Bon Secours Medical Group
Virginia
Comprehensive Coordinated Care
The Three Cs in Success!
BSVMG Journey

- Electrify – Connect Care
- Grow – Strategically
- Re-engineer – PCMH
- Connect – My Chart
- Coordinate – Nurse Navigation
- Proactive – Registries
- Clinical Innovation – Hi Tech and Hi Touch
- Medical Group Culture – Synchronization
- Advanced Payment Models – ACOs
- Healthcare Without Walls – Back to our Roots
- Next Generation Healthcare – Population Health meets Total Access
It’s a New World
Journey to Value Based Payments

- Payment for Outcome
- Risk Management
- Value Based Payments
- Fee for Service
- Process
Population Health Strategies

- PCMH
- Expanded Access
- Risk Stratification & Registry Outreach

Care Coordination & Transitions of Care
End of Life Palliative & Hospice
Benefit Design/Managed Care Contracts
Comprehensive Capacity
Much More than Access
Traditional Method of Managing Workflow

- Chronic Disease Monitoring
- Medication Refill
- New Acute Complaints
- Preventive Medicine Intervention
- Healthcare Support Team
- Care/Case Management
- Mental Health Providers
- Certified Medical Assistant
- Referral out to Specialists
Not Enough Time in Physician’s Day to Provide Comprehensive, Coordinated Care

Medical Home Goals:
- Comprehensive Chronic and Preventive Care

Patient Engagement:
- Time-intensive patient education
- Motivational interviewing
- Self-management follow-up
- Group visits

Enhanced Access:
- Same-day scheduling
- Expanded evening, weekend office hours
- Increased patient phone, e-mail access

Coordinated Care:
- Increased communication with other providers and specialists
- More thorough documentation
- Increased patient follow-up

New Time-Consuming Tasks:
- Disease registry data entry, maintenance, monitoring
- Increased patient outreach, phone contact
- Increased results reporting

PCP Time Required per Day to Meet Clinical Guidelines for 2,500 Patient Panel

- Acute Needs: 3.7 hours
- Chronic Needs: 10.6 hours
- Preventive Services: 7.4 hours
- Total: 21.7 hours
Healthcare Is A Team Sport

Care Management RN/LPN/MA

Medication Refill

Chronic Disease Monitoring

Test results

New Acute Complaints

Preventive Medicine Intervention

Point of Care Testing

Acute Mental Health Complaint

Chronic Disease Compliance Barriers

Medication Refill

Healthcare Support Team

Good Help to Those in Need®
Patient Centered Medical Home Practices - 35 NCQA Level 3

Current Status
• 35 Sites NCQA Level 3
• 156 Providers

In Progress
• Developmental & Special Needs Pediatrics
  – 3 Providers
• Pediatric Endocrine and Diabetes Associates
  – 3 Providers
• Pediatric Gastroenterology Associates
  – 3 Providers
• Pediatric Hematology-Oncology
  – 2 Providers
• Pediatric Neurology Clinic
  – 1 Provider
• Pediatric Lung Care
  – 4 Providers
• Bon Secours Pulmonary Specialists
  – 12 providers
• East Beach Medical Associates
  – 3 providers
• Glen Allen Internal Medicine
  – 3 Providers

*1ST in BSHSI – to submit level 3 applications using new thresholds and criteria
Expansion of Primary Care Medical Home Team

Core Team Inside Practice
- 2 Providers
- 1 LPN (Team Lead)
- 2 LPN/MA (Rooming)
- .5 RN (Navigation)

Extended Team System Level
- Behavioral Health Specialist
- Diabetic Educators
- LPN Panel Managers
- RN Virtual Navigators
- Clinical PharmD
- Social Worker
- Referral Coordinator
- ACP Coordinator
- Home Health
- Community Health Workers

NP At Home Program
- Geriatric Providers
- Cardiologist
- Pulmonologist
- Podiatrist
- Palliative Medicine
- Hospice

Medical Specialist

Good Help to Those in Need®
Nurse Navigator Model

Transitions of Care
- Maintaining Relationship

Coordinating Care
- Assuring Continuity Across Setting

Complex Case Management

Medication Reconciliation

Annual Wellness Visits
- Patient/Caregiver Engagement

Data Management
- Managing Symptoms
- Educating/Promoting Self-Management

Collaborating with Hospitals, etc
- including ED Outreach

Advance Care Plans
The Patient is the most underutilized resource in healthcare.
Roles and Responsibilities

RN Nurse Navigator

– Discharge Follow up and assessment
– Chronic Disease Management and education
  • Registry Use – Population Management
– Case Management : 120-150 patients
– Assists with Care Coordination – works with Hospital and Insurance company Case Managers
– Use protocols for patient management
Clinical Skills and Ongoing Development

• Goal = CCM within 2 years
• Continuing Education – every two weeks
• 10 part Pharmacology course
• “Stride” management course
• Responsible to Practice Dyad but “must” have lines of reporting to Medical Home Project Team and Administrative Director of Clinical Operations
How to use a Nurse Navigator

• Refer “Hotspotters” - patient’s who take a lot of time and effort
• Patients with High Risk of readmission
  – Assessed by NN using Risk Stratification Tool
• Coordination of Community resources
  – S.A.R.G
• Should not be pulled into daily workflow or do tasks that can be handled by other staff
• Float Pool – exhaust all other staffing resources first.
**Where Does a Case Manager Start The Day?**

<table>
<thead>
<tr>
<th>Inpatient Facility</th>
<th>Length of Stay</th>
<th>Admission Date</th>
<th>Discharge Date</th>
<th>Admitting Diagnosis</th>
<th>Readmission Risk</th>
<th>Provider City</th>
<th>Provider State</th>
<th>Provider Zip Code</th>
<th>Provider Specialty</th>
</tr>
</thead>
<tbody>
<tr>
<td>BON SECOURS MEMORIAL REGIONAL</td>
<td>7</td>
<td>10/30/2015</td>
<td>11/06/2015</td>
<td>Infection following a procedure, initial encounter</td>
<td>21.27%</td>
<td>RICHMOND</td>
<td>VA</td>
<td>23230</td>
<td>Internal Medicine</td>
</tr>
<tr>
<td>SENTARA NORFOLK GENERAL HOSP</td>
<td>364</td>
<td>01/01/2015</td>
<td>12/31/2015*</td>
<td>CHRONIC KIDNEY DISEASE STAGE V</td>
<td>---</td>
<td>CHESAPEAKE</td>
<td>VA</td>
<td>23321</td>
<td>Family Practice</td>
</tr>
<tr>
<td>CHIPENHAM MEDICAL CENTER</td>
<td>2</td>
<td>11/30/2015</td>
<td>12/02/2015</td>
<td>Unilateral primary osteoarthritis, right knee</td>
<td>---</td>
<td>RICHMOND</td>
<td>VA</td>
<td>23235</td>
<td>Internal Medicine</td>
</tr>
<tr>
<td>BON SECOURS DEPAUL MEDICAL CENTER</td>
<td>1</td>
<td>11/11/2015</td>
<td>11/12/2015</td>
<td>Cerebral infarction due to unspecified occlusion or stenosis of right middle cerebral artery</td>
<td>30.26%</td>
<td>CHESAPEAKE</td>
<td>VA</td>
<td>23321</td>
<td>Internal Medicine</td>
</tr>
<tr>
<td>SENTARA NORFOLK GEN HOSP BOC T CLAIM</td>
<td>7</td>
<td>11/13/2015</td>
<td>11/20/2015</td>
<td>Malignant neoplasm of bladder, unspecified</td>
<td>---</td>
<td>CHESAPEAKE</td>
<td>VA</td>
<td>23321</td>
<td>Internal Medicine</td>
</tr>
<tr>
<td>BON SECOURS ST MARYS HOSPITAL</td>
<td>2</td>
<td>11/23/2015</td>
<td>11/25/2015</td>
<td>ST elevation (STEMI) myocardial infarction of unspecified site</td>
<td>---</td>
<td>RICHMOND</td>
<td>VA</td>
<td>23230</td>
<td>Internal Medicine</td>
</tr>
<tr>
<td>LIFE CENTER OF GALAX RESIDENTIA</td>
<td>14</td>
<td>10/23/2015</td>
<td>11/07/2015</td>
<td>***</td>
<td>17.34%</td>
<td>RICHMOND</td>
<td>VA</td>
<td>23229</td>
<td>Family Practice</td>
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<tr>
<td>CHIPENHAM MEDICAL CENTER</td>
<td>21</td>
<td>10/22/2015</td>
<td>11/12/2015</td>
<td>Acute pancreatitis, unspecified</td>
<td>14.89%</td>
<td>RICHMOND</td>
<td>VA</td>
<td>23229</td>
<td>Family Practice</td>
</tr>
<tr>
<td>ENVOY OF WESTOVER HILLS</td>
<td>19</td>
<td>11/12/2015</td>
<td>12/01/2015</td>
<td>Sepsis, unspecified organism</td>
<td>---</td>
<td>RICHMOND</td>
<td>VA</td>
<td>23229</td>
<td>Family Practice</td>
</tr>
</tbody>
</table>

**Example: Discharge Summary**

---

*Good Help to Those in Need®*
NN Managed Patients

Average of 4100 Patients in these Categories Touched per Month

Readmission Rate

Good Help to Those in Need®
Transitions of Care & Annual Wellness Visits

Transitions of Care Visits

<table>
<thead>
<tr>
<th></th>
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<tbody>
<tr>
<td>HR</td>
<td>76</td>
<td>67</td>
<td>76</td>
<td>68</td>
<td>82</td>
<td>70</td>
<td>80</td>
<td>101</td>
<td>90</td>
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<td>87</td>
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<tr>
<td>RIC</td>
<td>149</td>
<td>145</td>
<td>161</td>
<td>152</td>
<td>121</td>
<td>123</td>
<td>144</td>
<td>193</td>
<td>146</td>
<td>246</td>
<td>239</td>
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</table>

Annual Wellness Visits

<table>
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<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>HR</td>
<td>530</td>
<td>533</td>
<td>468</td>
<td>597</td>
<td>813</td>
<td>842</td>
<td>753</td>
<td>763</td>
<td>811</td>
<td>819</td>
<td>838</td>
<td>838</td>
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<tr>
<td>RIC</td>
<td>1561</td>
<td>1454</td>
<td>1256</td>
<td>1140</td>
<td>1153</td>
<td>1214</td>
<td>1100</td>
<td>1592</td>
<td>1873</td>
<td>2039</td>
<td>1785</td>
<td>1785</td>
</tr>
</tbody>
</table>
Office Visits Scheduled After Hospital Discharge

13,186 Visits


1140  1096  1032  1149  1063  982  1132  1147  1152  1141  1091  1061
Payment Model For Nurse Navigator

Direct:
- Chronic Care Management (CPT code 99490)
- Transitions of Care (CPT 99495 and 99496)
- Medicare Wellness Visit (CPT GO438 and GO439)
- Advance Care Planning Coding (CPT 99497 and 99498)
- Pay for Performance PMPM- Coventry, Anthem, Cigna, Humana, Virginia Premiere
- PAF Forms ($125. form –completed)

Indirect:
- Avoidable Readmission
- Patient/ Physician Engagement
- Reduction of ED Utilization
- Referrals
PharmD Contribution-Volume
1835 Patient Visits & Consults—Mar-15 to Feb-16

- AWV
- Patient Consults & Edu Visits
- Senior Care Visits
- Drug Information Requests
- Comprehensive Medication Reviews

Colors:
- Mar-15
- Apr-15
- May-15
- Jun-15
- Jul-15
- Aug-15
- Sep-15
- Oct-15
- Nov-15
- Dec-15
- Jan-16
- Feb-16

Good Help to Those in Need®
RD Contribution-Volume
1580 Patient Visits – Mar-15 to Feb-16
BSVMG’s Three Committees Structure

Smart Care Teams

All Three BSVMG Committees are Active

1. Health Promotion
   - Depression screening
   - Colon screening
   - Mammograms

2. Acute/Episodic Care
   - Same-day triage
   - Same-day access
   - Med refills

3. Chronic Disease
   - Proactive visits
   - Follow-up visits
   - Gaps in care reports

4. Complex Chronic Disease
   - Post-discharge call
   - Reduce readmissions
   - Long-term care plan

5. Palliative & Hospice Care
   - Right care setting
   - Support function
   - Treatment access
   - Manage symptoms

Good Help to Those in Need®
# FY16 PCQIP Program Overview

<table>
<thead>
<tr>
<th>Incentive Goal</th>
<th>Specific Criteria and Weight</th>
<th>Maximum Incentive</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>First Filter</strong></td>
<td>BSVMG PC Provider Volumes ≥ Individual Volume Budget</td>
<td>Eligible for Incentive</td>
</tr>
<tr>
<td><strong>Meaningful Use</strong></td>
<td>Provider meets and maintains Meaningful Use for Calendar Year – MU Stage 1 or MU Stage 2 (100% weight)</td>
<td>20%</td>
</tr>
<tr>
<td><strong>Patient Satisfaction and Citizenship (replaces current patient satisfaction bonus incentive, if any)</strong></td>
<td>Provider’s patient satisfaction scores meet threshold set by BSVMG (50% weight)</td>
<td>30%</td>
</tr>
<tr>
<td></td>
<td>Provider meets three BSVMG Meeting Attendance Criteria (25% weight)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Provider satisfactorily completes required training, conflict of interest education, Self Assessments / Year End Reviews and Coding Compliance (25% weight)</td>
<td></td>
</tr>
<tr>
<td><strong>Quality</strong></td>
<td>Provider meets specific quality measures as set by BSVMG (100% weight)</td>
<td>50%</td>
</tr>
<tr>
<td><strong>MAXIMUM TOTAL FISCAL YEAR 2016</strong></td>
<td></td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$30,000 per PCP $21,000 per ACP</td>
</tr>
<tr>
<td>Measure Description (measured on Fiscal Year basis)*</td>
<td>Threshold</td>
<td></td>
</tr>
<tr>
<td>-----------------------------------------------------</td>
<td>-----------</td>
<td></td>
</tr>
<tr>
<td>1. Percentage of Provider’s attributed patients, with Diabetes, with Hemoglobin A1c of &lt; 8% (NQF 0575)</td>
<td>≥ 80%</td>
<td></td>
</tr>
<tr>
<td>2. Percentage of Provider’s attributed patients, with Diabetes, with Low Density Lipoprotein of &lt; 100 mg/dL (NQF 0064)</td>
<td>≥ 70%</td>
<td></td>
</tr>
<tr>
<td>3. Percentage of Provider’s attributed Medicare patients seen in the last 12 months who have received an Annual Wellness Visit</td>
<td>≥ 50%</td>
<td></td>
</tr>
<tr>
<td>4. Percentage of Provider’s attributed female patients, age 65 to 85, who have had a screening DEXA scan and/or are receiving therapy for Osteoporosis (NQF 0046)</td>
<td>≥ 60%</td>
<td></td>
</tr>
<tr>
<td>5. Percentage of drugs dispensed to Provider’s attributed patients that are generics</td>
<td>≥ 90%</td>
<td></td>
</tr>
<tr>
<td>6. Percentage of Provider’s attributed patients, age 50 to 75, who had appropriate screening for colorectal cancer (NQF 0034)</td>
<td>≥ 59%</td>
<td></td>
</tr>
<tr>
<td>7. Percentage of Provider’s attributed female patients, age 50 to 74, who have had a mammogram within 24 months. (NQF 0031)</td>
<td>≥ 73%</td>
<td></td>
</tr>
<tr>
<td>8. Percentage of Provider’s attributed patients, age 18 to 75, with Diabetes, who had hemoglobin A1c &gt; 9.0% (NQF 0059)</td>
<td>&lt; 10%</td>
<td></td>
</tr>
<tr>
<td>9. Percentage of Provider’s attributed patients, age 18 to 75, with Diabetes, who had a nephropathy screening test or evidence of nephropathy (NQF 0062)</td>
<td>≥ 94%</td>
<td></td>
</tr>
<tr>
<td>10. Percentage of Provider’s attributed patients, age 18 and older, who were discharged alive from acute myocardial infarction (AMI), coronary artery bypass graft (CABG), or percutaneous coronary interventions (PCI) within the previous 12 months, or who had an active diagnosis of ischemic vascular disease (IVD) and who had documentation of use of aspirin or another antithrombotic. (NQF 0068)</td>
<td>≥ 95%</td>
<td></td>
</tr>
<tr>
<td>11. Percentage of Provider’s attributed patients, age 65 and older, who have an Advance Care Plan discussion documented in their medical record, during an encounter within the measurement year. (Summary of that discussion should be placed in the problem list to facilitate access to this information)</td>
<td>≥ 10%</td>
<td></td>
</tr>
<tr>
<td>12. Access Measure: Provider opens schedule for patient appointment slots outside of normal business hours (Monday-Friday, 8:00am – 5:00pm).</td>
<td>≥ 120 appointment slots in Fiscal Year</td>
<td></td>
</tr>
</tbody>
</table>
Access Across Bon Secours Virginia

HealthCare Outside the Walls as well as Traditional Bricks & Mortar
Realizing the Value of Annual Wellness Visits
DOGBERT CONSULTS

YOU NEED A DASHBOARD APPLICATION TO TRACK YOUR KEY METRICS.

THAT WAY YOU'LL HAVE MORE DATA TO IGNORE WHEN YOU MAKE YOUR DECISIONS BASED ON COMPANY POLITICS.

WILL THE DATA BE ACCURATE?

OKAY, LET'S PRETEND THAT MATTERS.
Annual Wellness Visits: An Important Tool for Clinical Transformation

With its impact on **care coordination, safety and reliability**, and **engagement and loyalty**, the Annual Wellness Visit (AWV) is well situated to help facilitate Clinical Transformation.
Safety & Reliability: Closing the Gap

<table>
<thead>
<tr>
<th></th>
<th>No AWV - % Met</th>
<th>AWV - % Met</th>
<th>CMS ACO Benchmark</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast Cancer Screening</td>
<td>60.6%</td>
<td>88.7%</td>
<td>90%</td>
</tr>
<tr>
<td>Colorectal Cancer Screening</td>
<td>32.8%</td>
<td>67.2%</td>
<td>90%</td>
</tr>
<tr>
<td>Pneumonia Vaccination Status for Older Adults</td>
<td>53.6%</td>
<td>84.5%</td>
<td>90%</td>
</tr>
<tr>
<td>Influenza Immunization</td>
<td>92.0%*</td>
<td>96.9%*</td>
<td>90%</td>
</tr>
</tbody>
</table>

Two-Fold Opportunity:
Improve rates of AWVs completed
Achieve elite performance through post-AWV LPOC

*Influenza immunization rate includes patient declinations. Actual number immunized pending.

Time Frame: Calendar Year 2015; Data Source: Meaningful Use Quality Measures - ConnectCare
The AWV is core to our strategies for achieving clinical excellence.
# AWVs – Patients Seen

**Medicare IPPE/AWS FY2016 YTD Monthly Report**

<table>
<thead>
<tr>
<th>Metric</th>
<th>January 16 YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hampton Roads: Pts with IPPE/AWS/Medicare Pts Seen</td>
<td>63.19%</td>
</tr>
<tr>
<td>Richmond: Pts with IPPE/AWS/Medicare Pts Seen</td>
<td>45.97%</td>
</tr>
<tr>
<td>BSV Rollup: Pts with IPPE/AWS/Medicare Pts Seen</td>
<td>51.26%</td>
</tr>
</tbody>
</table>

Source: COCOA (ConnectCare)
CY2014 Results

MEDIATION RECONCILIATION

Hampton Roads  Richmond

30th Percentile
50th Percentile
90th Percentile

0.00%
10.00%
20.00%
30.00%
40.00%
50.00%
60.00%
70.00%
80.00%
90.00%
100.00%
CY2014 Results

FALLS: SCREENING FOR FALL RISK

- Hampton Roads: 73.38%
- Richmond: 27.86%
- 50th Percentile: 17.12%

Good Help to Those in Need®
CY2014 Results

DEPRESSION SCREENING

- 30th Percentile
- 50th Percentile
- 90th Percentile

Hampton Roads  Richmond

51.81%
16.84%
5.31%
CY2014 Results

DIABETES BUNDLE-ALL OR NONE

- 30th Percentile
- 50th Percentile
- 90th Percentile

Hampton Roads  Richmond

- 36.50%
- 23.48%
- 17.39%
## ACO Quality Metric Performance

<table>
<thead>
<tr>
<th>ACO Quality Metric</th>
<th>Hampton Roads</th>
<th>Richmond</th>
</tr>
</thead>
<tbody>
<tr>
<td>Falls Screening</td>
<td>2.00</td>
<td>2.00</td>
</tr>
<tr>
<td>Influenza Immunization</td>
<td>1.70</td>
<td>1.85</td>
</tr>
<tr>
<td>Pneumococcal Vaccination</td>
<td>1.70</td>
<td>1.85</td>
</tr>
<tr>
<td>BMI Screening/Follow-Up</td>
<td>1.55</td>
<td>1.70</td>
</tr>
<tr>
<td>Tobacco Use/Cessation</td>
<td>1.85</td>
<td>1.85</td>
</tr>
<tr>
<td>Depression Screening</td>
<td>2.00</td>
<td>2.00</td>
</tr>
<tr>
<td>Colorectal Cancer Screening</td>
<td>1.55</td>
<td>1.55</td>
</tr>
<tr>
<td>Mammography Screening</td>
<td>1.70</td>
<td>1.70</td>
</tr>
<tr>
<td>Blood Pressure Screening</td>
<td>1.85</td>
<td>1.85</td>
</tr>
<tr>
<td>Hypertension, BP Control</td>
<td>1.55</td>
<td>1.25</td>
</tr>
<tr>
<td>IVD - Aspirin Use</td>
<td>1.85</td>
<td>1.85</td>
</tr>
<tr>
<td>HF - Beta Blocker for LVSD</td>
<td>2.00</td>
<td>2.00</td>
</tr>
<tr>
<td>ACE/ARB for CAD and Diabetes and/or LVSD</td>
<td>1.55</td>
<td>1.55</td>
</tr>
<tr>
<td><strong>Possible Points</strong></td>
<td><strong>26</strong></td>
<td><strong>26</strong></td>
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<tr>
<td><strong>Points Achieved</strong></td>
<td><strong>22.85</strong></td>
<td><strong>23.00</strong></td>
</tr>
<tr>
<td><strong>% of Points Achieved</strong></td>
<td><strong>88%</strong></td>
<td><strong>88%</strong></td>
</tr>
</tbody>
</table>
Want to stop this from happening?

Take Action!

Replay the movie?
Financial ROI

Billable Events

- Annual Wellness Visits
- Transitions of Care
- Chronic Care Management
- Advance Care Planning
- Depression Screening
- Tobacco Cessation

Quality

- Quality Incentive Bonus
- Shared Savings
- Risk Adjustment
Questions?