Second Quarter 2015

Mission: We provide superior healthcare and value through an integrated partnership among patients, providers, and community resources.

Chairman of MWMD Board

Message from Thomas A. Janus, MD

The Alliance is thriving in its mission to achieve triple aim goals and to permit the physicians and the hospitals associated with the Alliance to maintain their independence. It is my belief that the principals the Alliance is trying to achieve (improving the health of our population and the patient experience of care while controlling the cost of care) will improve both the satisfaction we derive from our work and secure our financial stability in this healthcare reform environment.

One of the goals of the Alliance is to be transparent to our membership. I feel we have been successful in our efforts to be open and honest regarding our plans for the future. I want our members to know we will go to any extreme to be as transparent in our intent as we can be and I can assure you, the board works for all members of the Alliance. This is your Alliance, and I do believe strongly it is our future.

If you have a concern or problem, please feel free to contact either myself, any member of the board, or Travis Turner and we will help clarify as best we can. We are here to serve and protect the interests of our members.

Thomas A. Janus, DO

Welcome New Providers & Practices

- **PL Physicians-Pediatrics**
  Farangis Habib, MD
- **Virginia Center for Allergy and Asthma**
  Darshana Alle, MD
- **Aquia Family Medical Center**
  Tedla Anbessie, MD
  Yared Gebreyesus, MD
  Getachew Woldeher, MD
- **Internal Medicine of Virginia**
  Abla Awadh, MD

Referrals to Physical Therapy

When referring MWHC associates to PT please use the list of Alliance physical therapy practices below unless there is a medically necessary service not offered on the list:

- Fredericksburg Orthopedic Associates Physical Therapy in Fredericksburg, Stafford, Spotsylvania and Woodbridge (540) 479-4764
- Orthopedic Specialty Clinic and MidAtlantic Spine and Rehab Clinic in Fredericksburg and Massaponax (540) 361-1830
- Pratt Medical Physical Medicine and Rehabilitation (540) 785-7617
- Liberty Sports and Physical Therapy (Central VA Orthopedics & Sports Medicine) 540-372-6745
- Truong Rehabilitation Center (540) 374-3164
- Mary Washington & Stafford Physical Medicine and Rehabilitation Outpatient Services at MWH (540) 741-1542 & SH (540) 741-9647

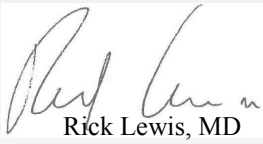
Inside this Issue:

Message from the Medical Director—Richard Lewis, MD

"To Screen or Not to Screen?" – That is the Question

Screening for treatable illnesses not otherwise apparent is something almost all of us incorporate into our practices, some (notably PCPs) to a greater extent than others. But since the nature of screening is such that most test results will be negative, it is crucial that the test have a high negative predictive value, be relatively simple and affordable, be universally applicable and be safe. The ACP (American College of Physicians) has done us all a great service in the form of the recent publication of "Screening for Cancer: Advice for High-Value Care from the American College of Physicians" (Ann Intern Med; 19 May 2015; 162(10):718-725). The ACP initially developed a framework to be used to understand how the value of screening strategies varies with their intensity which was published in the same issue on pages 712-717. This framework was then applied to available screening strategies for asymptomatic, average-risk adults for 5 common types of cancer having reviewed clinical guidelines from multiple relevant organizations, randomized clinical trials and studies of cost and resource use. "**High Value**" was defined as the lowest screening intensity threshold at which organizations agree about screening recommendations for each type of cancer and "**Low Value**" as agreement about not recommending overly intensive screening strategies. The following table summarizes their findings but I encourage you to look at the article itself which includes an additional 13 "High Value" care advice statements and provides more detail as to the rationale for recommendations as well as sources of data.

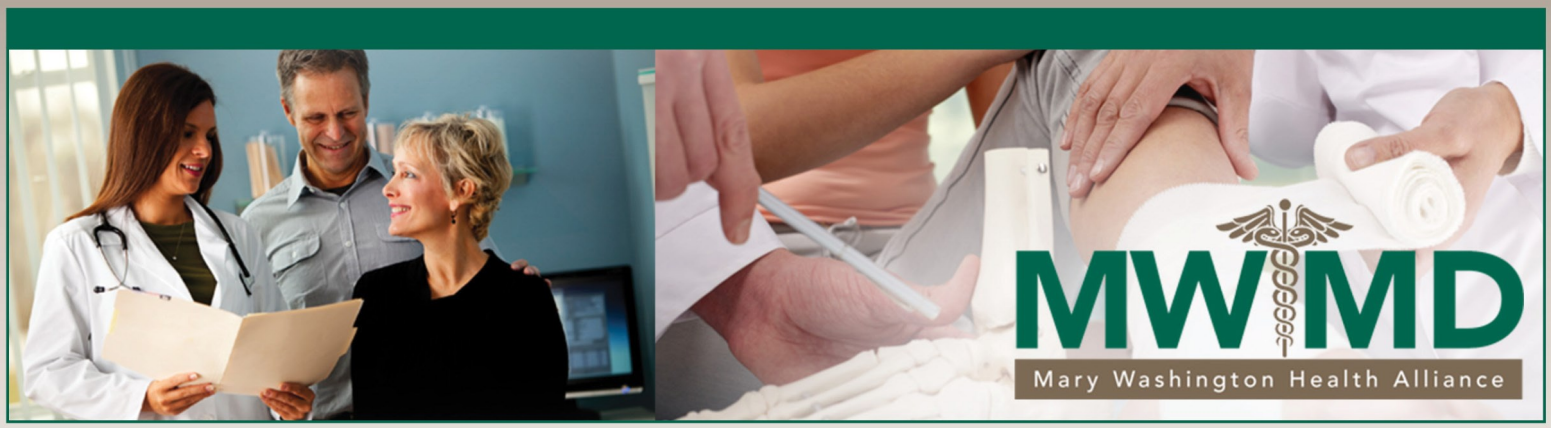
The ACP "strongly encourages clinicians to adopt a cancer screening strategy that focuses on reaching all eligible persons with these high-value screening options while reducing overly intensive, low-value screening". Taking these recommendations to heart will help the Alliance achieve our Triple Aim goals.



Rick Lewis, MD

Table 1. High- and Low-Value Screening Strategies for 5 Types of Cancer*

Cancer Type	Least Intensive Recommended Cancer Screening Strategies (High Value)	Cancer Screening Strategies That Are Not Recommended (Low Value)
Breast:	Women aged 40–49 y: Discuss benefits and harms with women in good health, and order screening with mammography every 2 y if a woman requests it Women aged 50–74 y in good health: Encourage mammography every 2 y	Women aged < 40Y or ≥75y and women of any age not in good health and with a life expectancy <10y : Any screening Women of any age: Annual mammography, MRI, tomosynthesis, or regular systematic breast self-examination
Cervical:	Women aged 21–29 y: Cytology testing every 3 y Women aged 30–65 y: Cytology testing every 3 y or cytology and HPV testing every 5 y	Women aged <21y or >65 y with previous recent negative screening results: Any screening Women of any age without a cervix: Any screening Women aged 21–65y: Cytology testing more frequently than every 3 y Women aged <30y: HPV testing Women of any age: Pelvic examination
Colorectal:	Adults aged 50–75y: Encourage 1 of the 4 following strategies: High-sensitivity FOBT or FIT (every year); sigmoidoscopy (every 5 y); combined high-sensitivity FOBT or FIT (every 3 y) plus sigmoidoscopy (every 5 y); or optical colonoscopy (every 10 y) (FOBT = Fecal Occult Blood Testing) (FIT = Fecal Immunochemical Test)	Adults aged 75y or adults of any age not in good health and with a life expectancy <10y : Any screening Adults aged 50–74y: Repeated colonoscopy more frequently than every 10y or flexible sigmoidoscopy every 5y if results of previous colonic examination were normal (i.e. without adenomatous polyps) Any age: Interval fecal testing in adults having 10y screening colonoscopy or more frequently than biennially in adults having 5y screening flexible sigmoidoscopy
Ovarian:	None	Women of any age: CA-125 screening, TVUS, or pelvic examination
Prostate:	Men aged 50–69y: Discuss benefits and harms of screening with men who inquire about PSA-based screening and are in good health with a life expectancy >10 y at least once (or more as the patient requests), order screening only if the informed man expresses a clear preference for screening, and order PSA testing no more often than every 2–4 y	Men aged 50–69y who have not had an informed discussion and have not expressed a clear preference for testing after the discussion: PSA testing Men aged <50y or >69 y and men of any age who are not in good health and have a life expectancy <10y: Any testing



Generic Alternatives

Generic Alternatives for Popular Name Brand Drugs

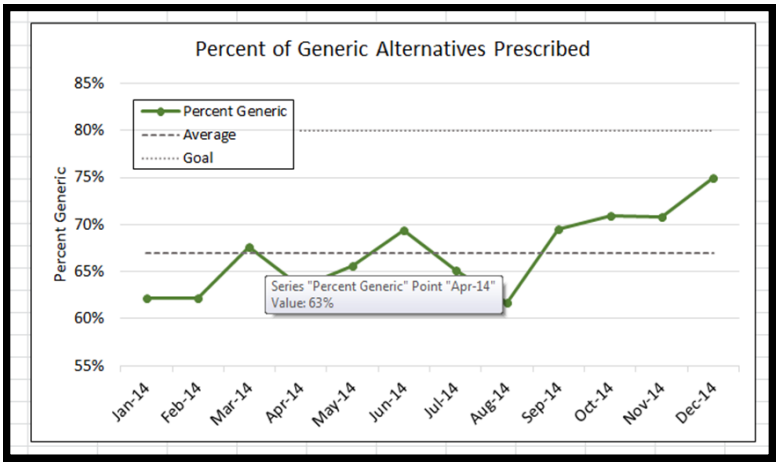
Recalling that (1) Generic Utilization Rate is one of our Network Core Measures for 2015 and (2) that the potential savings to our Network for every 1% increase in generic drug utilization is $200,000 - $400,000 dollars, I thought it would be useful to share the following table of our top 27 prescribed brand name drugs that have reasonable generic substitutions:

Generic Alternatives for Most Costly Prescribed Brand Name Drugs

Rank	Brand Name	Appropriate Generic Substitutes
#1	Nexium	Esomeprazole Magnesium
#2	Synthroid	Levothyroxine Sodium
#3	Nasonex	Fluticasone, Flunisolide
#4	Diovan	Valsartan
#5	Dexilant	Lansoprazole, Rabeprazole, Pantoprazole, Esomeprazole
#6	Lyrica	Pregabalin
#7	Celebrex	Celecoxib
#8	Benicar HCT	Losartan, Valsartan or Irbesartan plus HCT
#9	Benicar	Losartan, Valsartan, Irbesartan
#10	Viibryd	Citalopram, Duloxetine, Excitalopram, Fluoxetine
#11	Coreg CR	Carvedilol
#12	Glumetza	Metformin
#13	Astepro	Astelin, Azelastine Nasal, Flunisolide, Fluticasone
#14	Lunesta	Eszopiclone, Temazepam
#15	Intuniv	Guanfacine
#16	Epiduo	Azelex, Clindamycin Phosphate, Differin
#17	Aczone	Azelex, Clindamycin Phosphate, Differin
#18	Welchol	Cholestyramine, Colestid
#19	Focalin XR	Dexmethylphenidate
#20	Cymbalta	Duloxetine
#21	Welchol	Cholestyramine
#22	Vesicare	Solifenacin Succinate
#23	Azor	Amlodipine plus Valsartan, Losartan or Irbesartan
#24	Veramyst	Fluticasone Propionate
#25	Exforge	Amlodipine plus Valsartan
#26	Diovan HCT	Valsartan plus HCT
#27	Singular	Montelukast Sodium

Generic Drug Utilization Rate

As you can see from the graph below, we have been doing a great job as a Network improving our generic utilization rate for our MWHC self-insured lives from 62% to 75%. Hopefully, the information in the Generic Alternatives table will prove helpful in our continuing this trend as we approach our goal of 80% generic drug utilization.



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Committee Corner...

Message from Dr. Susan Holland
Chair, Clinical Quality Committee
Board of Managers

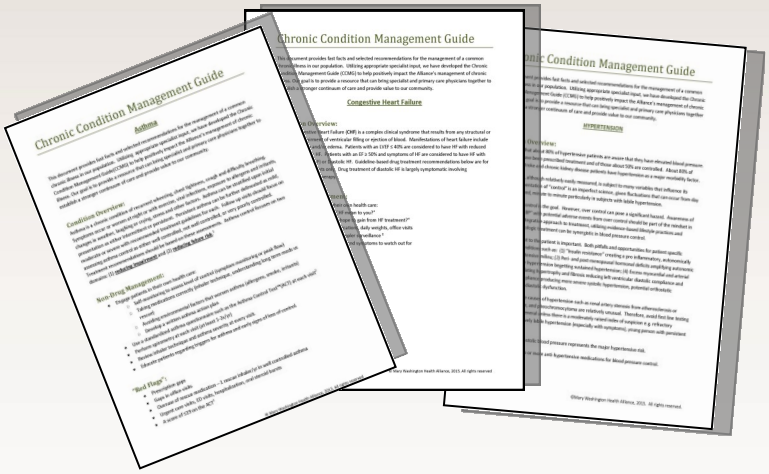
The Quality Committee continues to meet monthly. We have been busy putting together Chronic Condition Management Guides (CCMG's) . These are very concise guidelines including up to date, evidence based recommendations for management of chronic disease states. They have been compiled by our own specialists, and brought to our diverse committee for discussion. Review has centered mostly around usefulness to primary care providers.
We have completed and approved three to date, including: CHF, Asthma and HTN. These were distributed to all Alliance members via email from Dr. Lewis and will soon be available for perusal and downloading from our MWMD website.

Work is currently being done on the following topics: DM2, chronic back pain and COPD. We are also working on a guideline for outpatient management of chest pain.

The committee is considering presenting some of these topics together with distribution of physician specific performance and outcomes data at periodic provider Town Hall meetings.

We are also considering future topics including mental health issues, and discussion of streamlining flow between hospital and office based providers. We welcome suggestions for future topics.

We would like to extend a special thanks to Drs. Sikora, Wenger, Kallay, Lewis, Vranian, Parab, Janus, Sheets and Suthar for their work to date on these projects. We would also welcome anyone who would be interested in contributing to future projects to contact the committee.



Alliance Care Coordination Efforts

We have been fortunate since early March to have Joan Snyder leading our care coordination efforts. As you know, effective care coordination is key to the success of any ACO. Over this relatively brief period of time, a lot has already been accomplished. We have been using claims data to identify our high risk/high utilizer patients as well as asking our primary care physicians (PCPs) to identify complex cases that could benefit from our care coordination efforts. We have begun to engage patients with chronic illnesses and multiple co-morbidities. A notification system has been established to alert us when our patients are hospitalized which allows us to initiate face-to-face contact with our patients. This helps to ensure that there will be appropriate care transition and post-acute care coordination efforts to optimize a patient's health status and reduce readmissions. In large part, this involves networking with navigators and other key coordinators. We have also established a documentation system and identified appropriate program metrics to follow.
We are in the process of hiring additional personnel to expand our care coordination/population health management team.

Future plans involve branching out to coordinate with other community providers and services (see Box)

We anticipate eventually having access to a notification system to alert us when our patients register in the ED. We would like to collaborate with pharmacies, integrate advance care planning and palliative care, develop patient and provider satisfaction tools and incorporate social work into our care management programs. Clearly an ambitious but worthwhile agenda. We will of course keep you posted all along the way and hope that our efforts will be manifested in improvement in the health status of your patients and the efficiency of your practices. We look forward to your feedback as to how we are doing as well as getting suggestions from you as to how we can improve.

Future Plans

- Building relationships with PCPs
- Creating collaborative care plans
- Building rapport with Post Acute Care facilities such as skilled nursing homes
- Developing a resource guide for clinical, community and social service resources

New Website Enhancements

WEBSITE UNDER CONSTRUCTION

MSSP ACO Stand Alone Website

The stand alone ACO website has recently been approved by CMS for the Alliance's public reporting requirement.

It can now be accessed at URL (mwmd-aco.com). In addition, look for a link from the Alliance web page to the new website.

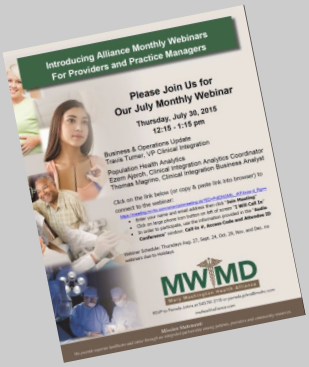
Alliance Website—New Content and Photos Coming

Look for changes in the coming weeks to the Alliance website to include up-to-date information and photos.

Visit both websites with all of the recent updates and changes at http://MWHealth Alliance.com and http://mwmd-aco.com

Alliance Webinars

Providers and practice managers, are invited to join us on the last Thursday of every month at 12:15 pm for our educational webinars. They are designed to provide additional details on the most recent Alliance activities, analytics and quality reports. A Q & A session is offered for further questions related to the topics discussed.



Please join us for our next webinar on Alliance Population Health Analytics on Thursday, July 30 at 12:15 pm.

Contact Pam Johns at (540) 741-2118 for the webinar link.

Alliance Slider Banner

Check out the latest slider banner which allows multiple pieces of content to occupy a single prominent space at the top of the Alliance website. Our banners feature current events, new developments as well as welcoming new providers to the Alliance. A new Events tab also includes articles of interest to the Alliance providers.

Heart Caring Physician Designation

HEARTCARING

Achieving HeartCaring physician designated status signifies a commitment to the special healthcare needs of women with a particular focus on their gender and sex sensitive cardiovascular care needs. If you are interested in being designated as a HeartCaring physician, please express this interest in an email to Pamela Johns at pamela.johns@mwhc.com.

HeartCaring Designated Physicians:

John	Cardone, MD	Virginia Cardiovascular & Thoracic Surgery
F. Lynn	Clemo, MD	Chancellor Internal Medicine
Gregory	Kauffman, MD	Cardiology Associates of Fredericksburg
Richard	Lewis, MD	Cardiology Associates of Fredericksburg
Thomas	Martyak, MD	Virginia Cardiovascular Consultants
Hong	Nguyen, MD	Chancellor Internal Medicine
Mary	Shuman, MD	Rappahannock Women's Health Center
Kurian	Thott, MD	Women's Health & Surgery Center
Robert	Vranian, MD	Virginia Cardiovascular Consultants

July 2015

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19	20 Membership & Operations 7:00 - 8:30 am Suite 309 FHA	21	22	23 Clinical Quality 7:00-8:00 am 1 West A MWH	24 Comm. & Educ. 7:30-8:00 am TMMP CR E	25
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August 2015

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September 2015

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ALLIANCE EVENTS