MWMD
Mary Washington Health Alliance

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, DO

the conversation project

With the ever increasing reliance on technology in healthcare, it is reassuring that conversing with our patients is still a viable and valuable component of how we care for them. Yet one conversation that many of us find difficult and awkward to have is End-of –Life decisions.

The Conversation Project is a public engagement campaign with the goal to ensure every person's wishes for end-of-life care are expressed and respected. It is not the intent to promote any specific end-of-life treatment. Rather, to encourage and support people in expressing their end-of-life wishes for care.

The concept is to promote "kitchen table" conversations with family and friends. I believe this to be a noble cause and one I support wholeheartedly. I also believe however, that physicians should be actively involved in these conversations. Physicians can and must be great allies to our patients as they process these emotional and potentially difficult decisions.

The most challenging conversations I have with my patients are often the most rewarding. They permit closer relationships and strengthen the physician-patient bond. To be sure, some will brush off the notion of having that conversation, but hopefully, they will respect you for caring enough to ask.

The Conversation Project movement wishes for all people regardless of age or state of health to have this discussion and make their wishes known to loved ones. Again, I applaud the ambition of the project. A reasonable place to start would be with those of advancing age and deteriorating health. I encourage all of you to address end-of-life care issues with your patients and to provide them with Advance Directives and Medical Durable Power of Attorney if they request them. If necessary, the Alliance can provide all practices with the resources to these documents or you may contact Teresa McCormack at Home Health & Hospice at 741-3567, email teresa.mccormack@mwhc.com.

One of the goals of the Alliance is to continuously improve the quality of the care we provide to our patients. What could possibly enhance that more than asking patients what they would want at this critical juncture of their life and respecting their wishes?

Thomas A. Janus, DO

Welcome New Providers & Practices

- **Maternal Fetal Specialists**
  Pushpinder Dhillon, MD
- **Rappahannock Neurosurgery**
  Agostino Visioni, MD
- **Rappahannock Neurology Specialists**
  Rachel Marie Paul, MD
- **Gastroenterology Associates of Fredericksburg**
  Narayan Dharel, MD
- **Preferred Pediatrics**
  Debra Conrad, MD
- **Fredericksburg Orthopedic Associates**
  Aaron Greenberg, MD
- **Radiologic Associates of Fredericksburg**
  Jaime Walton All, MD
  Natalie Chan, MD
- **Fredericksburg Foot & Ankle Center**
  Elizabeth Bourret, DPM

Inside this Issue:

Message from the Medical Director—Richard Lewis, MD

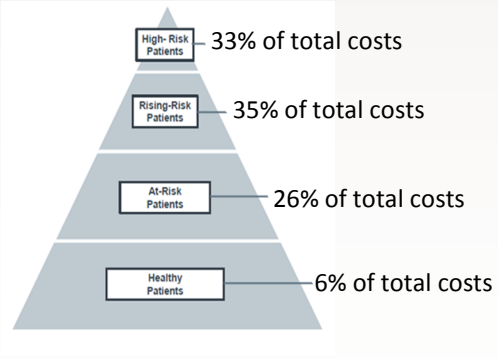
"IT AIN'T OVER TIL IT'S OVER"

I am dedicating this newsletter article to Lawrence Peter "Yogi" Berra who passed away at the age of 90 on September 22. As many of you know, he was as well known (if not more so) for his memorable quotes as for his 3 MVP awards and 10 World Series championships. As President Obama tweeted on September 24: "Yogi Berra was an American original – a Hall of Famer, jovial prophet, & humble veteran. We'll miss you, Yogi, but your legacy ain't over."

This month, we will explore the rationale for risk stratification in population health management. As Yogi famously observed in 1964:

"YOU CAN OBSERVE A LOT BY WATCHING"

Every health system has limited resources. Thus, one of the goals is to apply those resources most judiciously to achieve the greatest effect on improving the health of your population and the quality of care at the lowest cost (i.e. "The Triple Aim"). A useful tool to achieve this is to group the patients in one's network as follows:



The **High Risk** Patients are those who have already had catastrophic and/or very costly illnesses (e.g. widely metastatic cancer, advanced heart failure, CKD/dialysis) or who have 5+ chronic conditions. They generally comprise 5% of the patient population. As you might imagine, this group has the highest rate of ED visits/1000 (1412) and admissions/1000 (1781). Their overall PMPM (per member per month spend) is $4,900 compared to the population average of $946. **Rising Risk** Patients generally have 2-4 chronic conditions as well as other factors that identify them as ones who will likely advance into the high risk strata within a year or so. This group represents about 20% of the population. The **At-Risk** Patients have a single chronic condition or are at risk for developing one and make up about 40% of the overall patient population. Finally, the **Healthy** Patients are, as you might expect, relatively healthy with no identified physical needs and are about 35% of the population.

"NINETY PERCENT OF THIS GAME IS HALF MENTAL"

In our MSSP population, we have 702 high-risk patients, 2,808 rising-risk patients, 5,616 at-risk patients and 4,913 healthy patients. Their respective risk scores are 13.26, 5.21, 2.35 and 1.12. As you can see, overall risk more or less doubles as you go up the pyramid.

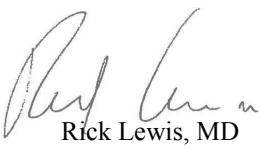
"IF YOU COME TO A FORK IN THE ROAD, TAKE IT"

Once these patients are identified, the next step is to provide our available resources appropriately. For the high risk patients, we make sure relevant community social services have been utilized as well as home health nurses and navigators. A number of these individuals will benefit from education regarding palliative and hospice care if this has not already been done. Not just high risk patients, but all the patients in our network should learn about advance directives and have the opportunity to document their wishes in this regard. Dr. Janus's article on "The Conversation Project" in this newsletter is quite germane in this regard. For the rising-risk patients it's important to ensure that medication regimens are well understood and complied with and that appointments with their PCP and specialists are being kept. Certain community-based resources can be helpful for these patients as well. For the at-risk patients, it's important to provide proactive chronic care self-management support though, in truth, it is important that all of our patients have a good understanding of the nature of their conditions and the treatment prescribed and the goals of care. As providers of care, we need to understand what our patients' motivations are in terms of what they hope to gain from effective treatment. As for our healthy patients, we, of course, want to keep them healthy with wellness education and guideline-based screening tests. We also want to keep them loyal to our healthcare system.

"IT'S DÉJÀ VU ALL OVER AGAIN"

We've previously discussed the importance of data acquisition and analysis in helping us to achieve our goals. Population risk stratification is just one of many useful applications of clinical and claims data. Another is documentation of network wide, specialty specific and individual provider performance data. The latest data will be coming to you in the near future in the form of your Quarterly Progress Reports.

"I WANT TO THANK YOU FOR MAKING THIS DAY NECESSARY"



Rick Lewis, MD

Committee Corner...

Message from Dr. Gregory Szlyk, Chair, IT Committee
Board of Managers

There are several large projects underway that require robust data analytics and reporting. The IT/Informatics Sub-Committee has been working to deploy the technology platforms needed to support these initiatives. Our work thus far has focused on three main objectives: Expanding Business Analytics, Integrating our Clinical Network and Population Health and Care Management.

Expanding Business Analytics (BA)

The ACO certification, MSSP, and BPCI programs all require specialized reporting and data collection tools. We have expanded our business analytics team and partnered with industry experts to provide the business intelligence to support these key programs. The Advisory Board/ Crimson is providing BA and reporting for the MSSP program. DHG consulting is working with our internal BA team on the BPCI program, and Koan Health is providing the metrics for provider specific CHIP reports.

Integrating our Clinical Network

We continue to enhance the capabilities of our network through our partnership with Rappahannock Health Connect (RHC). MWH, SH, and MWHC practices are already contributing demographics, lab reports and dictation. In addition, fifteen community practices are on track, this year, to integrate their EMRs and share care summary reports and other clinical results with the community. All Alliance members are eligible to join and access this data today. Practices can also sign up to receive notifications and access secure messaging services through RHC. Please register with RHC to tap into this growing resource. Contact Joyce Hanscome, Senior VP and CIO of MWHC at (540) 741-1020 for more information.

Population Health and Care Management

As our clinical data repository grows and care managers' responsibility increases, the Alliance will need a population management tool. The IT Sub-Committee is in the process of evaluating possible solutions to determine how they will interoperate with our current platform.

It has been very exciting to see how technology is helping the MWMD take shape and to see the potential it has to improve the quality of healthcare in our community. By sharing information through RHC we all can benefit from improved communication, care coordination, and access to clinical data across platforms. Technology can help to make our vision of integrated healthcare a reality. Please join RHC today to get connected and share in this truly remarkable endeavor.

MWHC RHC Click here to go to Clinical Portal

Rappahannock Health Connect Provides:

- A Community Health Record for providers and their patients
- Support for MWHC hospitals and physicians in meeting Meaningful Use
- Support for population health management & business outcomes analysis
- Facilitation of care planning, coordination, and communication between MWMD-managed patients and their care coaches and providers
- Quality outcomes reporting

Care Coordination Team Update

Since there are a large number of covered lives to manage under the Alliance, we have initially concentrated our efforts on two distinct groups: patients who are deemed to be high risk/ high cost and those in transition. High risk/high cost patients are identified through our data analytics program, per risk scores based on previous utilization, presence of chronic diseases and comorbidities. This allows us to target patients who require complex, multifaceted care and whose care is often combined with behavioral or social challenges. They are also most likely to have poor outcomes and unnecessary utilization. The Care Coordinators contact high risk patients and use motivational interviewing techniques to identify a patient's most pressing need or primary goals of care. They work collaboratively with the patients and their primary care providers to improve care. Many times, social issues take precedence as these often represent the largest barriers to care. The Care Coordinators work closely with home health agencies and other post-acute providers to prevent duplication and the resultant "phone fatigue" for patients.

Patients who are moving from one facility to another are at high risk for readmission. The Alliance nurses receive a daily census of inpatients so that they can monitor care during the "hand off" between providers. A "face to face" meeting helps to build trust and patients are most receptive to care coordination during times of high need. The Care Coordinators review discharge plans with the patient, including discharge meds, importance of follow up appointments and potential barriers. The nurses contact the patient within a few days of discharge to reinforce the intended plan.

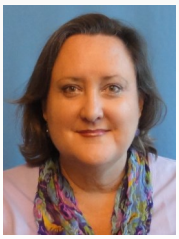
Through these two avenues, the Alliance Care Coordinators also hope to identify trends that may be used as the basis for establishing larger scale programs, such as educational materials to assist patients in managing chronic conditions or early collaboration efforts with palliative care. In this manner, we can reach more patients and support improvements in care for all Alliance patients. For more information about the Alliance Care Coordination program, please contact Joan Snyder at (540) 741-2119.

Welcome New Alliance Care Coordinators

Terry Sullivan, MSN, RN, CDE
Population Health Coordinator

Terry brings a wealth of nursing knowledge that will strengthen the Alliance's Care Coordination efforts. She possesses a solid knowledge base of chronic disease management as well as the resources available in the Fredericksburg area. Terry has been the Diabetic Educator at Mary Washington Hospital for over 12 years providing inpatient and family diabetes education and prior to that she was a nurse manager on several medical/surgical units. As adjunct faculty for second year Associate Degree nursing students at Germanna Community College, she taught students in the hospital setting and is active in our community providing education to local community clinics. She notes that what excites her about working in population health is "being able to focus on the preventative side and help patients with chronic disease maintain their best level of health."

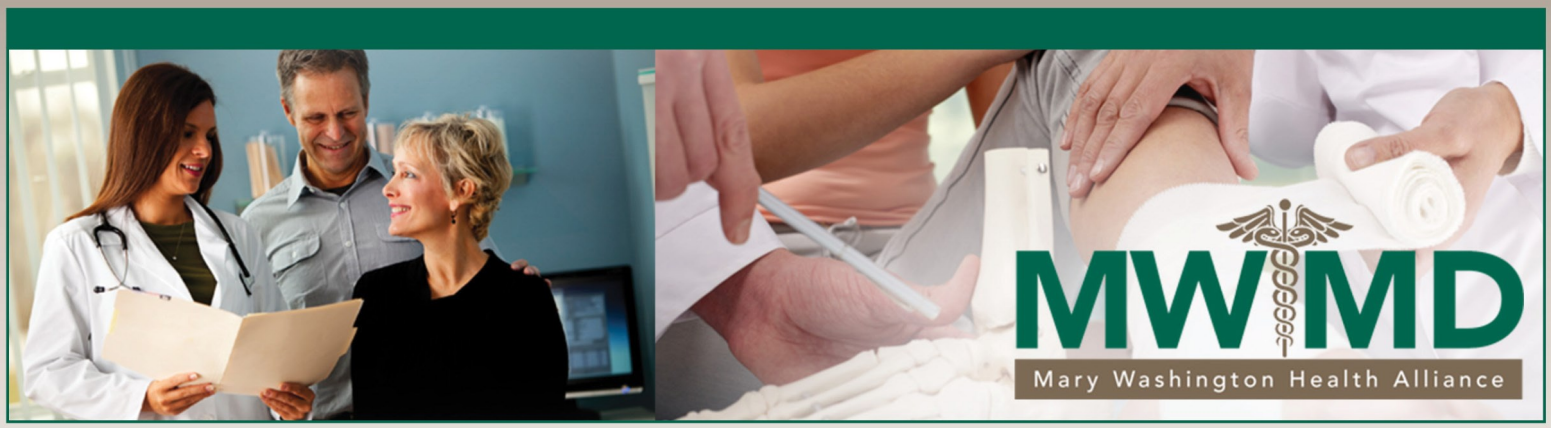
We look forward to learning a great deal from Terry because as you know, diabetes is a significant primary diagnosis and a major co-morbidity for many of our patients.



Kathleen Jimenez, BSN, RN
Population Health Coordinator

Kathy is returning to the Mary Washington Healthcare family after recently providing hospice/palliative care as a nurse coordinator for a regional healthcare company. You may remember her as the Nurse Manager of the Freestanding ED at Lee's Hill and Director of Medical Nursing at MWH prior to her departure. Kathy has a diverse background with over 16 years at Level I Trauma Centers and academic teaching hospitals, as well as over 13 years in Home Care and Hospice settings. She has provided care in various health systems throughout Virginia including Inova, Virginia Hospital Center and University of Virginia Health System. In addition to providing healthcare, she is also an author. Check out her publication, Nursing 101: The Little Handbook of Basic Essentials on Amazon for those interested in a career in nursing.

Kathy brings an abundance of experience with her especially in the field of hospice and palliative care which is an area of upcoming focus for the Alliance and we feel very fortunate to have her as part of our team.

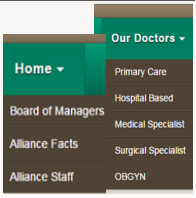


What's New - Updates

Website Enhancements

Monthly Webinars Are Now Posted!
View our educational webinars presenting information on the Alliance initiatives including PQRS, BPCI, MSSP, Care Coordination and Business Operations. Click on this link to take you to the Alliance Provider Education page: http://www.mwhealthalliance.com/mwha-provider-education

Drop-Down Menus Under "Home" and "Our Doctors" Tabs
Drop down menus provide a quick search option for patients seeking a provider and information within the Alliance



New HeartCaring Banner
The Alliance recognizes HeartCaring designated physicians on the website banner.

Please welcome our newest HeartCaring Designated Physicians:

Gregory Kauffman, MD	Cardiology Associates
Thomas Martyak, MD	VA Cardiovascular Consultants
Kambeez Berenji, MD	Polaris Heart & Vascular
Theron Stinar, MD	Fredericksburg Christian Health
Cynthia Wilkes, MD	Fredericksburg Women's Health

Physician Photo & Radio Spot
Patients can listen to our providers speak about their practice and receive tips for keeping a healthy lifestyle by clicking their photo on the "For Patients" page. If you would like to be interviewed for the Healthy Minute Radio Show and be included on our website for Medical Minute, please contact Pamela Johns at (540) 741-2118 or pamela.johns@mwhc.com.

Alliance Annual Event

Please join us on Thursday, December 10 at 5:30 pm for the Alliance Annual Event at the John F. Fick Conference Center. Dinner will be provided.

MWHC Associate Annual Wellness Visit

Please be sure to communicate with your front office and appointment/scheduling staff the requirement for a preventative office visit for Mary Washington Healthcare associates and their covered spouses. MWHC associates and spouses covered under the Innovation Health medical plan need to have an Annual Preventive Visit/Routine Checkup completed by their PCP or OB/GYN by October 31, 2016 in order to avoid a wellness surcharge in 2017. They have been encouraged by MWHC Human Resources to schedule this appointment as soon as possible and your practice may see an increase in requests for this type of visit.

As a reminder, The Well Adult Care visit has a $0 copay and is covered 100%.

If you have any questions concerning this requirement, please contact Pamela Johns at (540) 741-2118 or pamela.johns@mwhc.com.

Alliance Practice Reminder: Please refer to the MWHC associate health plan as *Innovation Health* rather than Aetna. This is the name of the partnership between Aetna and Inova.

October 2015

Sun	Mon	Tue	Wed	Thu	Fri	Sat
				1	2	3
4	5	6	7	8 Finance & Contracting 7:00-8:00 am 1West B MWH	9	10
11	12	13	14 Practice Relations Council 7:30-8:30 am 1 West B CR MWH	15 Board of Managers 7:00-8:30 am Suite 309 FHA	16	17
18	19 Membership & Operations 7:00 - 8:30 am Suite 309 FHA	20	21	22	23	24
25	26	27 Clinical Quality 7:00-8:00 am 3rd Fl CR MWH	23	29 Alliance Webinar 12:15-1:15 pm	30 Communications & Education 7:30-8:00 am TMMP Classroom E	31 

November 2015

Sun	Mon	Tue	Wed	Thu	Fri	Sat
1	2	3	4	5	6	7
8	9	10	11 Practice Relations Council 7:30-8:30 am 1 West B CR MWH	12 Finance & Contracting 7:00-8:00 am 1West B MWH	13	14
15	16 Membership & Operations 7:00 - 8:30 am Suite 309 FHA	17	18	19 Board of Managers 7:00-8:30 am Suite 309 FHA	20	21
22	23	24 Clinical Quality 7:00-8:00 am 3rd Fl CR MWH	25	26 	27 Communications & Education 7:30-8:00 am TMMP Classroom E	28
29	30					

December 2015

Sun	Mon	Tue	Wed	Thu	Fri	Sat
		1	2	3	4	5
6 	7	8	9 Practice Relations Council 7:30-8:30 am 1 West B CR MWH	10 Finance & Contracting 7:00-8:00 am 1West B MWH Alliance Annual Meeting John F. Fick Conference Center 5:30—8:00 pm	11	12
13	14	15	16	17 Board of Managers 7:00-8:30 am Suite 309 FHA	18	19
20	21 Membership & Operations 7:00 - 8:30 am Suite 309 FHA	22 Clinical Quality 7:00-8:00 am 3rd Fl CR MWH	23	24	25 	26
27	28	29	30	31		

ALLIANCE EVENTS