Bon Secours Medical Group Virginia

Comprehensive Coordinated Care

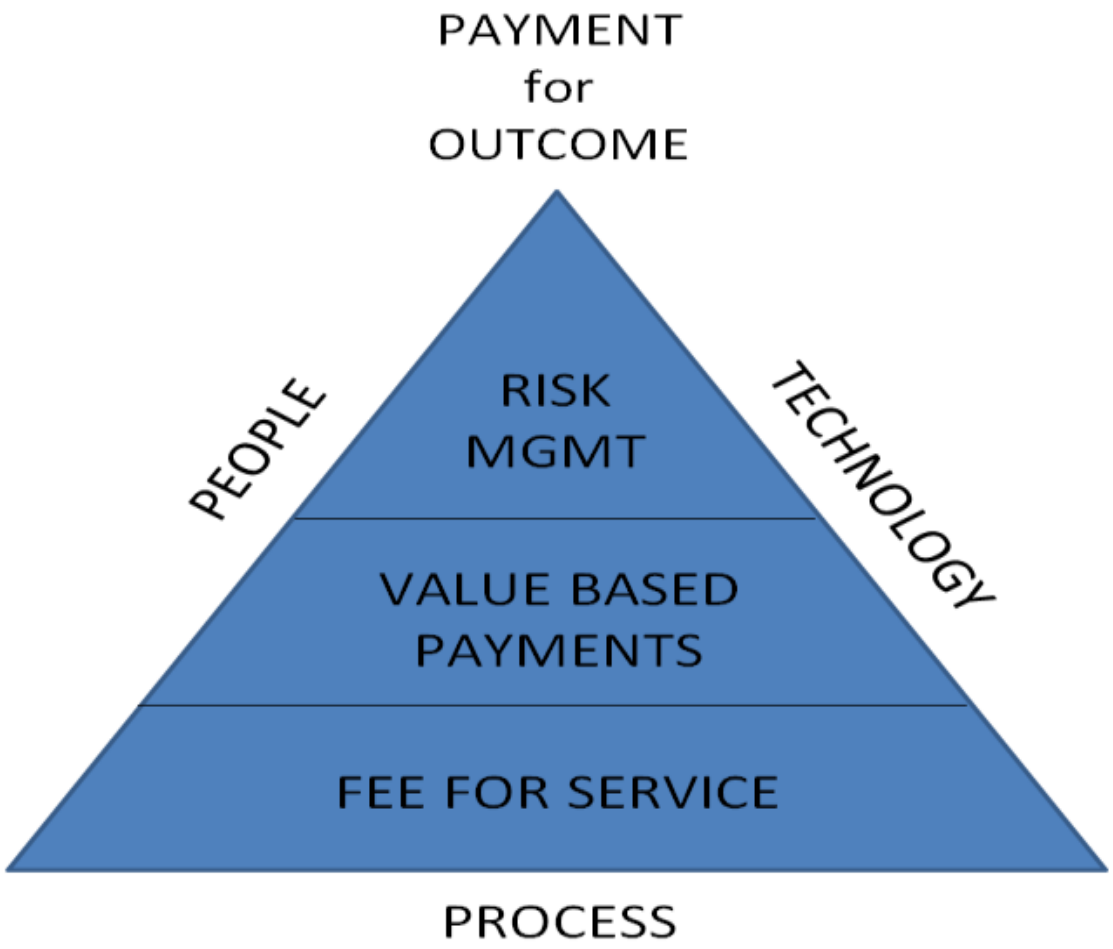
The Three Cs in Succcess!

BSVMG Journey

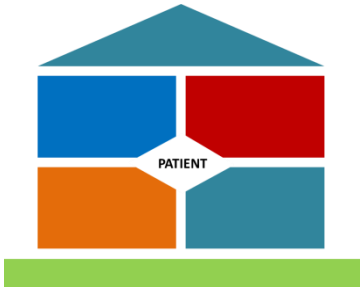
- **Electrify** – Connect Care
- **Grow** – Strategically
- **Re-engineer** – PCMH
- **Connect** – My Chart
- **Coordinate** – Nurse Navigation
- **Proactive** – Registries
- **Clinical Innovation** – Hi Tech and Hi Touch
- **Medical Group Culture** – Synchronization
- **Advanced Payment Models** – ACOs
- **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



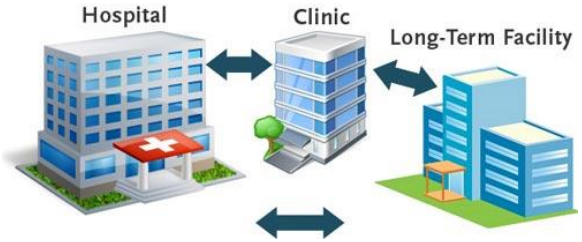
Population Health Strategies



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

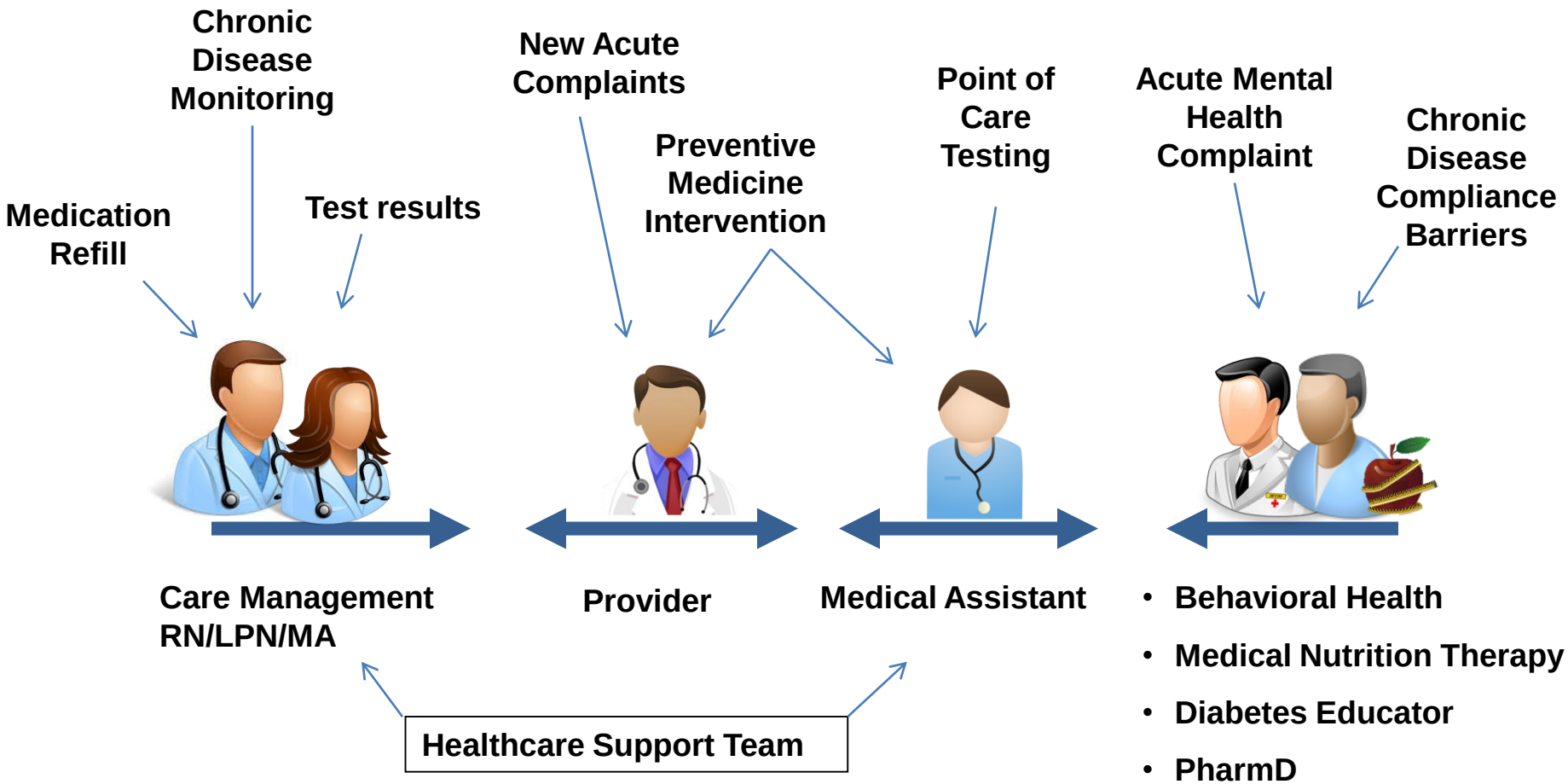
Not Enough Time in Physician's Day to Provide Comprehensive, Coordinated Care

Medical Home Goals:	Comprehensive Chronic and Preventive Care	Patient Engagement	Enhanced Access	Coordinated Care
				
New Time-Consuming Tasks:	• Disease registry data entry, maintenance, monitoring • Increased patient outreach, phone contact • Increased results reporting	• Time-intensive patient education • Motivational interviewing • Self-management follow-up • Group visits	• Same-day scheduling • Expanded evening, weekend office hours • Increased patient phone, e-mail access	• Increased communication with other providers and specialists • More thorough documentation • Increased patient follow-up

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



Patient Centered Medical Home Practices - 35 NCQA Level 3

Current Status

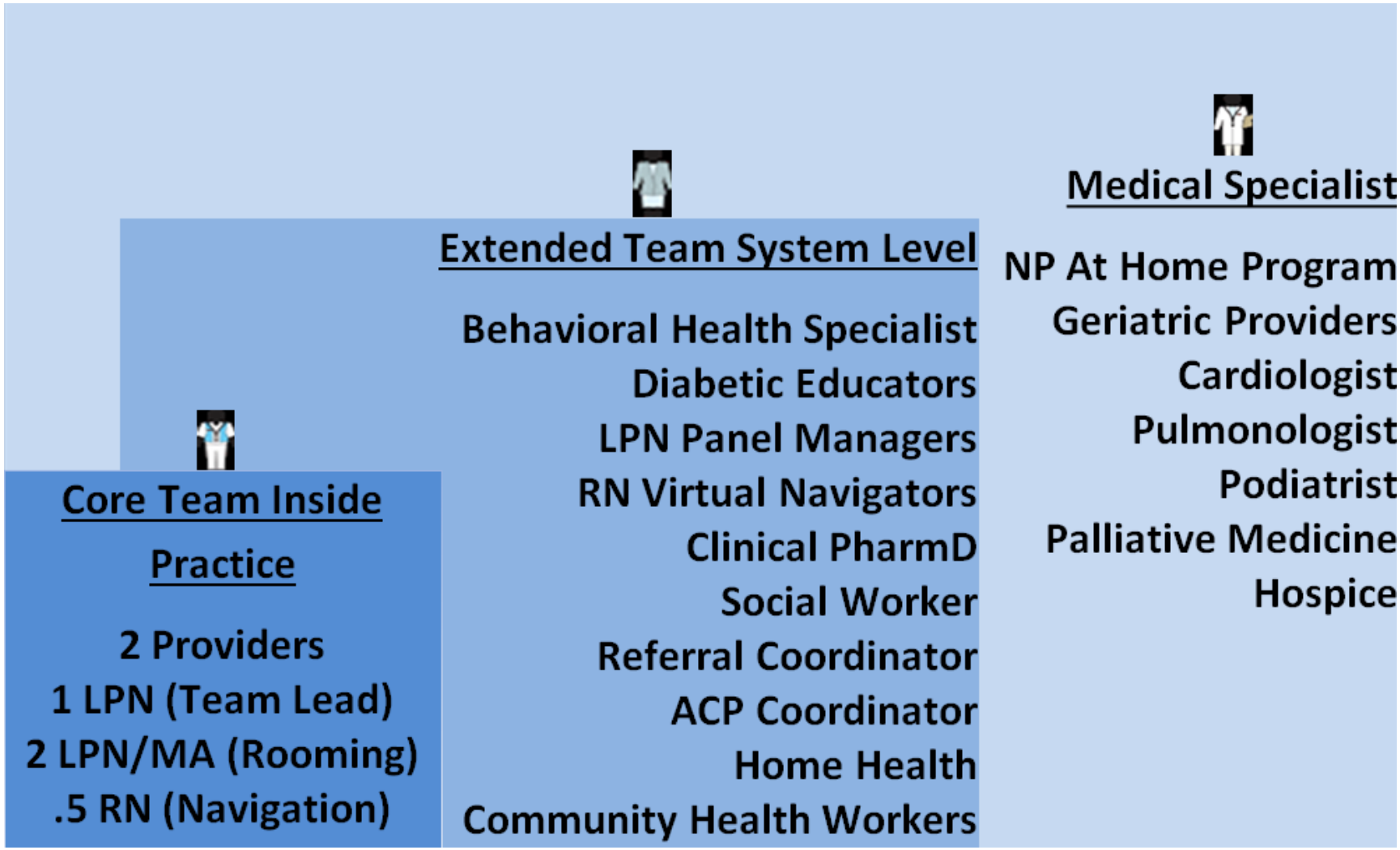
- 35 Sites NCQA Level 3
- 156 Providers

In Progress

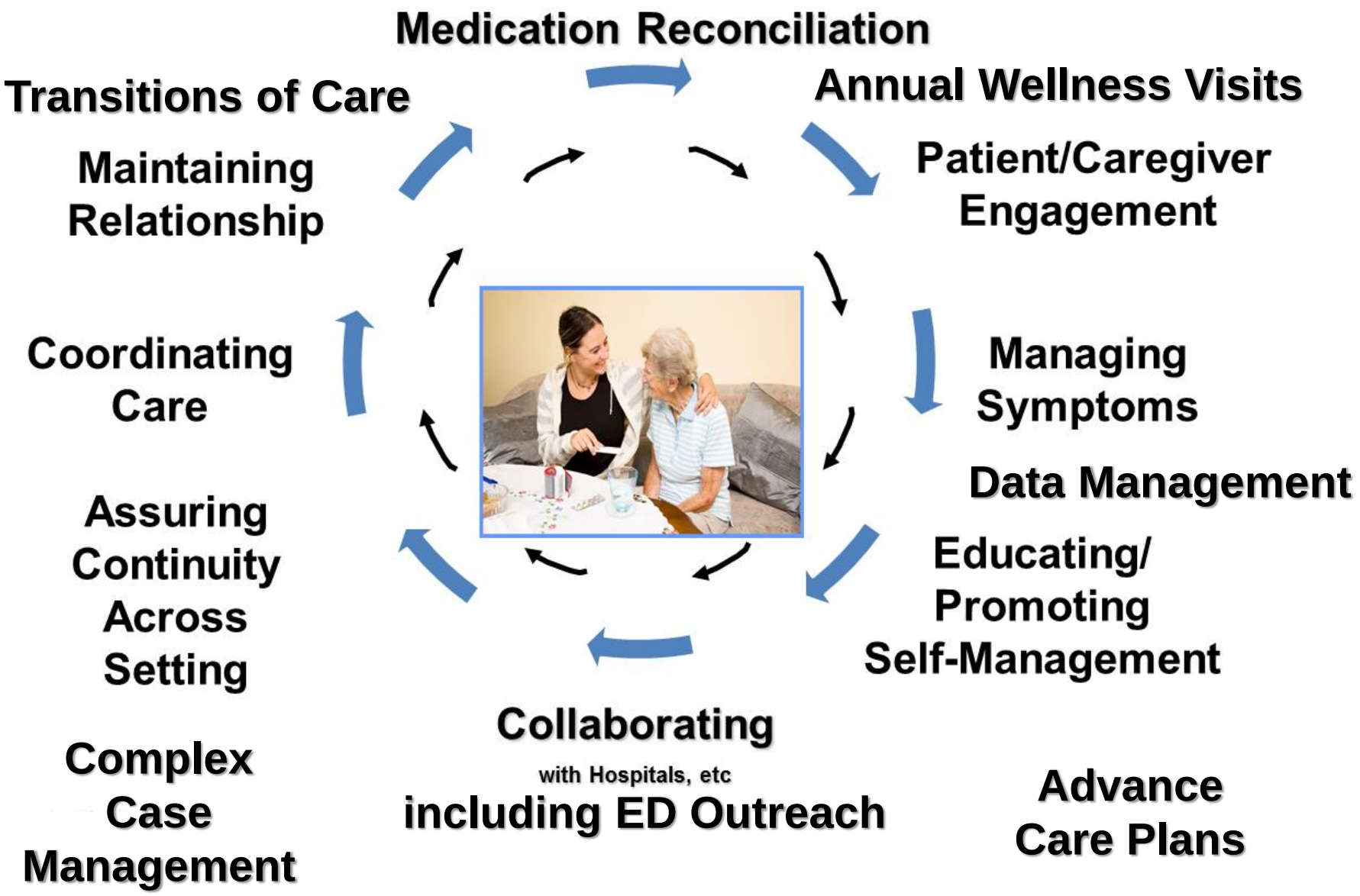
- Developmental & Special Needs Pediatrics
  - 3 Providers
- Pediatric Endocrine and Diabetes Associates
  - 3 Provider
- Pediatric Gastroenterology Associates
  - 3 Providers
- Pediatric Hematology-Oncology
  - 2 Providers
- Pediatric Neurology Clinic
  - 1 Provider
- Pediatric Lung Care
  - 4 Providers
- 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**

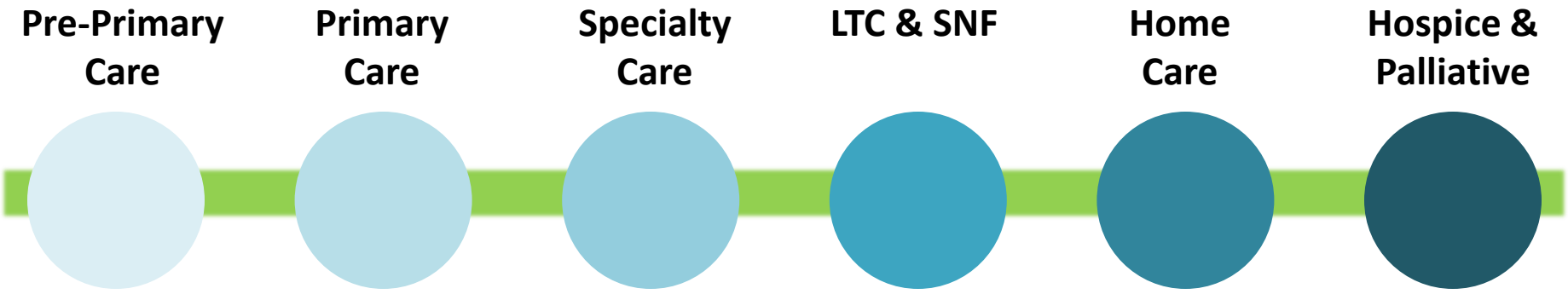
Expansion of Primary Care Medical Home Team



Nurse Navigator Model



Change Throughout the Continuum



The Patient is the most underutilized resource in healthcare

Embedded Care Navigators and Central Care Navigators

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

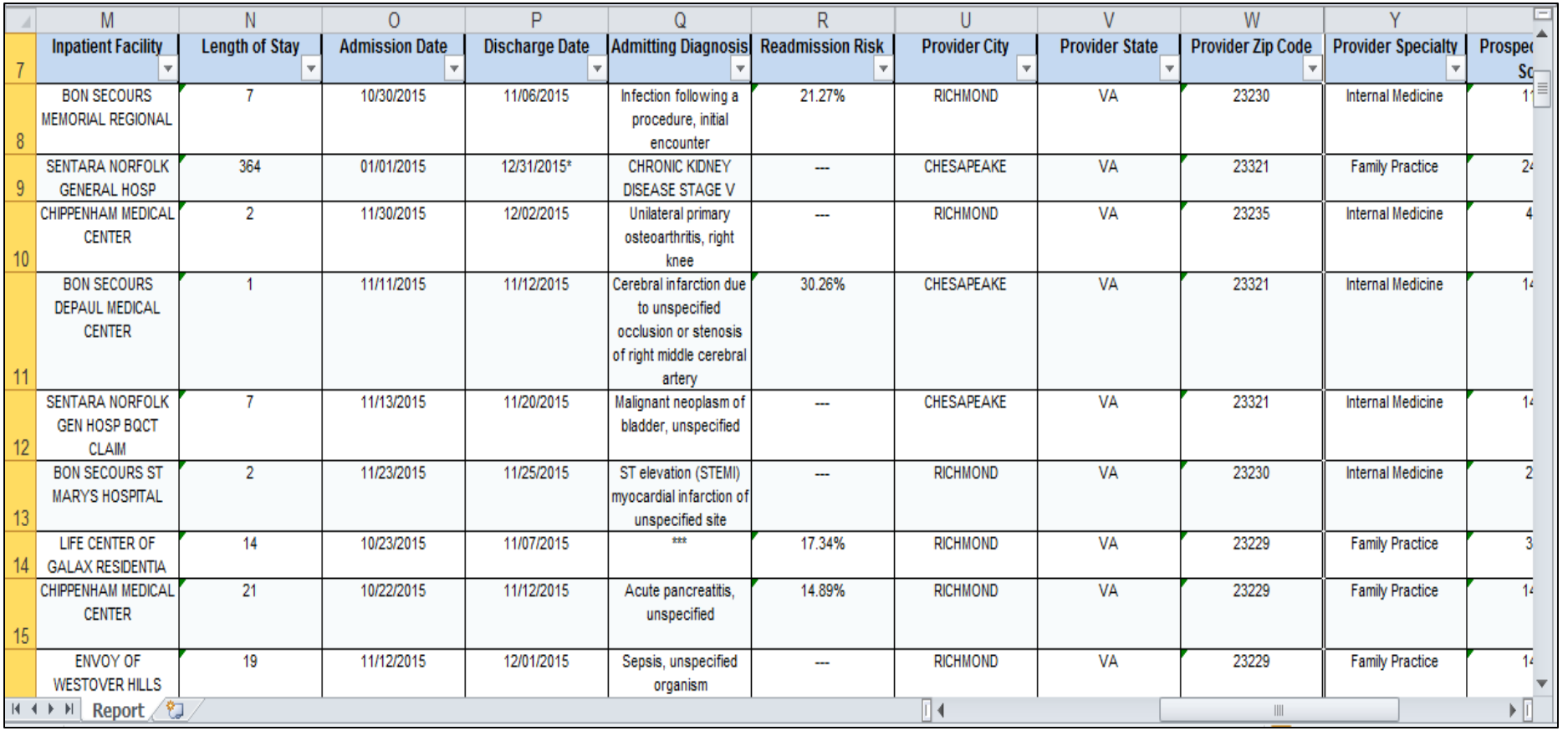
Clinical Skills and Ongoing Development

- 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?

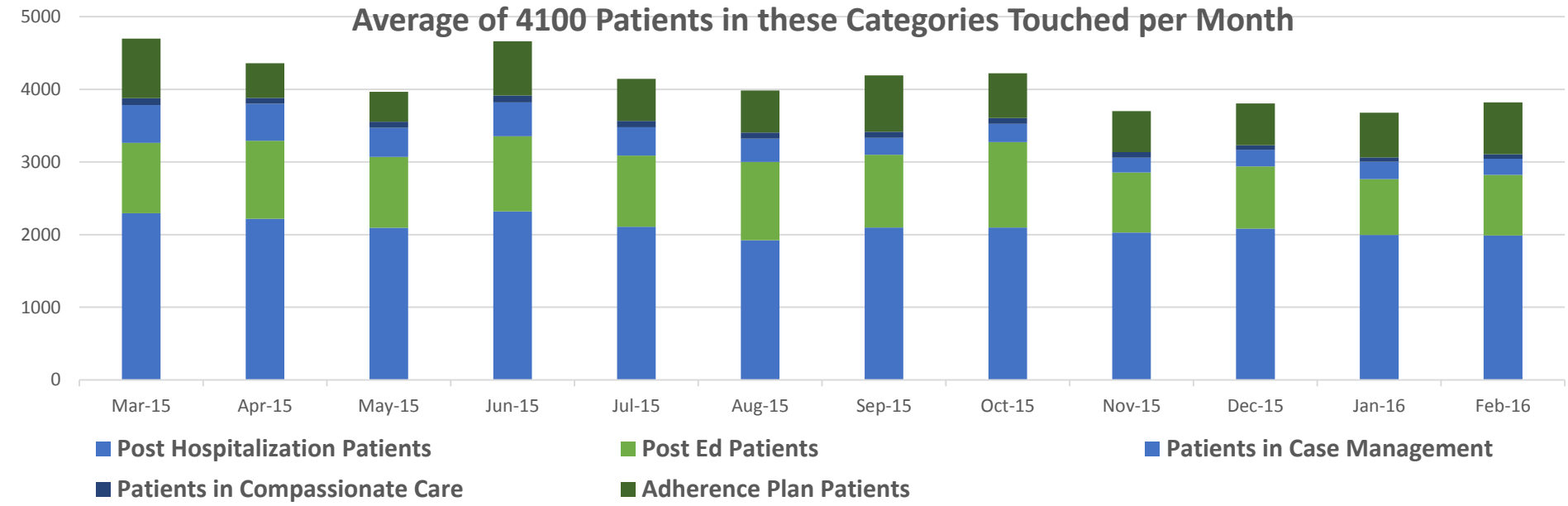


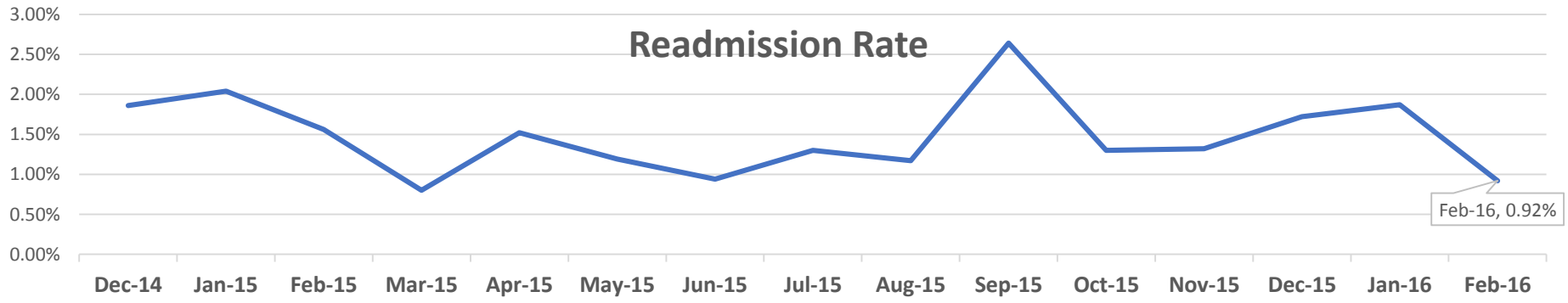
	M	N	O	P	Q	R	U	V	W	Y	
7	Inpatient Facility	Length of Stay	Admission Date	Discharge Date	Admitting Diagnosis	Readmission Risk	Provider City	Provider State	Provider Zip Code	Provider Specialty	Prospe Sc
8	BON SECOURS MEMORIAL REGIONAL	7	10/30/2015	11/06/2015	Infection following a procedure, initial encounter	21.27%	RICHMOND	VA	23230	Internal Medicine	1
9	SENTARA NORFOLK GENERAL HOSP	364	01/01/2015	12/31/2015*	CHRONIC KIDNEY DISEASE STAGE V	---	CHESAPEAKE	VA	23321	Family Practice	2
10	CHIPPENHAM MEDICAL CENTER	2	11/30/2015	12/02/2015	Unilateral primary osteoarthritis, right knee	---	RICHMOND	VA	23235	Internal Medicine	4
11	BON SECOURS DEPAUL MEDICAL CENTER	1	11/11/2015	11/12/2015	Cerebral infarction due to unspecified occlusion or stenosis of right middle cerebral artery	30.26%	CHESAPEAKE	VA	23321	Internal Medicine	1
12	SENTARA NORFOLK GEN HOSP BQCT CLAIM	7	11/13/2015	11/20/2015	Malignant neoplasm of bladder, unspecified	---	CHESAPEAKE	VA	23321	Internal Medicine	1
13	BON SECOURS ST MARYS HOSPITAL	2	11/23/2015	11/25/2015	ST elevation (STEMI) myocardial infarction of unspecified site	---	RICHMOND	VA	23230	Internal Medicine	2
14	LIFE CENTER OF GALAX RESIDENTIA	14	10/23/2015	11/07/2015	***	17.34%	RICHMOND	VA	23229	Family Practice	3
15	CHIPPENHAM MEDICAL CENTER	21	10/22/2015	11/12/2015	Acute pancreatitis, unspecified	14.89%	RICHMOND	VA	23229	Family Practice	1
	ENVOY OF WESTOVER HILLS	19	11/12/2015	12/01/2015	Sepsis, unspecified organism	---	RICHMOND	VA	23229	Family Practice	1

Report

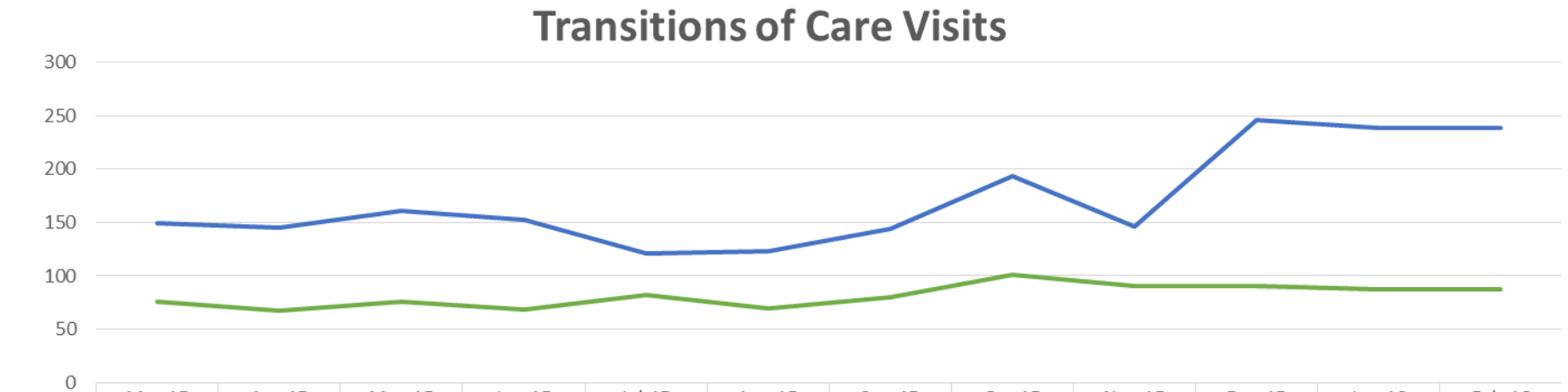
Example: Discharge Summary

NN Managed Patients

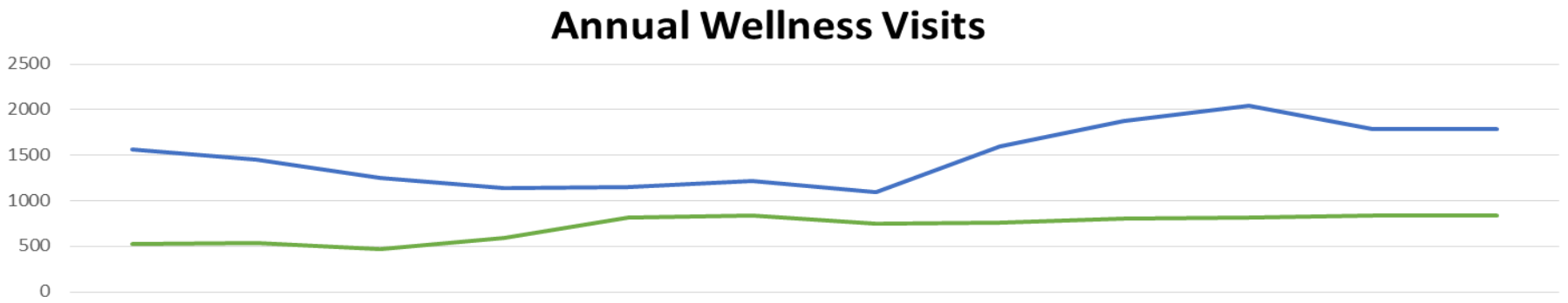




Transitions of Care & Annual Wellness Visits



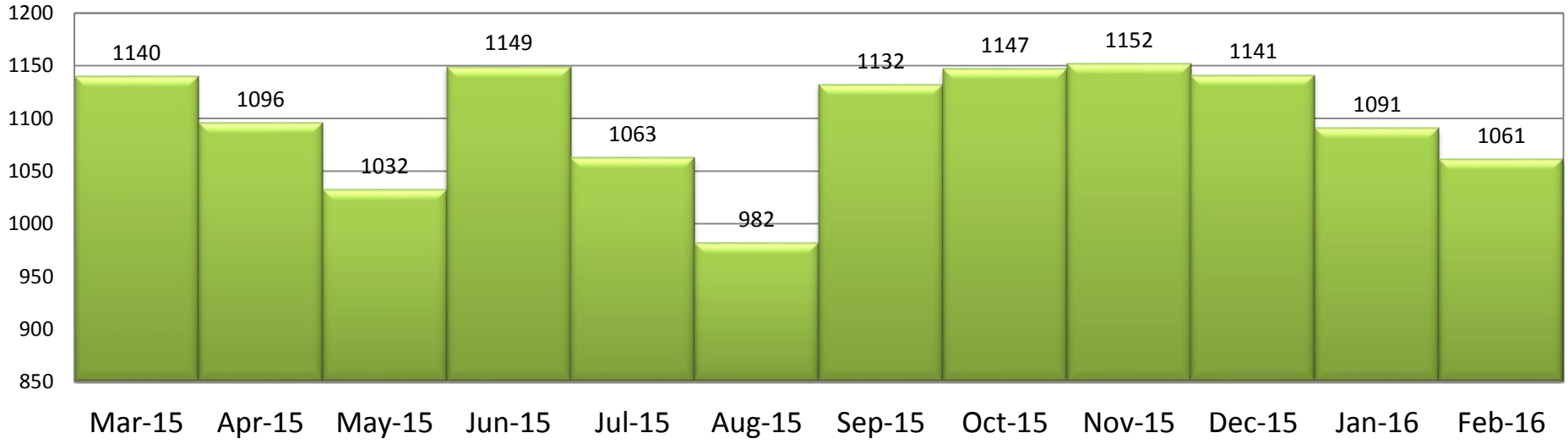
	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16
HR	76	67	76	68	82	70	80	101	90	90	87	87
RIC	149	145	161	152	121	123	144	193	146	246	239	239



	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16
HR	530	533	468	597	813	842	753	763	811	819	838	838
RIC	1561	1454	1256	1140	1153	1214	1100	1592	1873	2039	1785	1785

Office Visits Scheduled After Hospital Discharge

13,186 Visits



Payment Model For Nurse Navigator

Direct:

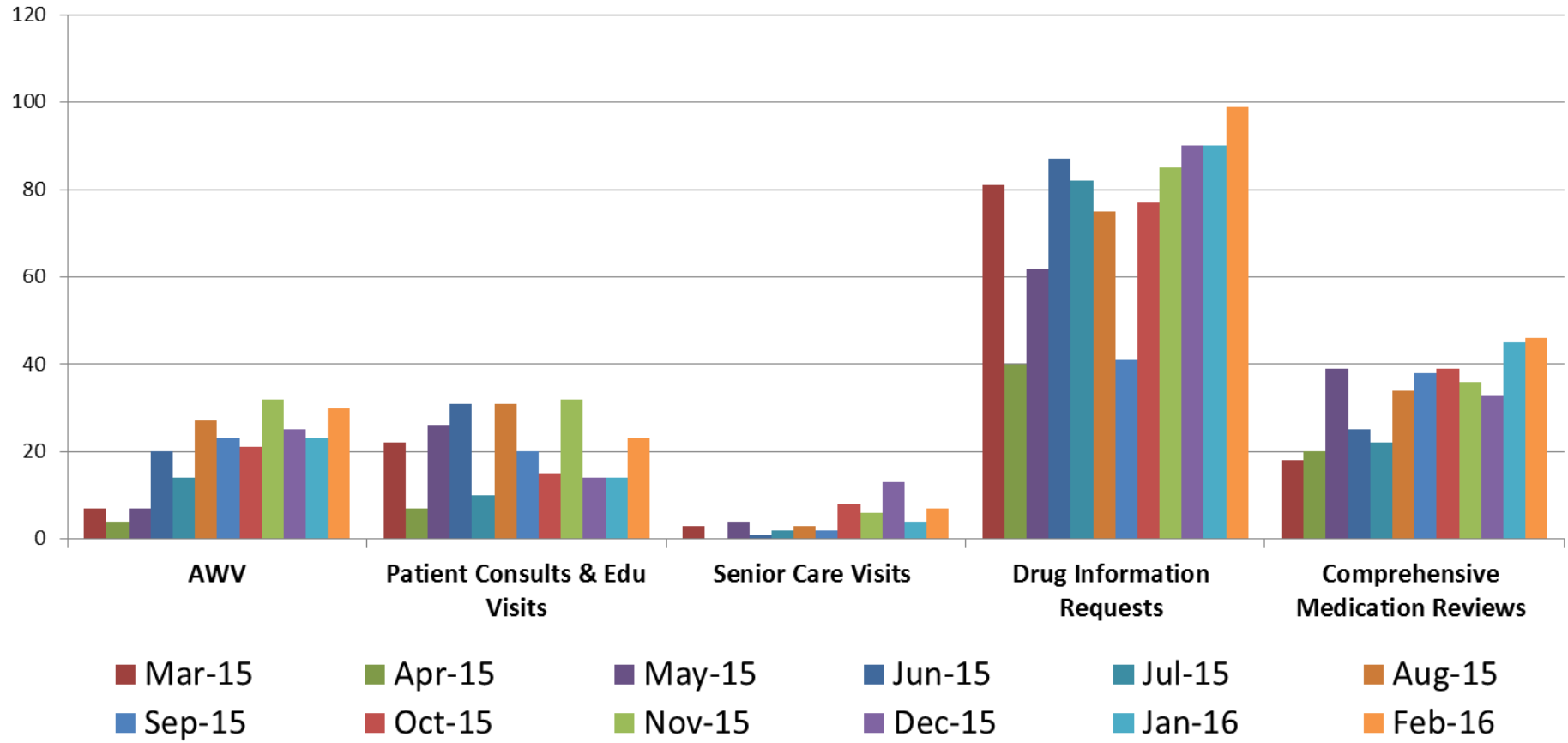
- Chronic Care Management (CPT code 99490)
- Transitions of Care (CPT 99495 and 99496)
- Medicare Wellness Visit (CPT GO438 and GO439)
- Advance Care Planning Coding (CPT 99497 and 99498)
- Pay for Performance PMPM- Coventry, Anthem, Cigna, Humana, Virginia Premiere
- PAF Forms ($125. form –completed)

Indirect:

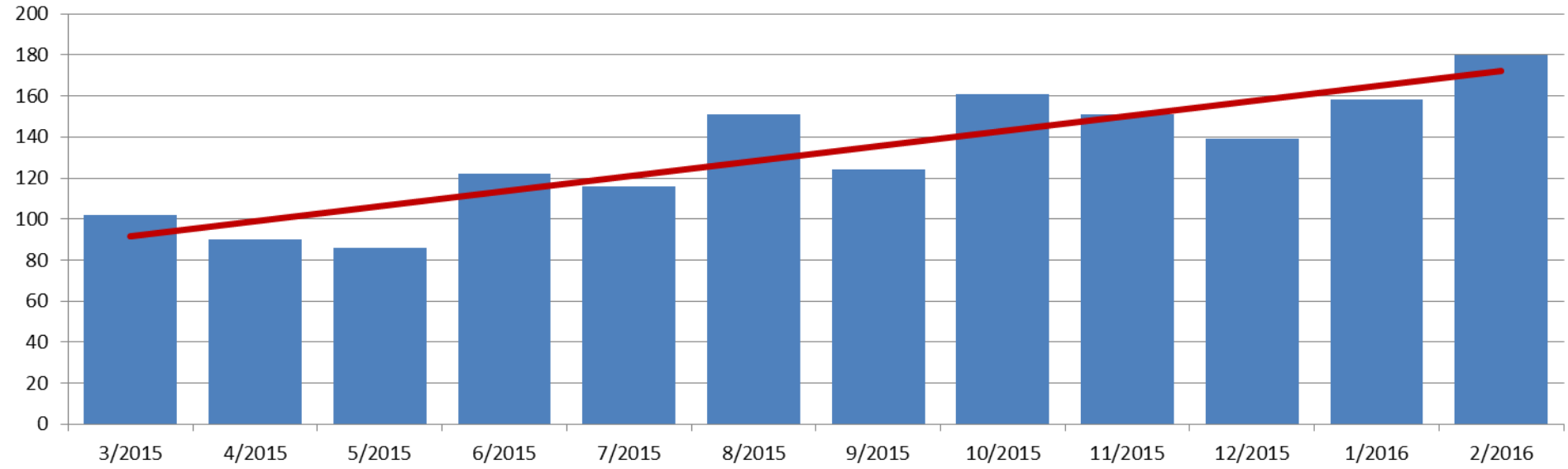
- Avoidable Readmission
- Patient/ Physician Engagement
- Reduction of ED Utilization
- Referrals

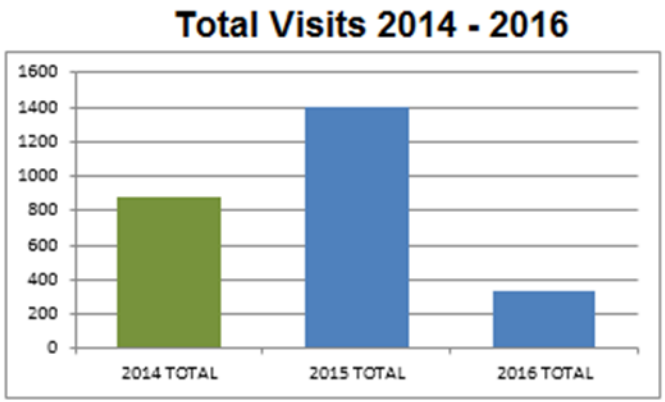
PharmD Contribution-Volume

1835 Patient Visits & Consults–Mar-15 to Feb-16



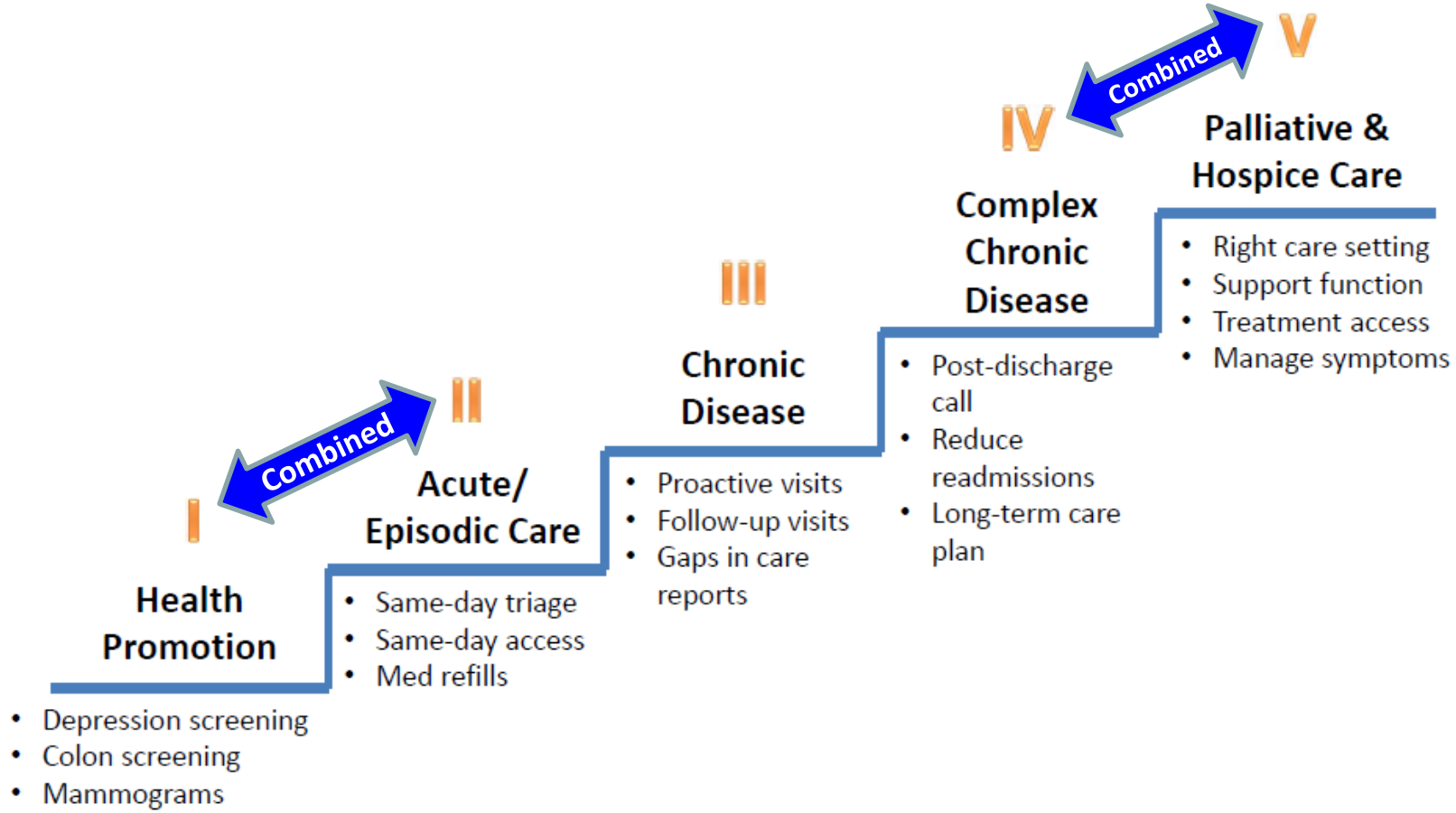
RD Contribution-Volume
1580 Patient Visits – Mar-15 to Feb-16





BSVMG's Three Committees Structure Smart Care Teams

All Three BSVMG Committees are Active



FY16 PCQIP Program Overview

Incentive Goal	*Specific Criteria and Weight*	*Maximum Incentive*
First Filter	BSVMG PC Provider Volumes ≥ Individual Volume Budget	**Eligible for Incentive**
Meaningful Use	Provider meets and maintains Meaningful Use for Calendar Year – MU Stage 1 or MU Stage 2 (100% weight)	**20%**
Patient Satisfaction and Citizenship (replaces current patient satisfaction bonus incentive, if any)	Provider's patient satisfaction scores meet threshold set by BSVMG (50% weight) Provider meets three BSVMG Meeting Attendance Criteria (25% weight) Provider satisfactorily completes required training, conflict of interest education, Self Assessments / Year End Reviews and Coding Compliance (25% weight)	**30%**
Quality	Provider meets specific quality measures as set by BSVMG (100% weight)	**50%**
MAXIMUM TOTAL FISCAL YEAR 2016		**100%** **$30,000 per PCP** **$21,000 per ACP**

PQCIP-Twelve Quality Measures

Measure Description (measured on Fiscal Year basis)*	Threshold
1. Percentage of Provider's attributed patients , with Diabetes, with Hemoglobin A1c of < 8% (NQF 0575)	≥ 80%
2. Percentage of Provider's attributed patients , with Diabetes, with Low Density Lipoprotein of < 100 mg/dL (NQF 0064)	≥ 70%
3. Percentage of Provider's attributed Medicare patients seen in the last 12 months who have received an Annual Wellness Visit	≥ 50%
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)	≥ 60%
5. Percentage of drugs dispensed to Provider's attributed patients that are generics	≥ 90%
6. Percentage of Provider's attributed patients, age 50 to 75, who had appropriate screening for colorectal cancer (NQF 0034)	≥ 59%
7. Percentage of Provider's attributed female patients, age 50 to 74, who have had a mammogram within 24 months. (NQF 0031)	≥ 73%
8. Percentage of Provider's attributed patients, age 18 to 75, with Diabetes, who had hemoglobin A1c > 9.0% (NQF 0059)	< 10%
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)	≥ 94%
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)	≥ 95%
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)	≥ 10%
12. Access Measure: Provider opens schedule for patient appointment slots outside of normal business hours (Monday-Friday, 8:00am – 5:00pm).	≥ 120 appointment slots in Fiscal Year

Access Across Bon Secours Virginia

OpenNotes® Inviting patients to read their health care notes

24/7

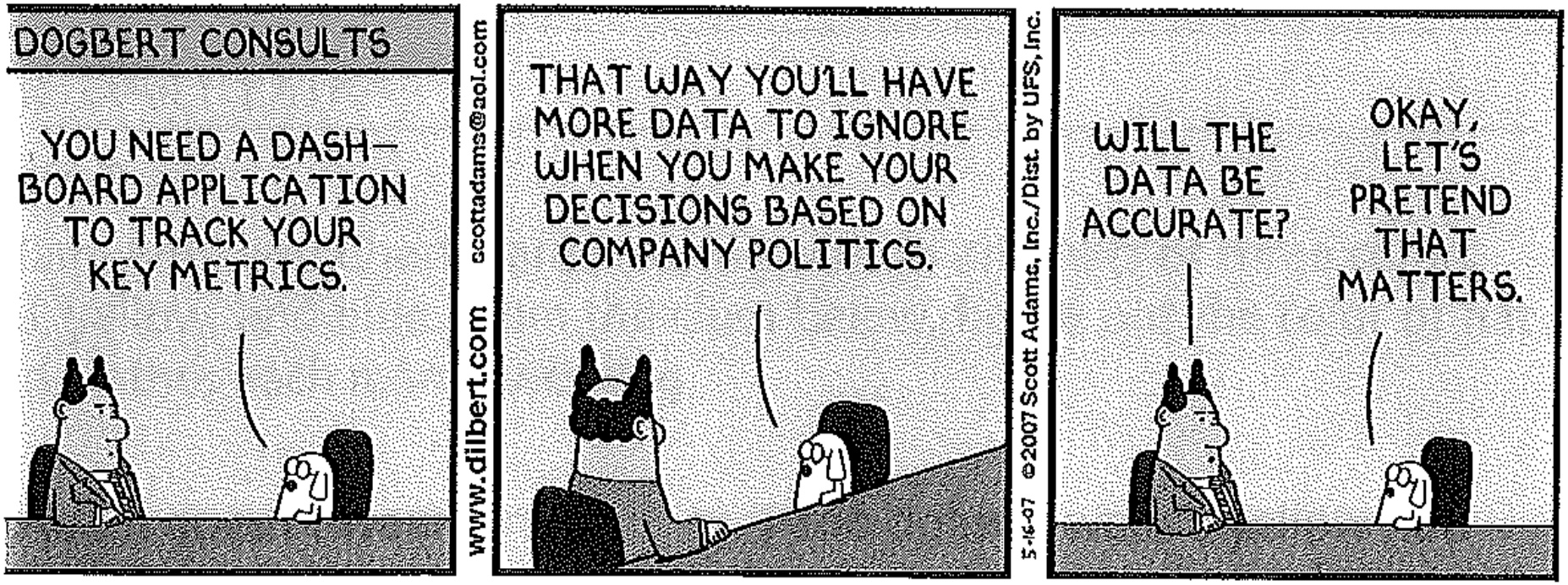
MyChart
Your secure online health connection

HealthCare Outside the Walls
as well as Traditional Bricks & Mortar

good health express
BON SECOURS
right time • right place • right care

BON SECOURS HEALTH SYSTEM
FAST CARE

Realizing the Value of Annual Wellness Visits


DOGBERT CONSULTS
YOU NEED A DASH-BOARD APPLICATION TO TRACK YOUR KEY METRICS.
www.dilbert.com
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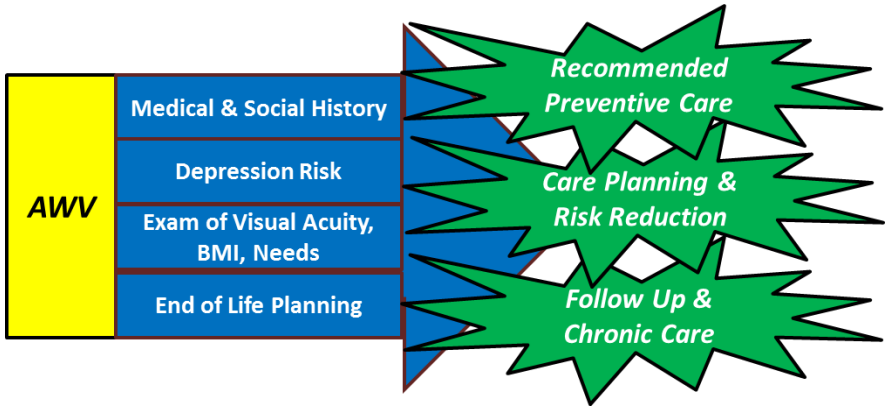
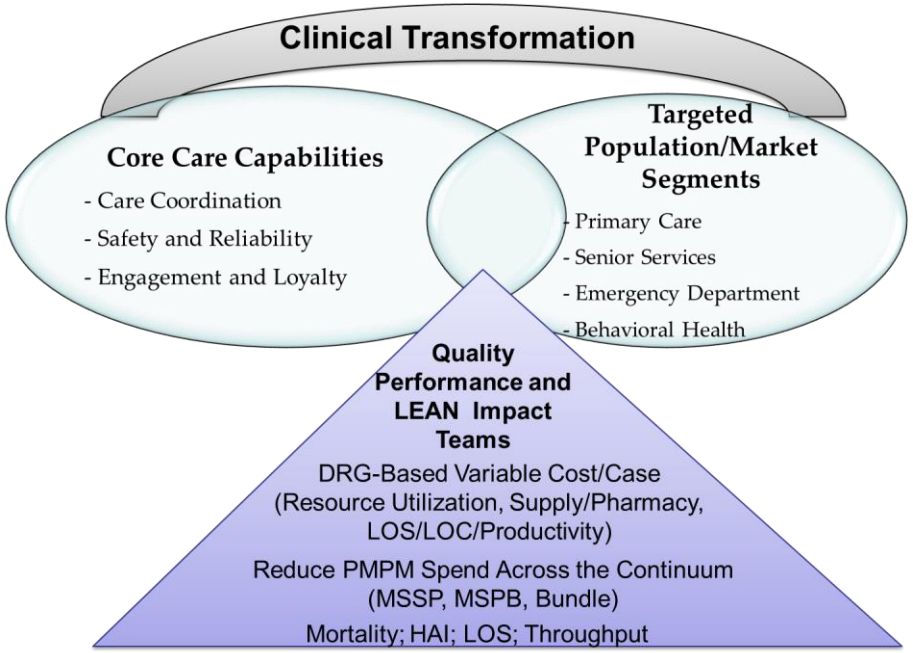
THAT WAY YOU'LL HAVE MORE DATA TO IGNORE WHEN YOU MAKE YOUR DECISIONS BASED ON COMPANY POLITICS.
5-16-07 ©2007 Scott Adams, Inc./Dist. by UFS, Inc.
WILL THE DATA BE ACCURATE?
OKAY, LET'S PRETEND THAT MATTERS.

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

	No AWV - % Met	AWV - % Met	CMS ACO Benchmark
Breast Cancer Screening	60.6%	88.7%	90%
Colorectal Cancer Screening	32.8%	67.2%	90%
Pneumonia Vaccination Status for Older Adults	53.6%	84.5%	90%
Influenza Immunization	92.0%*	96.9%*	90%

Increase AWVs → **Longitudinal Plan of Care**

Two-Fold Opportunity:

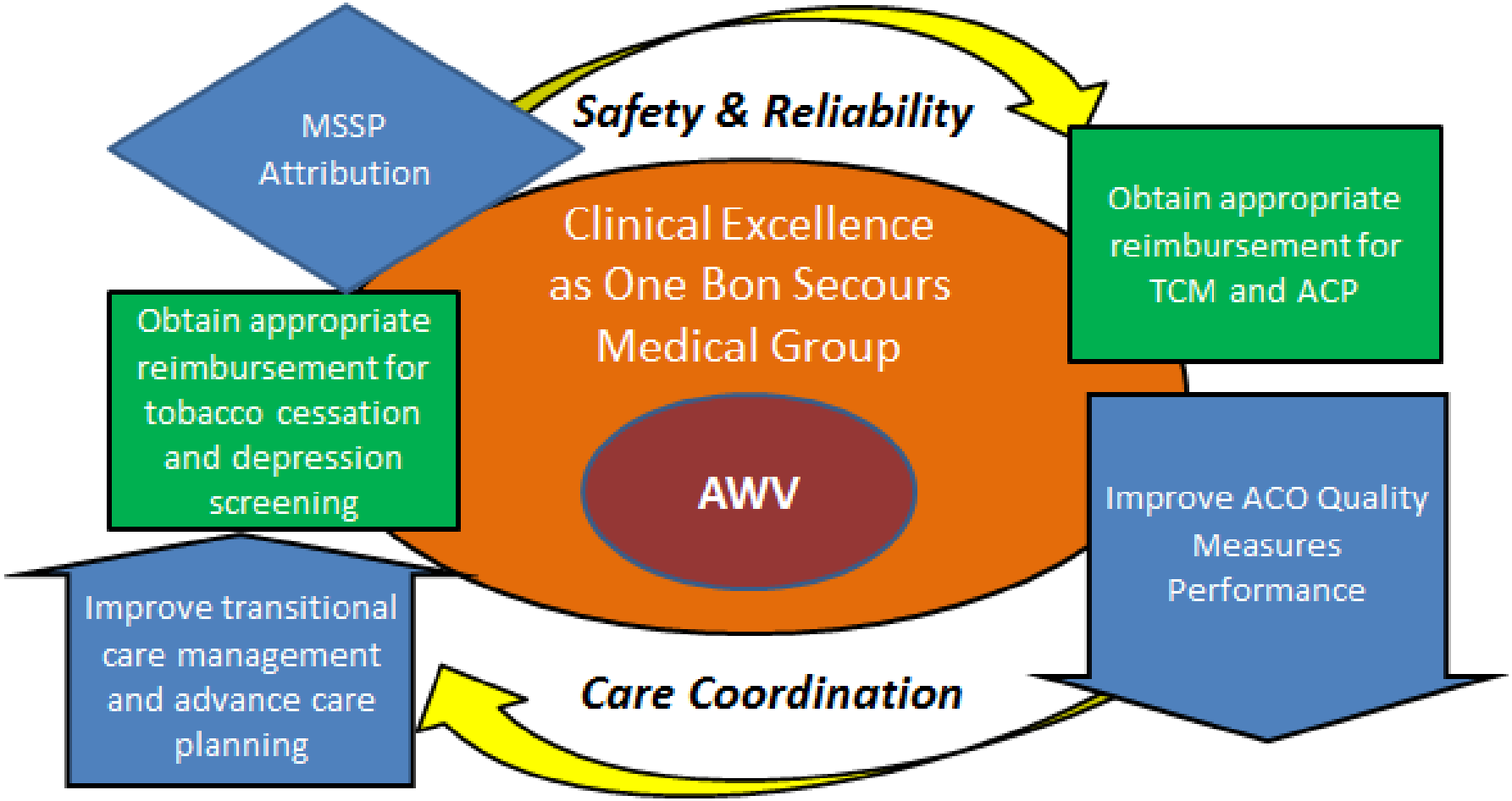
Improve rates of AWVs completed

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

Strategies & Tactics



The AWV is core to our strategies for achieving clinical excellence.

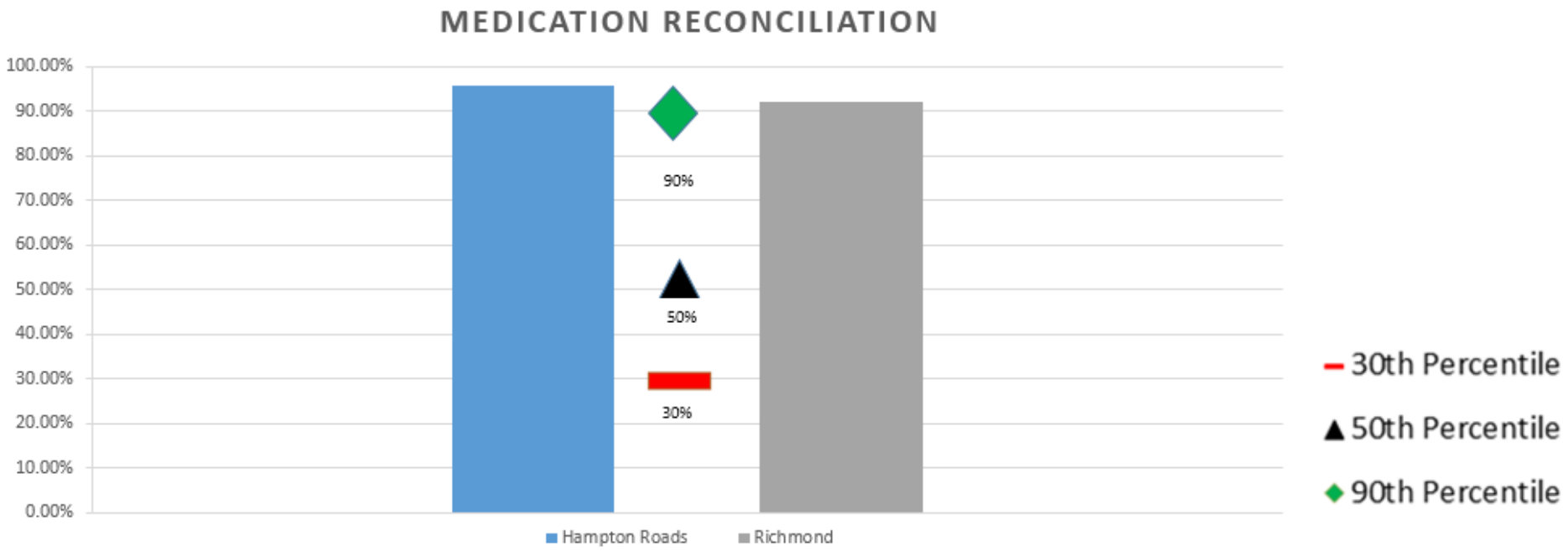
AWVs – Patients Seen

Medicare IPPE/AWS
FY2016 YTD
Monthly Report

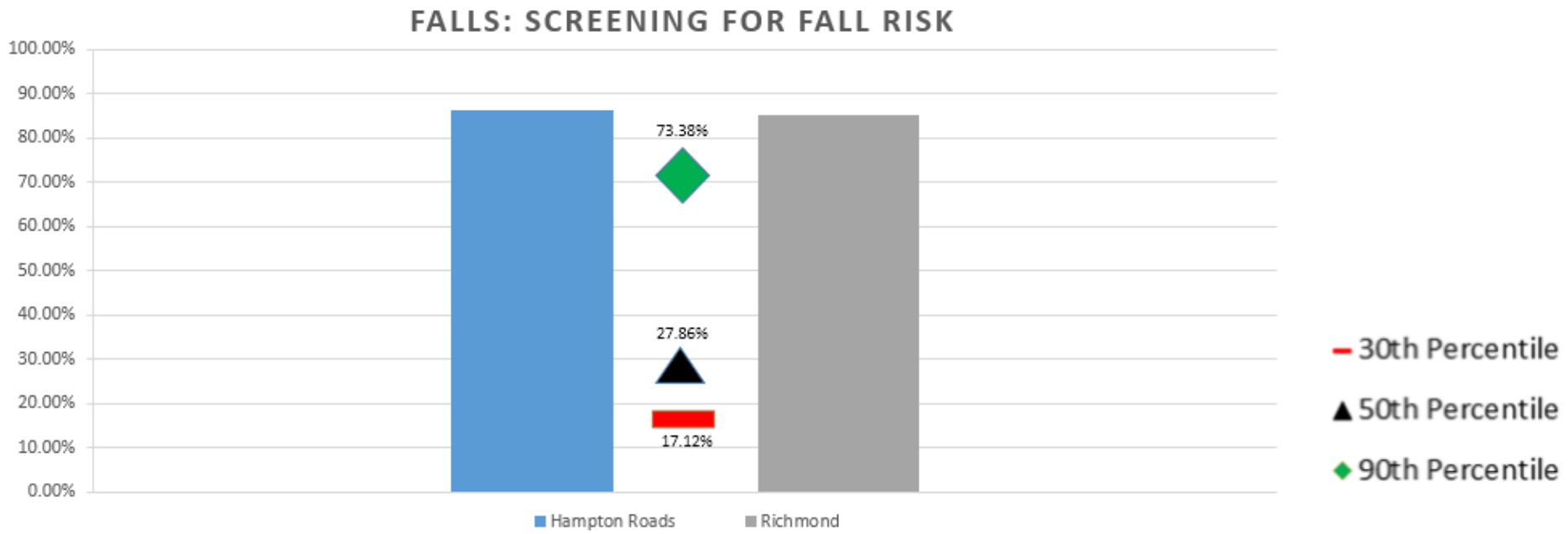
Metric	January 16 YTD
Hampton Roads: Pts with IPPE/AWS/Medicare Pts Seen	63.19%
Richmond: Pts with IPPE/AWS/Medicare Pts Seen	45.97%
BSV Rollup: Pts with IPPE/AWS/Medicare Pts Seen	51.26%

Source: COCOA (ConnectCare)

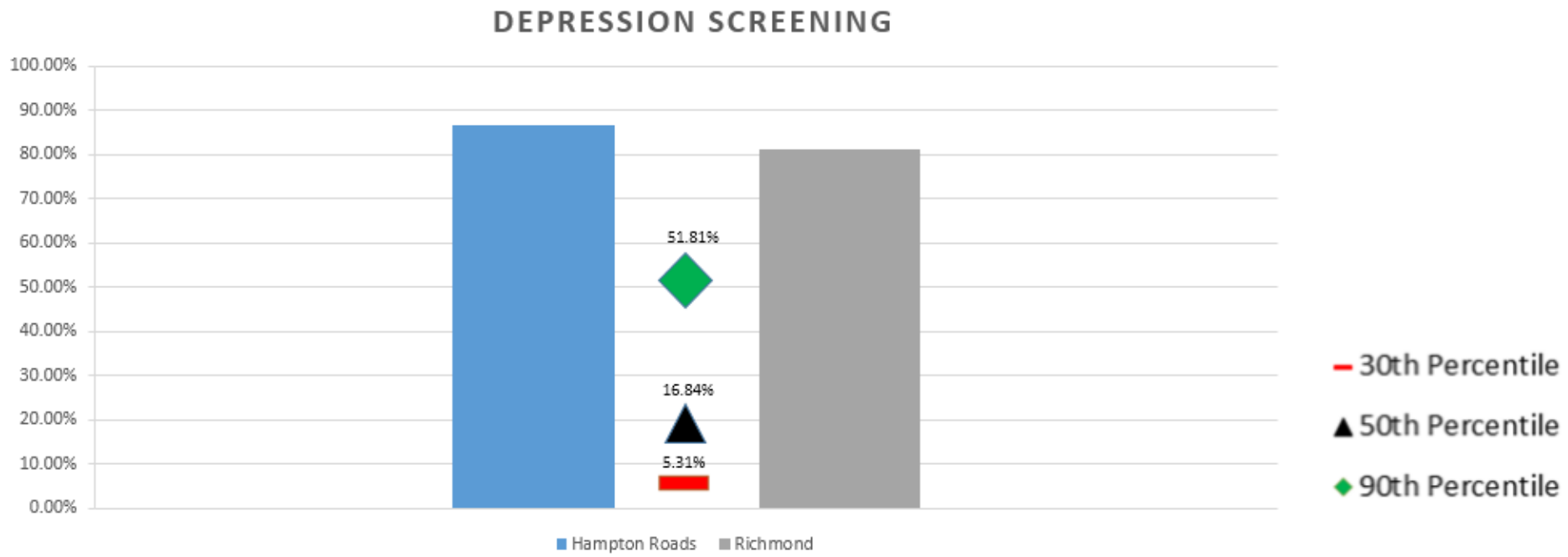
CY2014 Results



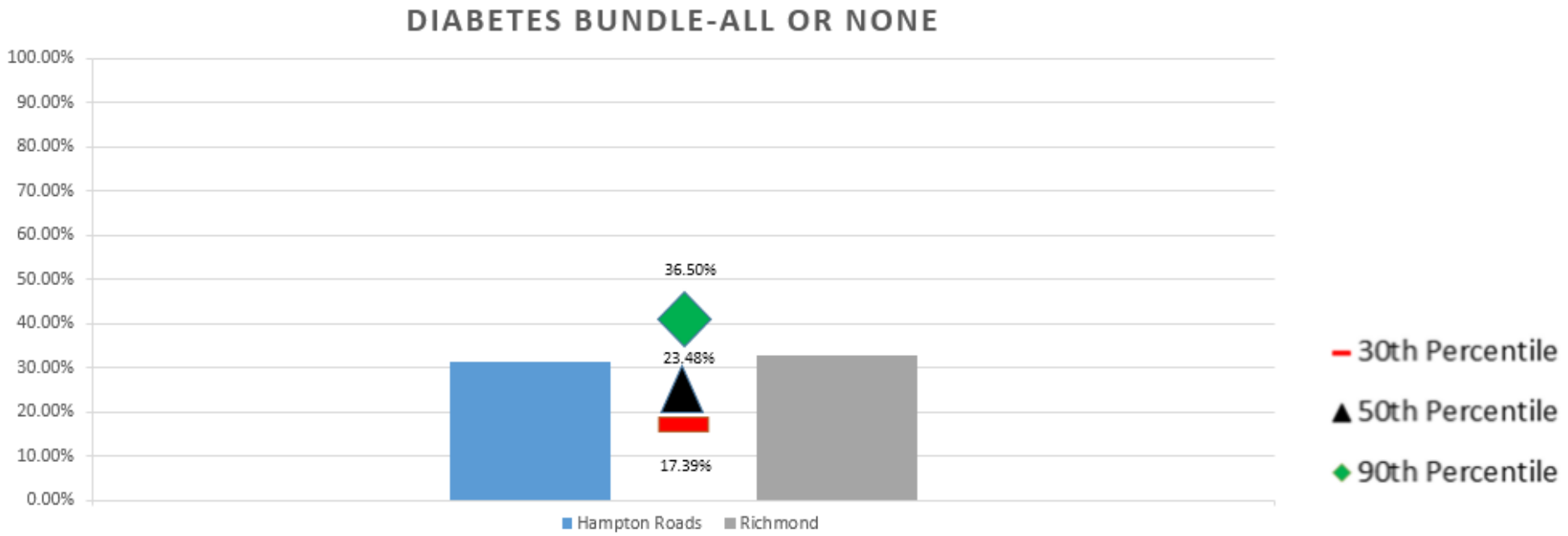
CY2014 Results



CY2014 Results



CY2014 Results



ACO Quality Metric Performance

ACO Quality Metric	Hampton Roads	Richmond
Falls Screening	2.00	2.00
Influenza Immunization	1.70	1.85
Pneumococcal Vaccination	1.70	1.85
BMI Screening/Follow-Up	1.55	1.70
Tobacco Use/Cessation	1.85	1.85
Depression Screening	2.00	2.00
Colorectal Cancer Screening	1.55	1.55
Mammography Screening	1.70	1.70
Blood Pressure Screening	1.85	1.85
Hypertension, BP Control	1.55	1.25
IVD - Aspirin Use	1.85	1.85
HF - Beta Blocker for LVSD	2.00	2.00
ACE/ARB for CAD and Diabetes and/or LVSD	1.55	1.55
Possible Points	26	26
Points Achieved	22.85	23.00
% of Points Achieved	88%	88%

Want to stop this from happening?

Take Action!

Replay the movie?

Financial ROI

Billable Events

Quality

Quality Incentive Bonus

Shared Savings

Risk Adjustment

Questions?