

Innovative Solutions for your Health

The physicians of Virginia Care Partners (formerly VQCP) care about your long-term health. As part of a network in the Richmond-metro area of more than 1,100 physicians and providers including behavioral health, we are building innovative programs that span the continuum of care – from the doctor’s office to the hospital to the home. By delivering more coordinated preventive and sick care that offers the right treatment at the right time, we can support you regardless of your health status. Our success means improved health and wellness for you – our patients.



Living with a chronic condition like diabetes or high blood pressure or undergoing hospitalization can be stressful. You and your family may feel overwhelmed and unsure where to turn to find the right care for your specific needs. You may not be aware of resources in the community that can help you better manage your condition. We are here to help.

New this year, VCP is offering Transitions of Care and Chronic Disease Care Management, two Care Management services offered free of charge to HCA-affiliated employees and their dependents who are enrolled in a Well Care medical plan. These optional services are part of HCA’s commitment to patient care and satisfaction. In partnership with the

HCA Virginia Richmond hospitals and under the direction of your VCP physician, a VCP nurse care manager will assist you in addressing your specific health needs. From providing clinical support to connecting you to additional resources, VCP can help you overcome the barriers to better health through quality, coordinated care.

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[Find a VCP doctor.](#)

From Hospital to Home: Transitions of Care

Should you visit the Emergency Department or be admitted to one of our Richmond/Tri-Cities-area HCA Virginia hospitals, a VCP nurse care manager will reach out to you either by phone or in person. As part of this service, they will:

- **Complete** an After Hospital Care Plan (AHCP), an instruction booklet customized for you to take home documenting discharge instructions, medications, follow-up required, questions for physician, symptoms of concern, who to call, etc.
- **Educate you** about your diagnosis and upon request, share the AHCP with your family members or others involved in your care.
- **Notify and share** your discharge summary with your primary care physician (PCP), or upon request, other specialists who are involved in your care. If you don't have a PCP, they can help refer you to a VCP physician and assist with scheduling.
- **Help you** schedule follow-up appointments, lab tests, etc., as appropriate.
- **Contact you** within two days of discharge to provide additional clinical support and answer questions.

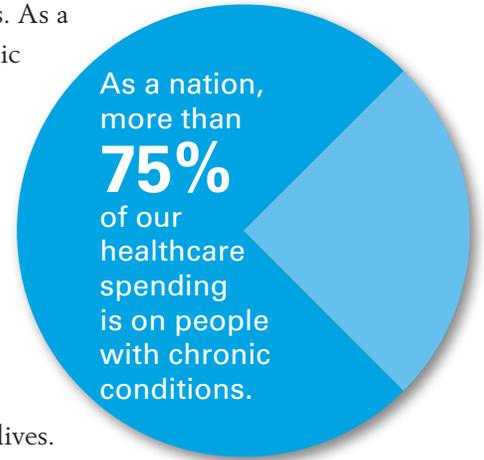
Participation in the program is not required, but VCP wants to ensure you and your family have the information and support you need to make a full recovery.



“The VCP nurse care manager visited me in the hospital to answer questions related to my discharge and served as a great resource in finding answers if she didn't know,” said Ernest Dube, phlebotomist, Henrico Doctors' Hospital. “She really cared about what was happening to me and wanted to help me get the best care for my recovery.”

Managing Chronic Disease – It’s a Team Effort

Chronic Disease presents one of our country’s greatest healthcare challenges. As a nation, more than 75% of our healthcare spending is on people with chronic conditions. Seven out of 10 deaths among Americans each year are from chronic diseases. (<http://www.cdc.gov/chronicdisease/pdf/2009-power-of-prevention.pdf>)



Even though chronic disease treatments and medicine have improved, the best treatment is proactive self-management. Good self-management through education and clinical support enables patients to reduce the risk of serious complications, such as heart, kidney and vascular disease – complications that can lead to hospitalizations and higher costs. Participation is not required, but HCA wants to make sure affiliated employees have the tools they need to lead healthier lives.

That’s why VCP primary care physicians and nurse care managers will work with eligible employees and family members to create individualized Coordinated Care Plans that include actionable goals to better manage diabetes and high blood pressure. Through physician recommendation and review, those who are selected will receive a Welcome Packet from their VCP physician with information about the program and the name of their dedicated nurse care manager who will contact them about the next steps in the program.

Better management of diabetes and high blood pressure in partnership with a VCP physician and nurse care manager means better health for a lifetime!

The VCP physician and nurse care manager will be working closely with employees to provide one-on-one contact and support.

VCP Care Management Program	Transitions of Care	Chronic Disease Management Diabetes and High Blood Pressure (Hypertension)
Description	Assist employees who have been hospitalized or in the ED with follow-up information and assistance to insure full recovery	VCP physician, nurse care manager and employee will create an individualized Coordinated Care Plan establishing goals for better self-management to improve wellness and reduce the risk of complications
Who is Eligible?	Anyone admitted to a Richmond-area HCA hospital or ED*	Pre-Selected employees and their dependents who qualify for services**
Cost?	None to employee; cost is fully supported by your health insurance coverage	None to employee; cost is fully supported by your health insurance coverage
Site of Service	Hospital if admitted and/or follow up by phone	Phone and Physician Office as needed
Services Provided	Documentation of After Hospital Care Plan (AHCP), a discharge instruction booklet, and assistance in coordinating follow up appointments and services.	VCP nurse care manager works one-on-one with employee in collaboration with physician to provide actionable goals, education, and clinical support.

*Excludes Maternity Delivery, Psych Admits and Rehab; includes West Creek and Hanover Emergency Centers ** Self-referral not available at this time

Your Preventive Care Partner

Even if you are healthy, annual wellness exams are important. If you are enrolled in an HCA Well Care medical plan, annual physicals are covered at 100%. A primary care physician, also known as a family physician, internist or pediatrician, is your partner in practicing smart prevention. As part of the annual exam, they will look for diseases such as diabetes and heart disease.

To help detect cancer as early as possible, they will make sure you receive recommended, age-appropriate, preventive screenings, such as colonoscopies and mammograms. Did you know that over 50,000 people die each year from colon cancer (www.ccalliance.org/colorectal_cancer/statistics.html), a form of cancer that is highly curable when found early with a simple colon screening? Your physician will also encourage you to adopt good preventive habits like getting a flu vaccine and making simple lifestyle changes that go a long way in warding off chronic disease. “The Health Affairs journal reported in 2008 that patients with a primary care physician have better management of chronic diseases, lower overall health care



costs, and a higher level of satisfaction with their care,” said Dr. Georgean deBlois, Chief Medical Officer, Virginia Care Partners.

Don't wait until you are sick to choose a primary care physician! By making an appointment now for an annual physical with a VCP primary care physician, you will have support for your health and wellness today and

benefit from an ongoing relationship should you and your family experience changes in your health status. Your physician will have your medical records, understand your history and therefore be a better advocate for you.

To find a Virginia Care Partner primary care physician, go to www.virginiacarepartners.com/physicians.

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