BROWN & TOLAND

MEDICAL GROUP'S

PPO SUBMISSION

Submitted by:

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Section 1: BTMG Background/Corporate Summary

California Pacific Medical Group, d/b/a Brown & Toland Medical Group (BTMG), is a California professional corporation with approximately 335 physician shareholders. BTMG manages the delivery of care for approximately 1,500 physicians. This physician network consists of approximately 363 primary care physicians and has physicians representing each specialty offered in the Bay Area.[1] Since its inception in 1993, BTMG has supported clinical and administrative services from HMO plans. Each of the 1,500 physicians enrolled in BTMG participate in the group's HMO network. In 2001, BTMG began offering clinical and administrative services for PPO plans; 687 of BTMG's HMO participating physicians participate in the group's PPO network.

BTMG is governed by a Board of Directors that includes fourteen physicians – eleven of whom are shareholders of BTMG and the remaining three of whom are appointed by the University of California at San Francisco.[2] BTMG's Board actively participates in strategic planning and management of the physician group. Board members serve on BTMG committees that establish and manage compliance with policies in areas such as Utilization Management, Quality Improvement, Peer Review, and Credentialing. These committees' responsibilities are described in Attachment A.

BTMG employs 212 FTEs[3] and manages sixteen physician committees that support clinical and administrative services for HMO and PPO products in the areas of: Utilization Review, Quality Management, Medical Case Management, Disease Management, Medical Review & Authorizations, In-Patient Management, Payer and Provider Contracting, Discharge Planning, Physician Education, Patient Customer Service, Asthma Intervention, HIV Programs, Wellness Programs, Credentialing, On-Site Physician Review, Physician Education, Managed Care Applications, and Physician Reporting and Analysis.

BTMG's 2004 clinical and administrative budget is approximately $[redacted] million. (See Attachment B for a copy of the 2004 Budget.) This budget includes expenses allocated to BTMG's clinical care management as well as to maintain BTMG's data management system. In addition to resources spent annually in support of its clinical and administrative services, BTMG has invested resources in infrastructure, including $10 million in its information technology and data management system over the last 5 years. In addition, BTMG has approved a $12 million investment in physician clinical and administrative systems that will integrate clinical and administrative data within a practice and across the medical group. This investment will enable BTMG's HMO and PPO network physicians to access through the Internet a patient's complete treatment

[1] No other physician group in the Bay Area has a network that includes as many specialties as BTMG.

[2] UCSF physicians, primarily employees of the University of California, participate in BTMG through a medical group integration agreement and, in accordance with University policy, are not eligible to serve as shareholders of BTMG.

[3] BTMG has a total of 237 employees, including part time and non-permanent employees.

history. This program is currently being implemented and will provide clinical laboratory results to HMO and PPO physicians for all of their patients. The initial phase is projected to be "live" in late 2004.

Having focused almost exclusively on providing services for HMO products until 2001, BTMG's resources are increasingly being devoted to clinical and administrative services for PPO products. Last year, BTMG's Board approved additional annual investments exceeding a million dollars – on top of what is currently spent – to enable BTMG to implement quality improvement and utilization review with PPO products. (Attachment C is the budget approved by the Board for this investment.) Also, as PPO products become more prevalent in the market, more of BTMG's resources will be shifted from managing HMO products to managing PPO products.

BTMG's focus on PPO programs is consistent with the general marketplace trend away from HMO and to PPO products. Payer reaction to extensive regulation in California of HMO products, as well as growing consumer preference for provider choice associated with PPOs, is resulting in a dramatic shift in the San Francisco managed care market from HMO to PPO products. Consistent with this trend, the number of patients enrolled in HMOs that BTMG serves has declined in each of the last three years, from 236,840 patients in 2001, to 213,952 patients in 2002, and 202,789 patients in 2003. As of April 2004, BTMG's HMO membership has dropped to 199,172.

PPO care management by a physician group poses challenges different from HMO care management because PPO plans do not routinely pass claims data through physician groups. Infrastructure investments (in both time and capital) are required in order for physician groups to access PPO claims. BTMG has made these investments and is now obtaining and analyzing PPO claims.[4]

[4] BTMG began collecting PPO claims on October 1, 2003. It is currently using these claims to identify patients for its case management and disease management programs (these programs are described in Section 3). In addition, BTMG is formatting the claims for processing to generate reports in connection with its utilization review process (also described in Section 3) and is working with PPO network physicians to ensure that future claims are submitted in readable format.

Section 2: Structure of BTMG PPO Program

BTMG's PPO program is a comprehensive plan that provides services on behalf of physicians, patients, and payers. This program consists of a health care delivery network, clinical programs, and administrative services.

1. Health Care Delivery Network.

BTMG allows only those physicians who also participate in its HMO network to participate in its PPO network. This is an efficient means of ensuring that high quality physicians who have experience with BTMG mandated guidelines – such as clinical guideline/protocol compliance – participate in the PPO network. Because BTMG's PPO and HMO clinical programs are generally the same, BTMG can save time and resources by relying on HMO physicians who have adhered to BTMG guidelines for years compared to new physicians who would almost certainly need closer instruction and monitoring to adhere to guidelines. Currently, the physicians participating in BTMG's PPO network account for roughly 80% of the care provided to BTMG's total HMO membership.

Further, BTMG's PPO network of providers covers all major medical specialties, including most tertiary services. Finally, BTMG does not restrict the ability of its PPO network physicians to participate – independent of BTMG – in PPO networks of payers with which BTMG does not contract.

2. Clinical Programs.

BTMG provides and manages multiple clinical programs within its PPO program. Whenever possible, these programs are the same as the HMO programs, in order to create the highest level of consistency and collaboration between physicians. This also promotes the concept of best practices, which should, in principle, benefit all patients. BTMG's clinical programs, more fully described in Section 3, include:

- Clinical Guideline/Protocol and Benchmark Adoption
- Utilization Review
- Case and Disease Management
- Quality Improvement
- Credentialing

3. Administrative Services.

In addition to the clinical programs, BTMG also provides administrative services within its PPO program. These services include:

Physician Relations: BTMG employs two persons to oversee physician relations with regard to PPO products. These employees provide support services to its PPO participating

physicians regarding eligibility, claims or quality issues that physicians may encounter with a contracted payer.

Claims Data Submission Support: In an effort to ensure complete and accurate submission of claims data, BTMG provides support to physicians. BTMG has assisted physician offices and their billing agencies in identifying and implementing the most appropriate claims data submission process for each physician office, through paper, direct submission, clearinghouse or other solutions. BTMG's Information Technology (including Claims Configuration) and PPO staff all support this process. The PPO staff also works with physicians who do not submit claims data appropriately to obtain their data and determine an ongoing solution.

Auditing Services: In an effort to improve payment accuracy on the part of the payer, and billing accuracy on the part of the physician, BTMG provides auditing services on behalf of its PPO participating physicians. These audits are conducted twice a year for PPOs that contract with BTMG. The applicable audit results are shared with the appropriate payers and physicians.

Physician Handbook: Effective March 1, 2004, BTMG developed a PPO Physician Handbook for its participating physicians. This handbook, with an emphasis on education and training, provides physicians and their office staff with information on clinical programs, contracts, applicable BTMG and/or PPO administrative policies, and other useful tools to effectively manage their BTMG PPO business.

Contracting: Subject to compliance with the FTC Order, BTMG plans to provide payer contracting on behalf of participating physicians. This will allow payers to negotiate a single contract with BTMG physicians (as opposed to hundreds of contracts) and will provide a consistent set of policies related to administrative, financial and clinical operations (which increases the accuracy of transactions).

Section 3: BTMG's Clinical Integration

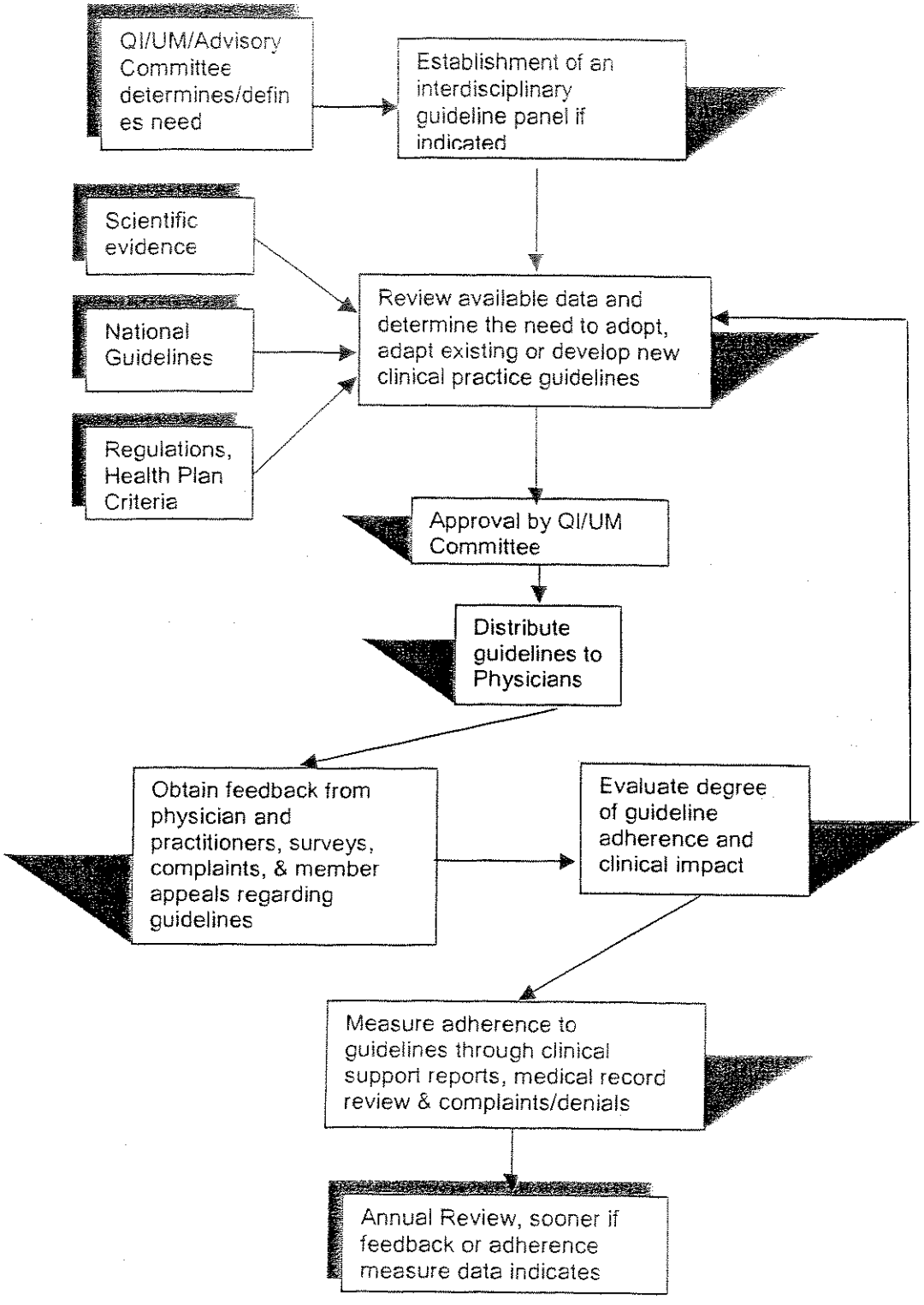
BTMG's clinical integration programs generally fit into five separate categories: (1) clinical guideline/protocol development and adoption, (2) utilization review, (3) case and disease management, (4) quality improvement, and (5) credentialing. Each of these is discussed below.

1. Clinical Guideline/Protocol Development and Adoption.

BTMG's Utilization Management ("UM"), Quality Improvement ("QI"), and Physician Advisory committees develop and/or revise and adopt guidelines/protocols to which each network physician is contractually mandated to adhere. Each of these committees meet approximately once a month to discuss developing, adopting, and/or revising guidelines/protocols. Physician Advisory committees consist of primary care physicians and specialists in the areas in which protocols are developed or adopted. Seven advisory groups exist: HIV, Asthma, Diabetes, Osteoporosis, Cardiovascular Disease, Ophthalmology, and GI. Attachment D lists the physician makeup of each of these advisory groups.

In developing or adopting guidelines/protocols, the committees determine areas in which protocols are needed, review literature, analyze national and regional utilization data (including data collected by BTMG), and review regulations and payer criteria. Proposed measures to which physicians will be held accountable are then developed and/or considered by the committees (taking into account literature reviewed and data analyzed) and, if satisfactory, adopted by the committees. Following this adoption, the guidelines/protocols are presented to the Board for approval. If approved by the Board, the guidelines/protocols are formally implemented and network physicians are contractually obligated to provide care consistent with the guidelines/protocols. BTMG solicits feedback from network physicians concerning guidelines/protocols and evaluates both the degree of guideline adherence and clinical impact of the guidelines. In order to assess whether any guidelines/protocols need to be revised, BTMG's UM, QI, and Physician Advisory committees, as applicable, meet no less than annually. Guidelines/protocols are reviewed more frequently if prompted by a medical literature review or physician request to compare existing protocols to BTMG's physician utilization data; they also consider advances in technology or clinical treatment. In addition, network physicians are consistently reminded of the guidelines/protocols through utilization review reports and BTMG mailings.

The following flow chart depicts the process by which clinical guidelines/protocols are developed and adopted.


QI/UM/Advisory Committee determines/defines need
Establishment of an interdisciplinary guideline panel if indicated
Scientific evidence
National Guidelines
Regulations, Health Plan Criteria
Review available data and determine the need to adopt, adapt existing or develop new clinical practice guidelines
Approval by QI/UM Committee
Distribute guidelines to Physicians
Obtain feedback from physician and practitioners, surveys, complaints, & member appeals regarding guidelines
Evaluate degree of guideline adherence and clinical impact
Measure adherence to guidelines through clinical support reports, medical record review & complaints/denials
Annual Review, sooner if feedback or adherence measure data indicates

Today, roughly 900 guidelines/protocols have been adopted by BTMG – 100 of which were developed internally within BTMG. Also, eight additional guidelines/protocols are being developed by BTMG, many of which will be implemented within a year. Attachment E lists the areas in which current guidelines/protocols apply and the areas in which guidelines/protocols are being developed. Attachment E also includes as an example the description of adult primary care standard services used by BTMG.

In addition to guidelines/protocols to which physicians are expected to adhere, BTMG has instituted benchmarks in practice areas that are also used to assess utilization. These benchmarks help BTMG to identify "physician outliers" whose care can be rationalized or improved through closer monitoring at BTMG.[5] Because of the network size and amount of historical data available within BTMG, BTMG is able to actuarially analyze its network physician data as its primary benchmark source. These benchmarks are developed, adopted, and revised through actuarial analysis and include adjustments for age, sex, and illness severity. BTMG's "Support Reports" are an example of usage of benchmark data by comparing physicians within BTMG to their peers. Attachment F contains sample support reports.

2. Utilization Review.

BTMG conducts utilization review to ensure compliance with guidelines/protocols, conduct benchmark analyses, and identify physician outliers. BTMG's utilization review can be separated into two general categories: (a) monitoring delivery of care, and (b) enforcing adherence to guidelines/protocols and benchmarks.

A. Monitoring Delivery of Care

BTMG monitors the delivery of care by analyzing physician utilization data. This requires that physicians submit to BTMG copies of claims the physicians submit to insurers. These claims provide clinical information on services rendered, diagnosis codes, and the providers of care.[6] BTMG began collecting claims from its PPO network physicians on October 1, 2003.

BTMG's PPO network physicians submit electronic or paper copies of PPO claims through one of the following methods:[7]

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[5] A "physician outlier" is a physician whose utilization substantially departs from BTMG's benchmarks and utilization of the physician's peer groups.

[6] Because payers do not pay physicians through BTMG with regard to PPO products, physicians must submit PPO claims directly to the insurers (and must also provide a copy to BTMG). Physicians submit HMO claims directly to BTMG because payers reimburse physicians through BTMG with regard to HMO products.

[7] In anticipation of the October 1, 2003 initiation of claims data collection, BTMG conducted training sessions for each of the PPO network physician offices to demonstrate the methods by which data could be submitted. Since October 1, BTMG continues to work with physician offices to ensure that claims are properly submitted.

Direct Electronic Submission: If the physician office or billing service submits electronic HMO claims directly to BTMG, they can also submit copies of BTMG contracted PPO claims electronically to BTMG.

ProxyMed Clearinghouse Electronic Submission: If the physician office submits claims through ProxyMed or uses a billing service that uses ProxyMed for payment, ProxyMed will submit copies of BTMG contracted PPO claims to BTMG on their behalf.

Web-Based Electronic Submission: Web-based electronic submission of PPO claims is available for most offices that use Medical Manager or Mysis as their practice management system. If a physician office has a web-based submission in place, they are provided with a complete set of technical instructions from BTMG.

Paper Copy Submission: If a physician office is unable to submit copies electronically, they may submit paper copies of all BTMG contracted PPO claims on original CMS 1500 forms. Most software systems allow individuals to print multiple copies of their CMS 1500 forms. If their system is unable to produce copies, they may send photocopies of the claims. These claims are scanned for loading into the PPO data warehouse.

A minimum of four BTMG employees collect the physicians' PPO claims and input claims data into BTMG's SQL 7 database (which is essentially a warehouse that stores the data). Once data are inputted into the SQL 7 database, the data are transformed and can be presented using COGNOS reporting and analysis software. "COGNOS" supports the running of standard reports, analysis through the use of multidimensional cubes of data, and analysis through ad hoc reporting. BTMG uses three tools to generate reports and analyze claims:

- COGNOS Upfront, which provides web-based data search capabilities,
- COGNOS Interactive, which generates reports from the web, and
- COGNOS Impromptu, is another tool to generate reports that also allows BTMG to review original claims data (if, for instance, an individual physician's utilization is being scrutinized).[8]

Once the data are transformed and can be manipulated in the database, employees within BTMG's Utilization Management and Reporting and Analysis departments run reports and analyze the data to assess physicians' utilization (measuring efficiency and quality of care) and to identify patients for case management and disease management programs (discussed later in this section).[9] Every month employees run reports identifying patients with chronic conditions

[8] Over the last five years, BTMG has invested in excess of $10 million in hardware and software technologies that enable the medical group to conduct utilization review.

[9] As previously mentioned, claims data is currently being used to identify patients for BTMG's case management and disease management programs. BTMG is in the process of formatting the data to

who have recently had a severe adverse event (e.g., patients with asthma who have had multiple visits to the emergency room). These reports will be delivered to the Medical Services department where case managers can:

- Share the information with physicians who have had recent contact with the member;
- Share the information with a payer to notify them of their member's condition;
- Consider initiating contact with the patient and enrolling them in a case management program.

The Utilization Management Department also runs reports on individual physician offices to randomly pull PPO patient charges for auditing purposes. On a semi-annual and ad hoc basis, each PPO network physician's utilization practices will be analyzed; measurement categories will include:

- Number of PPO patients seen;
- Referral practices;
- Average cost per referral;
- PCP average cost per patient/average cost per episode of care;
- Hospital length of stay;
- Coding patterns;
- Overall network evaluations;
- Evaluations by specialty;
- Evaluations by physician group practices;
- Evaluations compared to protocols;
- Evaluations compared to benchmarks;
- Evaluations compared to peer groups;
- Comparison of practice patterns among participating PPO and HMO network physicians.
- Disease state management;
- Patient access to care;
- Emergency room utilization;
- Patient demographic analysis.

Generally, two types of reports will be generated using the physician data, both of which will be used, in part, to assess adherence to guidelines/protocols and benchmarks: (1) reports regularly distributed to physicians and case managers, and (2) reports prepared and reviewed internally by BTMG to ensure adherence to guidelines/protocols and benchmarks (and analyze outliers), but that are not necessarily distributed on a regular basis to physicians.

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generate reports in connection with its utilization review process and is working with PPO network physicians to ensure that future claims are submitted in readable format.

i. Reports Regularly Distributed to Physicians and Case Managers.

Twice a year, physicians and case managers will be given seven separate reports that compare a physician's utilization to his peers, assess billing practices, and identify patients with chronic conditions whose care may be rationalized and/or improved through case managers. These reports are as follows:

1. The PPO Utilization Report – This report benchmarks individual physicians against their peers and indicates how the physician's practice patterns differ significantly from the physician's peers. The report breaks down services provided by the PPO physicians into categories so that appropriate comparisons can be made. Physicians can see if their practice patterns for evaluation and management ("E&M") vary widely from their peers, where they vary, and whether action should be taken to alter their practice patterns. An example of this report is provided on p. 1 of Attachment G.

2. The PPO Asthma ER Report – This report identifies PPO members who visited the ER with a primary diagnosis of asthma in the previous four months. The report is distributed to BTMG Medical Service nurse case managers to follow up with these patients. The report is also distributed to the PPO plans in which the members are enrolled so that the plans have the opportunity to enroll their members in their own disease management programs, if available. An example of this report is provided on p. 2 of Attachment G.

3. The PPO Asthma Inpatient Report – This report identifies PPO members who were admitted to the hospital in the previous four months with a primary diagnosis of asthma. The report is also distributed to BTMG Medical Service nurse case managers to follow up with these patients. The report is distributed to the PPO plans in which the members are enrolled so that the plans have the opportunity to enroll their members in their own disease management programs if available. An example of this report is provided on p. 3 of Attachment G.

4. The PPO HIV Inpatient Report – This report identifies PPO members with HIV who were admitted to a hospital in the previous month. The report is distributed to BTMG Medical Service nurse case managers to follow up with these patients. The report is also distributed to the PPO plans in which the members are enrolled so that the plans have the opportunity to enroll their members in their own disease management programs if available. An example of this report is provided on p. 4 of Attachment G.

5. The PPO ER Frequent Flyer Report – This report will identify PPO members who have had at least three ER visits within a rolling twelve month period. The report is distributed to BTMG Medical Service nurse case managers to follow up with these patients. The report is also distributed to the PPO plans in which the members are enrolled so that the plans have the opportunity to enroll their members in their own disease management programs if available. Please note

that this report has been designed, but is contingent on completion of discussions with the hospital and/or emergency room physician group (that is not currently participating in BTMG's PPO network) to obtain data. An example of this report is provided on p. 5 of Attachment G.

6. The PPO Inpatient Readmission Report – This report identifies PPO members who have had three inpatient stays within a rolling six month period. The report is distributed to BTMG Medical Service nurse case managers to follow up with these patients. The report is also distributed to the PPO plans in which the members are enrolled so that the plans have the opportunity to enroll their members in their own disease management programs if available. An example of this report is provided on p.6 of Attachment G.

7. The PPO E&M Report – This report describes evaluation and management coding level for each individual physician. The report is intended to give physicians a global view of their own E&M billing patterns. By understanding their own billing patterns, physicians can determine if they are coding appropriately, and make changes to the way they code for the interactions they have with their PPO patients. An example of this report is provided on p. 7 of Attachment G.

ii. BTMG Internal Reporting.

In addition to reports distributed individually to PPO network physicians and case managers on a regular basis, BTMG employees will also analyze physicians' care across practice areas to identify outliers, ensure adherence to guidelines/protocols, analyze utilization trends, and consider adopting new or revising existing guidelines/protocols and benchmarks. Most of the detailed review and analysis of claims will be conducted through this internal reporting. If, for instance, a physician's utilization relative to his peers appears high (as may be reflected in a PPO Utilization Report), BTMG will analyze the physician's individual claims over time, assessing the demographic population served, acuity, and other indicators that could explain a higher utilization. If no apparent justification for the physician's utilization level exists, the physician will be subject to corrective measures (discussed below).

Further, BTMG has developed tools to analyze physician-coding practices. Using these tools, BTMG evaluates physicians' coding patterns to determine if he/she is using the appropriate code for a service performed. For example, one key area measured is a physician's ratio of new patient visit codes to consultation codes billed. This type of evaluation will help identify "up-coding concerns" – i.e., when a physician uses a code that is above the level of intensity for the medical service performed and/or for which the medical chart does not support the coding level used.

Another key internal analysis area is the referral patterns of primary care physicians. BTMG monitors both the total number and type of referrals made by physicians. This tool allows BTMG to determine if a physician has unusual referral patterns to a particular specialty or ancillary provider.

BTMG will also analyze when a physician appears to be under-serving his/her patient population. For instance, BTMG has specific benchmarks that apply to primary care physicians, such as how often a physician is seeing patients (for many patient populations, BTMG prefers primary care physicians to see patients three times a year), referral practices, and emergency room visits. If a primary care physician is not seeing patients regularly throughout a year and his/her patients have higher than average referral rates and/or emergency room visits, BTMG will intervene to bolster the number of times the physician sees patients. BTMG's data show that more primary care visits reduce the number of referrals and emergency room visits. This ultimately saves costs.

Additionally, BTMG will analyze trends in practice areas and ancillary costs. For instance, between 2001 and 2002, BTMG discovered that the costs for MRIs – a service that represents the highest ancillary cost to BTMG, physicians, and payers – increased over [redacted]%. BTMG reviewed MRI claims and found that utilization during the year had increased by over [redacted]%. For each physician who ordered MRIs, BTMG reviewed where and why the MRIs were ordered, and found that primary care physicians' had increased orders for all types of MRIs and that many of the MRIs were ordered from a specific hospital that charged more than other MRI providers. BTMG worked with the physicians to reduce the number of MRIs ordered and requested that the hospital lower its MRI rates (which the hospital did). From 2002 to 2003, MRI rates were reduced by [redacted]% and utilization fell over [redacted]%.

Finally, BTMG will compare a physician's delivery of care for HMO patients to PPO patients. If data show different outcomes between these products – such as higher utilization associated with PPO products – BTMG presumes that a physician differs treatment simply by the method of reimbursement. Unless its claims analysis justifies such different outcomes (i.e., if different population bases are treated), BTMG will subject the physician to corrective measures.

B. Enforcing Adherence to Guidelines/Protocols and Benchmarks.

Through the data analysis and reporting discussed above, BTMG will distribute twice a year to PPO network physicians report cards that compare each physician's performance against benchmarks and guidelines/protocols. Any physician who is an outlier or is not adhering to guidelines/protocols or benchmarks must participate in a corrective course of action. The PPO corrective action process is identical to the HMO corrective action process, which typically is as follows: First, BTMG advises the physician that his/her utilization does not conform to standards and must be corrected. Detailed utilization reports are given to the physician, comparing his utilization to peer groups and guidelines/protocols. If the physician's utilization continues to be inconsistent with BTMG's standards, the physician must meet with a Medical Director to outline a specific course of corrective action. If the corrective action plan developed with a Medical Director does not conform the physician's utilization to standards, the physician's practice patterns are reviewed by BTMG's Peer Review Committee. This committee makes recommendations for utilization improvement and advises the physician that his delivery of care must improve within a specific time frame or he will be terminated from the network. The Peer

Review Committee may also require that specific treatments be subject to a second opinion. If the physician's utilization does not improve, he will be terminated from the network.[10]

Comparing physician utilization to peer groups, benchmarks, and guidelines/protocols as well as actively working with physicians to improve utilization has proven to be an effective approach to changing/improving physicians' delivery of care. In 2001, for instance, BTMG identified an unusual trend (by reviewing claims data) in its HMO network physicians' delivery of ophthalmology services: over a two-year period ophthalmology surgery costs increased [redacted]%. BTMG analyzed each of its 71 ophthalmologist's utilization over this period and identified ten physicians whose utilization was higher than their peers'. BTMG audited those ten physicians' charts and concluded that surgeries were performed that did not have documentation of a valid indication for the procedure. BTMG met individually with each of these ten physicians to review their practice patterns and established a monitoring process (that remains in place today) to ensure appropriate utilization. This process has decreased the total cost of surgeries performed by [redacted]% over two years.

Similarly, BTMG recently analyzed a physician's delivery of care and noticed that he performed more cataract surgeries than his peer group. Using COGNOS Impromptu, BTMG analyzed the physician's claims and concluded that his utilization could not be rationalized (i.e., at least some of the procedures were not necessary). After initial efforts to curb the number of surgeries performed did not yield adequate results, the physician was subjected to peer review and each of his recommended surgeries were required to have a second opinion. This reduced the number of surgeries performed, and the physician's utilization level is now consistent with his peer group's.

3. *Case Management.*

Through its utilization review, BTMG identifies PPO patients who are diabetics, HIV positive, have congestive heart failure, have asthma, and have other chronic conditions in which care can be improved and resources saved through BTMG's Case Management Programs. Through these programs, BTMG requires that physicians and practitioners caring for chronically ill patients share treatment information and develop a care plan. Documentation of the case management plan is sent to physicians and practitioners. See Attachment H for an example of a case management plan.

BTMG employs twenty case managers and support staff to oversee the group's Case Management Programs. In addition to programs for specific conditions, these employees are responsible for:

- Crisis case management for high risk patients;

[10] The frequency of monitoring an outlier physician depends on the severity of the physician's outlier status. It can vary from constant oversight to reviewing the physician's delivery of care once every few months. Also, the corrective action process can vary for certain physician outliers. For instance, a severe issue may be forwarded directly to peer review and not be subject to the initial corrective action processes outlined above.

- Coordinating care for patients identified in reports regularly distributed to case managers (described on pp. 10-11 of this submission);
- Identification of services or programs available through the PPO for assisting BTMG physicians and patients;
- Identification of and referral to community programs for support;
- Clarification of benefits for PPO patients; and
- Development of processes to ensure collaboration with PPOs.

Examples of BTMG's Case Management Programs for specific conditions, which apply to both HMO and PPO programs, include:

1. Diabetes Case Management Program[11] – Clinical studies indicate improved outcomes and reduced utilization for complications of diabetes when the care for diabetics is actively managed. BTMG keeps a registry of all diabetics treated by network physicians since 1998. To protect against complications arising from diabetes, BTMG's Diabetes Program is designed to ensure that diabetic care is not underutilized and/or patients are compliant with prescribed treatments. BTMG has implemented diabetes guidelines/protocols and, through utilization review, monitors physician practice patterns and patient compliance using claims, lab, and pharmacy data. Twice a year, primary care physicians are given "Support Reports" detailing the treatment of diabetics. (An example of a "Support Report" can be found on pp. 5-6 of Attachment I.) In addition, to ensure compliance with prescribed treatments, "Case Reminders" are sent to diabetics who (a) have not had a retina exam for twelve months, (b) have not been tested within a year for A1C (i.e., a laboratory blood test for evaluating the status of diabetics) or LDL (i.e, the laboratory part of a cholesterol screening that is most directly associated with increased risk of coronary heart disease), (c) who have a Hgb A1C value above 8, and (d) who have a LDL value above 100.

Moreover, with regard to high-risk diabetics (those with an Hgb A1C value above nine) a concurrent Case Management Program was instituted in 2004. BTMG's nurse case managers are required to facilitate referrals to hospital-based education classes and develop tools for nurses and physicians to discuss with patients to help ensure compliance with prescribed treatments.

Since BTMG instituted the Diabetic Support Reports, A1C and LDL testing rates and levels have improved. (See p. 13 of Attachment I demonstrating the improvements.) BTMG anticipates continued improvement in diabetic care as the personalized Case Management Program for high risk diabetics matures.

2. HIV Management Program[12] – BTMG developed a Case Management Program for network physicians' HIV patients who have been hospitalized, have not had an office visit for a year, have had two or more emergency room visits within three months, or who have been prescribed TPN (i.e., intravenous feeding), T20 (i.e., HIV medication for patients not responding to other therapies), or have HIV wasting (i.e, a disorder of metabolism seen in patients with

[11] Attachment I is a power point presentation describing this case management program.
[12] Attachment J to this submission is a power point presentation describing BTMG's HIV Case Management Program.

AIDS characterized by loss of muscle mass and body fat). In connection with this program, BTMG's HIV Physician Advisory Group developed and revised guidelines/protocols for treating and managing HIV patients. The goals of this program are to:

- Increase the percentage of HIV-infected members receiving care from an HIV expert (HIV experts care for about 84% of BTMG HIV-infected patients in 2003, up from 70% in 2002);

- Decrease the number of HIV-infected patients who did not have an office visit in a twelve month period (66 patients did not have an office visit in 2003); and

- To track and rationalize inpatient utilization by measuring ALOS, emergency department visits, and hospitalization. As a result of this program, from 2001 to 2003 hospital admissions per 1,000 HIV patients (served by BTMG network physicians) decreased from 129.8 to 114.4 and, during this time frame, the bed days per 1,000 decreased from 1,926 to 1,449.

3. Asthma Management Program[13] – BTMG developed an Asthma Management Program to manage asthma care, assist BTMG physicians in utilizing treatments, and provide asthma patients with educational materials and pharmacy information. BTMG's Asthma Advisory Board developed and implemented guidelines/protocols concerning the treatment of asthmatics. (The guidelines/protocols are described on p. 7 of Attachment K). Under this program, case managers are required to maintain utilization data for asthma patients, contact all asthma patients who had an emergency room visit or were hospitalized for asthma, and contact all BTMG network physicians whose patients are treated with a short-acting bronchodilator without an accompanying long-term steroid. Clinical Support Reports are also provided to primary care physicians detailing their asthmatic patients treatment including use of medications. After this program was implemented, hospital admission per 1,000 asthma patients fell from .58 in 2001 to .47 in 2003 and emergency room visits per 1,000 asthma patients fell from 1.02 in 2001 to .69 in 2003.

4. Emergency Department Case Management – BTMG is collaborating with its largest admitting hospital (which accounts for 80% of its physicians' admissions) to develop a Case Management Program for high risk patients using the hospital's emergency department. The program will be staffed with 1.2 RN FTEs and a .5 FTE Coordinator to support the tracking and evaluation of outcomes. The program (described in Attachment L) will include both HMO and PPO populations.

4. Quality Improvement.

BTMG has instituted a Quality Improvement Program, which, among other things, is designed to enhance coordination and communication among network physicians as well as to

[13] Attachment K to this submission is a power point presentation describing BTMG's Asthma Case Management Program.

promote consistent practice patterns. While various activities are conducted in connection with this program, most of the activities can be categorized in three ways.

First, activities are conducted to support clinical improvement and coordination – particularly developing and implementing preventive health and treatment guidelines as well as developing and investing in electronic programs to improve physicians' coordination of care for their patients. For instance, BTMG has a program to increase immunization rates across its pediatric population.[14] The program entailed developing immunization guidelines, identifying patients whose vaccinations have not met these guidelines, and working with physicians to ensure that the patients' vaccinations meet the guidelines. The immunization guidelines developed include:

- Immunize all children turning two years old who have not had a vaccination suggested by NCQA guidelines (these children have been identified using claims data);

- Develop reports that show individual physician screening rates compared to peer group that includes screening for the following vaccinations: DTP, Hepatitis B, HiB, IPV, MMR and VZV. (Page 4 of Attachment M provides a sample report.)

After the immunization program was implemented, immunizations increased across all six vaccinations from 2003 to 2004, and BTMG now ranks in the top quartile (relative to other medical groups) in the percentage of patients who receive the vaccinations. The percentage of BTMG patients who received each of the six vaccinations increased as follows:

- DTP increased from 61% in 2003 to 67% in 2004;

- Hep B increased from 54% in 2003 to 61% in 2004;

- HiB increased from 70% in 2003 to 78% in 2004;

- IPV increased from 63% in 2003 to 70% in 2004;

- MMR increased from 87% in 2003 to 90% in 2004;

- VZV increased from 79% in 2003 to 85% in 2004.

As to a program that should improve physician coordination, BTMG has approved a $12 million investment in administrative and clinical systems that will support the integration of clinical and administrative data within a practice and across the physician network. The integrated practice management and electronic medical record system will enable BTMG's HMO and PPO network physicians to access a patient's treatment history through the Internet.

[14] Attachment M to this submission is a power point presentation concerning BTMG's Immunization Program.

The first phase of this project is the implementation of clinical laboratory results which is targeted to be operational in late 2004.

Second, BTMG's Quality Improvement Program focuses on enhancing services and quality to patients. This includes (a) conducting patient satisfaction surveys, (b) conducting access to care studies, reports, and audits, (c) processing patient appeals and grievances, (d) investigating patient complaints, (d) requiring BTMG's Peer Review Committee to monitor quality of care (which can be done by analyzing reports that can identify deficiencies in care across the physician network), and (e) overseeing patient education programs.

Finally, through the Quality Improvement Program, BTMG administers its Hospitalist Program, which is described in Attachment N. Over 90% of BTMG's physicians use the Hospitalist Program to care for patients admitted to a hospital.

5. Credentialing.

BTMG has established a credentialing process that adheres to NCQA and payer requirements. There are four steps to becoming credentialed by BTMG, which generally take approximately three to six months to complete. Briefly, these are as follows:

A. Letter of Interest – Potential physician applicants first submit a letter of interest to BTMG's Credentialing Department, which is then reviewed by the BTMG Credentialing Committee. The committee makes a recommendation to and seeks approval of BTMG's Board of Directors. The physician receives written notification of the outcome within 60 days of the Board's decision. If the Board grants approval, the physician applicant proceeds to the next step.

B. Request for Application (RFA) – This is a one page document requiring a physician to submit proof of the following: current DEA license, malpractice face sheet showing coverage, CV, documentation of board certification, and a signed formal agreement if the physician is joining an established BTMG physician practice. Once this is completed by the physician, the RFA is reviewed by the Credentialing Committee. The committee makes a recommendation to the Board. If the RFA is approved, the physician proceeds to step three.

C. Initial Application – This is a more detailed application than the RFA, which is submitted to BTMG's Credentialing Department. Upon receiving an initial application, the staff queries all of the national databanks, verifies hospital privilege status, checks the office site review history, and confirms the applicant's standing with state licensing board(s) and NPDB. Once this is done, the entire file is forwarded to BTMG's QI Compliance Specialist for review. If any outstanding issues are identified through the verification process, BTMG's Vice President for Medical Services and Chief Medical Officer must review and sign-off on the file prior to presenting the application to the Credentialing Committee. The committee makes a recommendation to the Board for its decision.

D. Contracting – If the physician's Initial Application is approved, the physician enters into either a BTMG Primary Care or Specialty Care Physician Agreement, as applicable. If the

Initial Application is denied, the physician may be entitled to appeal the denial in accordance with BTMG's Fair Hearing Rights.

BTMG's credentialing system for PPO physicians exceeds current credentialing systems and requirements of PPO payers in several key respects. First, when a primary care physician, OB/GYN, or high-volume behavioral health practitioner first joins BTMG, staff from the Quality Improvement Department conducts an initial office site visit to review medical records and assess how records are stored. In addition, as part of their medical record and/or office site reviews, BTMG physicians receive feedback on the reviews, and when appropriate, tools to ensure the accuracy of patient records. Tools could include information on Advance Directives, standards for medical record documentation, and forms to use to appropriately track medication and allergies. (See Attachment O, BTMG Credentialing Policy and Procedure.).

Second, BTMG physicians must be re-credentialed every three years. During the re-credentialing process, BTMG reviews medical records for primary care physicians, and collects quality related information on the physician such as member complaints, grievances and indicator reports. This information is taken into consideration for each physician during Brown & Toland's recredentialing decision-making process.

Third, BTMG PPO physicians have the benefit of access to an established and experienced credentialing staff. This staff provides support and resources if the physician needs help, and is available to contact the PPO plans on the physician's behalf. For example, the BTMG Credentialing staff interacts regularly with payers in connection with audits, changes in demographic information, and accuracy of information. The BTMG Credentialing Department is knowledgeable and familiar with the most current requirements; and, the staff alerts physicians to any changes in credentialing requirements.

By participating in the BTMG PPO program, physicians (as well as PPO payers and PPO patients) receive several important credentialing benefits. First, this provides the physician with an efficient credentialing process, in particular by reducing the number of times the physician must go through credentialing because it has been "centralized" through BTMG. Furthermore, by utilizing credentialing through BTMG, a process with which the physicians are quite familiar, mistakes and delays are minimized, resulting in a faster process overall.

Shortly, BTMG plans to implement a convenient on-line method of sending initial and recredentialing information to BTMG applicants and active participating physicians. We anticipate that this on-line system will also allow a physician to access his/her credentialing information on a real-time basis.

Section 4: Conclusion

This submission is intended to provide the FTC staff with a general sense as to the clinical and administrative programs BTMG has instituted and is further developing for PPO products. BTMG would be interested in discussing in greater detail its PPO-related programs and activities with the FTC staff. Also, BTMG would welcome an opportunity for FTC staff to tour BTMG's facility and see first hand how patient care and physician behavior is monitored using BTMG's database.

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INDEX TO ATTACHMENTS

Tab	Document Description
A	Descriptions of BTMG Committees
B	2004 Administrative Expense Budget Summary
C	BTMG PPO Budget Overview
D	BTMG Committee Organization, Membership & Assignments
E	Clinical Guideline List
F	Sample Support Reports
G	BTMG Reports
H	Sample Case Management Plan
I	BTMG Diabetes Program Description
J	2003 Evaluation of BTMG HIV Management Program
K	BTMG Asthma Program Description
L	CPMC/BTMG Quality Services Emergency Department Program Proposal
M	BTMG Immunization Program (HEDIS/P4P 2003-04 Administrative Data Results)
N	Hospitalist Program Requirements for BTMG
O	BTMG Credentialing Policy and Procedure (to be provided)

ATTACHMENTS A-I

OF

BROWN & TOLAND MEDICAL GROUP'S PPO SUBMISSION

ATTACHMENT A

Attachment A

Quality Improvement Committee Responsibilities:

Development and Oversight of Clinical Utilization Protocols/Guidelines and policy
Guideline Development for Wellness and Prevention
Disease Management Programs
Health Education Activities
Provider and Patient Satisfaction
Access Studies and Audits
Patient Safety Initiatives
Appeals, Grievances and Complaints
Quality Indicators Inpatient/Outpatient

Utilization Management Committee Responsibilities:

Development and Oversight of Clinical Utilization Protocols/Guidelines and policy
Oversight of Clinical Variances (over/under utilization)
Oversight of Physician Auditing
Oversight of Physician Analysis and Reporting

Peer Review Committee Responsibilities:

Reviews, evaluates, and implements appropriate corrective action plans when trends, patterns of physician performance or potential problems are identified at the individual physician level.

Credentialing Committee Responsibilities:

Review national physician licensure and malpractice data banks
Review audits of physicians' medical records for compliance with BTMG documentation standards, confidentiality and guideline compliance

Additionally, there are multiple physician advisory subcommittees for the development of protocols, guidelines, policies, and programs in multiple areas such as: HIV, Asthma/COPD, Osteoporosis, Diabetes, Cardiovascular, Ophthalmology, GI, and OB/GYN.

ATTACHMENT B

REDACTED

ATTACHMENT C

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ATTACHMENT D

BROWN & TOLAND MEDICAL GROUP
COMMITTEE ORGANIZATION, MEMBERSHIP, & ASSIGNMENTS
(Updated: May 24, 2004)

I. MEMBERSHIP/ASSIGNMENTS

A. *Board Standing Committees*

1. Audit

Chair:	Laurie Green, MD	(CPMC/Spec)
Executive Representatives:	Mark Ficker/Mary Roggero	
Members:	Neal Birnbaum, MD	(CPMC/Spec)
	William Solomon, MD	(CPMC/PCP-Ped)

2. Contracting & Finance

Note: voting members must be on BTMG board of directors

Membership

Chair:	Joel Klompus, MD	(CPMC/CHW/PCP)
Executive Representatives:	Kelly Robison/ Mark Ficker	
Members:	Steve Cohen, MD	(CPMC/Spec)
	Laurie Green, MD	(CPMC/Spec.)
	Lin Ho, MD	(CPMC/CHW/Spec)
	Sunita Mutha, MD	(UCSF/PCP)
	Fiona Wilson, MD	(UCSF/PCP)

3. Credentialing

Membership

Chair:	William Solomon, MD	(CPMC/PCP-Ped)
Executive Representatives:	Janet Shestakov/Stanley Padilla, MD	
Members:	Barbara Bishop, MD	(St. Luke's-BayWest/PCP)
	Neal Cohen, MD	(UCSF/Spec)
	Al Frietzche, MD	(CHW/PCP)
	Alan Johnson, MD	(CPMC/PCP-Ped)
	Robert Mickel, MD	(CPMC/Spec-ENT)
	Robert Murray, MD	(CHW/Spec)
	Daniel Roth, MD	(CPMC/PCP)

4. Executive Compensation

Chair:	Daniel Roth, MD	(CPMC/PCP)
Executive Representatives:	Gloria Austin/Janet Shestakov	
Members:	Joel Klompus, MD	(CPMC/CHW/PCP)
	Fiona Wilson, MD	(UCSF/PCP)

5. Physician Compensation

Chair:	Mitchell Sollod, MD	(CPMC/PCP-Ped)
Co-Chair:	Lin Ho, MD	(CPMC/CHW/Spec)
Executive Representatives:	Mark Ficker/Kelly Robison	
Members:	Neal Birnbaum, MD	(CPMC/Spec)
	Neal Cohen, MD	(UCSF/Spec)
	Joel Klompus, MD	(CPMC/CHW/PCP)
	Eric Kwok, MD	(CPMC/PCP)
	Daniel Roth, MD	(CPMC/PCP)

6. **Peer Review**

Membership

Chair:	Eric Kwok, MD	(CPMC/PCP)
Executive Representatives:	Stanley Padilla, MD/Janet Shestakov	
Members:	Hugo Cheng, MD	(UCSF/PCP)
	Robert Dobrow, MD	(CPMC/Spec)
	Roger Friedenthal, MD	(CPMC/Spec)
	Bobbie Graves, MD	(St. Luke/PCP-Peds)
	Jenta Shen, MD	(Multiple hospitals/Spec)
	Frederic Whinery, MD	(CPMC/PCP)

7. **Quality Improvement**

Membership

Chair:	Fiona Wilson, MD	(UCSF/PCP)
Executive Representatives:	Stanley Padilla, MD/Nancy Griest	
Members:	Barbara Bishop, MD	(St. Luke's-BayWest/PCP)
	David Claman, MD	(UCSF/Spec-Pulm)
	Martin Ernster, MD	(CPMC/PCP-Peds)
	William Hagbom, MD	(CPMC/Spec-OB)
	Joyce Hansen, MD	(CPMC/PCP)
	David Lowenberg, MD	(CPMC/Spec-Ortho)
	Robert Mickel, MD	(CPMC/Spec-ENT)
	Jonathan Rodnick, MD	(UCSF/PCP)
	Frederic Whinery, MD	(CPMC/PCP)

8. **Utilization Management**

Membership

Chair:	Frederic Whinery, MD	(CPMC/PCP)
Executive Representatives:	Stanley Padilla, MD/Nancy Griest	
Members:	Gary Chan, MD	(CPMC/PCP)
	Glenn Chertow, MD	(UCSF/PCP)
	Steve Cohen, MD	(CPMC/Spec)
	Edward Diao, MD	(UCSF/Spec)
	Vernon Giang, MD	(CPMC/Hospitalist)
	Susan Huang, MD	(CPMC/Spec-OB)
	Robert Murray, MD	(CHW/Spec)
	Sunita Mutha, MD	(UCSF/PCP)
	Peter Sullivan, MD	(CPMC/Spec)

B. *Special Board Committees*

A. Nominating Committee

Chair:	Fiona Wilson, MD	(UCSF/PCP)
Executive Representatives:	Janet Shestakov/Richard Angeloni	
Members:	Ad Hoc	

B. Physician Communication

Chair:	Fiona Wilson, MD	(UCSF/PCP)
Executive Representatives:	RichardAngeloni/Kelly Robison	
Members:	Roger Friedenthal, MD	(CPMC/Spec)
	Erik Kwok, MD	(CPMC/PCP)
	Mitchell Sollod, MD	(CPMC/PCP-Ped)

C. *Subcommittees*

A. Asthma Advisory Group

Chair:	Charles McDonald, MD	(CPMC/Pulmonary Diseases)
Members:	Stephen Lazarus, MD	(UCSF/Pulmonary Diseases)
	John McQuitty, MD	(UCSF/Pediatric Pulmonology)
	Nicole Lederman, MD	(CPMC/Family Practice)
	Karen Hardy, MD	(CPMC/Pediatric Pulmonology)

B. Colonoscopy Advisory Group

Chair:	Frederic Whinery, MD	(CPMC/PCP)
	Judith Walsh, MD	(Internal Medicine)
	Richard Sundberg, MD	(Internal Medicine/GI)
	Damian Augustyn, MD	(Internal Medicine/GI)
	Lawrence Yee, MD	(Colon & Rectal Surgery/ General Surgery)

C. Congestive Heart Failure

Chair:	Peter Alperin, MD	
	Steve Blumlein, MD	(Internal Medicine/Cardiology)
	Ernest Haeusslein, MD	(Cardiology)
	Teresa DeMarco, MD	(Cardiology)
	Kenneth Maybury, MD	(Internal Medicine)
	Chuck Morris, MD	(Cardiology)
	Ann Thorson, MD	(Cardiology)
	Jeff Tice, MD	(Internal Medicine)
	Rupsa Yee, MD	(Cardiology)

D. Diabetes Advisory Group

Chair:	Mike Potter, MD	(UCSF/Family Practice)
Members:	Fiona Wilson, MD	(UCSF/ Internal Medicine)
	Robert Rushakoff, MD	(UCSF/Internal Medicine)
	William Parmer, MD	(CPMC/Internal Medicine)
	George Kimmerling, MD	(CPMC/Internal Medicine)
	Martha Nolte, MD	(UCSF/Endocrinology)

E. HIV Advisory Group

Chair:	Stephen Becker, M.D.	(CPMC/Internal Medicine)
Executive Representatives:	Stan Padilla, M.D.	
Members:	Gary Feldman, M.D.	(CPMC/Family Practice)
	Maureen Flaherty, M.D.	(CPMC/Family Practice)
	Monica Gandhi, M.D.	(UCSF/Infectious Diseases)
	Lawrence Goldyn, M.D.	(CPMC/Internal Medicine)
	Malcolm John, M.D., M.P.H.	(UCSF/Internal Medicine)
	Stephen Knox, M.D.	(CPMC/Internal Medicine)
	Jennifer Ross, M.D.	(CPMC/Internal Medicine)
	Lisa Sterman, M.D.	(CPMC/Internal Medicine)
	Shelley Gordon, M.D., Ph.D.	(CPMC/Infectious Diseases)
	Todd Pope, M.D.	(CPMC/Internal Medicine)
	Lorna Thornton, M.D.	(CPMC/Internal Medicine)

F. **Ophthalmology Subcommittee**

Chair:	Steve Cohen, MD	(CPMC/Ophthalmology)
Members:	Susan Day, MD	(CPMC/Ophthalmology)
	Kevin Denny, MD	(CPMC/Ophthalmology)
	Wayne Fung, MD	(CPMC/Ophthalmology)
	Lee Schwartz, MD	(CPMC/Ophthalmology)
	Stuart Seiff, MD	(UCSF/Ophthalmology)
	Michael Turan, MD	(CPMC/Ophthalmology)

G. **Osteoporosis Task Force-meets on an ad hoc as needed basis.**

Chair:	Frederic Whinery, MD	(Internal Medicine)
	Barbara Bishop, MD	(Internal Medicine-non PCP)
	Douglas Bauer, MD	(Internal Medicine)
	Steve Cummings, MD	(Internal Medicine)
	Deborah Lindes, MD	(Internal Medicine)
	Frederic Whinery, MD	(Internal Medicine)
	Deborah Sellmeyer, MD	(Endocrinology, Diabetes & Metabolism)
	Steven Harris, MD	(Endocrinology, Diabetes & Metabolism)

H. **PPO Advisory Group**

Chair:	Joel Klompus, MD	(CPMC/ Internal Medicine)
Executive Representatives:	Kelly Robison	
Members:	John Belzer, M.D.	(CPMC/ Orthopaedic Surgery)
	David L.Curtis, M.D.	(CPMC/ Rheumatology)
	Laurie Green, M.D.	(CPMC/OB/Gyn)
	Alan C. Johnson, M.D.	(CPMC/ Pediatrics)
	Stuart Rosenberg, M.D.	(CPMC/Urology)
	Lawrence G. Shore, M.D.	(CPMC/ Pediatrics)
	Mitchell C. Sollod, M.D.	(CPMC/ Pediatrics)
	Pearl J. Yee, M.D.	(CPMC/OB/Gyn)

II. BOARD OF DIRECTORS – ASSIGNMENTS TO COMMITTEES

• Neal Birnbaum, MD	Audit Physician Compensaion
• Neal Cohen, MD	Credentialing Physician Compensation
• Steve Cohen, MD	Contracting & Finance Utilization Management Ophthalmology Subcommittee *(Chair)*
• Roger Friedenthal, MD	Peer Review Physician Communication
• Laurie Green, MD	Audit *(Chair)* Contracting & Finance PPO Advisory Group
• Lin Ho, MD	Physician Compensation (Co-Chair) Contracting & Finance
• Joel Klompus, MD	Contracting & Finance *(Chair)* Executive Compensation Physician Compensation PPO Advisory Group *(Chair)*
• Eric Kwok, MD	Peer Review *(Chair)* Physician Communication Physician Compensation
• Sunita Mutha, MD	Contracting & Finance Utilization Management
• Daniel Roth, MD	Executive Compensation *(Chair)* Credentialing Physician Compensation
• Mitchell Sollod, MD	Physician Compensation *(Chair)* Physician Communication PPO Advisory Group
• William Solomon, MD	Credentialing *(Chair)* Audit
• Frederic Whinery, MD	Utilization Management *(Chair)* Peer Review Quality Improvement

• Fiona Wilson, MD	Nominating *(Chair)* Physician Communication *(Chair)* Quality Improvement *(Chair)* Contracting & Finance Executive Compensation Diabetes Subcommittee

ATTACHMENT E

BROWN AND TOLAND MEDICAL GROUP
CLINICAL PRACTICE GUIDELINES

PRIMARY CARE CLINICAL SCOPE OF PRACTICE (18)

1. Allergy
2. Cardiovascular
3. Dermatology
4. Endocrine System
5. GI System
6. OB/Gyn
7. Infectious Disease
8. Mental Health
9. Musculoskeletal System
10. Nervous System
11. Ophthalmology Services
12. Otolaryngology
13. Pain Management
14. Renal System
15. Respiratory System
16. Rheumatology
17. Urinary System
18. Hematology

PREVENTIVE HEALTH GUIDELINES (4)

- **Birth to 10 Years**
- **11 to 24 Years**
- **25 to 64 Years**
- **65 and Older**

DISEASE MANAGEMENT GUIDELINES (9)

- **ASTHMA**
  1. Asthma Treatment Guidelines in Adults and Pediatrics

- **DIABETES**
  1. Diabetes Mellitus (Type 2) Treatment Guideline

- **HIV**

  1. Use of Recombinant Human Growth Hormone in HIV-Associated Wasting

  2. Anabolic Therapy for Treatment of HIV-Associated Weight Loss

  3. Testosterone Therapy and Hypogonadism in HIV+ Men

  4. Standard Immunization, Drug Prophylaxis and Routine Health Maintenance Screening for Adult Patients Living with HIV

  5. Indications for the Initiation of Antiretroviral Therapy in the Chronically HIV-1 Infected Patient

- **OSTEOPOROSIS**
  1. Screening and Treatment

- **COLORECTAL CANCER**
  1. Screening and Referral

MEDICAL SCREENING GUIDELINES (7)

1. Allergy Testing
2. Amniocentesis and Chorionic Villus Sampling
3. Bone Density
4. BRCA 1 and BRCA 2 Screening
5. CT Guidelines
6. MRI Guidelines
7. Behavioral Health

MEDICAL/SURGICAL TREATMENT GUIDELINES(52)

1. Antidepressant Rx
2. Autologus Chondrocyte Implantation
3. Blepharoplasty
4. Breast Reconstruction
5. Catheter Ablation
6. Chronic Pelvic Pain
7. Cosmetic Procedures
8. Enbrel Clinical Review Guidelines
9. Hysterectomy
10. IL2 (Aldesleukin)
11. Investigational Services
12. Lyme Disease Vaccine
13. Mohs Micrography Surgery
14. Nutritional Counseling

15. Obesity Procedures
16. Orthognathic – Le Fort
17. Otoplasty
18. Palivizumab (Synagis™)
19. Reduction Mammoplasty
20. Removal of Skin Lesions
21. Stress Incontinence (Utilizing Biofeedback)
22. TMJ (Management)
23. Urinary Incontinence
24. Uvulopalatopharyngoplasty (UPPP)
25. Vein Stripping
26. Mental Health Partial Day Program
27. Case Management
28. Chemical Dependency
29. Emergency Services
30. Cancer Clinical Trials
31. Rehabilitation
32. Skilled Nursing Facility
33. Arthroscopy, other than knee
34. Artificial Insemination
35. Bone Marrow/stem cell transplantation
36. Erythropoeitin Alfa guidelines
37. Cerezyme guidelines
38. Heart-lung transplantation
39. Infertility Services
40. Laminectomy
41. Laparoscopy
42. Orthotic/prosthetic applicances
43. Pain Management
44. Pulmonary Rehabilitation
45. Septoplasty
46. Sleep Apnea
47. Total Hip Replacement
48. Total Knee Replacement
49. Travel Medicine Vaccinations
50. Tympanoplasty
51. Viral Hepatitis guidelines
52. Weight Management guidelines

MEDICAL RECORD GUIDELINES (6)

1. Patient Right and Responsibilities
2. Advance Directives
3. Access to Care and Service
4. Confidentiality
5. Medical Record Documentation Standards
6. Office/Patient Safety Standards

TOTAL:
96 GUIDELINES APPROVED AND DEPLOYED TO NETWORK

FUTURE/OR IN DEVELOPMENT GUIDELINES (8)

CHF
Unstable Angina
Lipid Screening and Treatment
DVT Prophylaxis in Surgical Patients
Syncope Evaluation and Treatment
Hypertension Treatement
Low Back Pain Evaluation and Treatment
Mental Health Screening and Referral

AVAILABLE RESOURCES TO NETWORK PHYSICIANS:

INTERQUAL is a clinically validated approach to clinical decision support to promote care facilitation, quality and patient satisfaction It includes a broad range of criteria to assist with care planning, level of care determination and retrospective monitoring.

There are over 700 clinical guidelines that include the below areas for screening and treatment:

1. Acute Medical Adult and Pedicatric Criteria
2. Acute OB Services
3. Surgical Procedures
    - Cardiology/Cardiothoracic
    - General Surgery
    - Hand, Plastic, and Reconstructive
    - Neurosurgery
    - Obstetrics and Gynecology
    - Ophthalmology
    - Oro-Maxillo-Otolaryngology
    - Orthopedic
    - Podiatry
    - Specialized Procedures
    - Urology
    - Vascular

InterQual clinical decision support tools strengthen BTMG's ability to meet the organization's care management goals:

- ***Facilitates and improves patient care:*** Reduces practice pattern variation between physicians and supports appropriate care decisions leading to better outcomes, improved safety and enhanced quality of care for patients.
- ***Helps manage resources.*** Assists in identifying over- and under-utilization of services.
- ***Promotes high inter-rater reliability between physician decision makers.*** Objective and rule-based criteria facilitate consistent and accurate decision-making to meet quality improvement goals.
- ***Demonstrates quality.*** Supports the accountability of BTMG to oversight and accreditation bodies, including NCQA.

- *Focuses on case management.* The depth and breadth of the clinical content aids in managing all aspects of inpatient and outpatient care to guide efficient use of resources and proactively manage cases.
- ***Improves decision-making.*** Key supplemental resources for physicians— extensive bibliographies, definitions of medical terms, discussions of patient management, drug lists, guides to the review process, glossaries, indices and safety warnings — enables BTMG physicians and staff to better understand patients and their treatments.

HAYES DIRECTORY, a web-based software, tracks new and emerging healthcare technologies that may potentially have a substantial impact on healthcare costs, utilization, and/or quality. In addition to producing over 80 comprehensive technology assessment reports every year, **HAYES, Inc.** provides a wide spectrum of health technology information services, including customized technology assessment reports, training in medical literature searching, study design and methodology, data analysis, epidemiological principles, and applied technology assessment.

THE HOSPITALIST MANUAL An evidence based approach manual for protocols to inpatient management of patients.

6/12/03

Adult Primary Care Physician Scope of Standard Services

Overview

The Health and Safety Code of California (Section 1367.69) and existing Knox-Keene regulations define Primary Care Physicians (PCPs) as physicians who have the "responsibility for providing initial and primary care to patients, for maintaining the continuity of patient care, and for initiating referrals for Specialist care. This means providing care for the majority of health care problems, including but not limited to, preventive services, acute and chronic conditions, and psychological issues."

Within the parameters of a managed care delivery system, expectations exist regarding the scope of services delivered by primary care physicians. Standards have been developed to clearly define the scope of services within which BTMG PCPs are expected to practice. Physicians who wish to function in the role of a PCP, regardless of their clinical specialty, must meet those standards.

It is recognized that no single physician is expected to provide the entire scope of services (e.g. every skill listed) which are described within this document. Rather, the PCP is expected to meet the intent of the definition by initiating care, maintaining continuity of care, and providing care for the majority of health care problems.

These standards delineate those services, which may be provided appropriately, within each individual physician's knowledge or skill level, by PCPs. It is acknowledged that physicians with varying levels of education and experience may require continuing education focused on specific skills or topics to retain the designation of primary care physician. These standards provide a guideline for BTMG to identify circumstances when additional knowledge or skills may be needed before a physician may be considered a PCP.

Situations are also identified where consultation with or referral to a specialist may be appropriate. It is assumed that consultations or referrals to a specialist for care will take place in the most appropriate, timely, and cost effective manner in light of the specific patient situation under consideration.

I. POLICY STATEMENTS

A. The PCP is responsible for providing attending coverage for patients during acute hospitalization in contracted facilities or coordinating this care with the hospitalist, if available. The PCP is responsible for communicating with assigned attending physicians in non-contracted or out-of-area hospitals for the purpose of facilitating repatriation of their patients into the BTMG network. The PCP is responsible for assuring that timely case management and discharge planning occur. For patients in a skilled nursing facility, nursing home or homebound in the city or county of San Francisco, the PCP is expected to provide attending coverage or coordinate this care with the contracted hospitalist, if available.

B. The PCP is responsible for providing the majority of and coordinating all the services required by the patient, except when precipitous emergency circumstances preclude the primary care physician's role.

1. The "majority" of services are defined as the ability to perform ninety-five percent (95%) of the functions included on the Clinical Skills list below.

2. The PCP is expected to provide periodic evaluation of all body systems, preventive services, acute and chronic care and to address psychosocial issues. For pediatricians and family physicians caring for children this includes assessment of growth and development, and nutritional status.

C. The PCP's responsibility is continuous.

1. The PCP is required to perform all duties expected of a PCP, such as on-call rotation and/or coverage for emergencies.

2. When care by one or more specialists is required, the responsibility of the PCP is to coordinate all services, not only his or her own, but also all services rendered by one or more specialists.

D. The PCP is expected to provide those services that can be provided within his or her skills, and to obtain consultation when additional knowledge or skills are required.

E. The PCP is expected to understand the primary concepts of benefit coverage. PCPs are expected to relay health plan decisions to patients in a positive manner. When the primary purpose of the visit is for a non-covered service, the PCP must inform the patient and obtain written acknowledgment. Once accomplished, the physician has the option of passing the cost of the service onto the patient.

F. When the PCP has determined that a referral to a specialist is required, it is the responsibility of the primary care physician to forward all relevant clinical and diagnostic data to the specialist prior to the consultation.

II. CLINICAL SKILLS

The following standards define those clinical skills or services ordinarily provided by a PCP and those ordinarily requiring consultation or referral.

A. Allergic Syndromes

1. Elicit a thorough allergy history and use environmental controls before allergy referral.
2. Treat acute and chronic asthma. Consider consultation or referral if treatment is unsuccessful, hospitalization is necessary or chronic steroid treatment is needed.
3. Treat all seasonal allergies when symptoms last less than 6 weeks per year or occur in 2 seasons but for less than 1 month each time. Consider consultation or referral for symptoms lasting longer than this perennially or unresponsive to treatment.
4. Treat chronic rhinitis and consider consultation or referral if problem is unresponsive.
5. Treat hives and seek cause. Consider consultation or referral if urticaria becomes chronic, over 6 weeks duration.

B. Cardiovascular System

1. Recognize congenital and valvular disease by history and physical examination. Include electrocardiogram and chest x-ray in the evaluation if a diagnosis other than a functional systolic ejection murmur is being considered. Consult when congenital or valvular disease has been diagnosed to determine a plan of treatment and follow-up.
2. Provide education, and prophylaxis against, acute rheumatic fever or bacterial endocarditis.
3. Evaluate and treat coronary risk factors including diabetes, hyperlipidemia, hypertension and smoking.
4. Recognize and evaluate chest pain by history, physical examination, and electrocardiogram. Consider consultation or stress testing in patients with atypical chest pain and 2 or more risk factors. Consider consultation if the clinical picture is confusing, if new onset chest pain suggests angina pectoris or stable chest pain changes with increased frequency or duration or decreased threshold for occurrence.

5. Treat angina medically with risk factor/lifestyle modification and nitrates, beta-blockers, calcium channel blockers, and other medication as appropriate. Consult for:

   a. Angina occurring despite maximal medical treatment.
   b. Non-invasive tests suggest a poor prognosis.
   c. Increasing angina after myocardial infarction.
   d. Sub-endocrinal myocardial infarction with or without angina

6. Treat hypertension to achieve satisfactory control. Consult if hypertension is refractory to treatment, if cardiomegaly, chest pain or congestive heart failures are associated, or if more critical complications such as encephalopathy, pulmonary edema, major vascular accidents or rapidly progressive nephropathy require immediate control.

7. Recognize and treat congestive heart failure, particularly maintenance treatment for those who are stable. Consult for patients with diastolic dysfunction, valvular disease, pericardial disease, or non-ischemic cardiomyopathy. Consult for acute congestive heart failure associated with myocardial infarction, arrhythmia, ischemia, and hypertension or if the cause of acute congestive heart failure is not known.

8. Determine if syncope is cardiovascular, i.e., valvular, arrhythmic, or autonomic. Consult if the patient has known heart disease or for recurrent episodes when the cause has not been identified. If a transient cause has not been identified and episodes are recurrent.

9. Recognize minor and major arrhythmias and their significance. Consults for patients with successful resuscitation, ventricular tachycardia, symptomatic bradycardia, recurrent paroxysmal bradycardia, recurrent paroxysmal atrial fibrillation, Wolff-Parkinson-White syndrome, AV Nodal Re-entrant tachycardia and for supraventricular arrhythmias refractory to medical treatment.

10. Distinguish acute pericarditis from other chest pain syndromes by history, physical examination, and electrocardiogram. Consult for pericardial effusion and other complications of acute or chronic pericardial disease.

C. Dermatology

1. Pre-Cancerous Skin Lesions and Skin Cancers
   Dermatologists will be the primary referral source for evaluation of patients presumed to have skin cancers or pre-cancerous lesions regardless of lesion size or location.

2. Psoriasis
   Manage limited cases of psoriasis. Refer if:

a. Diagnosis in question.
b. Lack of satisfactory response to topical treatment.
c. Pustular lesions present.
d. Arthritis present.
e. Special treatments such as phototherapy (UVB or PUVA), immuno-suppresives, retinoids or intralesional corticosteroids are being considered.

3. Warts

Attempt conservative methods. Refer to dermatologists when warts are large or numerous, or if ablative procedures appear more appropriate. Genital warts (condylomata acuminatum) often can be managed by the PCP but in females may also be referred to a gynecologist. PCPs referral suggested if:

a. Diagnosis in question.
b. Warts are large, numerous or symptomatic.
c. Lack of satisfactory response to treatment.

4. Molluscum Contagiosum

Referral suggested if:

a. Diagnosis is in question.
b. Lack of satisfactory response to treatment.

5. Hair Loss

Diagnose post-partum, post-surgical or male pattern baldness. Referral suggested if:

a. Cause is not obvious by history and scalp inspection.
b. Scarring alopecia is present.
c. Unresponsive to therapy or recommendations.

6. Fungus Infections

Use potassium hydroxide (KOH) examinations and/or fungal cultures to diagnose some cases of dermatophyte infections: tinea capitis, tinea corporis, tinea cruris, tinea pedis, tinea manuum, and onychomycosis, candida and tinea versicolor. Referral suggested if:

a. Diagnosis in question.
b. Lack of satisfactory response to treatment after a reasonable amount of time.

7. Herpes Simplex Infection

May diagnose some cases of oral, labial or genital herpes simplex virus infections and begin treatment with topical measures or oral antiviral agents. Referral suggested if:

a. Diagnosis in question.
b. Lack of adequate response to treatment.

8. Acne

Initiate treatment for most cases of acne. Referral suggested if:

a. Lack of satisfactory response to treatment after a reasonable amount of time (usually 3 months).
b. Cysts or nodules present.
c. Isotretinoin (Accutane) considered.
d. Scarring actively occurring.
e. Special treatment such as intra-lesion corticosteroid injection or acne surgery is contemplated.
f. Acne is associated with signs of androgen excess, such as hirsutism and androgenic alopecia.

9. Herpes Zoster

May diagnose and treat herpes zoster. Referral suggested if:

a. Diagnosis in question.
b. Lack of satisfactory response to treatment.

10. Impetigo and Pyoderma

May diagnose and treat impetigo and other bacterial pyodermas with oral or topical antibiotics. Referral is suggested if:

a. Diagnosis in question.
b. Lack of satisfactory response to treatment.

11. Dermatoses

Diagnose and treat common inflammatory dermatoses ("rashes") such as:

a. Contact dermatitis
b. Drug and other allergic eruptions
c. Seborrheic dermatitis
d. Atopic dermatitis
e. eczema

Referral suggested if diagnosis in question or lack of satisfactory treatment response.

12. Keloids

Evaluate patients: small, asymptomatic keloids in covered areas may not require treatment. Larger or symptomatic keloids commonly need treatment. Suggest referral to dermatologists for management of keloids. Prior-authorization may be needed. Patients referred without prior-authorization may be financially responsible for treatment. Referral suggested if keloid symptomatic.

D. Endocrine System

1. Diagnose and manage non insulin-dependent and insulin-dependent diabetes.

    a. Consider consultation or referral if unstable or unable to achieve optimal control.
    b. Consider referral to education programs at BTMG contract locations for newly diagnosed or unstable diabetics.
    c. Management per BTMG Diabetes guidelines.

2. Diagnose and treat thyroid disorders.

    a. Consider consultation or referral for hyperthyroidism/congenital hypothyroidism.
    b. Initiate work-up, (e.g.; fine needle aspiration, basic labs, for thyroid nodule, etc.) prior to referral.

3. Diagnose and treat lipid disorders with diet and/or at least 2 medications for minimum of six (6) months. Consider consultation or referral if goals of treatment are not met, especially with high risk patients, within 6 months to 1 year.

E. Female Reproductive System

1. Provide pelvic exams and Pap smears.

2. Diagnose and treat common GYN conditions, including vaginitis, sexually transmitted diseases, menstrual disorders such as dysmenorrhea or vaginal bleeding. Attempt treatment for vaginal warts; refer when unresponsive to treatment.

3. Perform endometrial biopsies when adequately trained.

4. Provide contraceptive counseling and management.

5. Identify breast lumps; refer for surgical management.

F. GI System

1. Diagnose and treat common GI conditions including esophageal and reflux disease, hiatal hernia, hyperacidic and duodenal ulcer disease, infectious diarrhea,

protracted vomiting, functional bowel disease, obstruction, and diverticulitis. Treat acute symptoms consistent with peptic disease. Consider consultation or referral if unresponsive to treatment after 1 month or for recurrent unresponsive disease.

2. Undertake evaluation and diagnosis of liver disorders. Consider consultation or referral for undiagnosed hepatocellular disease, obstruction or intractable ascites.

3. Diagnose and treat symptomatic hemorrhoids. May enucleate thrombosed external hemorrhoids when clinically appropriate. Consider referral if additional surgical intervention is required.

4. May perform screening flexible sigmoidoscopy if equipped and adequately trained.

G. Hematology

1. Diagnose and manage anemia (e.g.: iron deficiency, etc.)

2. Consultation for anemia of unknown cause, suspected thalasemia/sickle cell or oncologic anemia

3. Consider referral for bleeding/clotting disorder

H. Infectious Diseases

1.Diagnose HIV or hepatitis based on risk factors. Obtain cultures (blood, sputum, urine) & interpret results.

2.Diagnose tuberculosis.

3.Recognize meningitis/CNS infection and refer.

4.Diagnose endocarditis.

5.Diagnose and treat viral exanthemes.

6.Vaccinate appropriately (e.g.: tetanus-diphtheria, Hepatitis A&B, Pneumovax, etc.).

7.Manage HIV disease per BTMG HIV guidelines or refer to BTMG HIV Specialist.

8.Diagnose and treat STDs.

9.Provide standard travel vaccinations.

I. Mental Health

1. Treat depressive and anxiety disorders and manage medication for stable psychiatric disorders (e.g., schizophrenia or bipolar illness). Identify and manage substantial abuse disorders. Refer to Mental Health when necessary.

J. Musculoskeletal System

1. Diagnose and treat low back pain and sciatica without neurological deficit as described under "Nervous System" section.

2. Diagnose and treat common musculoskeletal medical and traumatic problems including chronic knee problems, runner's knee, sprains, and acute inflammatory conditions. Consider consultation or referral for intractable problems after a minimum of 6 (six) weeks' conservative medical therapy.

3. Manage chronic pain if consultation ruled out surgery.

4. Perform soft tissue or joint injection when clinically appropriate.

5. Diagnose and treat common foot problems including conservative care (e.g.: trimtoe nails, paring or chemical treatment of corns or calluses, treat sprains and strains with anti-inflammatory medications, appropriate shoe gear, and prescribe antibiotics and soaks for ingrown toe nails, etc.)

6. Refer for significant congenital orthopedic diagnoses.

K. Nervous System

1. Diagnose and treat neurologic pain syndromes, including headaches and migraines, myofacial pain and TMJ syndrome, low back pain, lumbosacral disk disease, and sciatica. Consider consultation or referral if neurologic deficit present or unresponsive to conservative measures and/or no improvement after therapy. This does not preclude investigation and treatment of suspected intracranial disorders, which may warrant more immediate intervention.

2. Manage uncomplicated stroke and TIA.

L. Nutritional Services

1. Provide dietary counseling for weight control, diabetes, high cholesterol, and hypertension.

M. Ophthalmology Services

1. Perform a thorough ophthalmologic history, eliciting factors of family history, symptoms, subjective visual acuity. Provide common eye related services

including distant, near, and color vision testing, gross visual field testing by confrontation, alternative cover testing, physical examination including direct fundoscopy without dilation, extra-ocular muscle function evaluation, and red reflex testing in pediatric patients.

2. Diagnose and treat common eye conditions including viral, bacterial and allergic conjunctivitis; blepharitis; hordeolum; chalazion; small subconjunctival hemorrhage; and dacryocystitis. Consultation or referral is recommended where a high index of suspicion for herpes exists.

3. May remove corneal foreign bodies and treat corneal abrasion including fluorescein staining, patching and slit lamp examination if available. Consider consultation, if needed.

4. Consider consultation or referral for sudden visual change or loss, lens opacification, visual change accompanied by pain, abnormal fundascopic examination, any eye symptom not responding to treatment, and pediatric patients with disconjugate gaze or other ophthalmologic problems.

N. Otolaryngology (ENT)

1. Treat tonsillitis and strep infections. Consider consultation or referral if 3 documented episodes occur within 4 or 6 months within 1 year.

2. Treat acute otitis media. Consider a referral for evaluation of otitis media based on documentation of one or more:

    a. Chronic: defined as infections unresponsive to antibiotic therapy and producing a hearing loss demonstrated through audiometry and/or clinical evaluation.
    b. Recurrent: defined as four or more acute infections per year and/or breakthrough infections while on low dosage maintenance antibiotics.
    c. Persistent: defined as middle ear effusion (also referred to as serious otitis or "glue ear") in excess of 3 months, not improving with an adequate trial of medication.
    d. Persistent retraction of the tympanic membrane.
    e. Complicating co-morbidity (e.g.: Down's syndrome or facial structure anomalies, cleft palate) complicating the treatment of otitis media.

3. Treat acute and chronic sinusitis with up to 2 courses of antibiotics. Consider consultation or referral if infection is not responsive after 2 weeks.

4. Treat nasal obstruction, vasomotor or allergic rhinitis. Consider consultation or referral if problem persists more than 3 months.

5. Remove ear wax.

6. Obtain consultation or referral for Bell's palsy.

7. Obtain consultation or referral for acute hearing loss, persistent hearing loss not attributable to fluid or wax, parotid masses, hoarseness persistent more than three weeks, or hemoptysis.

O. Pain Management

1. Diagnose and initiate treatment for acute pain problems, including, but not limited to musculoskeletal pain, neuralgias, and acute inflammatory conditions. Consider consulting a pain management specialist for complex pain problems not responsive after 4 weeks of conservative management.

2. Manage chronic pain problems after consultation and treatment plan implemented by pain management specialist.

P. Renal System

1. Evaluate and manage renal insufficiency: identify systemic cause (e.g.; CVD, diabetes, hypertension, medications, obstructive.)

2. Obtain consultation for cases with unclear diagnosis or progression.

Q. Respiratory System

1. Diagnose and treat common respiratory conditions including asthma, acute bronchitis, pneumonia, and COPD.

2. Manage asthma per BTMG asthma guidelines.

3. Consider consultation or referral for persistent pleural effusion, unresolved pneumonia, hemoptysis, lung mass, interstitial disease, sarcoid, TB, cystic fibrosis, unusual infections, or dyspnea of unknown etiology.

R. Rheumatology

1. Diagnose and treat common rheumatologic conditions including non-specific musculoskeletal pain, bursitis, tendonitis, and osteoarthritis. Consider consultation or referral if unresponsive after 2 - 3 months of therapy, or if functional impairment exists.

2. Diagnose and treat acute inflammatory arthritic diseases. Consider consultation or referral to establish long-term management if unresponsive to treatment plan or aspiration and/or injection is needed.

3. Diagnose and treat uncomplicated collagen vascular diseases. Consider consultation or referral depending on the extent and severity of manifestations.

S. **Urinary System**

1. Diagnose and treat both initial and recurrent urinary tract infections. Consider consultation or referral for unexplained hematuria.

2. Diagnose and initiate medical treatment for BPH.

3. Evaluate and treat male sexual dysfunction. Refer cases unresponsive to therapy.

ATTACHMENT F

REDACTED

June 2, 2004

«PCPName»
«st_address»
«city1», «state2» «zip2»

Dear Doctor:

Over the past 18 months, Brown & Toland Medical Group (BTMG) has sent our physicians periodic clinical support, access and utilization reports. It is our hope that these have been useful to you, allowing you to compare your performance with the performance of your peers. You may find enclosed the following items in this reporting package:

PCP Access Report
PCP Utilization Report
Asthma Clinical Support Report
Asthma Patient Chart Inserts
Childhood Immunization Support Report
Women's Health Support Report

The clinical reports are intended to help you manage your patients with chronic illnesses, or to provide preventative screenings for your eligible members. They correspond to Pay-4-Performance (P4P) measures, the health plan administered bonus incentive program. By following treatment guidelines for these services, BTMG can maximize its health plan quality bonus.

The clinical support reports go hand-in-hand with the Access and Utilization Reports. The Access report measures your patient's access to you practice, their referral patterns to specialists and their ER use. The Utilization Report measures services you bill for, compares those with your peers, and includes total specialty costs for your patients.

Please carefully review each report you receive. As always, we strongly encourage you to provide us with your feedback. We have enclosed a fax-back comment sheet, and some of you will receive women's health forms, please send them back with your comments.

Thank you

June 2, 2004

«PCPName»
«st_address»
«city1», «state2» «zip2»

Dear Doctor:

We are pleased to distribute the Spring 2003 Childhood Immunization, Women's Health and Asthma Clinical Support Report. The Asthma Support report now includes patient chart inserts with pharmacy fill data, which will allow you to review patients who may be under treated. Our last HEDIS measurement of all BTMG patients with asthma noted a significant need to improve appropriate medication use in the pediatric population. On the back of the individual patient chart inserts you will find the updated pediatric asthma guideline. This was modified and reviewed by the BTMG Asthma Advisory Group and the QI Committee.

In regards to immunization data, this area is most dependent upon claim submissions. We know based-on HEDIS chart extraction, that our immunization rates are excellent, however there are a number of offices who still lag in data submissions. As a reminder, all immunizations and vaccines are carved-out (paid fee-for service). Please work with your staff to ensure that your claims data submissions are as complete as possible.

Attached you will also find the most recent Women's Health Clinical Support Report. Of all clinical support reports you may receive, this is the most difficult database to administer and maintain. These patients may be cared for by both you and an OB/GYN, which may create some of the billing and availability issues. Again these are all P-4-P measures and due to their overall importance, regardless of who performs the exam, we would like to maintain this patient list as accurately as possible. Please sign and date your list of patients who may be inappropriately listed as needing a test: (i.e., S/P TAH, and/or S/P bilateral mastectomy) and fax them to BTMG. We hope to keep this list continuously updated to more accurately reflect your panel and screening rates.

What is not included is a listing of patients aged 18-25 requiring annual chlamydia screening. This is a HEDIS measure, and may be a P4P measure in 2005. Due to the small sample of patients, we will not at this time be launching a campaign to increase screening. BTMG rather asks you to screen annually as recommended.

As you are well aware our P-4-P bonus is due in large part to providing top quality care; and physicians will be rewarded accordingly. Finally, if you see patients assigned to you for whom you have no contact information, we encourage you to call your BTMG Physician Relations representative to help with this outreach.

Again, thank you for your excellent work.

Fiona Wilson, MD
Vice President Quality Initiatives

June 2, 2004

«PCPName»
«st_address»
«city1», «state2» «zip2»

Dear Doctor:

We are pleased to distribute the Spring 2003 Childhood Immunization and Asthma Clinical Support Report.

A few notes:

The Asthma Support report now includes pharmacy fill data, which will allow you to review patients who may be under treated. Our last HEDIS measurement of all BTMG patients with asthma noted a significant need to improve appropriate medication use in the pediatric population.

On the back of the individual patient chart inserts you will find the updated pediatric asthma guideline. This was modified and reviewed by the BTMG Asthma Advisory Group and the QI Committee. Included also is a chart insert, again to facilitate improved treatment of patients who are on beta-agonists only who may need to step-up to inhaled steroids.

In regards to immunization data, this area is most dependent upon claim submissions. We know based-on HEDIS chart extraction, that our immunization rates are excellent, however there are a number of offices who still lag in data submissions. As a reminder, all immunizations and vaccines are carved-out (paid fee-for service). Please work with your staff to ensure that your claims data submissions are as complete as possible.

As you are well aware our P-4-P bonus is due in large part to providing top quality care; and physicians will be rewarded accordingly.

Again, thank you for your excellent work.

Fiona Wilson, MD
Vice President Quality Initiatives

BROWN & TOLAND
MEDICAL GROUP

PCP Support Reports Comment Sheet

Please complete and fax to: (415) 972-4179 Attn: Jonah Frohlich

1. **Which hospital do you consider yourself primarily affiliated with? (check any that apply):**

☐ CPMC ☐ UCSF ☐ St. Luke's ☐ St. Mary's ☐ St. Francis ☐ Seton ☐ Other

2. **Did you receive a patient chart insert with a diabetes member and their lab and Rx histories?**

☐ Yes ☐ No

3. **Did you find the patient chart insert useful?**

☐ Yes, very useful ☐ Yes somewhat useful ☐ Not very useful ☐ Not at all useful ☐ Not sure yet

4. **What were the biggest problems you had with the patient chart inserts**

☐ Incorrect lab data ☐ Incorrect Rx data ☐ Incorrect patient data ☐ Just doesn't work for me

☐ Other, please specify: _____

5. **What other elements would you want to see in the chart inserts (if any)?** ☐ None

_____

_____

6. **Additional comments, information, features, or changes that would increase the effectiveness of this report?**

_____

_____

ATTACHMENT G

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ATTACHMENT H

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ATTACHMENT I

Program description

- Population-based approach to manage 6,000 members with diabetes
- Program is overseen by VP of Quality Improvement (also a practicing physician) and includes support from data analysts and nurse case managers
- Funding is internal with some pharmacy support for special projects

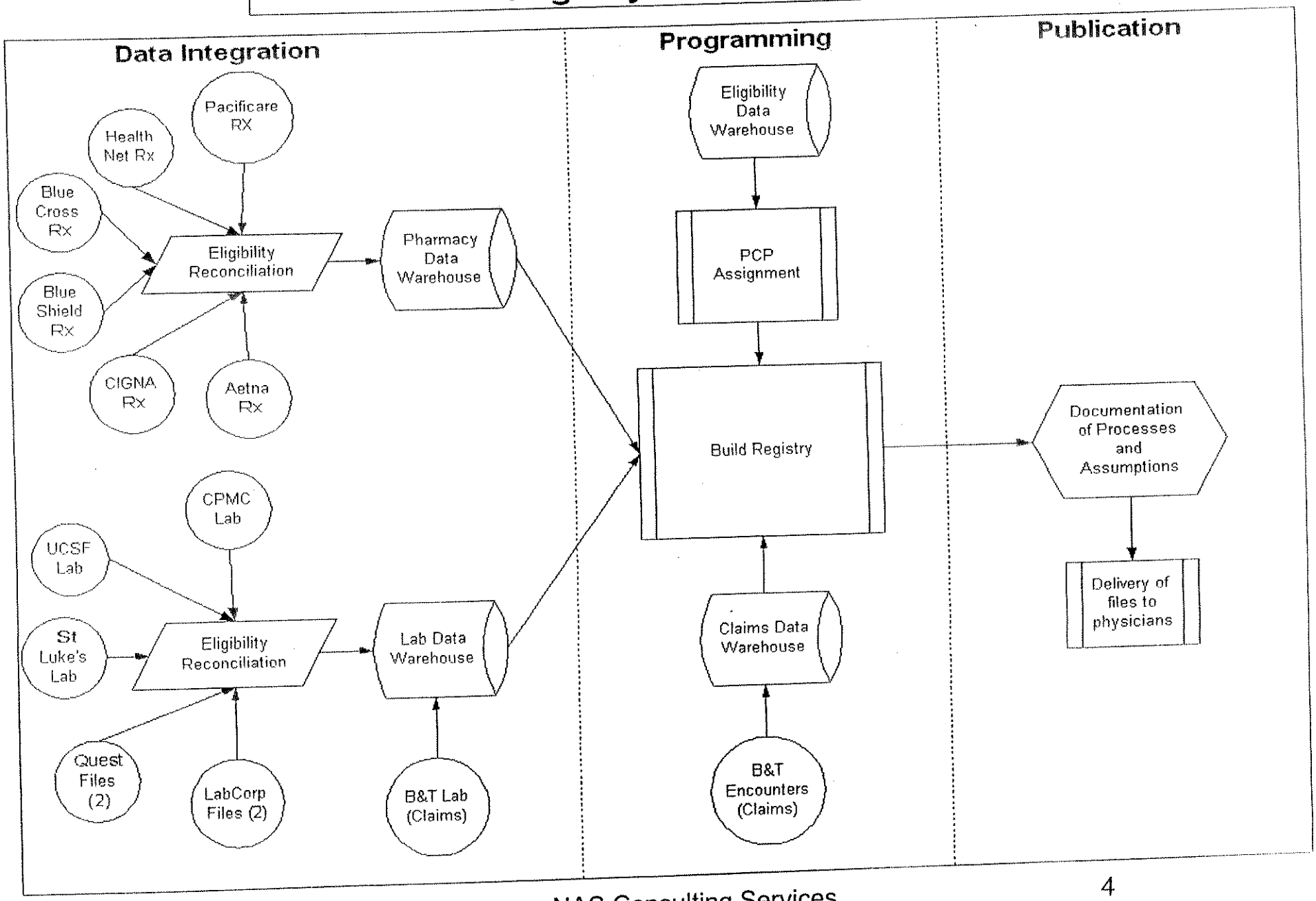
Program elements

- Diabetes registry
- Physician reporting
  - Population-based reporting
  - Peer-to-peer comparisons
  - Individual patient level reporting (includes adherence to medications)
- Patient reminders
- Physician bonuses (new in 2003)
- Nurse case management (new in 2004)

Reaching physicians using registries

- Physician outreach (it's still on paper!):
  - Biannual "support reports" to primary care physicians listing patients with diabetes not treated to guideline
  - Reporting outcomes include lab results (A1C and LDL) prescribing profiles and retina exams
  - BTMG guideline included in report package
- Provider reaction to program:
  - After years of CQI, we are finally receiving positive feedback from a majority of physicians
  - Data is much better, and reports are updated with physicians records

Registry Development



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Registry also used to:

- Create annual patient reminders (for patients not treated to goal)
- Set targets for and deliver bonuses to physicians
- Target patients for case management

Patient Reminders

- Sent annually to a subset of members not treated to goal:
  - No A1C or LDL test in past 12 months or;
  - A1c >8 or LDL > 100 or;
  - No retina exam in past 12 months

Physician Bonus

- Based on LDL-testing rates for members with diabetes:
  - <70% of members tested: $[redacted] per member
  - 70%-79% tested: $[redacted] per member
  - 80%-89% tested: $[redacted] per member
  - 90+% tested: $[redacted] per member
- Decision to reward bonus on LDL testing based on historically lower testing rates
- Allow for physician feedback on missing labs before awarding bonuses

Nurse Case Management

- Target high-risk patients:
  - A1C between 10 and 12 (n=208)
  - A1C > 12 (n=61)
- Facilitated referrals to hospital-based education classes
- One-on-one nurse case management
  - Development of tools for use by both nurses and physicians to discuss compliance issues and lab results with patients

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Barriers

- Barriers overcome
  - Data is accurate and timely
  - General acceptance of reporting (in some cases it's even warmly welcomed)
  - Increasing acceptance of treatment to guideline
- Key challenges to the program
  - Acceptance of bonuses based on performance
  - Non-compliant patients and providers still a challenge

Biggest accomplishments

- Improved A1C and LDL testing rates and levels
- Better and more timely information in the hands of physicians and case managers
- Bonuses based on quality

Next steps

- Increase bonuses to physicians based on additional metrics (i.e., levels)
- Generation of electronic reports at the point of care (integrated with practice management system or patient eligibility lookups)
- Focusing limited nurse case-managers time on well-targeted cohorts