Dr. Charles Sorensen

[Music]

Margaret Flinter: Welcome to Conversations on Health Care with Mark Masselli and Margaret Flinter, a weekly show where we speak to the top thought leaders in health innovation, health policy, care delivery, and the great minds who are shaping the health care of the future. This week, Mark and Margaret speak with Dr. Charles Sorenson, CEO Emeritus of Intermountain Health, an innovative integrated health care system based in Salt Lake City, committed to improving access to care, advancing telemedicine and genomics, and improving outcomes while reducing costs.

Lori Robertson also checks in, the managing editor of FactCheck.org, looks at misstatements spoken about health policy in the public domain, separating the fake from the facts. We end with a bright idea that's improving health and well-being in everyday lives.

If you have comments, please email us at chcradio@chc1.com or find us on Facebook, Twitter, iTunes, or wherever you listen to podcasts. You can also hear us by asking Alexa to play the program, Conversations on Health Care. Now, stay tuned for our interview with Dr. Charles Sorenson, CEO Emeritus of Intermountain Healthcare.

Mark Masselli: We're speaking today with Dr. Charles Sorenson, President and CEO Emeritus at Intermountain Healthcare, not-for-profit, Salt Lake City-based integrated health system, serving patients in Utah and Idaho. Dr. Sorenson has served for eight years as CEO of Intermountain. Prior to that, he spent 10 years as chief operating officer, while continuing to perform weekly surgeries in urology. He's the founding director of Intermountain Healthcare's Leadership Institute. Dr. Sorenson earned his BA at the University of Utah, his MD at Cornell Medical School.

Dr. Sorenson, welcome to Conversations on Health care.

Dr. Charles Sorenson: Thank you. It's a pleasure to be with you.

Mark Masselli: You served at the helm of a highly regarded health system, one that strives for value and quality through an integrated approach to care delivery. Former President Obama said Intermountain was a health system that should be emulated everywhere in the country, saying it offers high quality care at below average costs. If you could share with our listeners, what's unique about Intermountain's approach?

Dr. Charles Sorenson: I think it really comes from our roots. Intermountain was founded in 1975 when The Church of Jesus Christ of Latter-day Saints decided to donate its 15 community hospitals that it owned to a newly created nonsectarian, not-for-profit health system, which they named Intermountain Healthcare. Since then, Intermountain has been completely independent from the church. It began with a charge from the founders to the original board to become a model health system.

I've been on the board for 20-plus years and worked with Intermountain for over 40 years. As a person there on the front line, I really saw that in play from the first it was a focus on quality. It was also a focus really before almost any place else, talking about are these health care costs going to be affordable to the community. What made a difference for us, one is information systems. Dr. Homer Warner, an extraordinarily capable MD, Ph.D. trained cardiologist, he came by the late 1960s, one of the true pioneers in using computers to track clinical outcomes and to assist in clinical decision-making.

By the early 1980s, we had objective information on clinical outcomes and costs for the majority of the things that we did at Intermountain. That was huge. By the later 1980s, Dr. Brent James joined us. He was one of the first people in the world to apply the things that Professor W. Edwards Deming had learned about industrial production, adoption of best practices, and elimination of inappropriate variation, led an industry to higher quality products at lower production costs.

Brent thought the same could be done at Intermountain. The reason he came is because we have these data systems that would help us understand what we were really doing. That combination led to by the mid-1990s we found that our clinical programs, which focus on implementation of evidence-based best practices across the enterprise. When we eliminate unwarranted variation, don't do things that just add cost or risk, we get better clinical outcomes at lower overall cost for the community.

Margaret Flinter: Dr. Sorenson, you have a successor as CEO. That's Dr. Mark Harrison. He's been continuing really the innovative path. You've launched one of the nation's largest virtual hospital networks. We understand you're also creating a drug manufacturing entity to address the high cost of pharmaceuticals. He has clearly credited you for laying the groundwork that made this innovation possible. Talk with us a little more, if you will, about this culture of innovation at Intermountain and how that is so vital to addressing some of the great challenges in American health care.

Dr. Charles Sorenson: I think this work at innovation at Intermountain information systems and followed later by the telemedicine, and precisions genomics, and more recently with our venture with other colleagues around the country into producing generic drugs, all that goes back to the roots of what can we do to provide consistently excellent outcomes for people and do it at affordable cost because we realize that health care is increasingly unaffordable. We've really looked to innovation technical solutions that both improve care and at minimum, don't increase cost, but preferably reduce cost.

When we started a few years ago in telemedicine, the first thing we thought of is how much waste there is in people who have to go to an

emergency room, a high cost venue for treating something simple like a sore throat or a bladder infection. We do that remotely. That's led to our telemedicine program for primary care, which we call Connect Care. That's really growing. Then we've had this network of hospitals throughout Intermountain West here where we can provide support to patients who need consultations in neonatology, critical care, cardiology, where the specialist can be at the bedside virtually with the patient and a local primary care physician. It's been fabulous. We've been able to keep people in their communities, avoid the costs of transport, and get great outcomes.

All of us have stood by in dismay and have seen the unbelievable unaffordability and unavailability of drugs that have been generic since I was in medical school.

Margaret Flinter: Right.

Dr. Charles Sorenson: Go out and visit our primary care clinics and I asked a group of primary care doctors and said, what's the biggest problem that's inhibiting you from providing the care they need to your patients? One of our pediatricians said, the cost of drugs. Then I asked her, I said, well, okay. Well, what kind of drugs? Amoxicillin. I said, amoxicillin?

Margaret Flinter: Right.

Dr. Charles Sorenson: She said, yeah. It's either not available or it costs so much. Patients on a high deductible health plan can't afford it. Dr. Harrison has really propelled this since he's come here and, as you know, has had other good health systems that have joined us. We're going to take a swing at making a difference here because we've got a responsibility. If we can get together and have the size of these health system to help us to be able to produce generic drugs at more affordable price for the communities we serve, then that's a win for everybody.

Mark Masselli: Let's talk about one of your most recent ventures. You're the founding director of the Intermountain Healthcare Leadership Institute, which is offering experienced health executives mentorship and training and leadership processes you've developed at Intermountain, and things such as character, personal vision, and ethics, things that can sometimes get lost in the business side of the equation. Talk to us about the genesis of this leadership institute and what you hope to achieve.

Dr. Charles Sorenson: It started about seven or eight years ago, I guess. [inaudible 00:08:18] colleagues around the country asked me, Charles, where are we going to find physicians who have credibility with other clinical people and they understand leadership? Then I thought we needed to develop a different program for training clinic leaders. We aren't selected as

medical students are trained through residency in leadership. It's still very much command and control authority and expert director rather than working with a team of diverse skills to noble purpose and having a team leader who inspires that team, empowers them to give their best. That's where we really want to focus.

As we were developing that, we ran a couple of cohorts internally, including some great external faculty, including some of the folks at the Harvard Business School, who have been really helpful in this process. Some of the people on my team that we were developing that said, we probably ought to focus not just on doctors, how about if we included half the cohort being physician leaders, and half being operational administrative leaders? We can learn from one another. I said that's great. We're really focused in our program on that intersection of clinical and operational expertise, and focused, as you mentioned, on leaders because I think health care leadership requires real servant leaders, people who have intense personal drive to fulfill an organization's mission and somewhat paradoxically having a deep personal humility and well managed ego.

Those are the kind of people that I think can inspire everybody around them to give their best to an organization. We really want to focus on emotional intelligence. I've thought, why do we still study people like Washington, or Lincoln, or Gandhi years after their time has passed? We study them because of their ability to engage people in a noble cause in challenging times. I think that's what we need in health care.

Margaret Flinter: Intermountain recently launched a partnership with Utah Governor Herbert and former HHS Secretary Michael Leavitt's group, Leavitt Partners, in a quest to address the social determinants of health. Could you talk with us about these efforts at mitigating some of the health problems that populations face and some of the partnerships that you think are required to address the social drivers of poor health, which remains just such a huge challenge to clinicians everywhere?

Dr. Charles Sorenson: Yeah. Everybody knows that the United States spends about twice as much per capita on health care than the most other Western democracies. As you just mentioned, the social determinants of health just have this gigantic impact on health and health care costs. You and your listeners are probably aware of various studies that have been published in the last year or two that track total spending by country on health and social programs combined. While the United States is the highest on health care spending, if you combine social spending and health care spending, the United States is really right in the middle of the pack on the total spend.

The sad thing about that is by failing to address some of those social determinants, then obviously it's not just about cost. It's about the

human suffering that could have been prevented if we address those social determinants.

With great input and support from Governor Leavitt and Governor Herbert, Dr. Harrison is leading our team to see how we can be proactive in addressing some of those social determinants, poverty, lack of access to appropriate care, especially preventive care, help with addiction recovery services, behavioral health issues. Intermountain will start these initiatives to see if we can demonstrate that we can make a real difference on the total spend on health care and fulfilling Intermountain's mission of helping people live the healthiest lives possible.

Mark Masselli: We're speaking today with Dr. Charles Sorenson, President and CEO Emeritus at Intermountain Healthcare, a not-for-profit integrated health system. He's now founding director of the Intermountain Healthcare Leadership Institute.

Dr. Sorenson, Intermountain has been trying to develop care delivery systems that promote value. When your organization sees telemedicine as a highly effective tool, how do you define that suite of opportunities to connect with patients when they need to at distance? Tell us what you're thinking about at Intermountain in this whole area?

Dr. Charles Sorenson: We first thought about that as we were -- these big spaces between population centers in the western United States, how do we get the services of experts to the people who are needed in these more remote communities because we've always felt that at Intermountain, we want our patients to get the same high quality service, no matter where they present at our Intermountain system. Traditionally, that meant you had to transport people by ground or air to our larger centers when some complication came up. Probably about eight or nine years ago, we began to have real success, first in the areas of neonatology and maternal fetal medicine, where our experts at our major centers and our children's hospital could connect with specialists in our community hospitals that are more remote, being able to see the patient, consult with a physician onsite, and even help say the pediatrician in a local community do an urgent procedure that needed to be done right there, such as helping them with a little kid who has pneumothorax, put in a chest tube.

We had some rapid returns on that investment in terms of avoiding the cost of transport, so better outcomes, lower time in the hospital. It was really powerful. Obviously, the other benefit is we don't have to have busy specialists traveling all around the state and trying to see people in clinic because these problems come up real-time. It's not like they come up when the --

Margaret Flinter: It’s convenient.

Dr. Charles Sorenson: -- when it’s going to be there.

Building on that, then we started to think about how inconvenient health care was for much simpler problems. Say, a woman starts getting a bladder infection the traditional way is okay. I've got to leave my job and go away in the doctor's office when -- if they're not having a fever or flank pain, a straightforward prescription works. Doing Connect Care, which is on your mobile device, you can talk to the doctor, you can relate your symptoms, doctor has access to your electronic medical record. They can say, well, sounds like we really ought to get you on some antibiotics. I'd like to get a urine culture. I’m going to send you things, so you can go get a culture at a nearby Intermountain facility.

Now, with all of these situations, actually what does it do to Intermountain’s revenues and the fee for service environment, it decreases. There’s another instance we're doing the right thing for the patients actually we're punished in a fee for service environment by having less revenues. We've been focused since the first. The board has always supported doing the right thing at Intermountain, even when that reduced our revenues.

That's one of the reasons why I absolutely believe that we are not going to fix the health care problems in the United States of quality or cost as long as we're stuck in this fee for service, where we get paid based on how much we do and especially paid to do expensive rescue care. We get paid almost nothing to prevent problems. We can move to population-based payments. We can use our resources and our experts to address things on the front end and still be the very best by following evidence-based best practices and doing that at an affordable cost. We've got to move in that direction.

Margaret Flinter: Well, Dr. Sorenson, in all of your many years of leadership and administration, I understand that you’ve continued your clinical practice in urology and surgery. You had a front row seat on changes in the acute care setting. There's also been a lot of cultural changes, the movement towards more of an interdisciplinary team-based model, the focus on safety, the rise of advanced practice providers, Pas, and nurse practitioners in the acute care setting. Now, I'm really curious what do you make of all the changes and the degree to which those things have moved things forward in a positive way?

Dr. Charles Sorenson: I love it. I was never looking for a move to an administrative position because I love being in the clinical settings. I loved working with our team in the operating room, with our team in the clinic, with other fabulous professional colleagues in all specialties, taking care of really sick patients. That team was part of my family, just people who you

totally trust them with my own life. I've been involved in helping found the Intermountain Medical Group and on the board and stuff like that, but never looking for an administrative position. When they asked me if I'd take one, I really didn't want to. A lot of it is I just didn't want to leave those teams. Ultimately I thought, well -- so, I think we need to have doctors involved in making decisions and then none of us are willing to do it, then shame on me.

I did it. I said I just can't give up being with the teams. It's just such an important thing for me because it builds camaraderie as people or you can measure the outcomes and get better together, and learn from things that didn't go so well. I totally and enthusiastically embrace this movement team-based care, and not only for specialists, but even for primary care. My dad was an internist. He was such a dedicated doctor. I also saw how lonely it could be being just a doctor, even in a clinic where you're taking care of your own patients, but you don't have the team, the whole team there.

Now with increasingly complex patients, it can just be overwhelming for an internist say to be confronting an elderly patient who's got social problem, who maybe has depression, has diabetes, and to that doctor to try to do that all by herself is oppressive. When you have a team that comes together and she as the lead of that team can make the medical decisions, and then have experts on the team that help address the social determinants, the behavioral health monitoring, I think this not only reduces the chance of error, but I think it dramatically can reduce clinician burnout.

Mark Masselli: We've been speaking today with Dr. Charles Sorenson, founding director of Intermountain Healthcare's Leadership Institute and President and CEO Emeritus at Intermountain Healthcare. You can learn more about their innovative approach to care delivery by going to intermountainhealthcare.org or you can follow them on Twitter @Intermountain.

Dr. Sorenson, thank you for your team-based leadership and for joining us on Conversations on Health Care today.

Dr. Charles Sorenson: Thank you very much. It's been an honor to be with you.

[Music]

Mark Masselli: At Conversations on Health Care, we want our audience to be truly in the know when it comes to the facts about health care reform and policy. Lori Robertson is an award-winning journalist and managing editor of FactCheck.org, a nonpartisan, nonprofit consumer advocate for voters that aim to reduce the level of deception in U.S. politics. Lori, what have you got for us this week?

Lori Robertson: Beginning January 1st, Medicare Advantage enrollees may be

required to use lower cost alternatives to more expensive drugs for new prescriptions for medications administered in a clinical setting. Health and Human Services Secretary, Alex Azar, has described the new policy as “unleashing our Medicare Advantage plans to negotiate discounting on $12 billion of drugs.” Some patient advocacy groups meanwhile have described the policy as one that “could erect barriers to care for cancer.”

Step therapy is a practice of requiring patients to take less expensive or preferred alternatives to certain medications before moving on to the more costly options or the drugs prescribed by physicians if the original treatments aren't effective for the patient. An August memo from the Centers for Medicare and Medicaid Services said Medicare Advantage plans could use step therapy for Part B drugs next year. Part B drugs are those administered by a physician or in a clinical setting.

The CMS policy would only apply to new prescriptions. Beneficiaries already receiving Part B medications won’t be affected. Drug manufacturers of the more expensive remedies could lower their prices, so that they don't lose business to the lower cost alternatives. Experts we consulted said the impact could be small. There are about 20 million people with Medicare Advantage plans. That's one-third of all Medicare enrollees. Medicare Advantage plans spend about $12 billion per year on Part B drugs.

Savings would depend on how many Medicare Advantage plans decide to use step therapy and how many drug therapies can be subject to the policy. As for barriers to care, the Department of Health and Human Services says there is an appeals process. Enrollees can request an exception from their plan to get medication without first trying an alternative. Those requests will generally be reviewed within 72 hours.

That's my fact check for this week. I'm Lori Robertson, managing editor of FactCheck.org.

Margaret Flinter: FactCheck.org is committed to factual accuracy from the country's major political players and is a project of the Annenberg Public Policy Center at the University of Pennsylvania. If you have a fact that you'd like checked, email us at chcradio.com. We’ll have FactCheck.org’s Lori Robertson check it out for you here on Conversations on Health Care.

[Music]

Mark Masselli: Each week, Conversations highlights a bright idea about how to make wellness a part of our communities and everyday lives. For all the people in the world without limbs, acquiring prosthetics can be costly

and out of reach. It's especially challenging to make prosthetics for children, since they are in constant state of growth. Rochester Institute of Technology's scientist, Dr. John Schull stumbled upon a clever and affordable solution, provided online open source templates to anyone anywhere in the world who has access to a 3D printer, and provide prosthetic hands for next to nothing.

Dr. John Schull: I've made this Google Maps mashup. If you have a 3D printer and you'd like to help, put yourself on this map. If you know someone who needs a hand, put yourself on this map.

Mark Masselli: He founded the e-NABLE Network, which has massed thousands of volunteer makers in upwards of 40 countries around the world, providing cheap but functional prosthetics for children in need.

Dr. Schull: We know that we've delivered about 800 hands devices. We suspect that a comparable number have been downloaded by people we can't track because we put all of our design on the Internet.

Mark Masselli: The simple limb designs have become more sophisticated as recipients of the prosthetic devices provide feedback for designers to make more efficient devices.

Dr. Schull: These things grip or un-grip. They're much less functional than our biological hand. They're also less functional than a fancy myoelectric hand. For kids, it's huge. Our hands don't even pretend to look like regular hands. They look like superhero, Iron Man hands. For that very reason, they're very popular with kids.

Mark Masselli: e-NABLE, a global collaborative network of open-source designs, linking to makers with 3D printers to provide low cost prosthetic limbs to children and adults around the world, who might otherwise not be able to afford them, now that's a bright idea.

[Music]

Mark Masselli: You've been listening to Conversations on Health Care. I'm Mark Masselli.

Margaret Flinter: I'm Margaret Flinter.

Mark Masselli: Peace and health.

Margaret Flinter: Conversations on Health Care is recorded at WESU at Wesleyan University, streaming live at chcradio.com, iTunes, or wherever you listen to podcasts. If you have comments, please email us at chcradio@chc1.com or find us on Facebook or Twitter. We love hearing from you. This show is brought to you by the Community Health Center.

[Music]