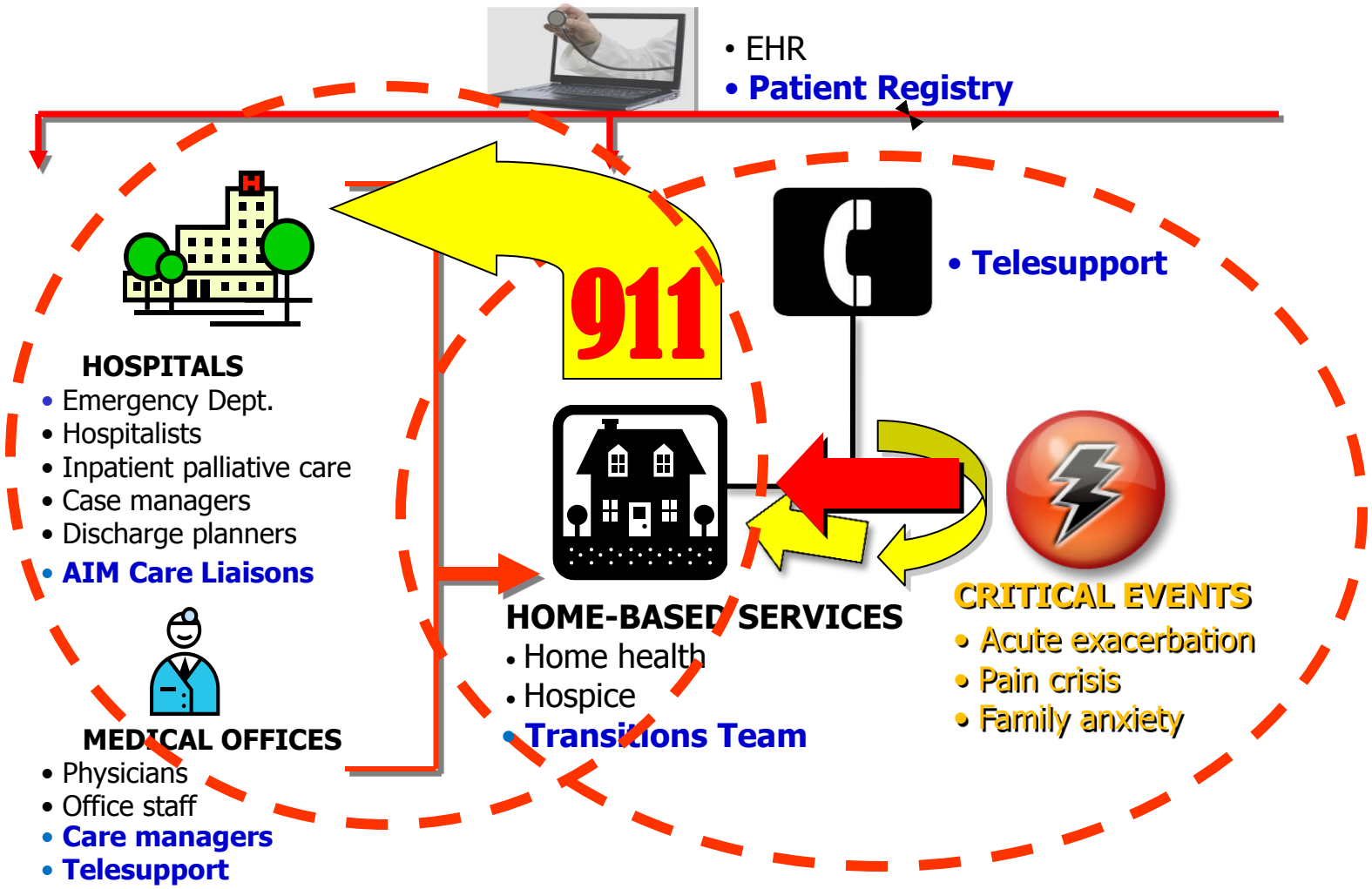
28% in Last Year of Life
8% in Last Month of Life

Variation = Overtreatment:

- Hospitalization
  - Readmissions
  - ICU days
  - LOS
- ER Visits
- Specialty consults
- Tests, procedures

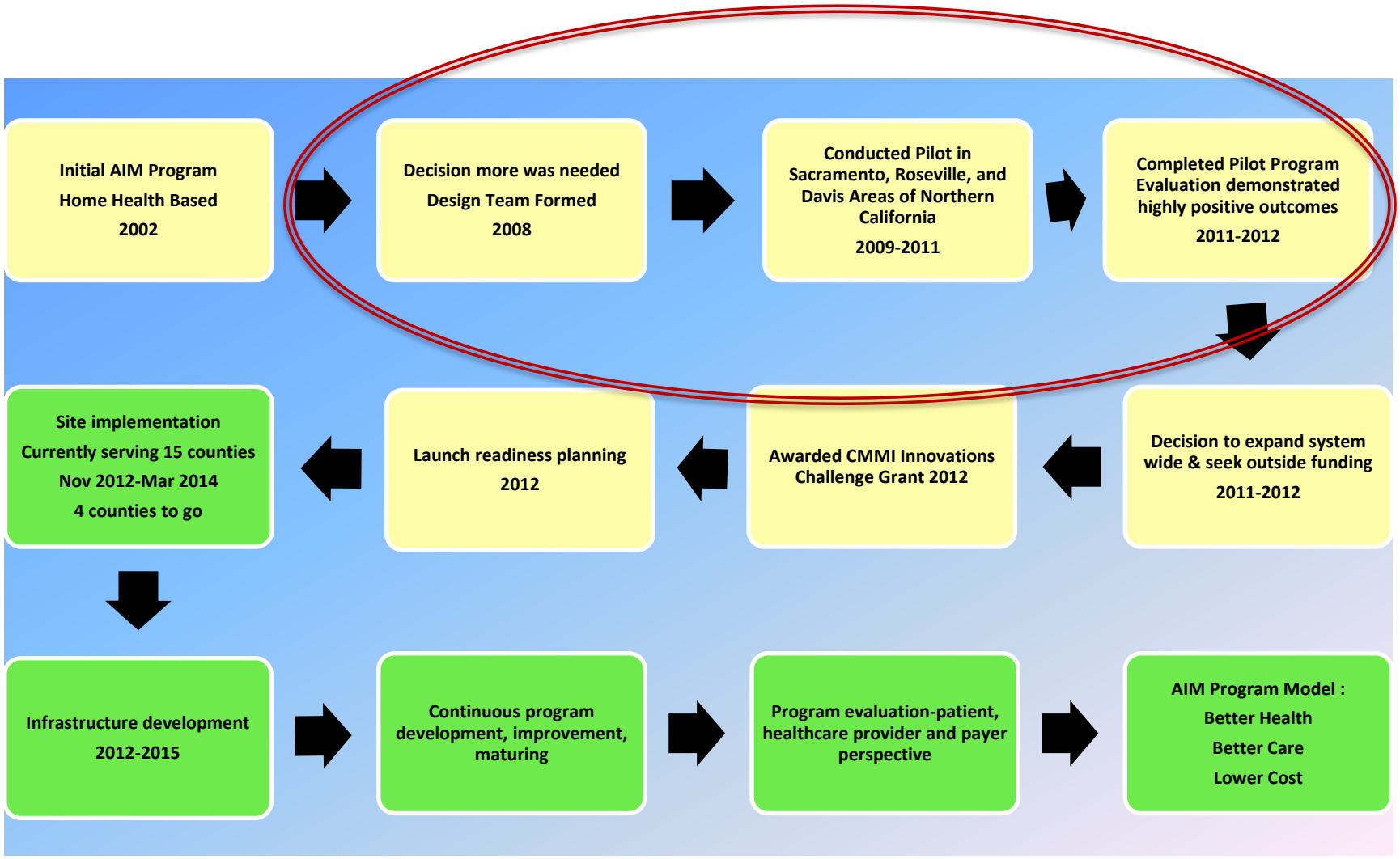
Dartmouth Atlas 2008

System Fragmentation → System Integration



New AIM staff & services

The AIM Journey



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

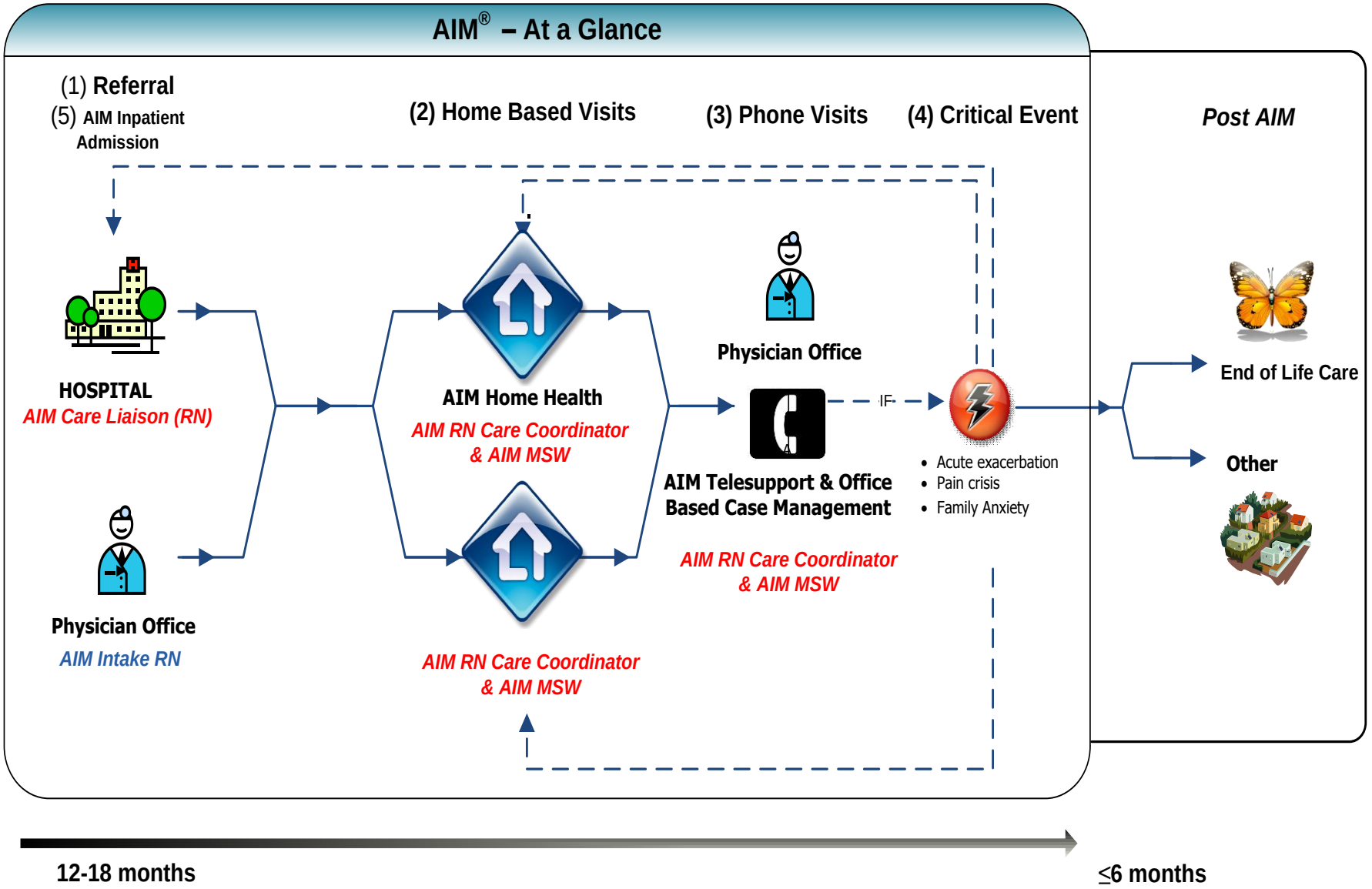
1. Advanced Care Plans
2. Self Mgt plan of Red Flags Symptoms
3. Medication Management
4. Ongoing Follow Up Visits
5. Engagement & Self Management Support

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



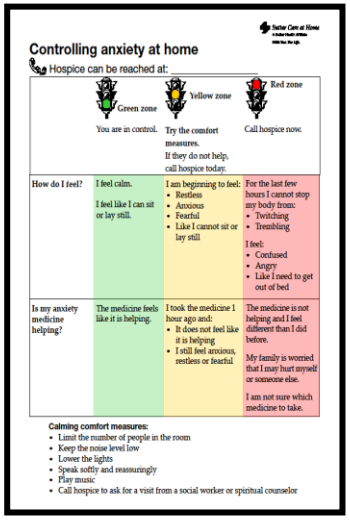
What's Different About Clinician & Patient/Family Person-Centered Approaches?

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



Controlling anxiety at home

Hospice can be reached at:

	Green zone	Yellow zone	Red zone
	You are in control.	Try the comfort measures. If they do not help, call hospice today.	Call hospice now.
How do I feel?	I feel calm. I feel like I can sit or lay still.	I am beginning to feel: • Restless • Anxious • Fearful • Like I cannot sit or lay still	For the last few hours I cannot stop my body from: • Twitching • Trembling I feel: • Confused • Angry • Like I need to get out of bed
Is my anxiety medicine helping?	The medicine feels like it is helping.	I took the medicine 1 hour ago and: • It does not feel like it is helping • I still feel anxious, restless or fearful	The medicine is not helping and I feel different than I did before. My family is worried that I may hurt myself or someone else. I am not sure which medicine to take.

Calming comfort measures:

- Limit the number of people in the room
- Keep the noise level low
- Lower the lights
- Speak softly and reassuringly
- Play music
- Call hospice to ask for a visit from a social worker or spiritual counselor

Early Indicators of Success

	Internal Analysis of Pilot Results		Independent Evaluation of Pilot Results			
			Primary Evaluation Model *		Alternative Evaluation Model**	
	AIM Patients Pre/Post	AIM Patients Pre/Post	All Patients	w/in 6 months Death	All Patients	w/in 6 months Death
AIM n=	245	403	205	77	203	76
Matched Compare Group n=			44,741	827	201	18
Percent of Inpatient Admissions	-53%	-51%	-57%	-76%	-26%	-61%
Percent of ED Visits	-16%	-24%	-19%	-33%	-22%	-29%
Percent ICU Days	-75%	-84%				
Change in LOS	-1.6	-0.9	-64%	-86%	-24%	-73%

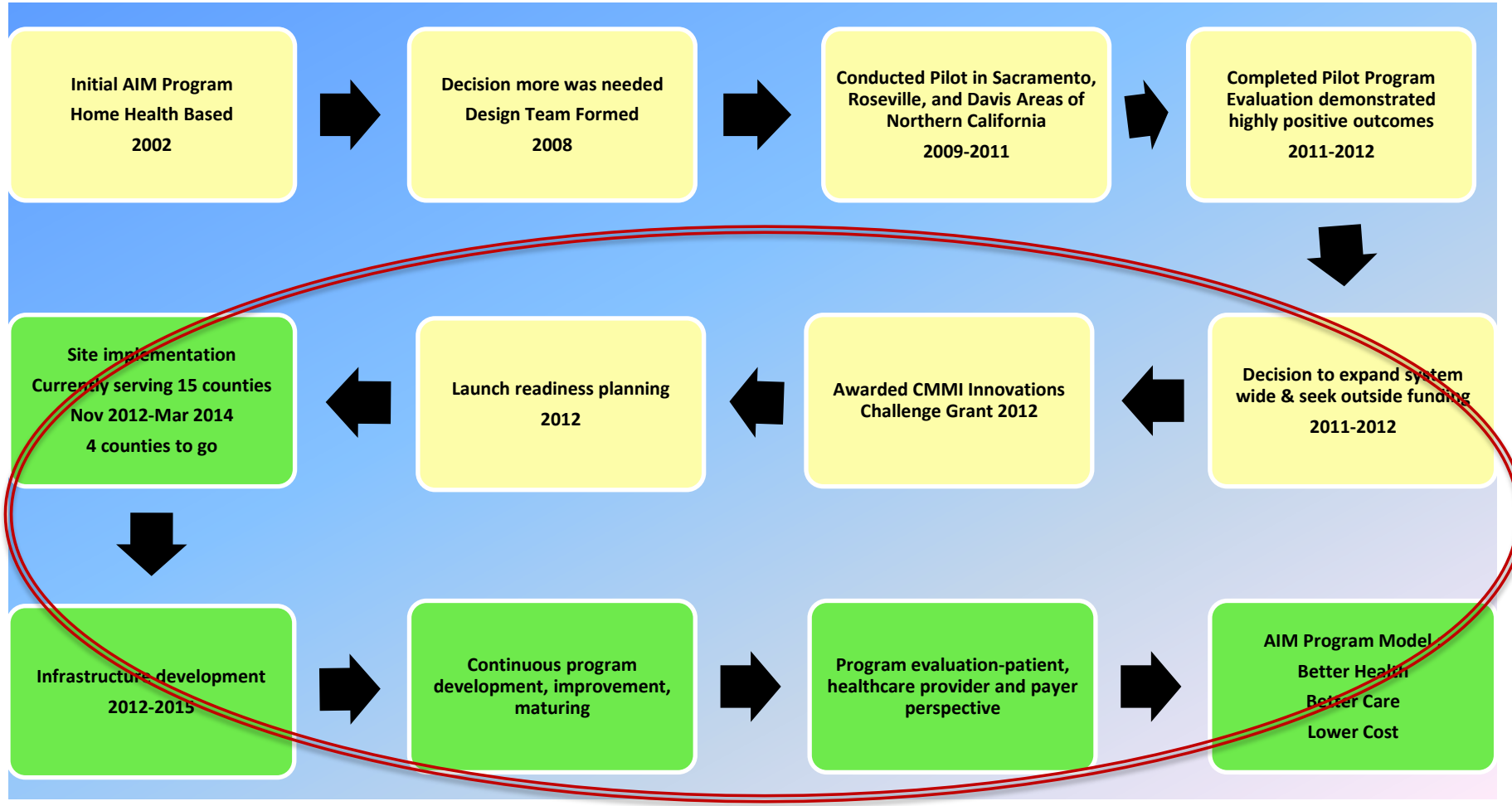
* Matched Compare Group Medicare FFS

** Risk Adjusted Controls Compare Group Medicare FFS

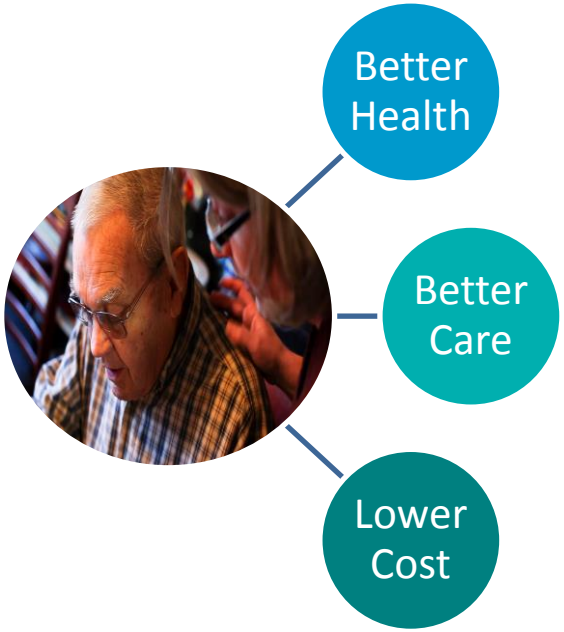
CONSISTENT RESULTS OF AIM ENROLLMENT (THE "AIM EFFECT")

- **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**

The AIM Journey



CMMI Innovation Challenge Grant



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*

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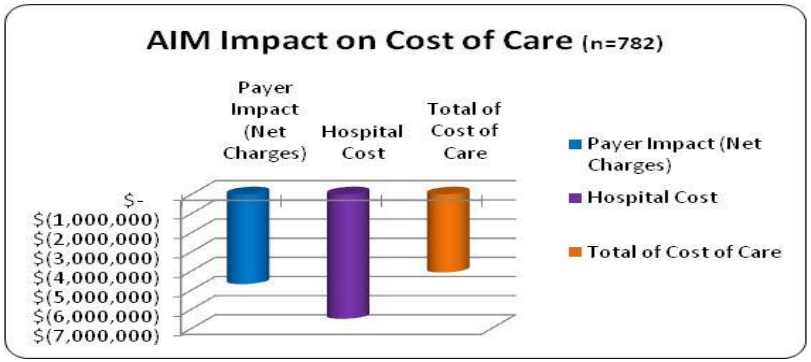
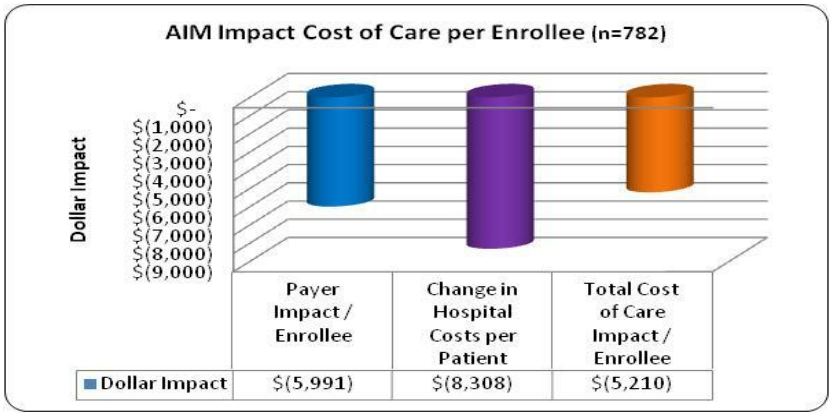
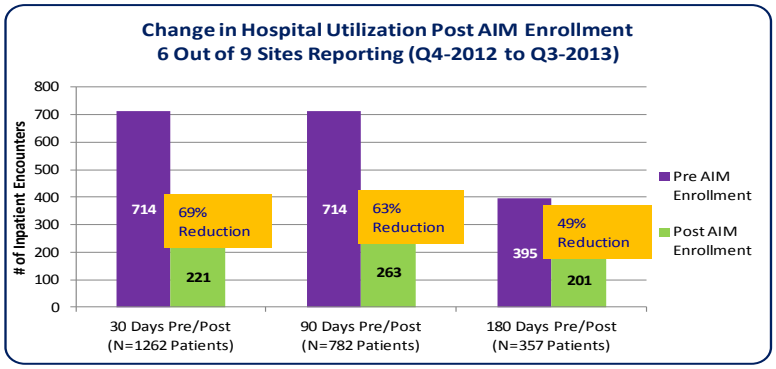
Sutter Health
Advanced Illness Management (AIM)®

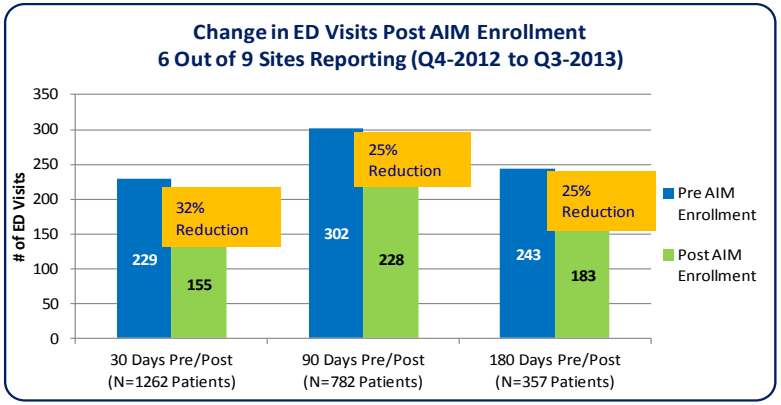
90 Day Pre/Post Utilization and Cost Analysis 12 Months Rolling Q4 2012- Q3 2013

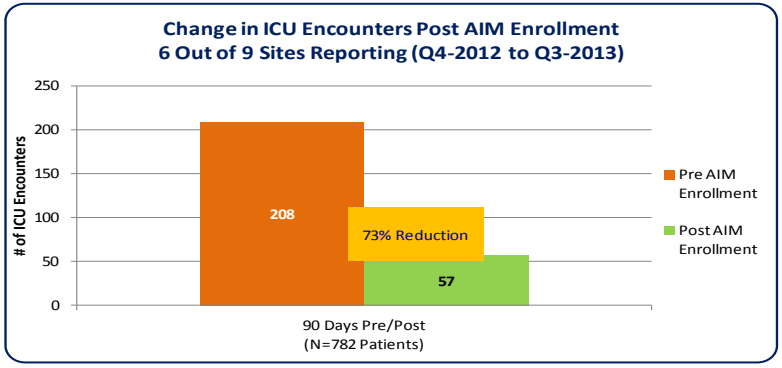
6 Out of 9 Sites Reporting





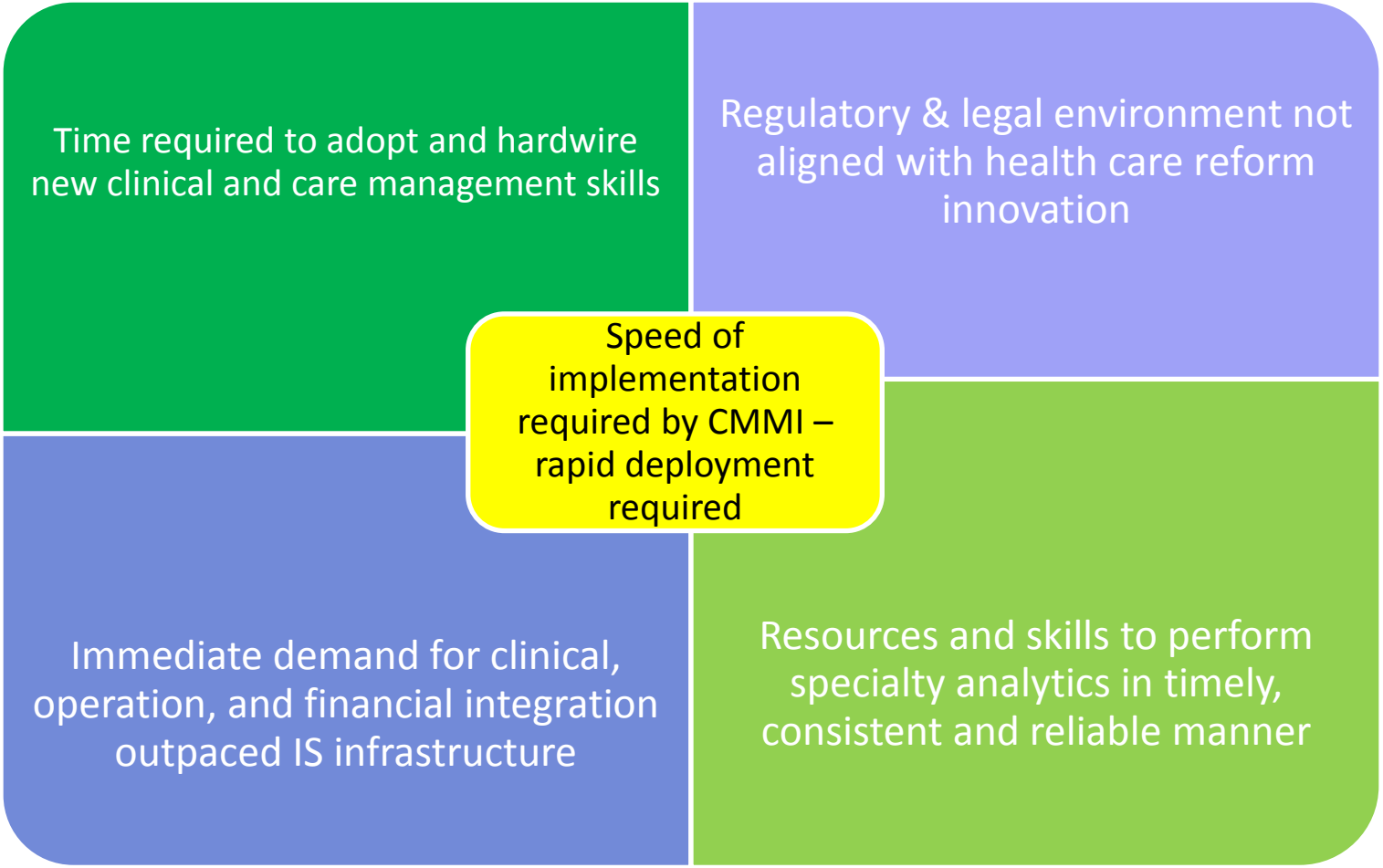






*At this time data is not available for East Bay Region (EBR) due to a recent electronic medical record system conversion and for Central Valley Region (CVR) due to insufficient pre/post data. Both should be available for the quarter ending 12/31/13.

Challenges


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

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)