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

Chairman of MWMD Board

To succeed in population health, reduce cost, and improve quality and patient satisfaction, it has to begin with primary care physicians. Only via a well functioning primary care workforce can we achieve better care by way of a commitment to prevention, adherence to evidence based medicine and reducing cost through a reduction in low value and unnecessary services.

As such, newer programs have been created to assist primary care physicians with these goals.. Reimbursement for these services is recognized by both CMS and the commercial plans. Transitioning from a strictly fee for service to a fee for value methodology, PCPs should anticipate a larger portion of their total income streaming from these types of initiatives. I would like to utilize this article to review some of these programs which will improve reimbursement for physician practices, and benefit MWHA as well.

Annual Wellness Visits (AWVs), are nothing new nor novel to Alliance physicians. A great asset for physicians, it reimburses $175 for the initial AWV and then $119 for each subsequent AWV. Likewise there is a great benefit to the Alliance, as each AWV will augment our attribution, assist in achieving our quality measures and close gaps in care. An example of the financial benefit to physician practices, one of our internal medicine groups achieved $260,000 in reimbursements from AWVs last year.

Transitional Care Management (TCM), reimburses physicians for overseeing the care of a patient for the 30 day period post discharge from a hospital or SNF. The concept is to intensely manage the patient during this high risk time for readmission to an acute care hospital. Reimbursement for this program ranges from $167 to $236 based on the level of complexity.

Chronic Care Management (CCM), is a program that reimburses for non face to face services with Medicare beneficiaries who have multiple, significant chronic conditions. These services include communications with the patient or family members, or with other health professionals for care coordination and medical management. A monthly stipend of $42 per month is provided for each Medicare beneficiary enrolled in the program. CCM is a great tool for assisting the high risk and rising risk patients within the Alliance

In addition to these programs, the Alliance offers our own care coordination programs for both Medicare and commercial payments. Successful performance in these programs will reimburse primary care physicians $9 per quarter per attributable Medicare patient, and $1 per month for each commercial insurance attributable patient.

Finally, with the passage of the ACA came reimbursement for assessments of certain medical disorders such as depression screening, alcohol and drug use and abuse, tobacco cessation counseling, as well as developmental screening. These are all assessments primary care providers perform routinely, but may not be coding and billing to receive reimbursement

If all the above modalities were performed on a regular basis, we would be well on our way towards value based care and population healthcare management. The utilization of these modalities will reduce the cost of caring for our patients while at the same time enhancing both quality and patient satisfaction. Perhaps just as important, it is justly paying those providing these services.

For more information on any of these programs, please feel free to contact either myself or the MWHA administrative staff.

Thomas A. Janus, DO

Inside this Issue:

Committee Corner...

Message from Daniel Woodford, MD
Chair, Clinical Quality Committee,
Board of Managers

Quality Committee Update

As we continue to work as an Alliance towards achieving the Institute of Healthcare Improvement's Triple Aim goals of improved patient experiences and population health while lowering cost, the Quality Committee has determined to shift our paradigm from a focus on metric performance and reporting to global management of specific disease processes or conditions that impose the greatest burden on our system. Metric performance and reporting is critically important but tends to fall almost exclusively on individual providers, generally at the primary care level. Furthermore, we have developed a very strong team of analysts and a system of data extraction that has made our metric reporting incredibly efficient and centralized. We all owe this team our gratitude for covering our collective quality reporting requirements under the previous PQRS and evolving MACRA environment!

Moving forward, though, our new paradigm focusing on disease processes is intended to harness the true strength of the Mary Washington Health Alliance—cooperation and collaboration among our specialists, who are experts in their chosen fields; primary care providers, who are our patients' partners and advocates for their care; and a hospital system that has combined a historical commitment with a new progressive impulse to care for our regional community. Our shared objective is to provide the safest, most advanced and effective healthcare possible in a fiscally responsible manner, and by emphasizing a multidisciplinary approach, become a type of "center of excellence" that will attract patients from our region and beyond.

Over the last six months or so, we have launched our new approach with a pilot program aimed at improving our system-wide care for patients with COPD, which is an exceptionally prevalent problem in our community, and are in the midst of developing a more formalized process for managing back pain and addressing the use of opiates in our community. As part of the COPD pilot, our pulmonologists have stepped up wonderfully to engage with more of these patients in the hospital and provide early follow up after discharge. Our navigators on the hospital side along with the Alliance's RN Care Coordinators, who are really the connective tissue of our organization, have been able to develop more tools by which to remain in contact with our targeted patients both in and out of the hospital and ensure consistent care is being given. We have partnered with the Palliative & Hospice Care team to provide more goals of care discussions and perhaps eventually supplement outpatient care. And, of course, we are asking our primary care providers to help coordinate all these efforts by seeing these patients as soon as possible after hospital discharge.

With regard to back pain treatment and opiate use, we are engaging our neurosurgeons, orthopedic spine surgeons, and physical medicine & rehab specialists to define and aggregate the latest specialty-specific guidelines on management of acute back pain. By defining the appropriate available resources, we hope to expand the capacity of the Alliance to cover these episodes beyond what our primary care providers can do in the regular course of business and mitigate the inappropriate use of the ER. Furthermore, we hope to use this issue as a means of developing models for communicating with both our member providers and our patient population on health related topics and Alliance resources.

Overall, we are very excited about the direction the Alliance is taking towards enhancing patient experiences and improving population health and quality of care. We cannot emphasize enough that in these efforts, our strength is our diversity of training and expertise and we intend to utilize that to the fullest. To that end, I would enthusiastically invite any Alliance member to provide the Quality Committee with any input or ideas you might have regarding specific disease management, collaborative projects, or ways the care coordination team might enhance your patient care. We truly desire a recognition by each member of the Alliance of the value that is added by working together as a multidisciplinary team to create a level of care our community deserves!

Message from the Medical Director—Richard Lewis, MD

Your Alliance and the Quadruple Aim

You're probably all familiar with the concept of the "Triple Aim" © which was first introduced by the Institute for Healthcare Improvement (IHI) in 2007. The goal of the triple aim is to provide a framework for a healthcare system focused not on volume, but on improved quality of care and patient satisfaction, better health outcomes for the population and reduced costs. With **46%** of U.S. physicians now experiencing symptoms of "burnout", there is a renewed focus on physician well-being as being a component of what is now being referred to as the "**Quadruple Aim**".

The Quadruple Aim

You're probably also familiar with the many **contributing causes to physician burnout** – a syndrome characterized by emotional exhaustion and depersonalization; a feeling of reduced personal accomplishment, loss of work fulfillment, and reduced effectiveness:

- Too many **regulations**
- Excessive **hours** worked
- Convoluted health care reform **laws**
- Lack of professional fulfillment
- Implementation of **MACRA**
- Work-life **imbalance**
- Reimbursement challenges
- **EHRs** that take away from patient time
- Prior authorization
- Quality reporting
- Onerous **recertification** requirements

The Alliance's performance in MSSP, Bundled Payments for Care Improvement, Million Hearts and value-based contracts all attest to our commitment to population health and the **Triple Aim**. But, perhaps, what has not been as well recognized, has been our commitment to improving the Physician Practice Experience and, thereby, fostering the **Quadruple Aim** as well. Here are some examples:

Relieving your burden of yearly PQRS/Quality Reporting
Significantly easing your burden of participation in MACRA
Supporting the care of your patients via collaboration with Alliance RNs
Providing multiple sources of support for your practice revenue (enhanced commercial contracts, PMPM payments, Advanced APM bonuses, QuE payments, Million Hearts Model payments, ECC and 4C care coordination payments)
Relieving you of the stress of commercial payer negotiations
Decreasing the administrative burden of participation in Alliance care coordination programs

With regards to the latter, we have our new **ECC** (NGACO Medicare lives) and **4C** (commercial lives) **care coordination programs** which include monitoring practice performance via claims which significantly decreases your responsibility for documentation. Details of these programs are provided in the "Care Coordination Team Update" column in this newsletter.

The Alliance is keenly aware of the additional burdens being placed on practices as the U.S. health care system transitions from volume- to value-based care. We feel that it is one of our obligations to try to "lighten your load" administratively while enhancing the value of care you provide and thus improve your practice experience and advance the "Quadruple Aim".

Rick Lewis, MD

Care Coordination Team Update *from Joan Snyder, RN, MS*

Medicare Program

The Alliance "Embedded" Care Coordination Program (ECC) for Medicare patients has been in place and operating well for several years, although the program was fairly labor intensive for all involved. The Alliance Board of Managers recently approved revisions to this program, which coincides with the start of our participation in the Next Generation ACO (NGACO) Program.

The revised program now has 3 main activities:

- annual patient care visits for all attributed patients - not just AWV's
- early follow up visits (within 3 business days) for High Risk/ Rising Risk hospitalized patients
- closure of "gaps in care" for High Risk/Risking Risk patients

There will no longer be a requirement for extensive documentation by the practice and compliance will be measured through claims analysis. In addition, the NGACO patient attribution will remain constant for the entire year, without the "churn" experienced through quarterly additions/ deletions from CMS during the current program. For two of the measures, payment will also now be based on a tiered compliance schedule that reflects continual progress towards an annual goal rather than a focus on activity completed during independent quarters of the year.

Commercial Program

The Commercial Collaborative Care Coordination program at Mary Washington Health Alliance was implemented in April 2017, with payment based on the level of practice attribution from Aetna, Innovation Health and Cigna patients. In the Fall of 2017, we added a large number of attributed Anthem patients to this program, which in turn raised the level of payments considerably. Recently, the Alliance Board of Managers also approved updates to this program, which are aimed at strengthening a practice's ability to complete targeted interventions in four key areas:

- high risk patient outreach
- inpatient admissions/readmissions reductions
- appropriate emergency department utilization
- closing "gaps" in care.

An Alliance nurse will collaborate with each practice to create a specific action based on the greatest area of opportunity identified in reports from the payers each quarter. A practice must meet with their designated RN Care Coordinator at least two times each quarter to gauge progress towards achieving goals and revise the plan as necessary.

We hope that these updates will make both Care Coordination programs more effective and efficient, and strengthen our ability to meet our targeted objectives.

Welcome New RN Care Coordinators

Heather Henry, RN
RN Care Coordinator

Heather comes to the Alliance from a medical-surgical unit (4 South) at Mary Washington Hospital where she developed nursing expertise working with patients who have respiratory disorders and other complex medical diagnoses. She has also worked in an outpatient pediatric practice, a home health setting and a skilled nursing facility, which provided the platform for her to develop skills in caring for diverse groups of patients. She began her nursing career at VCU Health System and is proud to be from the "Northern Neck" of Virginia. Heather earned her Associates Degree in Nursing from Rappahannock Community College. We are excited to add Heather's positive energy and skill in working with patients who have COPD to our team!

Margaret Jennings, RN, BSN
RN Care Coordinator

Margaret comes to the Alliance after spending the past 9 years at Diabetes and Thyroid Associates – the private practice of Dr. Mark McClanahan. She has worked in diverse outpatient practice settings, including multi-specialty clinics and student health clinics. Margaret also has experience in emergency department and home health nursing. She earned her Bachelor of Science in Nursing degree from George Mason University and is working on a post graduate degree in counseling. We believe her combined expertise will be invaluable to our patients and our team!

New Preferred Provider in NGACO

LabCorp

The Alliance has formed a Preferred Provider relationship with LabCorp Companies of America as part of our participation in the Next Generation ACO. This collaboration allowed for qualifying for Population Based Payments (PBP) which are predetermined percentage reduction to base fee for service payments.

We are encouraged to promote accountability for quality, patient safety, cost and overall care of patients aligned in our Next Generation ACO. LabCorp will be reaching out to Alliance practices that do NOT have current MWHC Laboratory relationships as well as current practices utilizing LabCorp services.

What's New - Updates

GPRO Reporting Update

We are pleased to announce that the Alliance has completed our 2017 MSSP Quality reporting satisfying the Network's MIPS Quality requirements. We collected data on 15 measures from approximately 2,800 patients which represents over 9,000 measures worth of data collection. We made our final submission for the network on Friday, March 9th. Thank you to all the practices that supported our chart abstractors with remote access, on-site assistance and report pulls throughout this process. We achieved a quality score of 87% for the network!

We will be meeting with practices and providing follow-up education regarding areas of opportunity in the coming weeks.

New Medicare Cards

Starting in April 2018, CMS will begin mailing new Medicare cards to our beneficiaries that includes a new Medicare Number. Medicare is removing Social Security Numbers from the Medicare cards and replacing it with a new alpha-numeric number.

CMS plans to have a transition period where you can use either the HICN or the Medicare Beneficiary Identifier (MBI) to exchange data with them. The transition period will begin April 1, 2018 and run through December 31, 2019.

For more provider information about the new Medicare cards, check the webpage below for updates.

https://www.cms.gov/Medicare/New-Medicare-Card/Providers/Providers.html

Annual Meeting—April 10

You are cordially invited to our Annual Meeting

Tuesday, April 10, 2018 6:00 — 7:30 pm
Dinner served at 5:30 pm

Topics to be covered include:

- ✓2017 Year in Review
- ✓Performance Distribution Overview
- ✓2018 and Beyond

John F. Fick III, Conference Center,
Auditorium 1, 2 & 3
1301 Sam Perry Blvd.
Fredericksburg,

RSVP to Pamela Johns at 540.741.2118 or pamela.johns@mwhc.com

Welcome New Practices and Providers

Mark Rausch, MD
BetterMed Urgent Care

Brett Chicko, DPM
Brett Chicko DPM Family Foot and Ankle Center

Arijit Chanda, MD
Michael Foster, MD
Cardiology Associates of Fredericksburg

Michael Perraut, MD
Centercare Family Practice

Cornell Shelton, MD
Cornell J. Shelton MD, PLLC

Kerri Gray, MD
Arthur Brantz, MD
Healther Elsner-Boldt, MD
Laura Robinette, MD
Exigent dba AllCare

Milan Patel, MD
Gastroenterology Associates of Fredericksburg

Lisa Simmons, MD
Hematology Oncology Associates of Fredericksburg

Walid Hammad, MD
Khaled Said, MD
PACS at Ruther Glen

UPCOMING ALLIANCE EVENTS

April 2018

Sun	Mon	Tue	Wed	Thu	Fri	Sat
1 	2	3	4	5	6	7
8	9 Finance & Contracting 1W CR MWH 7 am	10 Alliance Annual Meeting 5:30 pm Dinner 6:00 Meeting Fick Center	11	12 Board of Managers 7 am MWHC Executive Boardroom	13 Communications & Education 7:30 am MWH 1 West A	14
15	16	17 IT Committee FHA CR 315 3 pm	18	19	20	21
22	23	24 Clinical Quality 7 am MWH 1 West A	25	26	27	28
29	30					

May 2018

Sun	Mon	Tue	Wed	Thu	Fri	Sat
		1	2	3 PCP Forum 2300 FHA Suite 309 7 am	4	5
6	7	8	9	10	11 Communications & Education 7:30 am MWH 1 West A	12
13	14	15 IT Committee FHA CR 315 3 pm	16	17 Board of Managers 7 am MWHC Executive Boardroom	18	19
20	21	22 Clinical Quality 7 am MWH 1 West A	23	24	25	26
27	28 	29	30	31		

June 2018

Sun	Mon	Tue	Wed	Thu	Fri	Sat
					1	2
3	4	5	6	7	8 Communications & Education 7:30 am MWH 1 West A	9
10	11 Finance & Contracting 1W CR MWH 7 am	12	13	14	15	16
17	18	19	20	21 Board of Managers 7 am MWHC Executive Boardroom	22	23
24	25	26 Clinical Quality 7 am 1 West A IT Committee FHA CR 315 3 pm	27	28	29	30