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Transitions of Care and Reducing Readmissions

Elizabeth A. Miller, RN, MSN
Director, Clinical Operations

Stan Padilla, M.D.
Chief Medical Officer

Brown & Toland Physicians
San Francisco, CA

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

Brown & Toland Physicians

Integrated Medical Group Characteristics

Patient Education
- Personal Health Record
- Tailored patient education
- Self management
- General Health Information

Ancillary Services
- Lab
- Radiology
- Pharmacy
- Home Health
- PT

Administration
- Eligibility Management
- Claims processing
- Capitation management
- Case –Mix Adjustment
- General financials
- Clinical decision support

Patient Advocacy
- Customer service
- PCP assignment
- Credentialing
- Consumer Satisfaction

Patient Access
- Primary Care Focus
- Comprehensive Specialist Network
- Broad Service Area
- Multiple Hospital Choices
- Centers of Excellence

Medical Delivery
- Primary care
- Specialty care
- Hospitalist
- Collaboration with Network hospitals
- Clinically integrated EHR
- Accessible Services

Physician Incentives
- Cost Effectiveness
- Physician Efficiency
- Use of Electronic Tools
- Care-Mix Adjustment

Physician Support
- Provide Electronic Tools
- Customer satisfaction
- Integrated Practice Management
- Physician Account Management
- Enterprise-wide reporting

Population Health Management
- Predictive Modeling
- Disease Registries
- Clinical Support Reports
- Best practices
- Disease Prevention
- Education and Reminders
- Wellness Support

Medical Knowledge
- Evidence-based Protocols
- Clinical Pathways
- Medical policies
- Practice guidelines
- Clinical decision support
- Alerts & Reminders

Patient Centric Intervention
- Care management
- Concurrent review
- Wellness Programs
- Disease Prevention
- Coordination of Services
- Predictive Modeling
- Home Visiting Physicians

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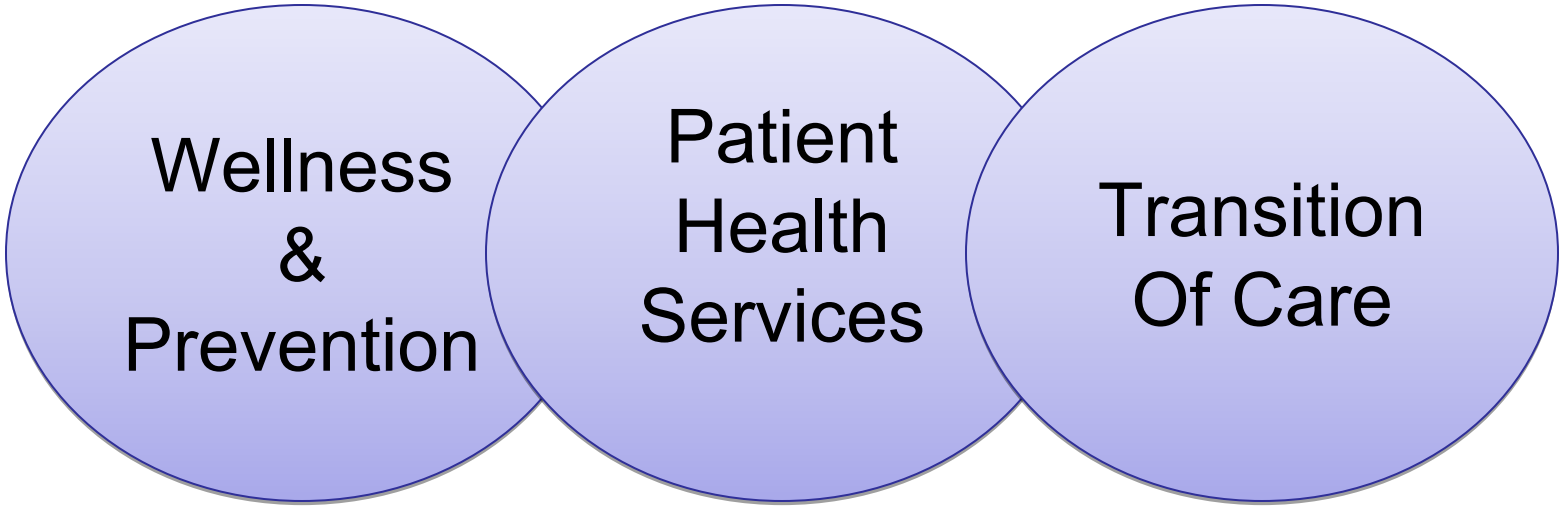
Care Management Model
Innovative Approach to Care



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

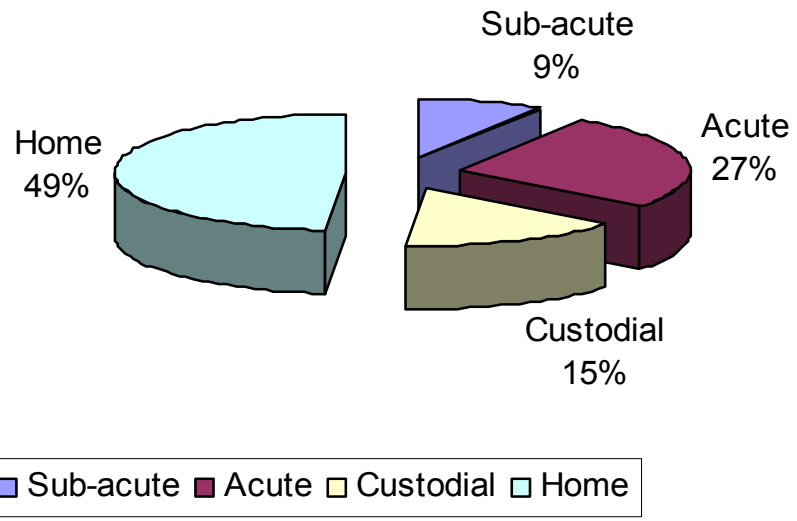
- Intensive Home Medical Management Program implemented in 2008 in collaboration with Health Net
- Staffed by physicians
- Targets highest risk seniors (2% of senior membership)
- Target Population:
  - Home or bed bound
  - Medically complex patients
  - Insufficient access to PCP
  - Acute illness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

IHMM

IHHM ENROLLMENT ALL HEALTH PLANS	
TOTAL 301	ENROLLED
12,247	Seniors
N	34 % male
N	66% female
Average age	84 years old
Relative Risk Score	14.8

Site of Expiraton in IHMM Program (25-months, 79 deaths)

Community, 64% (sum of custodial & private residence);
Hospital, 27%; SNF, 9%; Hospice Enrolled (41%)
Average Age (84.9 yrs), Average LOS in IHMM (192 days)



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

Measurement Outcomes Year to Date 2010	
Senior Acute Days	1128
Senior Acute Admits	229
Senior Acute ALOS	4.9
Senior Readmission	10%
Senior Observation Days/k	86

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

- Krames Patient Education, Heart Failure Outcome Study, htpps://www.krames.com/QA Media/krames/pde/chf.pdf
- Robert Wood Johnson Foundation, “Combining Better Systems and Intensive Patient Education for Better Heart Care,” March 24, 2010, http://ihi.org/IHI/Programs/Strategicinitiatives/StateActiononAvoidableRehospitaluizationsSTAAR.htm
- 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 Care Transitions/CT Home.cfm Mark Williams, MD, F”HM
- Transitional Care Model http://www.transitionalcare.info Mary D. Naylor, PhD, RN, FAAN