

Patient Centered Medical Home



*Sutter Medical
Foundation*

A Sutter Health Affiliate

About Sutter Health: We're Creating Northern California's Finest Health Care Network



Sutter Health
Sacramento Sierra Region
With You. For Life.



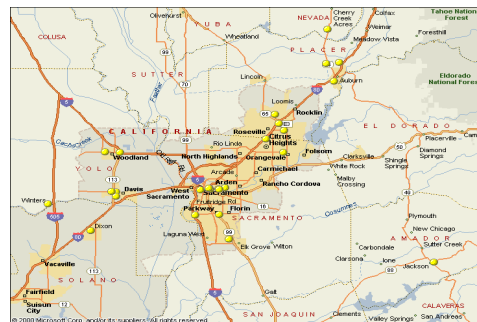
Serving more than 100 cities and towns with:

- 26 acute care hospitals
- 3,400 physicians (8 physician medical foundations)
- Approximately 48,000 employees
- \$7.7 billion in revenues (2007)
- \$8.7 billion in assets (2007)
- Home health & hospice, and long-term care services
- Medical research and medical education/training
- 24 fundraising organizations; tens of millions raised each year

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About Sutter Medical Foundation Central Division

- 45 Care Centers providing primary care to the Greater Sacramento 4 County area
 - Midtown – City of Sacramento
 - Elk Grove/Laguna – South Sacramento County
 - Yolo – Yolo County
 - Foothill – Northeastern Sacramento, Placer, and El Dorado Counties
- 1,700 employees
- 450 physicians aligned across three Medical Groups
 - Sutter Medical Group
- Broader working relationship with the 500 Sutter Independent Physicians
- 425,155 Active Patients
- As a Not-For-Profit organization, SMF re-invests any profits back into health care that benefits our patients.



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Why did Sutter Embrace Patient Centered Medical Home

- Sutter is embracing a transformation to a patient-centered medical home model to improve healthcare quality, remove waste, and reduce total cost of care
- Short term, it does not make sense from a financial perspective
 - Fee for service represents the majority (80%) of Sutter Health reimbursement structure
- Based on a post-payment reform model, potentially achieved through an accountable care organization, our network could see acute care cost savings

Expected benefits

- Improved patient outcomes
- Decrease total cost of care over time
- Appropriate use of hospital-based and ancillary services
- Better integration/ transition of care among our care components
- Protection of and increase in our market share

PCMH

- Our model uses evidenced-based care pathways to reduce variation, improve efficiencies and ultimately improve patient outcome. In it we balance team components with the patient's need to maintain a personal and continuous relationship with a regular site of care.
- Looking to the future, we see that the aging population and chronic disease burden along with shortage of primary care physicians will put increased strain on our resources.
- Preventative care and chronic disease management will continue to emerge as the standard of care.

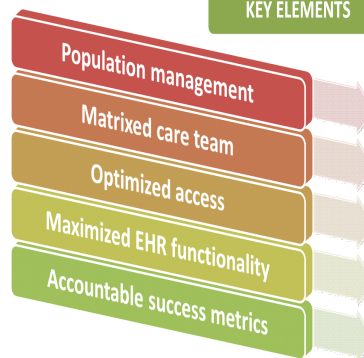
PCMH

What is PCMH and how is it differentiating?

- Integrated care team
- Anticipate patients' needs
- Proactive
- Offer alternative access points to care
- Improve care transitions
- Achieve greater care coordination

Sutter Adaptation of PCMH

KEY ELEMENTS



Population Management

- Proactive patient interactions
- Use of registries
- Enhances office work flows
- Acute, preventative and chronic disease management
- Coordination with existing or newly designed ancillary resources.

Matrixed Care Team

- All staff functioning to the top level of licensure
- Physician-led teams work collaboratively to provide personalized services to each segment of the patient population, using care pathways, evidence-based protocols and effective triaging of patients to the appropriate provider
- Team focused on preventative, wellness and chronic disease management
- Daily huddles

Optimal Patient Access

- Patient-initiated contact
 - Telephone: online-visits, messaging, information
 - In person
- Sutter-initiated contact
 - Telephone: online-visits, messaging, education
 - Home visits, group visits, educational programs
- After-hours care

Maximized EHR Functionality

- Patient Registries
- Secure e-messaging
- Secure e-visits
- Secure-eprescribing
- Secure –scheduling
- Secure- e-registration
- Connectivity between onsite team members and offsite ancillaries
- Support of standard or best practices at point of care
- Patient access to personal health information

Success Metrics

- Cost of providing care
- Revenue
- Quality of care provided
- Experience of care – both for patients and providers
- Experience of work

What this initiative is...

- **System funded project that supports a PCMH pilot as a “learning lab.”**
 - Develop a team based model of care
 - Leverage our electronic health platform (i.e. patient registries)
 - Population management using a variety of allied health extenders (i.e. case managers, social workers, pharmacists)
 - Integrate lean principles, methodology, and application within a practice
 - Implement change management for transformational projects
 - Measure new types of metrics (such as total cost of care)
 - Patient education around changes in practice environments
 - System & regional effectiveness on execution & implementation

What this initiative is not...

- The System is not expecting a direct ROI from this initiative.
- The System is not expecting the PCMH model to be the system standard for primary care in the future (subject to evaluation during 2 years in the pilots)

NCQA

- The implementation plan was built to create a PCMH that is congruent with a Lean practice, NCQA 2011 requirements
- We won't know how well we far with the NCQA standards until implementation is complete; however, the plan is designed to get the practice there. We will have a full list of what still needs to be done to meet NCQA standards.
- The PCMH Core Team will be discussing whether or not we want to move toward NCQA standards for the pilots. If the decision is made to do so, additional resources will be needed to go through the paperwork.

Initiative Facts

- Sutter Health approved PCMH Initiative to be piloted at 3 sites.
- Estimated cost - ~\$2.3 million/yr for 2 years (based on 10,000 unique patients for 3 pilot sites)
- Target Go Live: **October 1, 2011**

Options for managing interim period

- Sutter Health absorbs all of the increased expenses without any additional revenue in the hope that this will be right – sized in the future when payment reform takes hold.
- Limit redesign to isolated settings where we match investment to revenue increases
- Partnering with payor to begin gain sharing for achieved savings
- Move more business to global capitation
- Partner with a health plan or form a health plan
- Pursue developments toward becoming an accountable care organization

Financial Summary

- Funded at the system level
- ~\$750,000 allocation/ Pilot
- Projected financial impact
 - YR 1: (\$432k)
 - YR 2: (\$238k)
 - YR 3: breakeven
 - YR 4: \$120k
 - YR 5: \$300k

Revenue assumptions

- Assumed decrease in revenue as a result of decrease of in-person visits in favor of telephonic visits and messaging
- We see an opportunity to increase profitable care by proactively re-engaging non-compliant patients. (downstream revenue)
- Assumed an increase in panel size from a base of 1,900 to 2,500 per physician
- We see an opportunity in improved compliance for visits, testing and documentation for chronically ill patients especially diabetes. This should yield higher level services billing, increase production pay-for-performance bonus

Affordability Assumptions

- Affordability Assumptions:
 - Reduced Total Cost of Care (i.e. reduced unnecessary ER admissions, hospital admits, and re-admits)
 - The hospital shows tremendous savings opportunity should we focus our efforts on hospital admissions particularly on Medicare patients
 - The hospital also has full capitation risk products that will also benefit from this initiative
 - As we move to more full-risk products as a system, we can begin to quantify the impact by reducing acute care admissions and ED visits.

Physician Compensation

- Assumes MD salaries will be on guarantee during pilot
- A compensation model will be created once we have more history.
 - Production based on panel size
 - Establish PMPY for 2,500 patients
 - Additional pay for greater panel size
 - Quality metrics
 - Access
 - P4P
 - EHR
 - Gain sharing opportunity

Cost

- Assumed increase in staffing levels
- IS investment to address programming and report building

Staffing

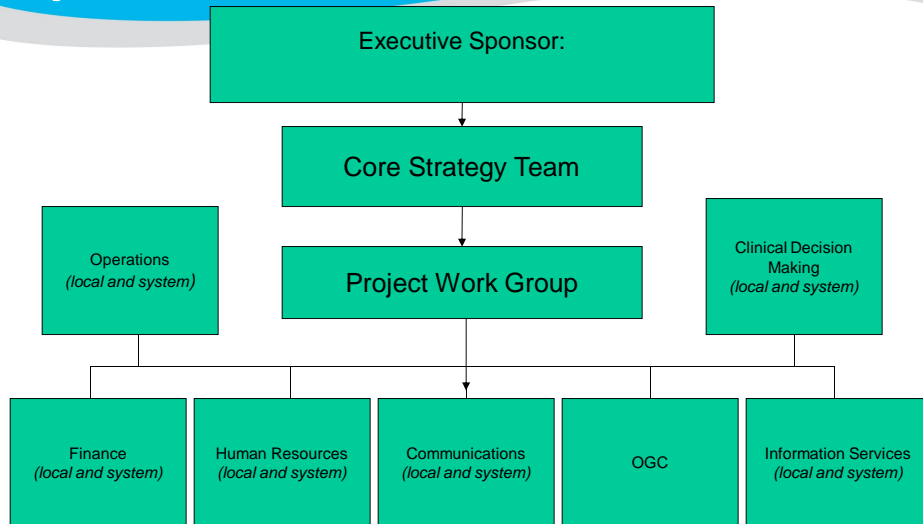
- **Office Based Case Manager (1.0 FTE)**
 - ✓ Working in concert with the Regional Care Management Program
- **MSW Case Manager (0.5 FTE)**
 - ✓ Working in concert with the Regional Care Management Program
- **Pharmacist (0.33 FTE)**
 - ✓ Working with System Outpatient Pharmacy Department to spread position across the 3 sites
- **Medical Assistant (1.0 FTE)**
- **Licensed Vocational Nurse (TBD)**

The medical home model assumes a ratio of 5 FTEs per PCP

Metrics

- Quality
 - Processes within patient categories
 - Disease monitoring & control
 - Clinical Outcomes
- Financial
 - Total Cost of care
 - Utilization in IP environment
 - Revenue opportunities
- Growth
 - Panel size
- Service
 - Online & Telephone Access
 - Data management
 - Patient Satisfaction
- People
 - Staff Satisfaction
 - Physician Satisfaction

Pilot Implementation Support Structure: System Level



Pilot Implementation Support Structure: System Core Strategy Team

Includes medical leadership from the three pilot sites, the executive sponsor, the program manager, an operations executive and Sutter Operating System representation.

- Oversee Project Work Group
- Provide subject matter expertise and identify additional experts and resources as needed
- Assist in responding to high level SMT issues
- Advisors to the Executive Sponsor
- Committed to project from start to finish
- Maintain connection to other transformation efforts

Pilot Implementation Support Structure: System Project Work Group

The Project Work Group includes colleagues whose knowledge, skills and expertise will help Sutter Health successfully implement and refine a PCMH model of ambulatory care.

- Advise and provide recommendations on project deliverables, scope changes and policy issues
- Advise and/or work with local implementation teams as needed
- Provide direction and guidance
- Act as liaison to additional experts and resources
- Serve as advocates for the project
- Fill other roles as defined by the project

Regional Implementation Structure

Regional Implementation Team

- Director of Ambulatory Care Transformation, Dr. Steve Smith (SMG) – Co-Lead
- Director of Development & Innovation, Kiren Rizvi (SMF) – Co-Lead
- SMF COO, Gary Zufelt (SMF)
- Director of Clinical Operations, TBD (SMF)
- SMF Senior Financial Analyst, Tom Egan (SMF)
- Regional Ambulatory Care Management Director, Jan Van der Mei, RN (SHSSR)
- Regional IS Director, Darrel Schmucker (SHSSR) OR IS Project Manager, Joy Bailey (SHSSR)
- Regional IS Analyst, Janine Kelada (SHSSR)
- Regional Director of Communications, Nancy Turner (SHSSR)
- Regional Pharmacist, Angela Leahy (SHSSR)
- SOS Interim Director, Kathleen Boice (SH)*
- Project Manager, Kia Koch (SH)*
- Project Manager, Michael Pitzner (SH)*

* System resources

Care Center Implementation Team

Regional Implementation Team

The Regional Implementation Team will be responsible for managing the implementation of the affiliate pilot. The team will meet regularly to monitor progress and identify resource needs for successful implementation. Regional teams will have parallel dyads at the System level for their specific functional areas of expertise.

- Direct oversight of care center implementation
- Perform Gap analysis of pilot site
- Educate care center physicians and staff in model elements, including soliciting their input in refining the model for local application
- Develop and provide education
- Develop communications for patients
- Provide resources to support implementation

Care Center Implementation Team

The Care Center Team will be responsible for implementing, modifying, refining the PCMH model.

- Responsible for day to day operations
- Liaison to remainder of clinicians and staff
- Primary resource for educating patients
- Lead regularly scheduled “mini-retreats” to re-assess and refine the model
- Feedback to Regional Implementation Team for troubleshooting, resource needs, etc.