



BROWN & TOLAND
PHYSICIANS

Treating people, not just patients.SM

Brown & Toland Physicians



- Clinically integrated multi-specialty network of over 1,700 physicians caring for over 330,000 patients in San Francisco Bay Area.
- Brown & Toland and Alta Bates Medical Group affiliation as of August 2011.
- Using the latest technology, Brown & Toland electronically connects independent physicians and area hospitals to facilitate the improvement of health care quality and to reduce costs.
- Brown & Toland's Pioneer ACO "care management convener" approach involves a core of a subset of its physician network, 190 doctors.

Brown & Toland Physicians: Aim



- To achieve three-part aim of improving health of patients, improving the delivery of care, and thereby reducing the cost of care for patients through a “care management convener” approach, with key measurements such as:
 - Reduce the rate of unnecessary (unplanned) readmissions (including tracking readmissions by specific disease states, e.g., CHF, COPD)
 - Track improvement of certain disease indicators, e.g.:
 - ✦ Diabetes (e.g., A1C, LDL)
 - ✦ Cardiovascular health (e.g., Blood Pressure, BMI, smoking, cholesterol management)

Brown & Toland Physicians: Care Management Drivers



Care management programs – three “pillars”:

- **Transitions of Care:**

- Enhance and extend inpatient quality programs to ambulatory settings , including patient home settings.

- **Patient Health Services:**

- Address the needs of moderate-to-high risk patients burdened by acute illness, chronic disease, age, or self-care deficits.

- **Wellness & Prevention:**

- Prevent or reduce risk factors, and to enhance a patient’s capacity to sustain a healthy life.

Drivers to accomplish our aim

Aim and Outcome

- Reduce readmissions
- Improve certain disease indicators

Primary Drivers

Transitions of Care

Patient Health Services

Wellness & Prevention

Secondary Drivers

ED case management, to avoid unnecessary admits

Post-Discharge Program (at-home support, Rx recon)

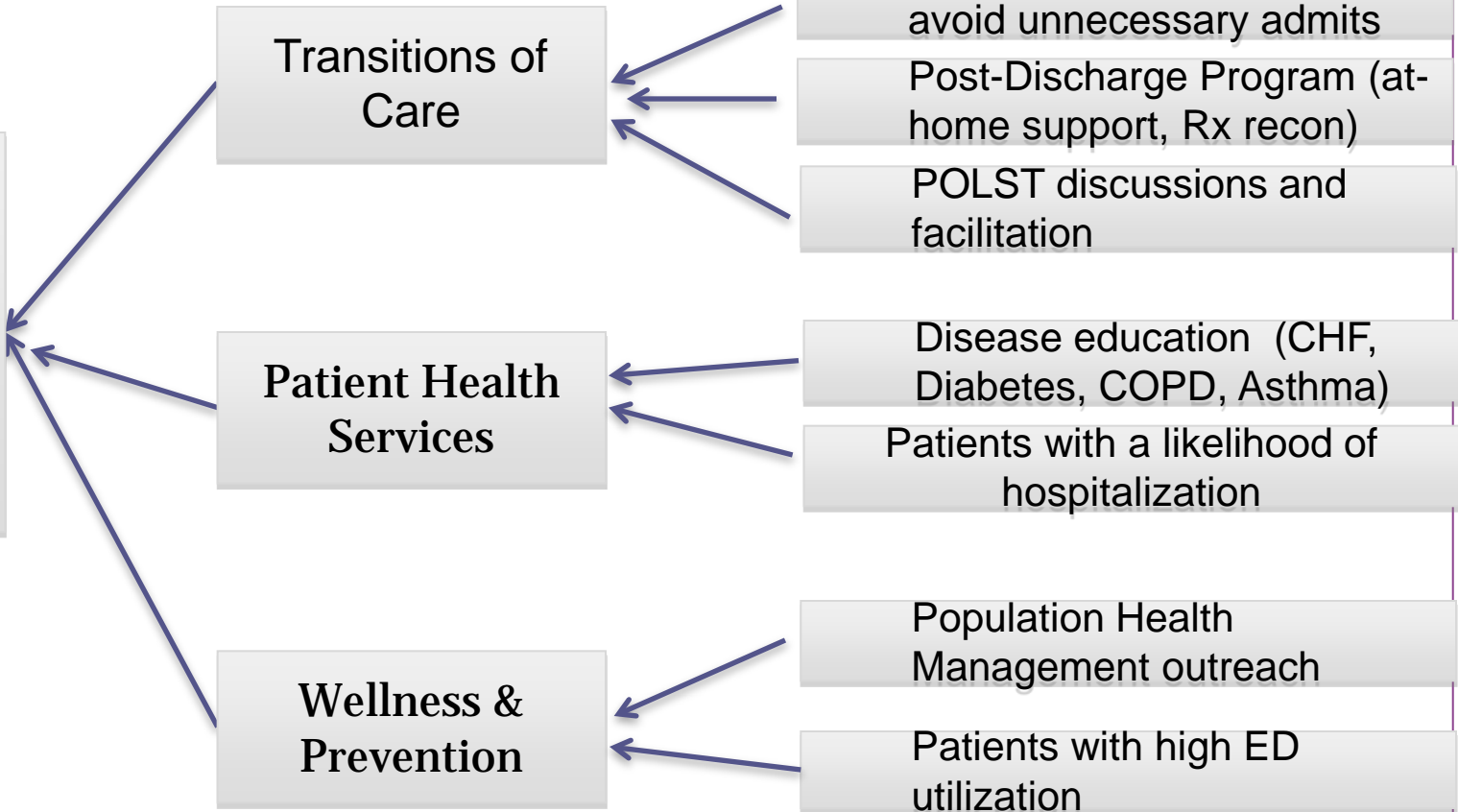
POLST discussions and facilitation

Disease education (CHF, Diabetes, COPD, Asthma)

Patients with a likelihood of hospitalization

Population Health Management outreach

Patients with high ED utilization



Our strengths



- “Clinical Integration” aligned with ACO Triple Aim.
- Physician ownership and governance.
- Integrated EHR system, includes over 75M diagnostic reporting results.
- Care management convener programs and services leveraged for all products.
- Mature history managing risk, including capitation and P4P programs.
- Experience in commercial ACO initiatives.
- Payer-agnostic funding for data exchange implementation.

Our challenges



- Network model relies on collaboration, including support at facility sites.
- Further EHR deployment needed
- Meaningful Use and enhanced point-of-care analytics.
- CBO report: “spending was either unchanged or increased” for similar programs/pilots involving disease management and care coordination.
- Medicare FFS payment system not aligned with ACO objectives and goals.
- CMS data integration for quality reporting.