Care Delivery & Integration Center Workshop

Managing Populations, Maximizing Technology: Population Health Management in the Medical Neighborhood

Bon Secours
Virginia Medical Group

October 15, 2013

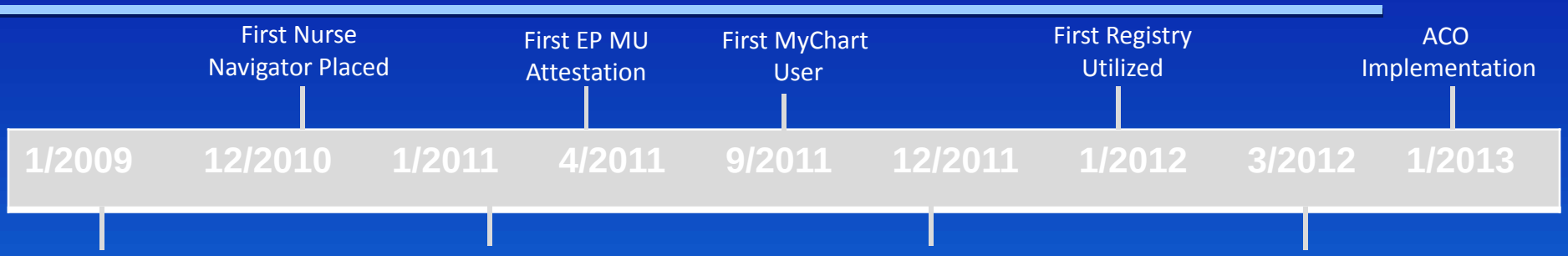
PCPCC Annual Fall Conference

PCPCC's Ten Recommended Health IT Tools to Achieve PHM:

- 1. Electronic Health Records
- 2. Patient Registries
- 3. Health Information Exchange
- 4. Risk Stratification
- 5. Automated Outreach
- 6. Referral Tracking
- 7. Patient Portals
- 8. Telehealth/Telemedicine
- 9. Remote Patient Monitoring
- 10. Advanced Population Analytics

Source: Managing Populations, Maximizing Technology: Population Health in the Medical Neighborhood. Shaljian & Neilson: PCPCC 2013

BSVMG Transformational Vision Timeline



Current Status:

EMR – 108 physician practices live
NCQA PCMH Level 3 – 71 providers
MyChart Users – 73,884 BSHSI/68,223 Virginia
Nurse Navigators – 51
Registries – Diabetes, CHF, High Risk, Obesity, Asthma, COPD, Hepatitis C
Integrated Equipment – EKG, Spirometry, Vital Signs
Advanced Payment Models – ACO, Cigna, Anthem, Humana

	Richmond	Hampton Roads	BSMG Total
Volume FY12			
Employed Providers	297	156	453
Total Employees (includes Home Health and Hospice)	1,091	564	1,655
Monthly Distinct Patient Volume (3-year rolling average)	252,437	77,590	330,027
Monthly Distinct PCP Volume (3-year rolling average)	168,132	24,732	192,864
MyChart Users			64,272
Vitals FY12			
CG-CAHPS	82%	82%	82%
Patient Engagement (CE11)* *Benchmark changed from all industry to healthcare-specific	75th percentile	86th percentile	78th percentile
Physician Engagement	97th percentile	42nd percentile	76th percentile
Employee Engagement	83rd percentile	76th percentile	81st percentile
Voluntary Turnover	9.5%	15.6%	11.5%
NCQA PCMH Level 3 Providers	56	10	66

PCMH
Nurse Navigator Team

Population Outreach: Phytel & Epic Registries

Phytel receives claims data from Athena

Patient, age 18-99 with Uncontrolled DM, with no appointment in the past 3 mos

Phytel places an automated call to the patient and reminds of the need for an appointment

Patient contacts the office to make appointment

Phytel has Disease-Specific Outreach Protocols for the Following:

- Diabetes
- Asthma
- Hypertension
- Hypercholesterolemia
- Thyroid Disorders
- Coronary Artery Disease
- Heart Failure
- COPD

Epic Sample Logic…

Multiple Co-Morbid Condition Managemen

Logic…..

((1 AND 2 AND (3 OR 4 OR 6 OR (7 OR 8) OR (9 OR 10) OR (11 OR 12) OR (13 OR 14))) OR (1 AND 3 AND (4 OR 6 OR (7 OR 8) OR (9 OR 10) OR (11 OR 12) OR (13 OR 14))) OR (1 AND 4 AND (6 OR (7 OR 8) OR (9 OR 10) OR (11 OR 12) OR (13 OR 14))) OR (1 AND 6 AND ((7 OR 8) OR (9 OR 10) OR (11 OR 12) OR (13 OR 14))) OR (1 AND (7 OR 8) AND ((9 OR 10) OR (11 OR 12) OR (13 OR 14))) OR (1 AND (9 OR 10) AND ((11 OR 12) OR (13 OR 14))) OR (1 AND (11 OR 12) AND (13 OR 14)) OR (2 AND 3 AND (4 OR 6 OR (7 OR 8) OR (9 OR 10) OR (11 OR 12) OR (13 OR 14))) OR (2 AND 4 AND (6 OR (7 OR 8) OR (9 OR 10) OR (11 OR 12) OR (13 OR 14))) OR (2 AND 6 AND ((7 OR 8) OR (9 OR 10) OR (11 OR 12) OR (13 OR 14))) OR (2 AND (7 OR 8) AND ((9 OR 10) OR (11 OR 12) OR (13 OR 14))) OR (2 AND (9 OR 10) AND ((11 OR 12) OR (13 OR 14))) OR (2 AND (11 OR 12) AND (13 OR 14)) OR (3 AND 4 AND (6 OR (7 OR 8) OR (9 OR 10) OR (11 OR 12) OR (13 OR 14))) OR (3 AND (7 OR 8) AND ((9 OR 10) OR (11 OR 12) OR (13 OR 14))) OR (3 AND 6 AND ((7 OR 8) OR (9 OR 10) OR (11 OR 12) OR (13 OR 14))) OR (3 AND (7 OR 8) AND ((9 OR 10) OR (11 OR 12) AND (13 OR 14))) OR (3 AND (9 OR 10) AND ((11 OR 12) OR (13 OR 14))) OR (3 AND (11 OR 12) AND (13 OR 14))) OR (4 AND (7 OR 8) AND (4 AND 6 AND ((7 OR 8) OR (9 OR 10) OR (11 OR 12) OR (13 OR 14))) OR (4 AND (9 OR 10) AND ((11 OR 12) OR (13 OR 14))) OR (4 AND (11 OR 12) AND (13 OR 14))) OR (6 AND (7 OR 8) AND ((9 OR 10) OR (11 OR 12) OR (13 OR 14))) OR (6 AND (9 OR 10) AND ((11 OR 12) OR (13 OR 14))) OR (6 AND (11 OR 12) AND (13 OR 14)) OR ((7 OR 8) AND (9 OR 10) AND ((11 OR 12) OR (13 OR 14))) OR ((7 OR 8) AND (11 OR 12) AND (13 OR 14)) OR ((9 OR 10) AND (11 OR 12) AND (13 OR 14)) AND 5)

Engaging Patients via EMR Portal & Nurse Navigators

Epic Patient Portal:

Number of "Activated Patients" Virginia BSHSI Total	 68,223 73,884
Number of messages/week	2,383
eRx Turnaround Time	10hr 40min
Appointment Request Turnaround Time	8hr 1min
Messaging TAT	10h 34min

Navigator Readmissions:

Month	Total Patients	Total counted in Readmit Stats (Denominator)	# with Post Hosp Readmission (Numerator)	30 DAY READMISSION RATE
Dec-11	182	139	0	0.00%
Jan-12	385	328	1	0.30%
Feb-12	498	439	13	2.96%
Mar-12	671	614	15	2.44%
Apr-12	587	547	9	1.66%
May-12	625	573	3	0.52%
Jun-12	556	494	4	0.81%
Jul-12	652	609	5	0.82%
Aug-12	763	686	2	0.29%
Sep-12	600	549	8	1.46%
Oct-12	821	748	10	1.34%
Nov-12	652	583	12	2.06%
Dec-12	834	766	10	1.31%
Jan-13	1025	934	13	1.39%
Feb-13	1035	925	9	0.97%
Mar-13	1090	975	7	0.72%
Apr-13	1175	1018	16	1.57%

***The Average BSV Hospital Discharge Readmission Rate for Previous 6 months – 14.2%**

INCLUSION CRITERIA:
1) Patient was seen as part of a Post Hospitalization Episode
2) Must have a documented Initial Hospital Discharge Date to be counted in Readmit Rate

DEFINITION:
A readmission is counted as having a documented Other Hospital Admission Date within 30 days of the Initial Hospital Discharge Date

Our Progress Toward Reform: 2009-2016

	Transaction	Interaction	Integration	Collaboration	Transformation
	IT supports individual providers in delivering care and measuring outcomes	Basic care coordination capabilities emerge with initial population-based metrics	Care coordination capabilities improve and health status measurement is possible	Seamless care coordination with demonstrable improvement in population health status	Triple Aim goals realized across the population
Accountable care sustainability					• Advanced population analytics • Continuous process improvement • Risk and financial management
Population management				• Evidence-based standards • Team-based care collaboration • Individual accountability	
Clinical integration			• Outcomes measurement and reporting • Virtual care team coordination • Individual engagement		
Care coordination		• Clinical decision support • Care management and registries • Population analytics			
Meaningful use	• Process measurement and reporting • Health information exchange • Clinical systems (ancillary, EHRs, EMRs)				

An accountable care organization (ACO) is a healthcare organization characterized by a payment and care delivery model that seeks to tie provider reimbursements to quality metrics and reductions in the total cost of care for an assigned population of patients

Bon Secours has been awarded the Medicare Shared Savings Program ("Medicare ACO")

Questions??

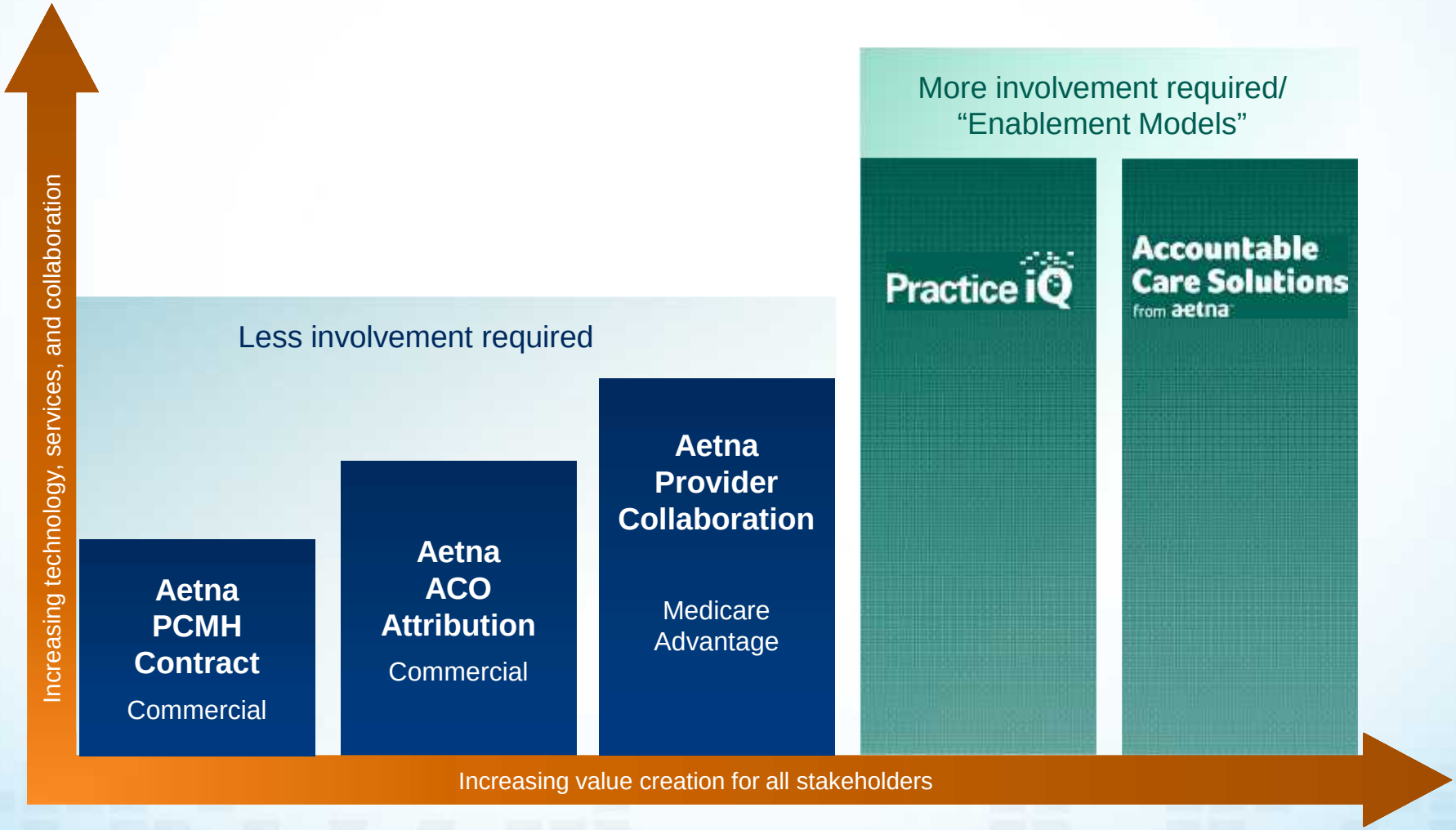
Maximizing Technologies, Managing Populations: eHealth Innovations

Aetna's Perspective

Brian Parker, President, Practice iQ

October 15, 2013

Aetna is committed to the shift from volume to value



How is value generated by PCPs?

1 Health Care Technology

Understand Cost & Quality

- Accessible data to manage performance and track patients
- Population based decision making with predictive modeling

2 Care Management

Facilitate Appropriate Care Delivery

- Identify and manage at-risk/high risk patients and those with chronic conditions
- Care coordination to drive appropriate utilization of resources

3 Operational/People Services

Support and monitor PCMH success

- People to lead transformation process and track ongoing performance and progress
- Managing inappropriate and redundant utilization based on data analysis

4 Incentive Payments

- Motivate behavior change among providers with rewards for demonstrating consistent and successful application of the medical home features
- Mitigate costs related to implementing new technology, care management processes, and people to transform and successfully operate as a medical home

Fields, D. (2010, May). Driving Quality Gains and Cost Savings Through Adoption of Medical Homes. Health Affairs, p. 29:5.

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PCMH 2.0

Test and prescribe vs. prevention and healing.

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Integrated Health Services

- Behavioral health
- Dietician
- Health education
- Mind-body medicine
- Pharmacy

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- Validated physician-connected Health Risk Assessment
- Personalized Prevention Plan
- Chronic care management interventions

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Preparing for Change

"The primary care practice of the future will have a workflow very different from that of today."

—Institute for Health Technology Transformation. *April 2012.*

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- EHR system
- System-wide secure messaging
- Clinic-facing patient dashboards
- Web-based interactive health risk assessment/personal prevention plan

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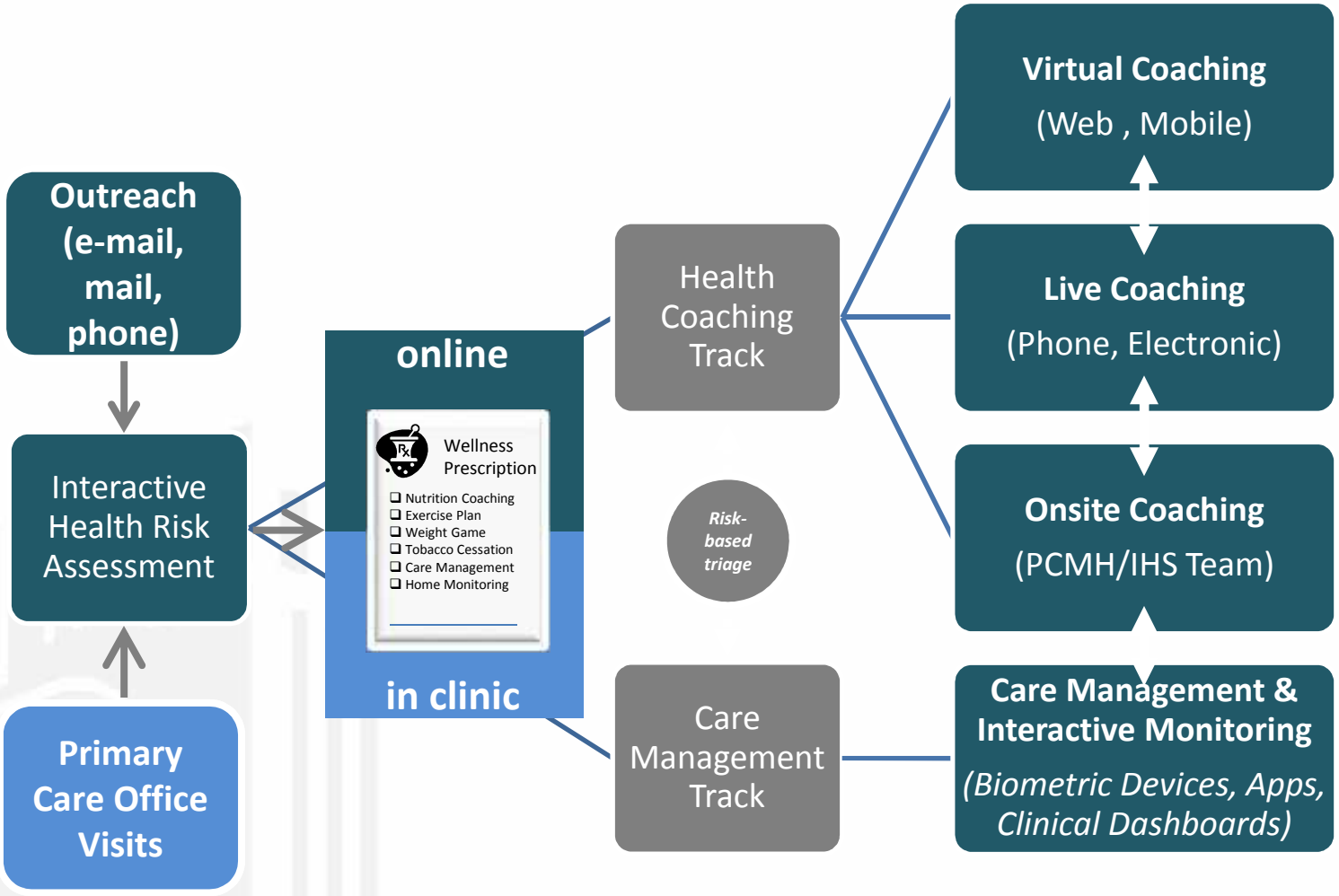

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