Building the Roadmap to Population Health Management with Bon Secours Virginia

For traditional health systems and physician groups, embracing the Accountable Care Organization (ACO) model is no easy matter. Value-based care has turned the tables on traditional fee-for-service reimbursement, rewarding providers instead for keeping an entire population healthy regardless of engagement status. Even before the advent of value-based care, though, pioneering medical groups and health systems were deploying population health solutions to drive higher-quality, more efficient patient care at a lower cost. With each new success, they have refined the roadmap for achieving truly impactful population health management.

Bon Secours Virginia Medical Group (BSVMG), a hospital-owned multi-specialty group practice with more than 100 locations in metropolitan Richmond, Va., is one such pioneer. In partnership with Phytel, BSVMG has been applying the roadmap for population health management success since 2010, with remarkable results. BSVMG’s 400 providers—45 percent of whom are primary care providers (PCPs)—serve more than 500,000 patients each year. Its transformation into an organization that embraces population health management is the result of a systematic strategy to reengineer clinical practice and integrate new technologies into clinician workflow.

This case study examines in more detail BSVMG’s approach to transitioning to value-based care—and outlines Phytel’s recommended roadmap to successful population health management. Physician practices that follow this roadmap will be well positioned to achieve quality outcomes and financial success in the changing healthcare environment.

Commit to Patient-Centered Medical Home (PCMH) Delivery Model

The first step in the roadmap to successful population health management is an organization-wide commitment to the Patient Centered Medical Home (PCMH) delivery model. The foundation of BSVMG’s strategy for value-based care is its medical home initiative—the Advanced Medical

Using Phytel to improve our quality scores was a no brainer. We’ve almost reached our payer’s quality target. We simply have to ramp up those quality protocols a bit more in the Phytel, and we’ll meet that objective. The result will be shared savings for that payer contract. That more than pays for the cost of Phytel.

ROBERT FORTINI
VP, Chief Clinical Officer, Bon Secours Health System
Home Project. One of the most significant objectives of the Advanced Medical Home Project is to improve capacity—making it possible for PCPs to double the size of their patient panel without overburdening themselves or sacrificing quality of care. Such an effort requires reduced waste, improved effectiveness and proactive initiatives to increase patient compliance with care plans. To meet this objective, BSVMG has invested in reengineering and refining clinical practice by implementing new technologies and care management processes.

“At first blush it may seem unlikely that traditional hospital leaders would embrace the medical home model and population health management,” said Robert Fortini, PNP, BSVMG’s Chief Clinical Officer, who was recruited by the medical group after launching and directing several successful NCQA-recognized medical home practices in New York state. “But with the advent of the Affordable Care Act, value-based purchasing, and opportunities like the Medicare Shared Savings Program, it makes strong financial sense for a healthcare institution to change the dynamic dramatically.”

Secure Payer Involvement and Alignment

Securing payer involvement is an important step in establishing a financial mechanism to sustain and scale the PCMH initiative. Although involving payers from the outset is ideal, often a practice must invest upfront in population health processes and technology to demonstrate results before payers will sign value-based contracts. BSVMG is a prime example of this.

The medical group took a leap of faith implementing its PCMH changes, recalled Fortini: “I got carte blanche from Bon Secours to do it the best way possible. So we purchased Phytel and ambulatory Epic with all its modules, and we embedded RN case managers in every practice – all without a proven model for payment. So for Bon Secours it was really an ‘If you build it, they will come’ investment. And they did come.”

First to come was Medicare, the biggest payer of all. BSVMG was selected as an early participant in the Medicare Shared Savings Program. And the practice has inked value-based contracts with two commercial payers—CIGNA and Anthem. CIGNA currently gives BSVMG a per-member per-month (PMPM) adjustment for care coordination. Anthem, the group’s biggest payer, pays a care coordination fee and will change to PMPM in the coming year. Several more commercial payers are lined up to sign contracts with the group.

Having the technology infrastructure in place and the ability to show how BSVMG could identify and intervene with at-risk populations and individual patients was key to gaining payer involvement.

Leverage Care Management Resources

The third step in the roadmap is putting the appropriate care management personnel and processes in place to support practices as they manage their patient populations. An important goal of BSVMG’s PCMH strategy was to create high-performance care teams led by physicians, which requires physicians to delegate clinical responsibilities so they can focus on those patients who truly require their attention.

To facilitate this process, BSVMG has invested significantly in embedding care managers into the primary care team. These embedded, professional case managers—called nurse navigators—are each assigned a panel of approximately 150 high-risk patients. They are able to meet the patient’s needs while freeing up physicians to see other patients. BSVMG also outsourced care management duties to inHealth (formerly CenVaNet), a Richmond-based care management organization that specializes in delivering a full continuum of services designed to help providers establish patient-centered medical homes for the patients they serve. inHealth, a Phytel partner, introduced BSVMG to Phytel and the potential of its ambulatory registry and software for managing population health.

Implement Technology to Identify and Address Gaps in Care

A critical complement to organizing the care team is implementing health information technology that empowers the team to efficiently manage population health. This technology is the key to enabling practices to scale their system for value-based care. With the right technology in place, organizations are able to realize the fourth step in the roadmap: identifying high-risk patients and gaps in care to prioritize appropriate interventions.
Phytel recommends implementing protocol-driven registries that automatically identify care gaps and trigger messages to patients for recommended care; applications that stratify patient populations according to identified health risks and create personalized, automated interventions; automated communications that follow a patient’s hospital or ER discharges to help prevent unnecessary readmissions; and sophisticated analytics that measure an organization’s effectiveness in its quality improvement initiatives.

BSVMG began its technology path on its own and has since partnered with Phytel. As a first step, BSVMG implemented Epic’s ambulatory EHR across the enterprise, establishing a strong foundation for documenting care and accessing health records. Then they turned their focus to building a registry within Epic’s inpatient EHR to help nurse navigators prevent 30-day readmissions. Based on the success of this initiative, BSVMG plans to delegate handling of care transitions directly to Phytel Transition®, a solution that will help scale the system more easily than the current homegrown approach allows. An important aspect of this scalability is the ability to align with multiple payers’ quality definitions and denominators while enabling analytics and predictive modeling across multiple clinical conditions. For organizations with multiple payer contracts, this flexibility is crucial. As each payer launches a unique quality improvement initiative with BSVMG, the switch to Phytel will enable the medical group to track, manage and demonstrate compliance with various quality measures and evidence-based standards simultaneously.

Through its contract with inHealth, BSVMG is already benefiting from Phytel functionality for addressing gaps in care. inHealth’s care management personnel use Phytel’s ambulatory registry and population health solutions to identify gaps in care among BSVMG’s populations and make appropriate interventions. Because Phytel automates these interventions, care teams are able to communicate with many patients at once, as specified by condition, measure and clinical protocol.

Phytel’s platform integrates with BSVMG’s ambulatory Epic infrastructure, as well as that of other critical source applications, and aggregates the data into a population-wide registry that enables the organization to implement multiple quality-improvement programs simultaneously. The registry stratifies the population by risk—providing a total population view while enabling each care team to drill down to the data they need on cohorts and individual patients. On behalf of BSVMG, care managers proactively run reports on patient populations in the Phytel registry. A typical query to the registry searches for diabetic patients who have not had a chronic condition visit-related charge in the previous six months and do not have a visit scheduled in the next two months. Whatever the targeted protocol—whether searching for patients with a chronic condition of those who simply require a preventive procedure like a colonoscopy—the system identifies patients due for recommended care and notifies them through automated outbound messaging. The care team is then able to track patient response in the Phytel system and monitor whether they come in for the necessary appointment.

**Results**

Using Phytel technology has helped BSVMG succeed in its performance-based contracts with commercial payers. For example, in the first six months of their value-based contract with CIGNA, BSVMG practices have hit many of their care quality metrics. By only slightly improving their gap-in-care metrics, BSVMG can achieve the index necessary to qualify for gain sharing—a development that will bring a projected annual savings of $4 million. Because the quality measures that need improvement line up with existing Phytel protocols, BSVMG plans to dial up those quality indicators in the Phytel system and give them more pronounced attention. They are confident that by doing so they will sufficiently improve their care quality index to qualify for shared savings in the coming year.

Another indicator of success is that BSVMG is demonstrably bridging the gap between value-based care and the fee-for-service (FFS) model. This transition is often a difficult one, requiring significant upfront investment before seeing any financial reward. By practicing population health management to bring patients in for chronic and recommended care, BSVMG has both improved quality and increased FFS revenue. Using the Phytel platform for patient outreach, BSVMG generated approximately 40,000 unique patient visits—all for preventive, follow-up or acute care. These visits generated more than $7 million in revenue for the organization and a return on investment on their technology spend of 16.6. This ability to transition to value-based care while achieving success in the current FFS model helps individual physicians and practices more readily embrace the PCMH model.

*Generated more than $7 million in revenue through these visits*
Implementing Phytel’s technology also has furthered BSVMG’s goals of gaining medical home recognition. Phytel is the first non-EHR vendor—and only the second company overall—to secure an agreement with the National Committee for Quality Assurance (NCQA) that allows practices using Phytel’s solutions to automatically meet certain NCQA requirements for recognition as a PCMH. Since BSVMG’s medical home project began in 2010, eleven practices have earned NCQA recognition as patient-centered medical homes (Level 3)\(^1\), and the organization may seek system-wide recognition.

**Measure Quality-improvement Effectiveness with Analytics**

The fifth step in the roadmap to successful population health management is to implement sophisticated analytics that measure an organization’s effectiveness in quality improvement initiatives. BSVMG has reached this point on the roadmap and will soon be expanding its implementation of the Phytel platform to include performance measurement at the level of individual groups, sites and providers, as well as feedback to providers on variances in care and quality reporting.

This functionality is particularly important to the medical group as they move into the accountable care organization (ACO) setting. BSVMG has contracted with multiple payers under ACO agreements, which requires the medical group to measure quality across all of the payers simultaneously. They must also provide quality reporting tools to their care managers. Phytel’s clinical analytics solutions play a key role in helping BSVMG manage risk contracts across multiple payers. This functionality for analytics and insight on both the clinical and administrative level will help the organization ensure that it is meeting the Triple Aim – lowering costs while improving quality and the patient experience.

As one of the most established vendors in the growing market for population health management, Phytel has the expertise to move your organization successfully along the roadmap to better outcomes at lower cost.

“We’re finding new and creative ways to use Phytel every day,” said Fortini. “I think embracing and using technology like this as completely as possible is going to be transformative for medical groups.”

\(^1\) As of March 2013, Bon Secours Medical Group has 8 practices recognized under the 2008 NCQA PCMH standards and 3 recognized under the 2011 NCQA PCMH standards.

---

**Solution: Phytel Population Management System**

**PRODUCT DISTINCTIONS**

- Drives population health management
- Can be used to build medical homes and ACOs
- Generates demonstrable quality improvement
- Implementation is smooth and rapid
- Nationally recognized, evidence-based protocols are customizable
- Registry seamlessly integrates with EMR, PM and other systems
- Identifies gaps in care in a patient population
- Automated patient messaging can be repeated at preset intervals

**RESULTS**

- Prompted 40,000+ unique patient visits for preventive, follow-up or acute care
- Generated more than $7 million in revenue through these visits
- Earned a return on investment on their technology spend of 16.6