MWMD
Mary Washington Health Alliance

Chairman of MWMD Board

Every day in the United States, 10,000 people turn 65, and this astonishing trend is expected to continue for 20 years. Never in the history of the United States, or the world for that matter, have this many people over the age of 65 been alive. It is our responsibility as physicians to maintain the health of this aging population and to help restore their health when morbidity strikes.

One very underutilized tool which can assist us with this is the Annual Wellness Visit (AWV). The intent of AWVs is to enable Medicare beneficiaries to receive recommended preventative services to support a healthier life by way of disease prevention, early detection and lifestyle modification. The potential to reduce hospitalizations and more serious health problems for Medicare patients is clearly a benefit of performing AWVs.

Intended primarily as a benefit for patients, there is value for primary care providers as well. The reimbursement for AWVs is attractive at $173 for an initial visit and $117 for subsequent AWV visits. Practices that employed AWVs on at least 25% of their patients generated greater practice revenue, while nonadopters saw a slight decline in their revenue. AWVs will also help improve quality measure performance as 18 quality measures are incorporated in the AWV. In addition, AWVs will help increase our NextGen attribution. This is particularly important with healthier Medicare patients whose attribution will drop off if they are not evaluated in an office at least once per year. A benefit to the Alliance is that these patients generally have a lower per member per year (PMPY) spend which will lower our aggregate PMPY spend and increase our financial performance.

Yet a recent national survey revealed less that 20% of Medicare patients receive a wellness visit. In addition, nationally more than 50% of PCPs offer no AWVs in their practice. Last month, the Alliance held a PCP town hall meeting to address the value associated with performing AWVs and how different practices within the Alliance are pursuing this goal. We will be happy to share those processes with any providers who are interested.

I believe there is a clear benefit to our Medicare patients, to our PCP providers and also to the Alliance in performing AWVs. To that point, the Alliance should set goals for what percentage of eligible patients receive AWVs annually. Ultimately, I would like to see this target be 80%. I envision this becoming a performance metric we utilize to gauge our annual physician performance distribution.

Thomas A. Janus, DO

Welcome New Practices and Providers

Ezra Morgan, MD
AllCare Family Medicine

Jennifer Ross, MD
Chancellor Internal Med.

Juan Munoz, MD
Colonial Internal Medicine

Vanessa Johnson MD
Kavita Kalidindi, MD
Community Care Clinic

Wahid Baqaie MD
Fredericksburg Orthopedics

Geoffrey Sloan, MD
GAF Sedation

Lauren Fiske MD
MWMG Infectious Disease

Brett Waverly, DPM
Orthopedic Specialty Clinic

Ayanna McCray MD
PedsPlus Primary Care

Nisha Alle, MD
Gustavo Elias, MD
Radiologic Associates of Fredericksburg

New Practice Name & Location
Daniel Trementozzi, MD
MWMG Family Medicine & Pediatrics
8051 Prosperity Way, Suite 100; Ruther Glen

Inside this Issue:

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

Message from the Medical Director—Richard Lewis, MD

LIFE IS A SERIES OF CHOICES

On a number of occasions, my wife has reminded me that "life is a series of choices' (especially after I've made, what she considered, the "wrong choice").

Similarly, the practice of medicine can be viewed as a series of choices.

For example:

- Should I prescribe an antibiotic for this patient's acute bronchitis?
- Should I order an MRI for this patient's low back pain?
- Should I continue treating this condition myself or refer to a specialist?
- Should I continue to observe and monitor or is it time to operate?
- Should I discharge my patient today or keep him/her in the hospital another day?

As it turns out, many of the treatment choices we make may be considered of no or low value to the patient. Several studies have shown that, on average, about 30% of such treatment decisions fall into this no/low value category. A survey commissioned by the American Board of Internal Medicine (ABIM) in 2014 included the following findings:

Nearly ¾ of U.S. physicians say that the frequency with which doctors order unnecessary medical tests and procedures is a serious problem for America's health care system

72% of physicians say that the average medical doctor prescribes an unnecessary

test or procedure at least once a week.

53% of physicians say that even if they know a medical test is unnecessary, they order it if a patient insists.

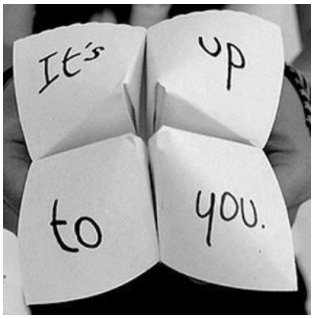
To help address these concerns, the ABIM launched the "Choosing Wisely®" campaign in 2012 which is designed to promote conversations between clinicians and patients by helping patients choose care that is:

- Supported by evidence
- Not duplicative of other tests or procedures already received
- Free from harm
- Truly necessary

Medical specialty societies were called upon to identify tests or procedures commonly used in their fields whose necessity should be questioned and discussed with patients. To date, over 70 medical specialty societies have published more than 500 recommendations of overused tests and treatments. These are accessible through the Choosing Wisely website (www.choosingwisely.org) where you can also download the Choosing Widely app to your iPhone/iPad or Android device. Some examples include:

- (from Anesthesiology) Don't obtain baseline laboratory studies in patients without significant systemic disease (ASA I or II) undergoing low-risk surgery – specifically, CBC, BMP or CMP, coagulation studies when blood loss (or fluid shifts) is/are expected to be minimal
- (from Pulmonology) For patients recently discharged on supplemental home oxygen following hospitalization for an acute illness, do not renew the prescription without assessing the patient for ongoing hypoxemia.
- (from Dermatology) Don't prescribe antifungal therapy for suspected nail fungus without confirmation of a fungal infection. Approximately half of all patients with suspected nail fungus do not have a fungal infection.
- (from Cardiology) Don't perform stress cardiac imaging or advanced non-invasive imaging as a pre-operative assessment in patients scheduled to undergo low-risk non-cardiac surgery.
- (from Gastroenterology) For a patient with functional abdominal pain syndrome (as per ROME IV criteria) CT scans should not be repeated unless there is a major change in clinical findings or symptoms.

I invite you to visit the Choosing Wisely website and review the recommendations pertinent to your specialty. You may or may not agree with all of them though keep in mind that these are recommendations promoted by the pertinent specialty society. And, of course, guidelines and recommendations are just that – "guidelines" to help "guide" your clinical decisions, not supplant your clinical judgement.



Avoiding unnecessary medical tests, treatments and procedures is good medicine and, as such, should be part of the Alliance's mission to enhance the health of our population.

Rick Lewis, MD

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Committee Corner...

Message from Gregory Szlyk, MD Chair, IT Committee, Board of Managers

On June 2, after almost two years of planning and preparation, Mary Washington Healthcare (MWHC) transitioned to a new electronic medical record, Epic. The new platform has replaced dozens of independent niche platforms with a fully integrated enterprise-wide solution. MWHC has retired dozens of legacy systems, and replaced them with the Epic platform, and in doing so has taken a giant step towards integrating the delivery of healthcare across our entire community. For the first time, providers in all areas of the care pathway are able to access a patient's complete medical record which includes ambulatory, emergency, inpatient, mother/baby, imaging, laboratory, pharmacy, procedural services, dietary, home health, rehab and more.

One particular area which directly impacts the Mary Washington Health Alliance is called Healthy Planet. Nurse care coordinators utilize Healthy Planet to identify, interact with, and track patients that require extra assistance. Epic allows Alliance nurses to work closely with home health and primary care practices to improve outcomes. Here are some observations from our nurse managers:

Epic brings together the inpatient and outpatient record so we don't have to look in multiple places to find out where the patient is getting care – we are always looking for ways to help the patient streamline their care. We can see the imported record for the employed practices and with 'Care Everywhere' we can see the claims information for practices who are not on Epic. It helps us to know who the patient is seeing consistently for their care and our nurses can work with them in addition to our own PCP's. Also, we can see home health information from hospital owned agencies (such as Continuum with UVA) when detail is pulled from 'Care Everywhere.' In the past, we would have to make multiple calls to locate this information.

Everyone agrees that help is needed to bridge the gap between the time when a patient is discharged and their follow-up visit with the PCP. Epic has helped the Alliance nursing team coordinate care because the entire treatment team uses the same platform.

We found one discharge instruction sheet that actually instructed the patient to follow up with the Alliance RNCC after discharge. This is exciting as it will not only support continuity with patient follow up, but also the practices can see this in 'Epic CareLink' to know that we are already working with the patient. It will also help to educate the nursing staff at the hospital as well.

Epic helps providers identify and track patients that are at high risk for readmission and allows the care team to efficiently manage their care. The Alliance nurses identify patient specific goals that the hospital staff and practices can see when they are reviewing patient records. This communicates what we are actively working on with their patients, along with our progress notes.

These are just a few examples of how Epic is already helping the Alliance deliver better care in a more efficient manner. Many practices are excited to see how Epic can help their practice. We hope to be able to provide more information in the coming months about the Epic community connect program, which allows community practices to deploy Epic in the office setting. To learn more about this program, please email Dr. Greg Szlyk at gregory.szlyk@mwhc.com.

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

Care Coordination Update

The month of June finds our Care Coordination programs in full swing. We now have six full time nurse care coordinators (RNCC) to support work at the practice level and provide individualized case management services for the high risk/ rising risk (HR/RR) patients. Each nurse meets with their dedicated practices on a monthly basis to update the practice on the work they've been doing with their patient caseload and collaborate with the practices on program improvements. The Alliance nurses provide transition of care support for all HR/RR patients who are discharged from a facility – acute care hospital, inpatient rehabilitation center and skilled nursing facilities alike. The goal is to ensure all patients return to a safe place for recuperation and follow the established discharge plan. The nurses also reach out to HR/RR patients who have complex needs or chronic illnesses but have not been recently admitted, to streamline care and support patient self- management activities.

On June 2nd, the RNCC team began documenting their work in Epic so practice personnel and providers now have direct access to the RNCC nurses notes. In Hyperspace or Epic CareLink, look for the Alliance nurse as part of the Care Team, and click on the Notes tab to see the type of nursing services being provided. In addition, you can communicate securely with your designated Alliance RNCC by using the InBasket feature in Epic. Your RNCC will be glad to review the Epic electronic patient record with you on his/her next visit and point out some special features that should make work easier for the entire team.

The first quarter of the revised Care Coordination programs is nearly complete and several new practices have been welcomed to these programs. There are now 28 practices participating in the Commercial Care Coordination program and nine practices committed to the Medicare (NextGen) Care Coordination program. We are beginning to see improvement in our quality metrics and appreciate the energy each practice has devoted to these programs. As a reminder, any of the "gaps" in quality metrics that you have identified as already addressed for Cigna patients can be sent back to the Alliance team to be reconciled with the payor and removed from the "gap" list in the future. This is the only payor group that we can routinely reconcile with at the present time. Successful completion of quality measures for all other payors is done through claims analysis. For participants in our Medicare program, remember to review your lists by the first week of July and send us the names of any patients that are not currently covered by your practice so we can remove them from the list for the remainder of the year (PS: practices participating in the Medicare care coordination program will receive one "point" for reconciling their patient rosters during the first quarter).

Thanks to all who take part in the Care Coordination programs – the RNCC team is excited to partner with practices and work toward the Alliance goals! If you would like more information about the care coordination programs, please contact Joan Snyder at 540-741-2119 or send an email to joan.snyder@mwhc.com.

COPD Nebulizer Program

On Thursday, May 24th, the Alliance NGACO Board of Governance approved a resolution to implement a program whereby the Alliance can provide nebulizers to those patients in our COPD pilot program who otherwise have difficulty obtaining them. The Alliance now has the authority to implement these types of programs under waivers provided by our Next Gen ACO participation to achieve Triple Aim© goals. We expect that this particular program will help us to optimize the care of our COPD patients and decrease their readmission rate. For more information on this program, contact Joan Snyder at 540-741-2119 or email joan.snyder@mwhc.com.

Thank you for your continuing commitment to high quality, cost effective care.

VHN Is Now MedCost

MEDCOST® As you may recall, MedCost acquired Virginia Health Network (VHN) a little over a year ago. Their focus for the next 18 months is to:

- Move to a single network and integrate business processes and systems. The VHN logo will be replaced with MedCost.
- Provide access to the VHN online account through MedCost.com.
- Enhance communications to keep us informed of key updates.

For any additional information, please contact their Richmond office at: (800) 989-3837 or email them at providercontact@medcost.com.

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What's New - Updates

Preliminary GPRO Audit

The Alliance analytics team conducts a Preliminary GPRO Audit twice a year. As was the case when we were in the Medicare Shared Savings Program, Alliance quality reporting replaces the obligation of our practices to report on their own. In addition, in NextGen, our quality performance will be a factor in the amount of savings we take home. These are the figures so far in terms of our compliance with four of the most challenging measures:

- **Diabetic Eye Exams** 23%,
- **BMI Screening and Follow-up** 44%,
- **Depression Screening** 53%
- **Medication Reconciliation Post Discharge** 7%.

Clearly, we have some work to do. Over the next few weeks, members of our analytics team will meet with our providers and discuss ways to improve our network's scores. We will provide a "Quality Tips" worksheet which details the key advice you will need to be ready for the visit.

Pratt Medical Center Joins Alliance

Effective October 14th, Pratt Medical Center will be returning to the Alliance as an independent medical group. We welcome Pratt Medical and their providers to the Alliance Network:

John Anderson, MD
Gloria Galdamez, MD
Stephanie Galuk, DO
Allison Goodlett, MD
Daniel Gray, MD
Rosemary Harwood, MD
John Kin, MD
Pooja Prasad, DO
Sarah Prince, MD
Yolanda Reid, MD
Rebecca Simes, MD
Janice Soliven, MD
Scott Walker, MD
Donna Wicker, MD
Henry Wicker, MD

Physician Credentialing & Reimbursement

House Bill 139 requires insurers to establish procedures to reimburse physicians for services rendered during the credentialing process. As a condition of payment, the physician is required to provide the patient with notice of the credentialing process, which is detailed in the statute.

ACTION REQUIRED: Include the required notice in patient work flows and documentation files. The text of the required notice is included in the statute below. http://lis.virginia.gov/cgi-bin/legp604.exe?181+ful+HB139ER

Welcome New Business Analyst-Steve Braun

The Alliance team welcomes Steve Braun, MBA as our new Business Analyst.

Steve has a background from the corporate side of firms such as AT&T, Capital One, and Kohl's. He has worked in management, compliance, analytics, and project/process management. Steve is coming to us from his most recent position as a process manager for a commercial bank in Glen Allen. This will be his first time working in a healthcare environment, but his breadth of knowledge and experience puts him in a great position to provide new prospective and insights to our team.

Steve rounds out our team by providing a warm sense of humor and enjoyment of team building activities in addition to his strong analytic skills.

Welcome Steve!

July 2018

Sun	Mon	Tue	Wed	Thu	Fri	Sat
1	2	3	4 	5	6	7
8	9	10	11	12	13 Communications & Education 7:30 am MWH 1 West A	14
15	16	17 Finance & Contracting 1W CR MWH 7 am	18 Business Relations Council FH Suite 511 CR 7:30 am	19 Board of Managers 7 am MWHC Executive Boardroom	20	21
22	23	24	25	26	27	28
29	30	31				

August 2018

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

September 2018

Sun	Mon	Tue	Wed	Thu	Fri	Sat
						1
2	3 	4	5	6	7	8
9	10	11	12	13	14 Communications & Education 7:30 am MWH 1 West A	15
16	17	18 IT Committee FHA CR 340 3 pm	19	20 Board of Managers 7 am MWHC Executive	21	22
23	24	25 Clinical Quality 7 am MWH 1 West A	26	27	28	29
30						

UPCOMING ALLIANCE EVENTS