

Bon Secours Medical Group Virginia

*Preparing for Future
Reimbursement
Infrastructure is Key*

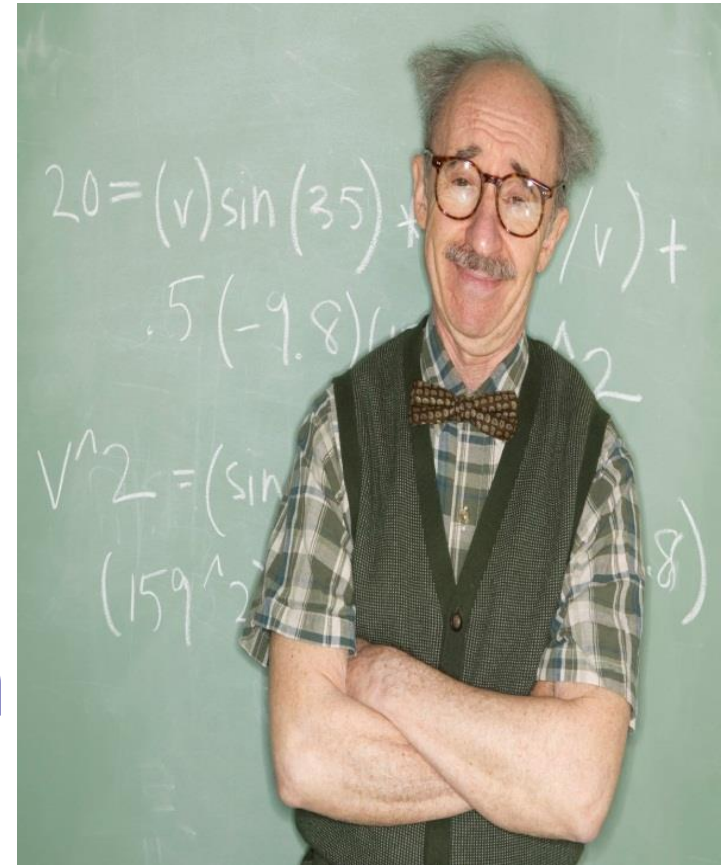
$$E(R+S)+C = APCMH$$

e = EMR

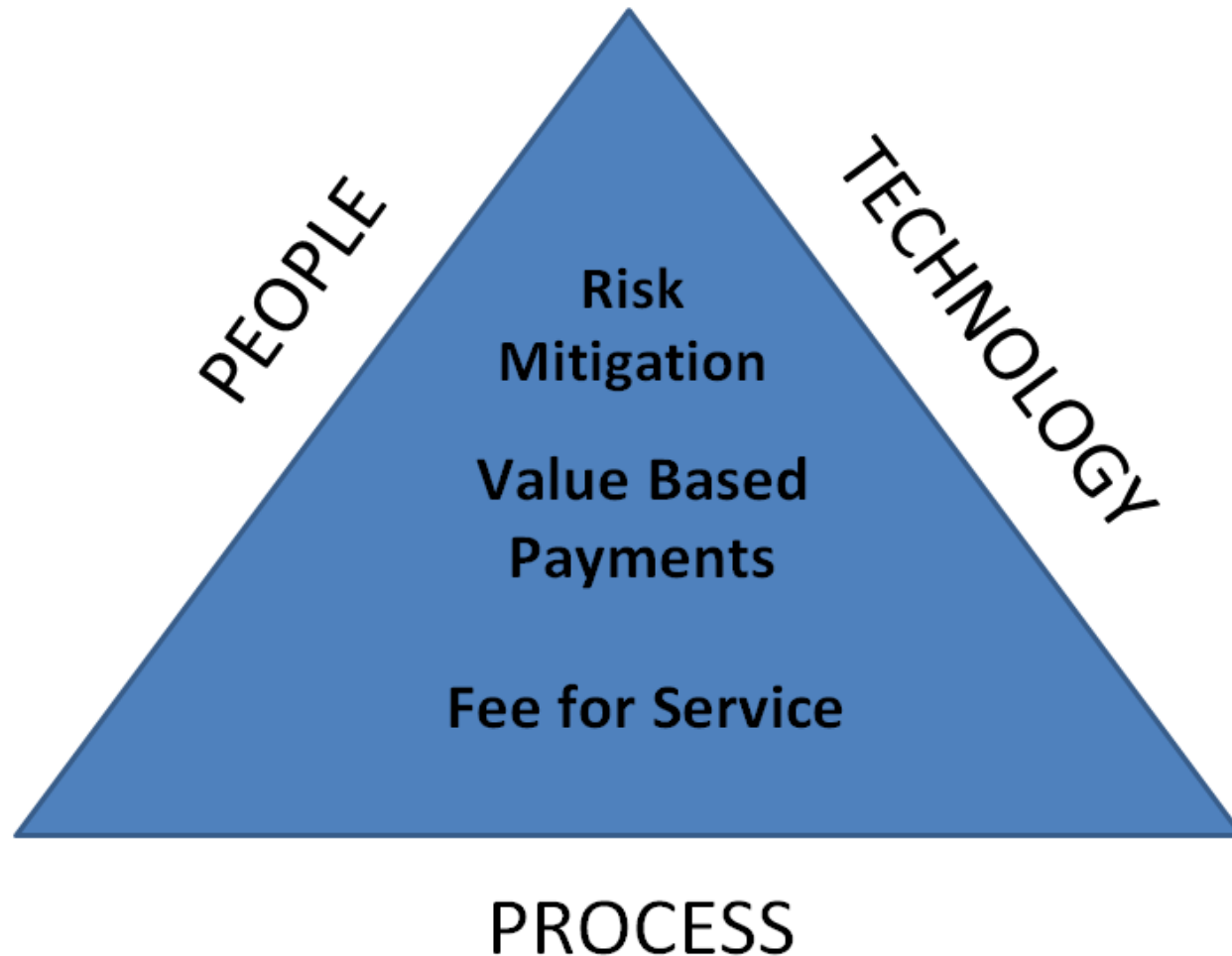
R = Redesign

S = Standardization

C = Care Coordination



Fee for Service, VBP & Beyond



It takes a village!

Provider*

Nurse Navigator*

PharmD

Registered Dietician

CDE

Integrated Behavioral Health

Home Health Team

Physicians

- Performance Expectations
- Leadership Development
- Reduce Burnout
- Promote Quality

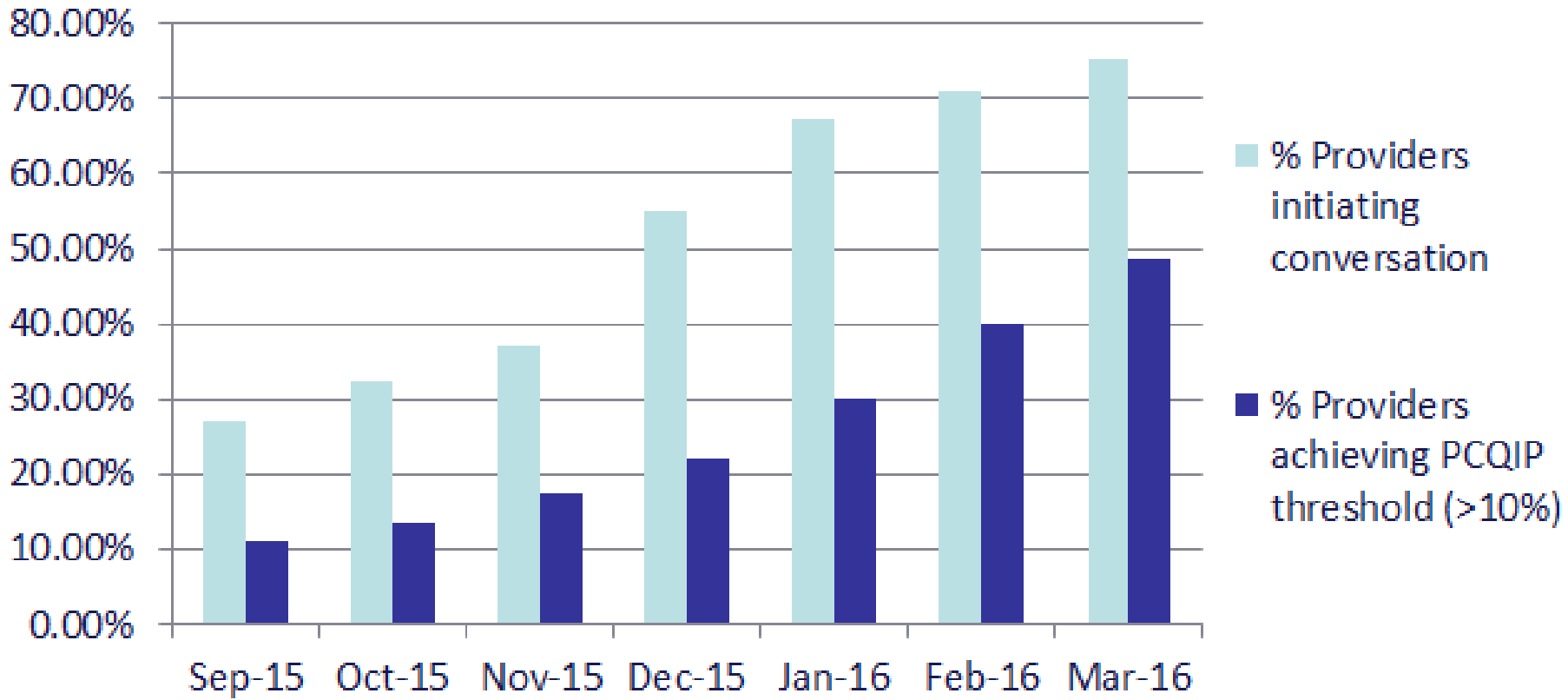
Physician Contracting

- Clear Expectations
 - Meaningful Use - EMR
 - Patient Satisfaction
 - Quality Standards
 - Visit Volumes
 - Access Standards
 - Compensation Model

PCQIP- Program Overview

<i>Incentive Goal</i>	<i>Specific Criteria and Weight</i>	<i>Maximum Incentive</i>
First Filter	BSVMG PC Provider Volumes \geq 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)	<p>Provider's patient satisfaction scores meet threshold set by BSVMG (50% weight)</p> <p>Provider meets three BSVMG Meeting Attendance Criteria (25% weight)</p> <p>Provider satisfactorily completes required training, conflict of interest education, Self Assessments / Year End Reviews and Coding Compliance (25% weight)</p>	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

PCQIP-Advance Care Planning by PCP



Leadership Development Program

- **Classroom learning**
- **Experiential – Site Leadership**
- **Self Development Labs**
- **Mentoring**
- **Hiring Experienced Leaders**

Physician Leadership Development

- The Physician Leadership Program is coordinated with BSHSI's System-wide Leadership Development and Talent Management Strategies
- After current Cohort, **120+** graduates from BSVMG



Provider Burnout & Stress

**46% of providers report
severe stress**

**Up to 60% of practicing
providers report
symptoms of burnout**

Provider burnout has been linked to decreased quality of care including:

- Patient dissatisfaction
- Increased Medical errors
- Increased Lawsuits
- Decreased ability to express empathy

WWW.ANNFAMMED.ORG , VOL. 11, NO. 5 , SEPTEMBER/OCTOBER 2013; JAMA. 2009;302(12):1284-1293. doi:10.1001/jama.2009.1384; Medscape Physician Lifestyle Report (2015)

Reduce Burnout/Promote Quality

Initiatives include Participation in the Heart of Virginia Healthcare Project & Stress Free Now For Healers Program



This is a unique opportunity for primary care physicians in Virginia to adopt new ways of working that are more enjoyable for all concerned, improve quality, and, in some cases, improve income.

LISA ELLIS, MD, FACP
GOVERNOR, VIRGINIA CHAPTER
AMERICAN COLLEGE OF PHYSICIANS

6-week Program Content:

- Personal Coach
- Online Curriculum
- Regular Relaxation Practice
- Tools to Reduce Stress and Improve Well being
- PRE and POST Assessments
- Program Evaluation- Feedback

Completion of Healers Version:

- CNE's- Registered Nurses
- CME's – Medical Doctors

Nurse Navigators

- Recruitment
- Orientation Program
- Performance Expectations
- On-going Training and Education
- Professional Practice Advancement

Nurse Navigator Workflow

Transitions of Care \$\$\$\$

Ensures High Risk Patients seen within 7 days of discharge
Develops Care Plans for High Patients
Monitors the integrated care continuum and patients' interactions, between the continuum and response to care

Communication Across Continuum

Daily communication with Providers, both Primary Care and Specialty.
Communication with Hospital/Payer Care Managers, Home Health Nurses, Hospice, Palliative Team, Dialysis Centers, (Post-Acute Settings) and At Home Team
Communicate patient and families

Data Management

Review 20 different patient lists a month for each Pay for Performance Programs:
High Risk, Daily Inpatient, High ED utilizers, Monthly/Quarterly Gaps in Care, Attribution, etc.
Manages 7 different data base sources
Reports manually all activities

Annual Wellness Visits \$\$\$\$

Intro to CCM
Intro to Advance Care Planning
Care Plan Development
Close Gaps in Preventive Care and Chronic Disease
Patient Care Assessment Forms



Complex Case Management \$\$\$\$

Improved quality of life by patient centric care
Takes proactive steps to coordinate plans of care among health care providers
Identifies needed supports and community resources
Identify and implements care management plan that best meets the needs of the patient to reduce care fragmentation

Disease Management \$\$\$\$

Removes barriers to care for patient, providers and systems of care (ie, affordability of medication, educational needs, and links the chain of care to specialist)
Develops Care Plans based on Evidence based guidelines and patient self-management plans

Advance Care Plans

Initiates and manages the conversation with high risk patients on Advance Care Planning
Ensuring patients and families understand process (ie, wishes communicated, form completion and proxy identified)

ED Outreach

Call all high risk patients released from ER within 24 to 48 hours post ER visit to ensure appropriate follow-up with practice.
Proactively outreaches to patient who are high utilizers of the ED to reengage in primary care setting.
Develops care plan to engage the patient for high utilizers

Orientation and Training

- All Employees – three full days:
 - New Hire Orientation
 - Medical Group Orientation
 - Day 21
- All Clinical Staff – an additional three full days:
 - Skills Fair
 - Medication Immunization/reconciliation
 - Skills Fair – Part Two
- Nurse Navigator Orientation 6-8 weeks

Medical Home Team Orientation

- Team Structure and Implementation
- Work Flows
 - Huddles
 - Rooming Protocols
 - Results Follow-up
 - POC Testing
 - Medication Refills
 - MyChart Activation

Performance Expectations

- Deliver Reimbursable Care: AWW, CCM, PAF, TOC
- Manage Transitional Care Coordination
- Continue Professional Development
 - Case Management Certification
 - Specialty Certification
- Provide Case Management for High Risk Patients
- Advance Care Planning

Continuing Education



Bi-Monthly
Education

All Nurse
Navigators

Professional Practice Advancement



join us on this journey
of nursing
professionalism

Introducing...

THE AMBULATORY
NURSING PROFESSIONAL
PRACTICE
ADVANCEMENT
PROGRAM

*The Professional Practice
Advancement Program (PPAP)
is a way to recognize and encourage
growth and excellence in nursing practice.*

**Four Clinical
Levels**

**Evidence based
practice**

**Increased job
satisfaction**

**Potential to
decrease Staff
turnover**

Orientation to all the tools:

- At Home Program
- Hospital to Home
- Palliative Care
- Home Health and Hospice
- FastCare
- Bon Secours 24/7
- Integrated Behavioral Health

It takes a Village....

Or the Medical Home Team

Case Study Example

51 year old female referred to case management with complex medical problems (diabetes, COPD, Obesity, Depression, Schizophrenia, Diverticulitis, Degenerative Joint Disease and Chronic Pain) coupled with illicit drug use. Patient has been prescribed over 44 medications within the past year and lacks the resources to manage her disease processes.

Challenges

- Multiple hospitalizations
- struggles with illicit drug use
- 71 ED visits
- 47 CT/MRI studies
- \$880,000 of care

Care Plan

Nurse Navigator established communication with patient on regular basis, developing a trusting relationship. Care Team assessed patient's support system, home safety, enlisted PharmD for consult with polypharmacy usage, medication management and coordination of medication assistance programs. Scheduled appointment with pain management specialist and began working on smoking cessation.

Current Status

Having coordinated care with multiple providers, home health care, mental health and social workers the patient has accepted her health conditions and understand the effect of lifestyle choices on her health. She has begun to work towards healthier choices.

Support Services or “Back Office” Critical to the Front Line Teams’ Success

Clinical Support Services & Informatics

- Analytics and Reporting
- Biomedical Equipment Management
- Central Scanning
- Electronic Medical Records-ConnectCare
 - Optimization – Build, Training, PACs
 - Quality Audits
- Referral Management
- SER Maintenance
- Super User Program

Analytics and Reporting

Over 50 Recurring Reports

– Weekly & Monthly

Registry management

Phytel:

Outreach/Remind

Insight/Coordinate



Biomedical Equipment Management

- Standardize equipment utilization and workflows across the markets
- Support and ensure performance of quality controls in all practices
- Ensure ongoing certification for all sites for regulatory purposes
- Assist with education of staff around new devices and new workflows
- Maintain inventory of all PC devices
- Lead discussion with vendors and administration for new device purchasing
- Make recommendations to assist in meeting quality metrics

Central Scanning and indexing

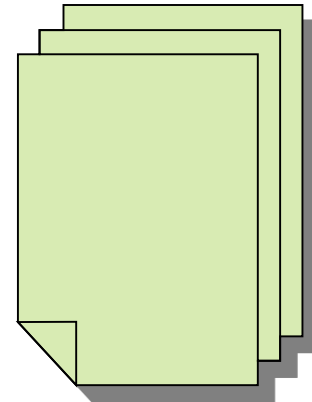
10,000 SCANS PER DAY

**130 Practice
Locations**

98.9% Accuracy

**72 Hour
Turn-around**

**Order
reconciliation and
alert satisfaction**



EMR – ConnectCare

- Build and customization support
- Ongoing education and optimization support
- Perform quality audits to identify provider inefficiencies and frustration early on
- Facilitate Physician Advisory Committee
 - Peer to peer training

Referral Management

- Educate practice managers and staff on referral management concepts:
 - Referral Work Queues
 - Appropriate authorization capture
 - MU requirements
- Monitor Referral Work Queues for productivity and timeliness
- Work with Operations leadership to identify training needs

SER Management – Referral database

- Ensure accurate capture of provider data to include communication preference
- Maintain updated information for providers to reflect changing fax, address, etc.
- Maintain attribution status - providers joining, leaving, geographic area
- Ensure accurate capture of provider specialty

Embedded Super Users

- Manage Downtime process and downtime recovery
- On-site, practice embedded first resource for CC issues; escalate as needed
- Communicate changes/updates/issues between CC team and practice staff
- Assist with training for new providers

Questions?