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VIRGINIACARE PARTNERS | An HCA affiliate

QUALITY LEADS

Progress Notes from the CMO, Dr. Georgean deBlois

April 2015

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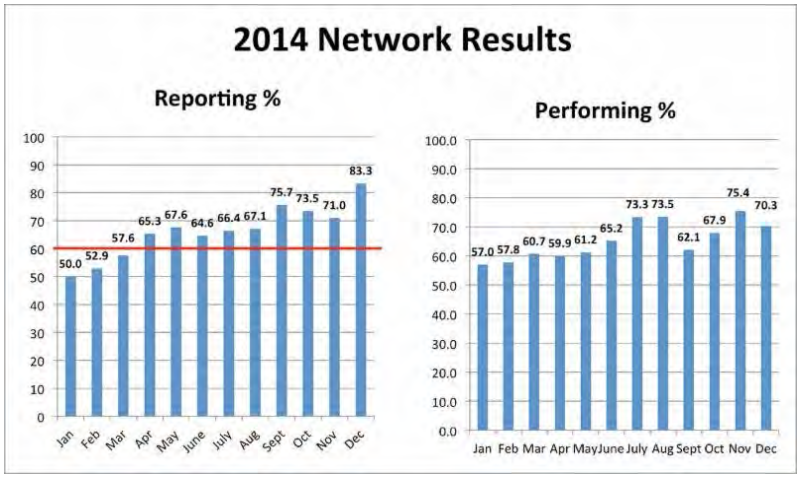
VCP - A New Year, New Name, New Logo

Virginia Care Partners...even though our name has changed, quality remains essential to everything we do. Approved by the Board, "VCP" is easier to say and easier to remember. We are updating our information both in print and online.

VCP Finishes Strong

Our network made tremendous progress in data reporting during 2014. Over 1.4 million patient encounters are reflected in the network reporting of **83.28%**, far surpassing the network benchmark threshold of 60%. This means that any individual physician reporting at >60% will earn a quality incentive bonus. We anticipate distribution of the bonuses to be mailed in May to the signatory of the Network Participation Agreement. As you may recall, practices will receive a single check with an explanation of how and by whom the bonus was earned. We will let you know when the bonus distributions are mailed.



In 2014, Network reported at 83.28%

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2015 Performance Plan

60% benchmark threshold reporting AND performing

Clinical Integration (CI) Networks are charged with continually increasing the bar on quality and performance. Our Board has established the **quality benchmark threshold at 60% for *both* reporting and performing**. Please refer to the 2015 Distribution Plan, sent in December, for details. We would like to clarify that as part of the "Physician Eligibility Criteria" approved by the Board in the 2015 Distribution Methodology, metrics for ***all hospitalists*** are gathered and reported by the hospital; ***all hospitalists*** are not subject to the reporting threshold and are eligible for distribution by meeting the 8 month requirement and the 60% performance threshold. Please do not hesitate to contact me at Gigi deBlois if you have any questions.

PQRS #130 - Every patient every visit

Cross-cutting measures such as PQRS #130, Medication Documentation play a key role in quality outcomes and health status for the network's member population. These measures apply to specialists as well as primary care. This measure, because of the number of applicable patient visits, has a significant impact on individual and network wide performance.

It is important for physicians to get credit for the good work they are doing by documenting these measures. If you think this is not being reflected in your quality data, please contact Chris Barker. We can work with you and your practice to troubleshoot i.e. 'Where do I record the information in the EMR?' so that it can be pulled by Crimson? Getting this right will help not only your network performance, but will also make sure you are capturing information important to payers including CMS.

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Care Management Corner

New this year, VCP is offering Transitions of Care to HCA employees and their dependents. We've met with Primary Care Physicians to introduce them to the Nurse Care Manager assigned to their practice. If an HCA employee or family member visits the emergency room or is admitted (does not include normal OB, psych or rehab) to one of the Richmond/Tri-Cities area HCA Virginia hospitals (includes free-standing EDs in Hanover and West Creek), a VCP nurse care manager will visit inpatients before discharge or contact them by phone in the case of an ED visit. VCP Care managers will:

- make sure patient understands their discharge medications and instructions
- make sure patient schedules appropriate follow up appointments or provide list of network PCPs if they don't have one
- contact your practice to notify you that patient has been hospitalized
- send discharge information and summary to your practice when patient is discharged
- provide contact information to patient for questions or concerns that may arise

after discharge and follow up by phone once patient is home

The Cigna contract also includes Transitions of Care for qualified Cigna patients who are admitted with a medical diagnosis for >3 days.

We are already making a difference:

> ***A VCP Nurse Care Manager reviewed the prescribed discharge medications with a patient who noted that there was an unfamiliar antibiotic on her list. She provided her cellphone number and asked the patient to call her in case there was a problem filling the prescription. She received a call the following day, and learned that the patient had not filled the prescription due to the high cost of $290.00 for two days of medication. After discussing options with the patient, the nurse care manager obtained the hospital culture and sensitivity report and faxed it to the specialist requested by the patient. The specialist utilized that information to prescribe a more affordable antibiotic. The patient and doctor really appreciated the nurse care manager's intervention.***

Closing Care Gaps

VCP Nurse Care Managers are also working with our primary care practices to close "Gaps in Care" for Cigna attributed patients identified through claims data. Care Managers assigned to the individual practices commit to working with the practice in the way that meets their needs. Not only is this good for patient care, it makes great business sense as patients are identified and contacted about coming in to see their physician and getting appropriate preventive or follow up care.

> *"We are working with VCP to proactively address gaps around preventive care and disease management,"* said Dr. Patrick Woodward, President of Virginia Physicians, Inc. *"VCP staff analyze reports based on Cigna's aggregated claims data for patients served by the VCP network, then our staff uses that information to reach out to patients to address those gaps in care."*

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VCP Welcomes New Staff

Kalpana Girish, MBA, Director of Clinical Analytics

Kalpana will advance the Network's goals by reviewing the cost and quality data provided by the physicians and the claims on patients attributed to VCP - information that will help us identify areas of opportunity. We will work with our members to communicate actionable information that can deliver value to the physician, the patient and thereby value recognized by the payer.

She brings over 14 years of experience, 9 in the healthcare industry, in clinical operations and strategic, healthcare quality and population care management for Kaiser Permanente and Aetna. Her work included the improvement of patient quality and outcomes through development of strategies based on stratification and engagement and managing operational processes through metrics, performance standards and analysis of outcomes.

Karen McFarland, Nurse Care Manager
Karen is joining the care management service teams. She has 23 years of nursing experience and has worked in Med-Surg, home health care performing in-home peritoneal dialysis and urgent care and was a team lead at a Nurse Call center. She earned her nursing degree in New York.

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