



Sutter Medical Center,
Sacramento

A Sutter Health Affiliate

SMCS Physician

Message from Tom Gagen, CEO

April 2008

At Sutter Medical Center, Sacramento we have a special commitment to upholding the Sutter Difference, a commitment for excellence that is built on the pillars of Service, People, Quality, Finance and Growth. The ultimate goal of the Sutter Difference is to improve the health care experience of our patients, physicians and the work experience of our employees.

The recently completed physician satisfaction survey is an important tool in this endeavor. The survey is designed to measure physician views of the quality of the department, services and attributes of SMCS and identify areas in need of improvement.

We partnered with Press Ganey, the health care industry's leading independent vendor of satisfaction measurement and improvement services, to conduct the survey between September and November 2007. We had a 35 percent return rate, and I want to extend a sincere thank you to all who completed the survey. According to the 2007 survey results, the medical staff's overall satisfaction has slipped in the past year, and we are working with physician and hospital leadership to develop action plans to address the areas needing improvement.

The survey results fall into four different dimensions of physician satisfaction: perceived quality of patient care, ease of practice, relationships with hospital administration and overall physician satisfaction.

Dimensions of SMCS Physician Satisfaction: Percentile Rank			
Hospital Size Benchmark 500+ beds			
Quality Patient Care	Ease of Practice	Relation with Leadership	Overall Satisfaction
53 rd	36 th	44 th	39 th

I am pleased to report that physician satisfaction scores increased in five questions between 2006 and 2007:

Question	2006	2007
Ease of Admitting Patients	71.5	76.4
Scheduling Outpatient Surgery	64.4	69.0
Radiology Communications with Patients	68.5	74.7
Turnaround Radiology Results	66.8	71.1
Timeliness on Written Orders	70.1	73.3

Those areas identified for needing improvement include Responsiveness/Confidence in Hospital Administration, Administration Deals with Change, Patient Care Made Easier, and Responsiveness of Nursing Staff Leadership. SMCS Administration team is taking the following action steps to improve satisfaction in these areas.

Responsiveness/Confidence in Hospital Administration

- An administrative team member will attend monthly medical staff department meetings, Medical Executive Committee, Credentials, etc., to hear and understand pertinent issues, report back on actions and keep the groups apprised of current initiatives and rationale.
- Communications with physicians will improve with regular columns in the monthly SMCS Physician newsletter from Director of Medical Affairs Rob Schott (his first column is on Page 3) and myself. In addition, other administrators will contribute regular updates of changes and issues to the medical staff.

Administration Deals with Change

Several crucial joint physician/administrative meetings will continue, including Quarterly Surgery/Administrative meetings, and the monthly Surgery/Anesthesia/Administrative meetings. In addition, the Administrative Team will meet with specific physicians on a quarterly basis to learn and share information.

SMCS Welcomes New Medical Staff Members

Michael P. Carroll, M.D.

1020 29th St., Suite 680
Sacramento, CA 95816
(916) 453-3300

Specialty: Hematology/Oncology,
Internal Medicine

Floyd L. Culler III, M.D.

Children's Specialists Medical Group
5301 F St., Suite 307
Sacramento, CA 95819
(916) 733-0888

Specialty: Pediatric, Endocrinology,
Pediatrics

Natasha W. Fine, M.D.

1201 Alhambra Blvd., Suite 335
Sacramento, CA 95816
(916) 731-7770

Specialty: Family Medicine

Jeffery S. Kahn, M.D.

Community Psychiatry Associates
2180 Harvard St., Suite 210
Sacramento, CA 95815
(916) 567-3500

Specialty: Psychiatry

Anubha Khanna, M.D.

9281 Office Park Circle, Suite 120
Elk Grove, CA 95758
(916) 691-5999

Specialty: Pediatrics

Ingvild G. Lane, M.D.

1020 29th St., Suite 480
Sacramento, CA 95816
(916) 733-3777

Specialty: Internal Medicine

Mark P. Owens, M.D.

5901 River Oak Way
Carmichael, CA 95608
(916) 483-4748

Specialty: Surgery, General

Felisa P. Tacata, M.D.

2180 Harvard St., Suite 210
Sacramento, CA 95815
(916) 567-3500

Specialty: Psychiatry

Physicians: Mark Your Calendar for Hospital Week; Order Shirts by April 11

The Hospital Week Barbecue and Gift Pick-Up on May 13 and 14 will celebrate the many successes and accomplishments made by SMCS in 2007, and will take a look at the future of the medical center through a Passport Event that gives a virtual tour of the Master Site.

The barbecue, which is for SMCS employees, volunteers and medical staff, will be held from 10 a.m.-1 p.m. and 4-6:30 p.m. May 13 at Sutter Memorial Hospital and May 14 for Sutter General Hospital at Sutter's Fort.

Physicians: If you haven't ordered your polo shirt celebration gift, please do so by Friday, April 11. You can order yours by calling 733-3097 or on the Internet at suttermedicalcenter.org/celebrate.

Sutter Medical Center Foundation Report

The following report was provided by Michael Abate, M.D., MEC Physician Liaison to the Sutter Medical Center Foundation Board.

- To date, the Capital Campaign has raised \$41 million; 29 physicians have made gifts.
- The Foundation Board of Trustees allocated funds for the following programs/services/equipment:
 1. Senior Care: Among the items purchased were hair dryers for the women residents, conference room furniture, a digital scale, and two standing frames for physical therapists to assist them with residents;
 2. Hear Institute: Nurse training provided for pressure ulcers, and a Thoratec CentriMag Blood Pump was purchased;
 3. Sutter Center for Psychiatry: Purchased Christmas supplies for Children's Unit;
 4. Children's Center: Cleft Palate Panel Services for patients were provided.
- **2008 Hard Hat Ball** – This year's event, which will benefit the Children's Center at SMCS, will be held on the top floor of the new Sutter Community Garage from 6-10 p.m. Saturday, May 17. Music will be provided by the Spiderband, featuring Sutter physicians and staff. RSVPs must be made by May 9. Call or e-mail Tracie Ramsey at 733-3863 or ramseyt@sutterhealth.org.

Medical/Surgical M&M Conferences Set for 2008

Starting April 18, the Medical/Surgical M&M Conference will be held the third Friday of each month from 12:15 to 1:30 p.m. The objective of the M&M conference is to present interesting cases for open discussion regarding patient care management and problem solving. Hot lunch will be provided. The schedule for 2008 is:

- April 18 – 7C Patio, Sutter Memorial Hospital
- May 16 – 7th Floor Board Room, Sutter Cancer Center
- June 20 – 7C Patio, Sutter Memorial Hospital
- July 18 – 7th Floor Board Room, Sutter Cancer Center
- Aug. 15 – 7C Patio, Sutter Memorial Hospital
- Sept. 19 – 7th Board Room, Sutter Cancer Center
- Oct. 17 – 7C Patio, Sutter Memorial Hospital
- Nov. 21 – Room 220, Sutter Cancer Center
- Dec. 19 – 7 C Patio, Sutter Memorial Hospital

Affordability Isn't a Concern Just for Hospital Administrators

By Rob Schott, M.D.

SMCS Director of Medical Affairs

At my college interview (for admission to a combined six-year undergraduate and medical program), I was asked to give my opinion on socialized medicine. I hadn't really thought about it before. A trick question? Do I have to join the Communist Party? Wear a funny hat? How am I supposed to answer this? Is there a wrong answer? It was probably the last time I gave pause to reflect before opening my mouth -- I was 17 years old. Many years later I went back to my file at the medical school and looked at the notes from my interviewers. "Impressive, but not as impressive as some of my 9.5's." I obviously didn't formulate the comprehensive solution to the accessibility problem during that interview. Damned with faint praise, I nonetheless got into the program, diverting me from entering the other nascent field that interested me: computer sciences.

This interview ambush was my introduction to the perpetual crisis of health care economics. For most of my career in medicine, health care has lurched from one crisis to the next, with the central themes including access, quality and affordability. Early in my career (in the 1980s), health care institutions seemed to be awash in cash. I watched a colossal, gleaming university hospital emerge on the hillside where I spent the first 15 years of my apprenticeship and early career. I worked as an emergency doctor on a Bell helicopter, equipped with two screaming jet engines ferrying patients from all over the state into the new facility. It wasn't until much, much later that I realized we were porting in the equivalent of bricks of cash as fast as those engines could drag us across the sky. Physicians were also doing well.

In 1965, with the signing of the Social Security Act, Medicare and Medicaid became the first public insurance program – socialized medicine for the elderly and poor! Predictably, this legislation was vigorously opposed by physicians and their representative organization, the AMA, throughout the writing of the legislation from 1958 through 1964. But at the time the legislation passed, physician earnings were twice that of the average tradesman. A few years after the introduction of Medicare, more patients had access to care. And these patients, particularly the elderly, were (and remain) high-intensity consumers of medical goods and services. As a consequence, physician incomes grew to seven times that of the average tradesman. In 1950, health care costs were estimated at less than \$20 billion a year. By 1960 it was \$27 billion and ballooned to \$250 billion dollars by 1980. In 1994, it passed the \$1,000 billion (trillion) dollar mark. With that much money sloshing around in the system, it was a good time to be in the health care sector.

That, however, was half a career ago. The byways of health care delivery are no longer paved with platinum. The crest of the wave passed many years back, particularly for physicians in California, and now healthcare institutions are struggling to remain fiscally viable. As a society, it is not possible to underwrite the "bottomless well" approach to health care, particularly with the proliferation of expensive diagnostic technology and treatments, which are sometimes with marginal benefit, or have yet to be fully validated. But because it is wired into our national genome, we work to make it available to everyone who might benefit. Collectively, it has been difficult deciding if and where to make the cuts that will be increasingly necessary.

I now have the opportunity to spend time contemplating these issues from a hospital system perspective. How do we provide comprehensive, high-quality, cost-effective care? The marketplace for health care delivery locally is competitive, and Kaiser, which is an insurance company outfitted with an integrated health care delivery system, dominates in Sacramento. Kaiser underwrites policy and then provides care through its aligned hospital and physician partners at a competitive price. Businesses are receptive: They are buckling at the knees carrying the burden of health care for their workers. Kaiser has generally been a cheaper and therefore attractive option, which has propelled their growth to a greater than 50 percent market share for the commercially insured workers in the Sacramento region.

For Sutter to grow market share, we need to be affordable. We can no longer pass through costs at rates that have consistently exceeded general inflation. The cost of hospital care is of bottom-line importance for plans and businesses (such as CalPERS) when making contracts.

-- Continued on Page 4 --

Continued from Page 3: Message from Director of Medical Affairs Rob Schott, M.D.

So how do administrators (and plans) assess affordability? There are innumerable metrics – a virtual alphabet soup of financial yardsticks: FTE/AOB, WI Cost (Acute) less BDDICPS, among others. It's dizzying from a physician perspective to weigh these various measures of institutional financial performance, so I'll focus on one measure: the CMI-Adjusted discharge cost. Richard SooHoo, our Chief Financial Officer, tells me that this is one of the single best measures of our cost for providing care. The numerator, CMI, is the Case-Mix Index, which is an adjustment for the types and severity of the cases, and the denominator is essentially discharges. It gives us an idea, in a single measure, of the cost of providing inpatient and outpatient hospital care for an average patient. So far in 2008, this number is \$10,699. During the same time period last year, it was \$12,008, and our target is \$10,000.

There's much that hospital administration can do to contain costs, although there are many constraints, because of the highly regulated nature of hospital care. (For instance, nursing accounts for about 60 percent of the hospital budget, and nursing ratios are mandated.) But by monitoring and measuring resource utilization, we have brought down our Cost per CMI Adjusted Discharge.

However, the most prolific, unpredictable and difficult-to-engage driver of the variable cost of hospitalization is me, the physician. All admissions to the hospital are through physicians. We direct the workup, devise the treatment plan and perform the therapeutic interventions. We have tremendous impact on a variety of critical variables such as Length of Stay; we are the field generals that call in the heavy diagnostic and therapeutic artillery (even to the point of specifying the manufacturer of the shells).

Most physicians are familiar with Length of Stay, but it is an abstraction. Variable and fixed costs are an accounting nuisance. We are traditionally the advocates for the patient and we cannot allow financial considerations to contaminate our relationship (except in cases where we own those financial consequences). But going forward, successful health care delivery systems will require a collaborative effort between the physicians and the hospital to effectively manage guideline-based patient care, as well as the costs of providing that care. Our ability to deliver on this promise will become more transparent as data are collected and reported, not only for institutions but for individual providers. As physicians, we need to understand hospital systems, just as the hospital administration needs to understand the concerns of the independent affiliated providers. We need to be healthy together.

Continued from Page 1: Message from CEO Tom Gagen**Patient Care Made Easier**

Administration will continue several key initiatives begun in the past few years to streamline the delivery of quality patient care. Key programs include the physician rounding and rapid rounding developed by our Blue Ribbon taskforce, our patient flow team, RMC, continuing improvements in transcription turnaround times, the use of medical hospitalists and intensivists, and the eICU program. We also will conduct twice-yearly forums with the medical staff office assistants to share new information and answer questions.

Responsiveness – Nursing Staff Leadership

The detailed medical staff survey results have been provided to the Nursing Operations Team, who will develop an action plan to address specific issues/challenges.

I will keep you informed of our progress on these fronts in future issues of this newsletter, and am committed to sharing and celebrating positive results due to our efforts. Again, I want to thank all of you who participated in this annual survey. This is an important tool as we strive to maintain an environment that excites and engages physicians to want to practice medicine and take very good care of our patients. Please contact me should you have questions about the survey or desire an update on our improvement progress.