Population Health in Virginia: Bon Secours Medical Group’s Big Breakthrough

By Mark Hagland

A lot of things are happening these days at Bon Secours Medical Group, a Richmond, Virginia-based multispecialty physician group affiliated with Bon Secours Health System. The physicians at Bon Secours Medical Group (BSMG), which encompasses about 530 employed physicians, and a 50/50 primary care physician-specialist mix, take care of a patient population of about 370,000 across central and eastern Virginia. In June 2013, the Chicago-based Healthcare Information Management and Systems Society (HIMSS) recognized BSMG as a “HIMSS Level 7” organization, meaning that the medical group had reached the highest level of electronic health record (EHR)/clinical information systems implementation, based on the HIMSS Analytics Electronic Medical Record Adoption Model (EMRAM) schematic.

What’s more, the leaders of Bon Secours Medical Group have been moving forward aggressively to leverage both their core EHR (from the Verona, Wis.-based Epic Systems Corporation) and a population health management solution (from the Dallas-based Phytel, Inc.), in order to execute a broadly based population health management strategy to support the organization’s participation in the Medicare Shared Savings Program (MSSP) for accountable care organizations (ACOs). BSMG became an MSSP ACO in January 2013.

Robert Fortini, R.N., M.S.N., the chief clinical officer at Bon Secours Medical Group, has had many years’ experience both as a clinician (he is a pediatric nurse practitioner by training and practice), and as a clinical administrator. He joined BSMG in November 2009. Fortini is helping to lead the organization’s broad push into population health management. And in that capacity, he is participating in the Health IT Summit in Atlanta, to be held April 15-16, and sponsored by the Institute for Health Technology Transformation (iHT2). The Institute became a part of Vendome Group, LLC, Healthcare Informatics’ parent company, in December 2013. Fortini will be participating on a panel entitled “Insights from Patient data: Managing the Health of a Population.”

Below are excerpts from HCI Editor-in-Chief Mark Hagland’s recent interview with Mr. Fortini.

What have been your organization’s biggest initiatives around population health, to date?

The major bulk of our work has been around supporting our medical home project, and that has involved delivery system redesign, more robust use of technology, and then good old-fashioned nursing-based case management using those tools, so the development has been multi-factorial.

How long has the medical home initiative been “live” or active?

Robert Fortini, R.N., M.S.N.
It’s been three years that we’ve operationalized it. I was here the first year building infrastructure, and focusing on Epic go-lives in ambulatory. As of now, we’ve been using Phytel for about three years, and have been using the capabilities in Epic for the same period of time.

And what has been involved, at the level of physician practice?

We’ve been doing a number of things, including administrative data and doing population outreach. In that regard, we’ve developed 20 chronic disease care protocols, and 15 preventative service category protocols, for about 35 protocols altogether.

Do you have any very broad metrics on this that you can share?

Yes, on an annual basis, the outreach engine, the module in Phytel that we’re employing for population health, triggers about 75,000 contacts a year, and arrives, not just schedules, but arrives 35,000 patients, meaning that the system creates a charge based on an outreach phone call, with 35,000 patients contacted every month based on the protocols we’ve developed, and the leveraging of the population health system.

What has been your organizational process around sharing data with the physicians?

Our physician governance model is based on a dyad approach. Each practice has a physician champion/site lead who works in a dyad model with the practice administrator. At the next level, there are regional medical directors and regional administrative directors, and they’re paired. And at the apex of the organization, we have a leadership group called our Clinical Council; that group encompasses about 16 executive leaders, including hospital-based CMOs, administrators, and others. It acts like a board of directors.

Do you chair the Clinical Council?

I chair one of the five subcommittees of the Council. With regard to those five, we have one for leadership; one for growth and onboarding; one for quality and clinical transformation, and one of mission and due diligence; and one on compensation. I’m the chair of the quality and clinical transformation subcommittee, and all our clinical policies and procedures and clinical workflows are vetted through that. And we’re shifting towards value-based payment of our physicians. It’s a formula that includes different variables, including meaningful use. We’re an MSSP ACO, so they have to hit the MSSP 33s—the 33 measures involved in the MSSP program—and various other specialty-specific measures.

What have been the biggest lessons learned so far with regard to pursuing data-driven, IT-facilitated population health management, at Bon Secours Medical Group?

Not to quote Atul Gawande, but you can’t practice like a cowboy anymore, you need a pit crew. Medical practice has very much evolved into a team sport. And for any physician to attempt to comply with all the documentation standards anymore, alone, in a vacuum, it would be impossible to practice. So you have to take away as many of those obligations away from the physician.

And part of that means pushing down everything possible to mid-level practitioners, right?

Yes, and I would be very liberal in terms of my definition of “mid-level practitioner”—that doesn’t just mean a nurse practitioner or PA [physician assistant]: it can mean a nurse case manager, a PharmD, a dietician, a social worker. I use pharmacists very aggressively on outpatient care; in fact, I have PharmDs doing annual wellness visits across Virginia now.

How do you optimize the leveraging of the data, in a program like yours?

That’s a day-to-day struggle. We’re obviously eventually going to get to a much more sophisticated business analytics methodology that allows for cleaner risk stratification and actionable lists. But for the time being, we’re doing this with homegrown solutions; we’ve built out various patient registries within Epic, and have applied tools to those registries—for example, a daily discharge report by physician, so everybody knows who their patients were who were discharged from the hospital yesterday. Then they do a risk scoring based on length of stay, acuity on admission, co-morbidities, and ED visits within a six-month period. It’s well-established in the literature, and it’s called the LACE Scoring Method. It literally gives you a score from 0 to 19. LACE stands for “Length of Stay, Acuity at Admission, Co-Morbidities, and ED Visits.”

When did you go live with using the LACE scoring methodology within Epic?
Over two years ago now. And using that methodology, we’re calling about 1,500 patients a month, and scheduling about 700 patients a month for doctor visits. The LACE scoring methodology involves three ranges: 0-5, 5-11, and 11 or above. If patients have a score of 11 or above, it’s a no-brainer; bring them in. If they’re in the 5-10 range, you problem-solve with the physician and make a decision on the fly. But just based on that, we’re bringing in 700 patients.

Do you have any explicit advice for our readers, based on your experience so far?

I’ve told this story here in a number of different venues before, but I’ll say that I have new data to support all of my efforts, and we’ll be sharing that at HIMSS. And the data really proves the return on investment for investing in this type of care team infrastructure, even in a simplistic way, to achieve outcomes. The ROI [return on investment] I’m getting is coming up close to 3:1, and is holding up. The ROI from Phytel is close to 5:1. What that means is that, for every dollar it costs me in expense, I’m realizing three dollars in revenue. Our nurse case manager program is costing $3 million a year, but is generating $9 million in revenue, through annual wellness visits, Medicare Advantage patient assessments, and transitions of care codes that Medicare is paying, for managing patients.