Transitions of Care and Reducing Readmissions

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Sixth National Pay for Performance Summit
San Francisco  March 2011
Brown and Toland Physicians

- Independent Practice Association (IPA) formed in 1993
- Comprehensive, multi-specialty network of 850 private practitioners
- Serving more than 300,000 members
- Health plans by product: 7 HMO, 14 PPO
- Commercial, Medicare Advantage, SFHP Medi-Cal and Healthy SF
- Hospital Network includes Sutter CPMC, CHW, Chinese Hospital, Seton Medical Center, Stanford, and UCSF
- Over 250 employees
Brown and Toland Physicians

- Brown & Toland Physicians hosts a sophisticated Information Technology platform
  - Electronic Health Record
  - Practice Management System
  - Brown & Toland Claims, Authorizations, Referrals and Eligibility (BTCARE)
  - Case-Mix Adjustment
  - Predictive Modeling

- IT infrastructure allows for clinical integration across all lines of business with data feeds from multiple hospital systems, laboratories and hundreds of community-based physicians’ offices

- Clinically integrated data is aggregated and shared enterprise-wide to provide clinical decision support for physicians, in both inpatient and outpatient settings, via a robust suite of reports

- Aggregated, risk adjusted and patient-centric clinical data is utilized to target populations for Care and Population Health Management programs to improve patient health outcomes
Care Management Model
Innovative Approach to Care

Wellness & Prevention
Patient Health Services
Transition Of Care

Patient Centered Physician Focused Delivery of Care
Transition Of Care Team

- Inpatient Concurrent Review, Ambulatory Care Management and Advanced Practice Nurses
- Patient centric activities create a safe transition between all levels of care including the patient’s home
- Care Managers visit the patient at bedside to introduce themselves and assess for potential challenges to discharge.
- Answer questions to prevent confusion with post-discharge instructions and communicate with the primary caregivers, the team including the primary care physician to optimize patients’ health recovery
- Home visits by Advance Practice Nurse, Care Manager, Social Worker or Physician
Patient Health Services

• 12,247 senior members

• Ambulatory Care Managers address the needs of the patients who are frail or burdened by illness, age, self-care deficits, chronic illness complications or have need for support, education or frequent monitoring

• Ongoing care management support services to assess, engage and foster self-management

• Collaboration between patient, family or caregivers and patient’s physicians to coordinate, medically complex needs to enhance well being and health maintenance
Wellness and Prevention

- Provide clinical support services to physicians with panel management information and reporting, HEDIS, P4P, ED visits, PCP visits
- CareAnalyzer™ Johns Hopkins University predictive modeling software tool
- Adjusted Clinical Groups (ACG) methodology analyzes Brown & Toland’s data repositories, pharmacy, claims, laboratory, inpatient authorizations, and member eligibility
Wellness and Prevention

• Care Management Team educates the patient, family members or caregivers on ways to maintain and sustain an active lifestyle
• Fosters optimal health outcomes of low to moderate risk members at risk of developing certain disease states or to prevent further deterioration of chronic disease process
Safe Discharge

- Dedicated RN Care Manager, Customer Service and Coordinators
- Make discharge post hospital MD visit appointments before discharge
- Track members with follow up calls 24-48 hours to ensure post-discharge instructions are understood and implemented, confirmation of appointment, prescriptions filled and to assess for potential needs
- Ascertain if transportation is available
- Any ancillary service or durable medical equipment ordered is in place
- Medications are filled and being taken appropriately
- POLST, end of life, social worker interventions
- Referral to appropriate resources
Avoid Readmissions Through Collaboration (ARC)

- Brown & Toland actively participates in the California Quality Collaborative: Avoid Readmissions Through Collaboration (ARC)
- Statewide effort to bring together hospitals and their community partners with goal of reducing readmissions
- 30% reduction in 2013
- 30 and 90 day readmission rate will be measured
- Steering Committee
- Webinars and face to face meetings
ARC

- Learning Communities and Action Communities
- Learn from
- What are your patients telling you?
- What are the other providers of care telling you?
- What are your medical records telling you?
- What is your data telling you?
- What are your processes telling you?
- Understand your current admission process, teaching processes, coaching processes, acute care follow up process
- Aim, measure and improve
IHMM

- Intensive Home Medical Management Program implemented in 2008 in collaboration with Health Net
- Staffed by physicians
- Targets highest risk seniors (2% of senior membership)
- Target Population:
  - Home or bed bound
  - Medically complex patients
  - Insufficient access to PCP
  - Acute illness potentially leading to hospitalization or Emergency Department
  - Advanced illness, not enrolled in a hospice program
  - Requiring transitional care upon hospital discharge
## IHMM

<table>
<thead>
<tr>
<th>IHHM ENROLLMENT ALL HEALTH PLANS</th>
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<tbody>
<tr>
<td>TOTAL 301</td>
<td>ENROLLED</td>
<td></td>
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<tr>
<td>12,247</td>
<td>Seniors</td>
<td></td>
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<tr>
<td>N 34 % male</td>
<td></td>
<td></td>
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<tr>
<td>N 66% female</td>
<td></td>
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<tr>
<td>Average age 84 years old</td>
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<tr>
<td>Relative Risk Score 14.8</td>
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An objective of the IHMM program is for patients and their support network to be informed of end of life options and resources. In-home visits by IHMM physicians prevent unnecessary end-of-life hospital admissions when death is imminent.
ED Pilot Program

- Partnership with CPMC Pacific Campus
- Notification of all senior members in ED
- ED/Hospitalists/CPMC Case Manager determine appropriate disposition of patient
- Admit, Observation, IHMM, Home, SNF
- Collaborating for timely notification and on-site CM in ED
- Members discharged home receive a Transition of Care
Medication Reconciliation

- Staffed by Advanced Practice Nurse
- Diagnosis of COPD, CHF, Pneumonia or Acute MI
- Any readmission
- Frail elderly with high disease burden
- ≥ 1 ED visit within last 6 months with CHF/COPD primary or secondary diagnosis
- ≥ 1 admission within last 6 months with CHF/COPD as primary or secondary diagnosis
- Referral from Care Management Team, Chief Medical Officer, or Health Plan
- Visit starts in hospital continues in home or SNF
# Measurement Outcomes

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<tr>
<th>Measurement Outcomes Year to Date 2010</th>
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<tr>
<td>Senior Acute Days</td>
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<tr>
<td>Senior Acute Admits</td>
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<tr>
<td>Senior Acute ALOS</td>
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<tr>
<td>Senior Readmission</td>
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<tr>
<td>Senior Observation Days/k</td>
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In Sickness and In Health

• Central element in Brown and Toland’s clinical integration is the connectivity of patients to team, provider network, physicians, hospitals, laboratories
• Allscripts Healthcare Solution’s TouchWorks electronic health record system
• Care Analyzer, predictive risk modeling
• Individual Care Plan for each member
• Coordination and communication across the continuum, in sickness and in health
Coordinating care in sickness, and in good health.

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References

• Care Transitions Program http://www.caretransitions.org Eric A. Coleman, MD, MPH
• Project RED (Re-Engineered DC) http://www.bu.edu/fammed/projected/index.html Brian Jack, MD
• Project BOOST (Better Outcomes for Older adults through Safe Transitions) http://www.hospitalmedicine.org/ResourceRoomRedesign/RR_CareTransitions/CT_Home.cfm Mark Williams, MD, F”HM
• Transitional Care Model http://www-transitionalcare.info Mary D. Naylor, PhD, RN, FAAN