ATTACHMENTS K-O

OF

BROWN & TOLAND MEDICAL GROUP'S PPO SUBMISSION

ATTACHMENT K

Asthma Management Program

- Goals
- Objectives
- Program Description
- Outcomes
- 2003 Accomplishments
- 2004 Forecast

Goals

- To provide education, case management, and pharmacy information to BTMG asthma members in a clinically appropriate and cost-effective way.
- To assist BTMG Primary and Specialty care Physicians in providing appropriate care and utilization of resources to their asthma patients.

Program Objectives

- Contact 100% of patients who had an ER visit or hospitalization for asthma
- Contact 100% of physicians whose patients are on a short-acting bronchodilator without an accompanying long terms steroid
- Maintain asthma related utilization rates from 2002

Program Description

- 1:1 Education: asthma physiology, correct use of peak flow meter, environmental triggers, & proper techniques for medication use
- Case Management
- Facilitated referral to a Specialist
- Coordination of authorizations for Xolair
- Clinical Support Reports to Physicians

Utilization Outcomes

	2001	2002	2003
Admits/1000	.58	.57	.47
ER/1000	1.02	.87	.69

Pharmacy Outcomes

- Significant improvement in appropriate medication use in 2004 (reflects 2003 data) compared to 2003 (reflects 2002 data)
- Moved from 75th percentile to 90th in 2004.

	2003	2004	% Rank in 2004
% on app. meds	68%	74%	90th

2003-2004 Accomplishments

Asthma Advisory Board developed/revised guidelines for:

- Xolair
- Management and treatment for asthma for pediatric population and adults
- Developed chart inserts for physicians to use with patients who are not optimally managed. Clinical indicators tracked include medications, specialist visits, ER/Inpatient visits, and spirometry.
- Developed reports to identify patients with hospitalizations or ER visits

2004 Forecast

- Continue development of reports to identify high risk patients
- Improve linkages to smoking cessation programs
- Develop guideline for ordering PFTs
- Implement quality of life survey for asthmatics

ATTACHMENT L

BROWN & TOLAND
MEDICAL GROUP

CPMC / Brown & Toland Medical Group Quality Services
Emergency Department Program
Proposal

Program Description

This proposal sets forth the objectives of the CPMC & Brown and Toland Medical Group Emergency Department Quality Services Program. The goals of the ED Quality Services Program will be as follows:

- To provide assistance to ED physicians and staff with patients requiring discharge planning
- To develop tools that would be used with high risk patients to ensure follow-up
- To expedite transfers from the Pacific campus to a campus/ organization of the physician's choice
- To coordinate the transfer of appropriate patients to skilled nursing beds at the California, Davies, or other outside campuses;
- To assist with coordinating the implementation and monitoring and enhancement of treatment protocols for patients presenting in the ED with certain common clinical diagnoses
- To develop processes for applying, tracking, and analyzing standardized admission criteria, ie, Interqual
- To decrease short stay admissions at CPMC by identifying alternate care, such as, observation beds
- To enhance the coordination of admissions evaluation/recommendation with CPMC hospitalists
- To contact payors for appropriate authorization of services outside the scope of ED
- To work with ED physicians and staff to identify solutions for barriers to timely service
- To enhance communication with Primary Care and/or Specialty Attending physician
- To increase overall patient satisfaction

Outlined below are the initial key areas of implementation for the ED Quality Services Program:

ED Case Management

The ED Case Manager is central to the success of the Program. The ED Case Manager would be physically on-site at times that are consistent with the highest patient volume in the ED and on-call case management support will be available at all other times.

1. Staffing will be from 2pm until 10pm daily. These times will be subject to change if determined to be appropriate.by the ED Quality Committee.
2. BTMG will identify and retain clinical nurses.
3. BTMG will cross train the Brown and Toland oncall case managers to back up the onsite ED Case Manager when they are not on site.

CPMC and Brown and Toland will agree upon a job description outlining the expected role of the Case Manager in ED activities.

The specific duties will be:

- Facilitate the transfers from the Pacific campus to another campus/organization of the physician's choice
- Facilitate discharges
- Communicate with families
- Develop protocols that will ensure close follow-up for high risk patients
- Address patients' social issues / conduct community social services coordination
- Assist with and develop a "frequent flyer" program
- Identify and monitor adherence to appropriate pathways/guidelines
- Develop processes for coordinating authorizations with payors
- Coordinate with available case management and disease management programs, such as HIV, asthma, CHF, etc.

Reporting will be available as to the activities of the Case Manager and oncall staff to continually assess the appropriateness and outcomes of their responsibilities.

Patients presenting to the ED with psychiatric related diagnoses will be treated by the existing Psychiatric Case Manager. Once the ED Case Management Program has been established and has addressed its objectives, consideration will be given to merging psychiatric case management responsibility into its role.

ED Operational Performance Measures

The following *Operational Performance Measures will be tracked:*

- Number of short-stay admissions *(operational and clinical indicator)- Tracking will be done by both entities for analysis*
- Number and timing of transfers for admissions to other CPMC campuses as well as outside organizations – Database will be established by BTMG
- Number and timing of transfers to SNFs at other CPMC campuses as well as outside organizations- Database will be established by BTMG

ED Clinical Performance Measures

CPMC and BTMG have agreed the following physician specific ED clinical performance measures will be tracked in the initial phase. BTMG will establish databases to track this information. CPMC will establish protocols for BTMG staff to access records to perform this process on retrospective basis, as needed.

1. Aspirin at arrival for presentation with AMI
2. Number of average minutes until first antibiotic for presentation of pneumonia
3. Oxygenation assessment for presentation of pneumonia
4. Time to thrombolysis with CVA

5. Time to consultations

Other ED Assessment Tools

The ED Case Managers will participate in quality and operational performance improvement of the ED. As part of the role, additional ED assessment tools may be recommended and employed by the ED Case Manager. This proposal assumes that 5 tools will be developed.

Development of ED Clinical Policies / Standing Orders

Treatment standardization within the ED is a desired outcome of the Program. Therefore, CPMC and Brown & Toland will create/adopt clinical protocols as part of the ED Case Management Program. The use of ED standing orders/clinical guidelines can significantly expedite patient flow in the ED. Standing orders/clinical guidelines will be used with appropriate cases to improve ED turnaround time per patient. Using best practices, as established by the American College of Emergency Physicians, the ED Program will facilitate the review, enhancement, development and measurement of standing orders and clinical guidelines.

1. The ED Quality Committee will oversee the evaluation of existing standing orders.
2. Using the top five ED diagnoses: abdominal pain, chest pain, extremity trauma, respiratory track symptoms, and vomiting/dehydration, the ED Program will evaluate the need for protocols/pathways.
3. The ED CM Program will assist with the design for the collection of data and coordinate analyzing the data to assess adherence with clinical guidelines, protocols, and standing orders.

Data Management / Reporting

Data management / reporting functions are a critical component of the program. Reports will be generated for management, ED physicians and staff regarding the performance indicators that would begin to be collected during the implementation phase and then continue on an ongoing basis.

CPMC will be responsible for generating aggregate data across all payers specific to the ED population.

BTMG will be responsible for developing databases to track and report case management and/or auditing activities of the ED Quality Services Program.

Physician/Staff Education

As part of the implementation phase of the ED Case Management Program, ED physicians and other staff members will be involved in shaping and educating others as to the role of the new ED Case Manager and the goals of the program.

The ED Quality Committee consisting of BTMG management, CPMC ED physician leadership and CPMC administrative staff will provide direction to the Program's implementation and ongoing objectives. Prior to the onsite CM role implementation, an agreed upon education program will be initiated to the physicians and staff at CPMC.

Brown & Toland Current Physician Case Management

The current Brown & Toland and the CPMC ED physicians committee will incorporate past evaluations into the ED Program. This includes review of short stay admissions and admission criteria for abdominal pain.

The initiatives developed by the ED Quality Committee will address CPMC's total patient population.

The following represents the pricing structure and proposed timelines for implementation of the ED Case Management Program. Both the pricing and timelines are reliant upon CPMC and BTMG working to achieve the goals established in this proposal. It may be necessary to adjust implementation timelines and other portions of this program. Such changes will be made based upon mutual agreement of BTMG and CPMC

Pricing is divided into two areas, development fees and a monthly operational fee.

Development Fees

Operational Performance Measures
For this proposal, the total development fee will be $[redacted]. For future development of measures, BTMG intends to use the rate of $[redacted] per measure.

ED Clinical Performance Measures
The development fee for the 5 measures listed in this proposal is $[redacted]. Future measures will be developed for a rate of $[redacted] per measure.

Development of ED Clinical Policies/Standing orders
The fee for this section is $[redacted] this include the development of the listed pathways, the step necessary to address standing orders and the associated protocols for monitoring activity.

Data Management and Reporting
Development of data bases, tracking tools and related reports will be at a fee of $[redacted].

Physician/Staff Education
The fee for initial education and training will be $[redacted].

Total fee for Development as listed in this proposal will be $[redacted].
An initial payment of $[redacted] will be due to BTMG at signing of the agreement. During the development period, BTMG will invoice CPMC for the remainder of the fee on a monthly basis.

Annual Fee

The annual fee is based upon the opinion provided by Sinaiko Health Care Consulting with a modification to the time of for the program coordinator and the data analyst. With this adjustment, the proposed fee is $[redacted] per year ($[redacted] per month). BTMG feels that as the program progresses, it will be necessary to increase the time of the program coordinator and the data analyst. This will result in an annual increase of $[redacted] ($[redacted] per month). The annual fee is to be paid on a monthly basis and BTMG will invoice CPMC accordingly.

Proposed Timeline

	Estimated Duration	Month 1	Month 2	Month 3	Month 4	Month 5
Staffing						
Job Description	10 days					
Hire	45 days					
Train	60 days					
Clinical Database/Reporting						
Spec Out Database	20 days					
R & A Writes Database	30 days					
Develop and Test Reports	45 days					
Assess ED Processes						
Review Current ED Processes	40 days					
Develop Protocols						
Audit Activity Process	45 days					
Onsite CM	45 days					
Educational Program						
Develop Education Materials	30 days					
Physician Training	15 days					
Staff Training	15 days					
Develop Training Schedule	35 days					
Schedule Meetings	15 days					
Education Program Roll Out	20 days					

ATTACHMENT M

BTMG Immunization Rates

HEDIS/P4P 2003-2004
Administrative Data Results
(data reflects years 2002-2003)

Goals & Objectives

Goal:

To improve immunization rates across the pediatric population

Objectives:

- To identify members who are not optimally managed to guideline and report this information to their physicians
- To work collaboratively with Physicians to ensure that members receive immunizations

Interventions

- Developed and distributed a clinical support report detailing information to Physicians whose patients satisfied the following criteria:
  - Children turning two years old who have not had a vaccination suggested by NCQA guidelines, based on claims data.
  - Report indicated Physician screening rate compared to overall BTMG rate for like Physicians
  - DTP, Hep B, HiB, IPV, MMR, and VZV were included in the report
- Conducted focus group with Pediatricians to share data on immunization rates and identify areas for improvement

Sample Report

BTMG Primary Care Physician Support Report for Childhood Immunizations

As of March 31, 2004

Patients who may be due for a vaccination in 2004 based on NCQA guidelines

Children turning 2 years old in 2004 who have not had all vaccinations suggested by NCQA guidelines, based on claims data received.

Primary Care Physician Name: *Total Number of Patients Indicated for Vaccination:* 6

			DTP	HepB	HIB	IPV	MMR	VZV
BTMG MRN	Patient Name	DOB	Incomplete	Incomplete	Incomplete	Incomplete	Incomplete	Incomplete
		05/07/2002	☐	☑	☑	☑	☐	☐
		10/16/2002	☐	☐	☐	☑	☐	☐
		04/29/2002	☑	☑	☑	☑	☐	☐
		10/02/2002	☑	☑	☑	☑	☐	☐
		04/11/2002	☑	☐	☐	☐	☐	☐
		10/25/2002	☑	☑	☑	☑	☑	☑
	Your 2003 Vaccination Rate:		33%	33%	0%	83%	67%	67%
	2003 BTMG Rate:		67%	61%	28%	70%	90%	85%

Assumptions:

BTMG members with DOB between 01/01/2002 and 12/31/2002

Members with evidence of the disease being vaccinated against, or contraindication for the vaccine, have been excluded. See the reverse side of this sheet for all procedure and diagnosis codes.

Report run: April 14, 2003

Outcomes

- Increased immunization rates across all 6 vaccinations from 2003 to 2004
- BTMG rates are in the top quartile compared to other medical groups
- Significant improvement in percent rank in 2004
  - IPV increased from between 50-75th percentile in 2003 to the 75th percentile in 2004
  - VZV increased from between 50-75th percentile in 2003 to the 90th percentile in 2004
  - HiB increased from the 75th percentile in 2003 to the 90th percentile in 2004

Outcomes

	2003	2004
DTP	61%	67%
Hep B	54%	61%
HiB	70%	78%
IPV	63%	70%
MMR	87%	90%
VZV	79%	85%

ATTACHMENT N

HOSPITALIST'S PROGRAM REQUIREMENTS FOR BROWN AND TOLAND MEDICAL GROUP

I. HOSPITALIST'S AVAILABILITY

A. Hospitalist must be available on a 24-hour basis 7 days a week for existing patients. New patients will only be accepted between 8 am and 10 pm daily. Hospitalist will be required to maintain a single point of contact for Brown & Toland Primary Care Providers and Specialists and PSO Staff.

B. The Hospitalist must maintain the adequate malpractice coverage that is customary for physicians providing in-patient services.

II. HOSPITALIST'S REQUIREMENTS AND SKILLS

A. Physicians performing duties as hospitalists must maintain a valid California license and be Board Certified in Internal Medicine or Family Practice.

B. Communication Skills
- Hospitalist must expedite communications with PCPs, Brown & Toland Medical Group, and Health Plans.
- The Hospitalist must have the ability to direct other physicians/family/patients.

C. Hospitalist must have the ability to establish a suitable working relationship with the PCP, ER Physicians, and Consulting Specialists. This individual, of course, must be comfortable handling difficult and confrontational situations.

D. The Hospitalist must embrace a managed care philosophy and be able to comfortably collaborate with the Brown & Toland Utilization Management Staff and Health Plan Utilization Management.

III. PROGRAM DESCRIPTION

A. The Hospitalist will be willing to perform pre-admission evaluation of potential ER admissions to avoid unnecessary admissions, as staffing levels allow.

B. Hospitalist must participate in determining the appropriate level of care along the continuum of care that the patient is receiving; i.e. they must make determinations with respect to the appropriateness of intensive care versus medical/surgical care.

C. The Hospitalist will meet with the specialty consultant on a daily basis or as needed basis to devise a plan of care and to mutually agree on an appropriate treatment plan.

D. The Hospitalist will hold family conferences as appropriate when there are difficult and complex cases that would benefit from such conferences. They should include the Brown & Toland Utilization Management Staff in these conferences.

E. The Hospitalist will maintain active communication with the PCP to develop a suitable transition to the ambulatory setting and to collaboratively agree on an ambulatory treatment plan at discharge. The Hospitalist will forward copies of all discharge summaries to the patient's PCP.

F. The Hospitalist will discuss cases with the Brown & Toland Utilization Review Nurses and/or Brown & Toland Medical Director on a daily basis to collaboratively establish the appropriate level of care, length of service, and discharge plans.

G. The Hospitalist will meet on a monthly basis with the Brown & Toland Medical Director to summarize utilization experience and to analyze the effect of action plans implemented throughout the month.

H. The Hospitalist will participate as, staffing levels allow, in the repatriation of shared-risk out of network transfers to CPMC and participate in the transfer of Brown & Toland's commercial full risk patients to CPMC.

I. The Hospitalist must have a clear understanding of the InterQual inpatient criteria standards.

J. Brown & Toland reserves the right to review the quality of care provided by the Hospitalist.

K. The Hospitalist program may refuse to accept new patient admissions from referring primary care physicians that are not regularly using the hospitalist service.

ATTACHMENT O