2015 Baptist Physician Partners Value Report

Improving the quality and connectivity of patient care through a clinically integrated network.

BAPTIST Physician Partners

Mission

The mission of Baptist Physician Partners is to shape the future of health care in our community through an integrated partnership of providers and Baptist Health hospitals working collaboratively toward common goals for improving quality, safety, efficiency and outcomes for our patients.

Vision

- Develop a physician-driven network with strong citizenship and leadership representation from multiple specialties
- Align incentives for all stakeholders that reward demonstrated performance
- Foster a culture of collaboration between physician and health system leadership
- Utilize a data-driven approach that provides accurate, available, reliable, real time, granular data at the physician level to improve the quality of care to the patient
- Demonstrate clinical excellence that is recognized by patients, payers and employers
- Optimize service line delivery in a patient and family-centric model that results in the highest quality of care

***Timothy Groover, MD, FACHE**, Vice President and Chief Medical Officer, BPP; **Edward Sim**, President of Physician Integration at Baptist Health; **Kyle Etzkorn, MD**, Chairman of the Board, BPP*

Baptist Physician Partners is pleased to present our inaugural Value Report, highlighting our clinically integrated network's significant growth and momentum to date.

With a goal of reducing fragmentation in the delivery of health care and positioning ourselves for changing payment models, Baptist Physician Partners (BPP) is helping physicians put into place the building blocks of population management while continuing to deliver outstanding care to their patients.

Since its inception in 2013, BPP has focused on building the infrastructure and leadership capabilities needed to proactively prepare for the transition from volume to value. As of February 2016, we have more than 700 physician members actively enrolled in the network and more than 40 physicians participating on the board and committees. As we grow the BPP network, we are focused on filling perceived specialty gaps, and increasing physician engagement and participation within our governance structure.

We launched an ambulatory nurse care coordination service in the fall of 2014, focusing on chronic complex, high-risk adult patients in our primary care offices. More than 1,500 patients have been touched by this service. In this Value Report we share several patient stories, highlighting the impact that care coordination has on our patients and families — improving health outcomes, enhancing patient experience, reducing costs and minimizing duplication. Our care coordination team continues to grow and mature as we add additional resources and depth to manage complex hospital discharges and populations covered under payer contracts.

To support these efforts, BPP has put into place the technology solutions, which are vital for aggregating, tracking and monitoring patient data within patient registries. This enables the creation of patient care plans that are followed by the care coordination team and helps us to better understand and manage populations. It also allows us to work more collaboratively to enhance patients' outcomes and experiences and reduce potential duplication of services. Our physician members will soon have access to accurate, real-time data that can be used to further enhance quality of care, increase efficiency, and promote transparency of data.

As we look ahead, our roadmap is full of potential — developing and expanding quality metrics, further integrating with our post-acute partners, expanding our payer contracting opportunities and managing populations at every level of risk, from healthy to high-risk. We continue evaluating market dynamics, and adjusting our pace as needed to remain competitive in this ever-changing environment.

We look forward to working collaboratively toward common goals for improving quality, safety, efficiency and outcomes for our patients in the coming years. We value your feedback and thoughts on improvements that will enhance BPP in the years to come.

Sincerely,

Timothy Groover, MD
Vice President & CMO
Baptist Physician Partners

Kyle Etzkorn, MD
Chairman, Board of Managers
Baptist Physician Partners

Edward Sim
President, Physician Integration
Baptist Health

Board of Managers

Baptist Physician Partners is governed by a 16-member Board of Managers. This physician-led Board is comprised of 11 (independent and employed) physicians and five health system executive representatives. The Board of Managers is responsible for the overall strategy and direction of the Clinically Integrated Network (CIN) and approval of committee findings, recommendations and action plans.

- Performance Improvement
- Information Technology
- Membership & Quality
- Finance & Contracting
- Executive
- Nominating

Committees

Performance Improvement Committee

This committee evaluates and identifies participation and performance criteria to create a high-performing CIN. They are involved in defining the metrics and monitoring the ongoing performance of the CIN, as it relates to meeting the established quality and citizenship metrics.

Key milestones/achievements:

- Convened the Adult Ambulatory Care Coordination Workgroup to recommend the definition, strategy and framework for the development of BPP's ambulatory care coordination service
- Put forth recommendations for quality metrics applied to the Baptist Employee Health Plan, CY16 payer contracts, and citizenship metrics for shared savings distribution to physician members

Timeline and Milestones

Information Technology Committee

This Committee helps to develop the ambulatory vision and goals for IT, acts as a single source of communication and distribution of IT information to ambulatory physician leaders, and identifies/proposes solutions to enhance physician-to-physician real time communication and the patient experience by leveraging new and existing technologies.

Key milestones/achievements:

- Put forth recommendation for Explorys to become BPP's data analytics solution

Membership & Quality Committee

This Committee identifies and validates membership needs, reviews applications, and makes recommendations to the Board of Managers. The Committee develops the education and communication plan to support Initiatives and engages Baptist Health and the broader medical staff.

Key milestones/achievements:

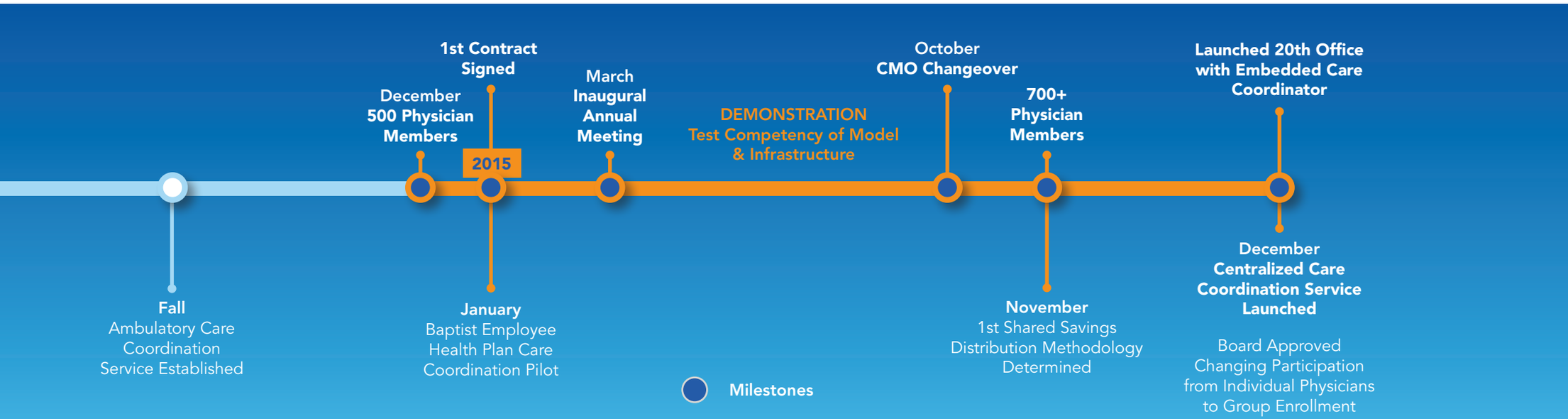
- Defined membership criteria and application process
- Developed outreach strategy to grow physician membership to 700+ physicians
- Established and recommended process to address "under-represented" specialties

Finance & Contracting Committee

This Committee evaluates the market's readiness to adopt CI payment models, identifies available contracting options to fund network development, and develops the distribution methodology that supports network objectives.

Key milestones/achievements:

- Developed and put forth recommendation for CY2016 shared savings distribution methodology
- Put forth recommendation for CY2016 Baptist Employee Health Plan agreement, BPP's first total cost of care agreement, managing approximately 16,000 lives



Care Coordination Service

341
diabetic patients currently under care coordination service

40%
of these patients had an improvement in HgbA1c following enrollment

Source: Cerner and Allscripts Touchworks (Oct. 2014 – Jan. 2016)

As we prepare for changing payment methodologies that tie reimbursement to value, the development of a scalable care coordination service is fundamental to the success of BPP.

How BPP Defines Care Coordination

BPP has engaged physicians and multidisciplinary stakeholders in the development of our adult care coordination model, which is defined as:

- Helping patients navigate the system, with improved access and communication across the care team
- Minimizing gaps in care
- Proactively managing patients at the lowest acuity setting with the appropriate resources
- Improving patient management and engagement
- Aligning providers and staff across the continuum of care

Initially, BPP's approach in selecting patients for care coordination was payer agnostic. We focused on those patients who were medically complex, had newly diagnosed or poorly controlled diabetes and were high utilizers of acute care services.

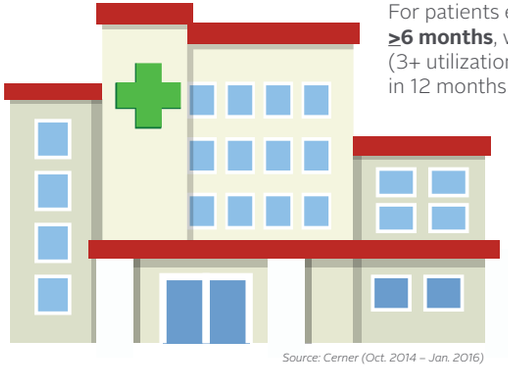
***Perry Carlos, DO**, Baptist Primary Care Physician with **Kathleen Ostynski, RN, BSN**, Ambulatory Care Coordinator, Baptist Physician Partners*

Since the launch of our care coordination service, we have begun to narrow our focus to those populations for whom we are contracted for shared savings. As the number of lives increases, we will scale the service accordingly. Over time, we intend to expand our care coordination reach over a broader continuum of care to include post-acute services and also to develop a pediatric care coordination model.

Our Evolving Care Coordination Model

Our model is a hybrid of embedded and centralized care coordination resources. Since our adult care coordination program launch in fall 2014, this team has touched nearly 1,600 patients.

Embedded Model – As of this report, BPP nurse care coordinators are embedded in 22 primary care offices that have high numbers of chronic complex patients and frequent utilizers of acute care services. These nurse care coordinators are referred high-risk, medically complex patients and are responsible for assessing their needs and intervening as appropriate. Guided by program objectives established by BPP leadership, care coordinators act as an extension of their respective offices, working in close collaboration with the physicians and care team. High patient engagement is attributed to



For patients enrolled in Care Coordination for **≥6 months**, who are classified as "high utilizers" (3+ utilization visits [ED, admissions, observations] in 12 months prior to enrollment):

Decrease in **overall utilization** by **27.5%** **post enrollment**

Decrease in **ED visits** by **42%** **post enrollment**

Source: Cerner (Oct. 2014 – Jan. 2016)

Helping Pat Take Control

When Pat Tonkovich was diagnosed with diabetes, his doctor provided printed patient education materials, along with a prescription and a glucose meter. "But I really didn't want to go on medication and I had no idea how to check my blood sugar," Pat said.

Fortunately, he had access to Mary, a BPP nurse care coordinator. "Mary showed me how to use the glucose meter and how to read the findings," said Pat.

Mary also helped Pat to modify his diet and stick to an exercise program. He lost 40 pounds in six months, and his hemoglobin A1C level went from 6.5 to 4.8.

"I feel empowered," said Pat. "I can do this. I'm not scared of diabetes anymore."

Keeping Mary on Track

As a stroke patient with atrial fibrillation, Mary Wilkerson is relieved she can count on Manuela, her BPP nurse care coordinator, to make sure her heart rate and blood pressure numbers are in the correct range.

"Manuela calls at least once a week to check on me and see how my numbers are doing," says Mary. The medication that Mary takes for Afib causes her nosebleeds; however, Mary has no worries, she calls Manuela who works with her doctor to adjust the dosage.

When Mary reported serious stomach pain, Manuela was able to get her in to see a gastroenterologist the next day. "Manuela is wonderful; she's saved me some trips to the ER," Mary says.

the "warm" handoffs that occur upon enrollment in care coordination by the referring physician during an in-office visit.

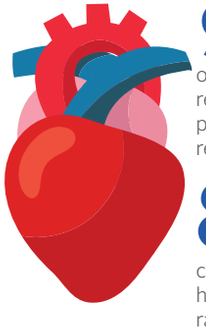
To help improve quality and decrease fragmentation of care, our nurse care coordinators provide disease management education, perform medication reconciliation, assist with community resources, and maintain frequent and routine contact with their patients. On average, a care coordinator's caseload is approximately 50 patients.

Centralized Model – Our centralized nurse care coordinators are focused on managing medically complex patients who are discharged from a Baptist hospital, as well as those high-risk individuals within the populations we serve through shared savings contracts. This model also supports primary care offices that have fewer chronic complex patients who could benefit from care coordination services.

While most of the patient interactions take place by phone, care coordinators may visit patients during their hospitalization to help anticipate potential problems that could affect post-discharge care. When patients are hospitalized, the care coordinators monitor the hospital course and assist with making timely follow-up appointments needed after discharge.

Care Coordination Workflow Management

To ensure they can be efficient and effective, our care coordinators must have access to timely patient data. Computerized technology supports their workflow management and documentation needs.



98
open heart surgical patients referred to care coordination post-operatively, with a readmission rate of

8.3%
compared to the overall open heart surgery readmission rate of **17%**.

(For the time period April 1 – Nov. 2015)

In December 2015, BPP began implementing Allscripts Care Director, which is used by the care coordination team to:

- Prioritize and manage lists of new and existing care coordination patients
- Provide assessment and create evidence-based care plans that can be sent to the physician's EMR as well as shared with the patient and family
- Receive notification when a care coordination patient is admitted to the hospital
- Obtain discrete data, measuring the care coordinators' activities, interventions, and impact on patient outcomes

Continuing the Journey

In 2016, our care coordination leadership team will work in concert with the Performance Improvement Committee to develop medical management guidelines, based upon nationally accepted standards of care. Our goal is to decrease clinical variation and evaluate drug costs; develop standardized patient education materials; and to identify and pilot patient engagement tools. Additionally, we will focus on closing care gaps for our contracted lives and working collaboratively to reduce readmission rates.

For BPP and the care coordination team, success is measured by improved quality and patient outcomes, positive patient and family experiences and reduced costs. We look forward to sharing additional data in next year's Value Report as our service matures and more data is available regarding our contracted populations.

Patient Satisfaction Survey Results

Care Coordinator listens and answers questions **3.64**	Care Coordinator works well with PCP and other providers **3.62**
Satisfied with amount of time Care Coordinator spends addressing needs **3.60**	Easy to reach office and Care Coordinator **3.50**
Clear understanding of plan of care **3.50**	Care Coordinator involves family and caregiver, based on preference **3.50**
Care Coordinator has improved management of chronic condition **3.39**	Key 4 Strongly Agree 3 Agree 2 Disagree 1 Strongly Disagree

Overall Score **3.54**

Risk Stratification

Different levels of disease risk require different levels of intervention, care management, and resources. Naturally, BPP's initial focus has been on the high-risk population because they are high utilizers of acute care services with many complex medical issues. As our model matures, our focus will continue to expand to other risk levels, allowing us to develop appropriate strategies for each strata. Explorys, our data analytics platform, will help facilitate our risk stratification analysis.

Data Analytics Platform

Clinically integrated networks need meaningful data to understand the populations being managed and to assess a longitudinal view of each patient's health status.

Baptist Physician Partners' Information Technology Committee conducted an extensive review of available data analytics platforms and recommended the selection of Explorys. The Explorys platform will aggregate data from disparate sources including clinical, claims, and billing data to allow BPP to analyze and manage outcomes, risk potential and costs across the continuum of care. We have recently completed the first phase of our implementation, involving the mapping and validation of two EMR data sources (Cerner & Allscripts Touchworks) and claims data for our first contract with the Baptist Employee Health Plan.

Provider Validation

A critical phase of deployment includes validation of the data to ensure that it is accurate, complete, and reliable. Extensive work has been completed to ensure data sources are "trusted" prior to deployment to providers. Data validation policies and procedures have been established, and providers have been engaged throughout the process.

***Timothy Groover, MD, FACHE**, Vice President and Chief Medical Officer, BPP, and **Pamela Rama, MD,** BPP Finance and Contracting Committee Member, review metrics currently built in Explorys.*

Explorys displays relevant, actionable data utilizing two primary tools: metrics dashboards and patient registries.

Metric Dashboards

Using dashboards, providers can monitor their performance on quality metrics and compare their individual results to their practice's performance, BPP's performance, and established benchmarks. In addition, the provider has the ability to identify patients who are not meeting the metrics in real-time, so that proactive intervention can be applied. To date, 19 primary care metrics have been built and are in final stages of provider validation.

Patient Registries

As BPP and its providers work together to successfully track and manage patient populations, seven preventative and/or disease based registries have been built to provide clinically relevant information on groups of patients at a glance. Within a diabetic registry, a provider can easily identify potential gaps in care by viewing the last A1C result, last office visit, and other data points. In addition, the provider can stratify risk within a subset of patients and identify high-risk patients who would benefit from more aggressive intervention. Providers and care coordinators can reach out to these patients to schedule appointments, develop care plans or link them to care management programs sooner. These timely actions will lead to an improvement in quality outcomes and the patient experience, while decreasing unnecessary and/or preventable acute care utilization.

In January, BPP began a multi-phased roll out of our data analytics toolset to our primary care providers. This roll out includes final provider validation, a pilot of the metric communication tools and subsequent sharing of data to all primary care providers.

In the coming year, BPP will begin to integrate additional claims data to mirror future shared savings payer contracts and new EMR sources to support management and prevention of diabetes and cardiac-related conditions. We also plan to expand primary care metrics and begin exploring the creation of specialty-specific metrics.

Our focus remains on providing valid, accessible and transparent data to support our providers' continued ability to deliver high-quality, cost-effective patient care.

In a sense, the wait for BPP's analytics platform has been like the anticipation of the newest smartphone release. As we take off the plastic wrapping and push the ON button, the measure of success will lie in how well the new technology helps to move us toward our goals of improving the quality of health care across the care continuum, and reducing the associated costs.

Our data analytics toolset will help us improve quality and value across the care continuum.

Quality improvement across the continuum

During fall 2015, BPP experienced a transition in physician leadership. David Rice, MD, our inaugural Chief Medical Officer, was named Baptist Health's new vice president and Chief Quality Officer (CQO), becoming the first physician to lead the quality charge for the health system.

The CQO is focused on quality improvement across the continuum of care at Baptist. This new role broadens the opportunities for collaboration and communication that have already begun to take place with BPP's care coordination teams. The BPP ambulatory nurse care coordinators regularly interface with Baptist's inpatient nurse navigators, ER care managers, social workers, and home health team to better coordinate care in a longitudinal manner.

In January, BPP, under the direction of Mary Leen, Director, Ambulatory Care Coordination, hosted its second annual care coordination retreat for more than 70 team members across the health system. Topics included industry updates on population health and the payment shift from volume to value, advance care planning and palliative & hospice care, clinical updates on chronic diseases, community health & wellness resources, and coaching on techniques for better patient engagement.

Our collaboration and partnership will continue to grow as Dr. Rice builds the necessary infrastructure, teams and culture to support the strategy and focus on zero patient harm. Through concentrated efforts on hand hygiene, reduced readmission rates, and transparency of data, the collaboration between the quality teams at Baptist and BPP will help us achieve the triple aim – improved outcomes and patient experience at a reduced cost.

Craig Shapiro, MD, *Designated Quality Physician Champion and BPP member;* ***David Rice, MD,*** *Vice President and Chief Quality Officer at Baptist Health;* ***Michelle MacDonald, RN,*** *Director of Cardiovascular Services at Baptist Jacksonville; and* ***Tammy Daniel, RN****, Vice President of Patient Care Services at Baptist Jacksonville, debrief during hospital rounds.*


BAPTIST HEALTH
RN

Helping Ken remain independent

Ken Heusinkveld, 85, has atrial fibrillation and macular degeneration, which makes reading his prescription bottles quite difficult. Living on his own, he had nobody to help him until Kathleen, a BPP nurse care coordinator, stepped in. Ken visits Kathleen once a week so she can go through his daily pill holder and make sure the right pills are in the right slots. She also checks his vital signs and sometimes, she just listens. "I just don't know what I would do without Kathleen," says Ken. "She's helped me hold onto my independence."

Kathleen is glad she's been able to help. "We've been able to keep him out of the hospital and maintain his quality of life," she says.

Performance Measures

Metrics for 2016 Contract with Baptist Employee Health Plan

ADULT

Preventative/Wellness

Breast Cancer Screening

Percentage of female plan members 50-74 years of age who received a mammogram during CY2016 or CY2015. (Excludes women having bilateral mastectomy.)

Colorectal Cancer Screening

Percentage of plan members 50-75 years of age who received the appropriate colorectal cancer screening.

Condition Specific Care

Controlling High Blood Pressure

Percentage of plan members:

18-59 years of age whose last BP on record in CY2016 was <140/90 mm Hg; or

60-85 years of age with a diagnosis of diabetes (Type 1 and Type 2) whose last BP on record in CY2016 was <140/90 mm Hg; or

60-85 years of age without a diagnosis of diabetes whose last BP on record in CY2016 was <150/90 mm Hg.

Diabetes Care (Type 1 and Type 2)

Blood Sugar Control

Percentage of plan members 18-75 years of age with diabetes (type I and type 2) who had HbA1c of less than 8.0% during CY2016.

HbA1c Testing

Percentage of plan members 18-75 years of age with diabetes (type I and type 2) who received an HbA1c test during CY2016.

Diabetes Nephropathy Test

Percentage of plan members 18-75 years of age with diabetes (type 1 and type 2) who received a nephropathy screening test (or had evidence of nephropathy) during CY2016.

Cost and Efficiency Measure

Percentage of Generic Prescriptions

Percentage of total generic prescriptions dispensed during CY2016 compared to the total prescriptions dispensed during CY2016 (based on Florida Blue pharmacy claims for CY2016).

PEDIATRIC

Preventative/Wellness

Asthma

Percentage of pediatric members 5-18 years of age with an asthma diagnosis who had at least one prescription asthma controller during CY2016.

Immunizations

Percentage of pediatric members 2 years of age who received required immunizations by their second birthday.

What Patients Value About Care Coordination

"She answers all of my questions and provides clarification on things that are not clear to me."

"Checking with me regularly to keep me motivated."

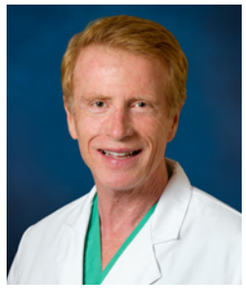
Board of Managers

Kyle Etzkorn, MD
Chairman

Jennifer Fulton, MD
Vice Chairman

Timothy Groover, MD, FACHE
Chief Medical Officer

Charles Cousar, MD



Paul Dillahunt, II, MD

Michael Erhard, MD

A. Hugh Greene, FACHE

Cam Greene, MD

Ceree Harden

Richard Picerno, MD

David Rice, MD

Edward Sim

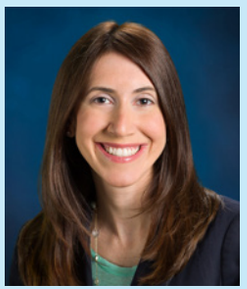
Todd Snowden, MD

Keith Stein, MD, FCCM, FCCP

Mark Stich, DO

John Wilbanks, FACHE

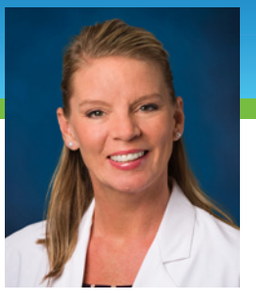
Scott Wooten, FACHE



Sharon Kaplan, FACHE
Executive Director
Baptist Physician Partners

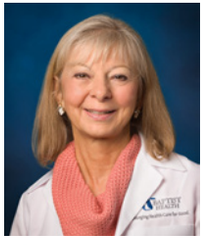
Care Coordination Team As of February 2016

Mary Leen, ARNP
Director, Ambulatory Care Coordination



Katie Kiley, RN
Manager, Ambulatory Care Coordination

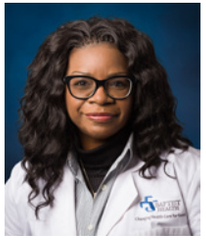
Centralized Model



Paulette Daniel, RN
Medically Complex

Lynn Overbey, RN
Baptist Employee Health Plan

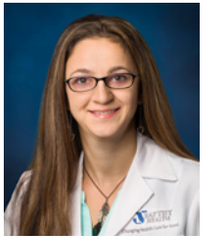
Embedded Model



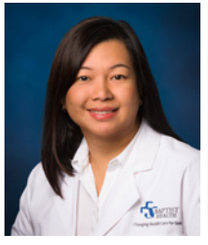
Alysia Agnew, RN
Kingsley
Roosevelt

Anna Barrett, RN
Black Creek South
Fleming Island

Wilma Bolden, RN
Yulee



Manuela Cismaru, RN
Lakewood



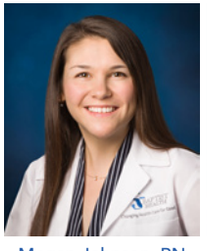
Jane Gemoto, RN
Bartram Park

Lauren Harris, RN
Pavilion

Cathy Henderson, RN
Collins Road

Christine Hilario, RN
Regency Square

Veronica Holmes, RN
Mandarin South

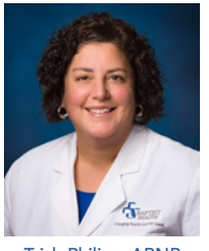


Megan Johnson, RN
IMG

Laurie Krause, RN
Lane Avenue

Dana Moser, RN
Ponte Vedra

Kathleen Ostynski, RN
Mandarin North



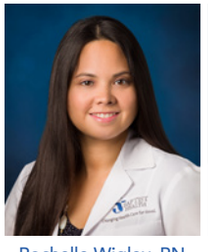
Trish Philips, ARNP
Larmoyeux

Kathryn Rothstein, RN
Baptist South IM

Ruby Rupac, RN
Pavilion

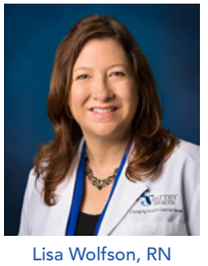
Yashica Smalls, RN
Harbour Place

Harriett Stephens, RN
Lane Avenue



Rochelle Wigley, RN
IMG

Patsy Williams, RN
University
University South



Lisa Wolfson, RN
Baymeadows
Reedy Branch

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Ceree Harden
Aalok Kuthiala, MD
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Terry Hayes, MD
Girish Shroff, MD
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Peter McGraw, MD
Matthew Paton, MD
David Rice, MD
James Smart, Jr., MD
Carlos Sotolongo, MD
Keith Stein, MD
Mark Stich, DO
Maryellen Wechter, MD

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Bethany Atkins, MD
Amanda Bagby, MD
Julie Baker, MD
Jonathan Balog, DO
Darlene Bartilucci, MD
Mark Bedard, DO
Regina Bielawski, MD
Virginia Black, MD
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Traci Bragg, MD
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Gerald Burford, MD
John Butcher, MD
Patricia Calhoun, MD
Anthony Capasso, MD
Jing-Jing Cardona, MD
Perry Carlos, DO
David Carter, MD
James Cheek, MD
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564
Specialists

420
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