MWMD
Mary Washington Health Alliance

Message from the Medical Director

To Be Or Not To Be? - That is the Question Hamlet, 1603

"'Tis nobler in the mind to suffer the slings and arrows of outrageous fortune…" or is it just better to go ahead and readmit that patient in the ED with an exacerbation of a chronic illness? That, indeed, can be a conundrum. Like it or not, an economic consideration has been added to the decision-making process. The Hospital Readmission Reduction Program (HRRP) was established under the Affordable Care Act in 2010 and required that CMS impose financial penalties on hospitals with higher-than-expected 30-day readmission rates for patients with CHF, AMI and pneumonia beginning in 2012. Indeed, readmissions for these targeted conditions subsequently declined (collectively from 21.5% to 17.8% between 2007 and 2015). Concern was raised about potential unintended consequences such as (1) physicians avoiding readmissions or delaying them beyond the 30-day limit, (2) health care systems diverting resources away from other (potentially more beneficial) quality programs and (3) actually decreasing quality at "safety net" resource-poor hospitals who are disproportionately penalized.(Nearly 2 billion dollars in penalties have been imposed since 2012).

Now there is evidence of possible harm associated with HRRP. A study based on data from 8.3 million Medicare hospitalizations since the inception of the HRRP program was reported in JAMA on December 25, 2018 and showed statistically higher mortality rates for patients with HF and pneumonia and no significant change in acute MI patients. Whether this finding is a direct result of HRRP policy requires further study but clearly there is no evidence that patients have benefitted from HRRP. This also calls into question the validity of using readmissions as an appropriate metric of quality care. Another study supporting this concern was published in JAMA Cardiology November 28, 2018 and revealed that US News & World Report top-ranked hospitals for cardiac care had lower 30-day mortality rates and higher patient satisfaction scores than unranked hospitals but had similar (for AMI and CABG) or higher (for CHF) 30-day readmission rates.

To Readmit or Not to Readmit? – That is Also A Question

This is not to say that we should ignore the issue of 30-day readmissions altogether. No recently discharged patient yearns to return to the hospital and readmissions certainly add to the cost of care (at least in the short term). The Alliance has plenty of data to support this from our BPCI program experience. But just as there are avoidable ER visits and avoidable admissions, there are avoidable readmissions (e.g. a HF patient inadvertently discharged without a prescription for a diuretic). In my view, the keys to appropriately limiting readmissions are:

1. Providing optimal inpatient care
2. Conducting thorough medication reconciliation prior to discharge
3. Educating the patient about his/her own condition such that he/she may participated meaningfully in his/her own care and
4. Ensuring appropriate, timely outpatient f/u post-discharge.

Rick Lewis, MD

Inside this Issue:

Message from the Chairman of MWMD Board

114,826, 109,588 and 116,107, these are the total annual Emergency Department (ED) visits to MWHC facilities in the years 2018, 2017 and 2016 respectively. Compare that to the total population of our primary service area, slightly over 450,000 lives. The volume of ED visits is strikingly high; suggesting approximately 24% of our service population visits the ED annually. Of course we know this is not the case, studies suggest approximately 8% of patients who utilize the ED are responsible for 24 % of the visits. EDs are the only facilities where patients have access to a full range of services regardless of the severity of illness. Patient volumes in the EDs have been growing faster than the population for decades. To continue our pursuit of improving quality and reducing cost, the Alliance must address ED over-utilization. Rather than the right care at the right place at the right time, too often, the ED is the model of the wrong care at the wrong place at the wrong time.

This is not the fault of the ED physicians. They are not advertising or recruiting patients. Indeed, there is no place I would rather be than in one of our Emergency Departments if I was having an acute MI, suffering major trauma, bitten by a venomous snake or a myriad of other true emergencies, as that skill set is what makes EDs so valuable in our society. Sadly, too many patients visiting EDs do not have life threatening events, nor do they have true emergent or even semi-urgent medical conditions. There are numerous reasons why this occurs, but none more pronounced than they perceive a lack of access to care in a more appropriate location.

It is not simply the financial implications of this phenomenon that should demand our focus, though that in itself is quite staggering. There is also cause for concern regarding the impact it has on quality. When an ED is bogged down caring for nonurgent medical conditions, the subsequent long waits, overcrowding and added stress on the ED staff take away from their ability to fully care for those with true emergent conditions, and this becomes a quality issue.

As the Primary care system in America finds itself unable to meet the demands of patient care, EDs have become the primary resource of health care for more and more patients. All age groups, all demographics, those with and those without insurance have increased ED utilization over the past few decades. Often, they cannot get into a primary care office. Sometimes they are referred by the primary care office as the office cannot accommodate the patient. Lack of transportation to the physician's office prompts a 911 call with EMS expenses added to the ED visit expenses. Frequently, patients perceive their medical disorder as being more serious than it actually is and feel Emergency Department services are necessary. And clearly there are times when the patient simply self refers as it is more convenient for them. It also needs to be stated that EDs must care for patients regardless of their ability to pay, which increases the non urgent utilization.

So what to do about this? First we need to educate our patients and make sure they are reasonably comfortable in assessing what is emergent, what is urgent and what is non urgent. The Alliance can help with this by creating and disseminating to our practices guidelines which can be posted in waiting rooms or exam rooms. Although challenging to implement, all physicians need to find ways to accommodate these patients in our offices. Yes, it can make our lives less predictable, but we are physicians and caring for patients is not always a predictable endeavor. Accommodating these patients will improve quality, decrease health care spend and also improve revenue for the practices. Perhaps the time has come to place urgent care centers next to EDs and enable triage to the appropriate level of care center. There are hurdles that need to be cleared with this last approach, but the overall benefit should be worth the effort.

This is an enormous challenge not just for the Alliance, but for healthcare across America. The time to take on this challenge is now. Our commitments to improving quality of care, improving the patient's experience and reducing cost demand we start now.

Thomas A. Janus, DO

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

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Committee Corner...

Message from
Kurian Thott, MD
Chair, Communications & Education
Board of Managers

As we have evolved into a more integrated and mature ACO over these past few years (including our recent acceptance into the highly selective Next Generation ACO program), our Alliance has been working hard to be successful in this program and others. As with any program we participate in, there is a team of dedicated professionals working behind the scenes helping make all this possible. It is our goal to help keep you informed on what's going on with the Alliance and how these initiatives impact you.

Many of you will be attending the Annual Meeting on April 2nd, and we will be doing something a little different this year. Instead of a didactic style meeting with one-way interaction, we will be utilizing a panelist format so that our members can hear from each of the committee chairs in a discussion we hope will engage our members in a way that promotes dialogue and feedback.

My task with this committee has been to find creative ways to get information out to our physicians and practices in a way that is not overwhelming or burdensome. It is my hope that our membership has found the quarterly newsletters and Dr. Lewis' monthly medical director reports helpful and informative. As always, we are here to serve and help you in any way possible and I always appreciate any feedback and suggestions that can help you get high quality, timely and useful information.

Welcome New Providers

New Practice

Northern Virginia Hematology Oncology Associates
Ghana Kang, MD
Hamed Khosravi, MD

New Providers

American Anesthesia Associates
Ruth Neary, MD

Cardiology Associates of Fredericksburg
Peem Lorvidhaya, MD

MWMG
Mustafa Abbasi, MD (Family Medicine)
Maha Alattar, MD (Neurology)

MWMG Hospitalist Services
Avnit Ahuja, MD

Oracle Heart and Vascular
Prithviraj Rai, MD

Pratt Medical
Clemens Esche, MD
Andrea Jackson, MD
Renick Smith, MD (formerly Rappahannock Gastro)
Waring Trible, MD (formerly Rappahannock Gastro)

Virginia Cardiovascular Consultants
Prajwal Deshmekh

NGACO Beneficiary Mailing

As part of our Next Generation ACO (NGACO) requirements, we notified our 14,600+ prospectively aligned patients on March 20th that their Alliance Physician is participating in the Next Generation ACO. The Alliance is 1 of only 51 recognized in the country and notifications to the beneficiaries is a benefit as well as a requirement.

An important component of this notification included informing the Beneficiaries of "Home Visits after Hospital Stays" and the "3-Day Stay Waiver." We emailed a copy of the letter to your practice manager. Please let us know if you would like another copy.

Beneficiaries may reach out to you directly with questions about the NGACO or you may send them to us (Pamela Johns (540) 741-2118) or CMS (1-800-633-4227).

What's New - Updates

Care Coordination Team Update

Farewell Message from Joan Snyder

The Alliance said goodbye to Joan Snyder at the end of February. We want to thank her for her years of invaluable service to the Alliance and will miss working with her. Here is her message to us:

"It is with mixed emotions that I am leaving the Alliance staff, effective 3/1/2019. I have truly enjoyed working with each of you, and sincerely appreciate your support over the past four years. I am so proud of what you have accomplished and look forward to hearing about your continued success in 2019. I will be transferring to a "very" part time job within Mary Washington Healthcare, so my current email address can be used if you need to contact me in the future. Again, thanks for the hard work and willingness to work together for a common goal."

Welcome Terry Sullivan, RN, MSN, CDE
Alliance RN Care Coordinator Manager

As we say a fond farewell to Joan Snyder, we welcome Terry Sullivan into her new role as Manager of the Alliance RN Care Coordinators (RNCCs). In addition to several years' experience as an RNCC, Terry has given many years of service to MWHC, including 11 years as a diabetes nurse educator. Terry can be reached at 540-741-2456 and

Annual Dinner Meeting April 2nd, 2019

Join us for the Alliance Annual Meeting
Panel Discussion Featuring Alliance Provider Committee Chairs
Tuesday, April 2nd, 2019
John F. Fick Center Auditorium 1,2,& 3
5:30 pm Dinner and 6:00 pm Meeting

-Featured Speakers-

- **Dr. Kurian Thott—"Modes of Communication" Communications & Education**
- **Dr. Jeffrey Frazier "Contracting"—Finance & Contracting**
- **Dr. Patrick McManus "Quarterly Distribution" — Membership & Operations**
- **Dr. Dan Woodford "Enhancing Quality" —Clinical Quality**
- **Dr. Greg Szlyk "Epic Connect" —IT Committee**

Michigan Medicine Clinical Guidelines

Our Clinical Quality Committee has approved the posting of the link to the "Michigan Medicine Clinical Guidelines" website: https://www.uofmhealth.org/provider/clinical-care-guidelines on our Alliance web page. This website contains a wealth of up-to-date information regarding evidence-based guidelines and best practices for 25 common conditions including COPD, HTN, Diabetes and CHF, an excellent reference containing the latest recommendations for Cancer Screening in adults and downloadable patient education materials.

GPRO Quality Update

March 22nd was the final day of the quality reporting window for our network and we completed the reporting! We would like to take this opportunity to thank our practices for participating in this effort and being so accommodating to our analytics team.

While we get full credit for reporting this year, we will be held to a tougher standard in 2019. **Please adopt these four key points of advice for documentation in 2019:**

1. Screen Patients for ALL types of tobacco use, a review of smoking alone is not sufficient for the Tobacco Screening Measure
2. If you take multiple blood pressure readings per a visit please record them all. We can take the best score, but it must be documented
3. If a patient does not want to receive a flu shot document their refusal. If a patient refuses they won't count against us
4. Make sure that Diabetic patients have their HbA1c tested at least annually

In subsequent months we may be selected for additional auditing by CMS. In this event we will collect the required elements for CMS to support our effort. If you have any questions or concerns, please reach out to Thomas Magrino at 741-3085 or thomas.magrino@mwhc.com.

UPCOMING ALLIANCE EVENTS

April 2019

Sun	Mon	Tue	Wed	Thu	Fri	Sat
	1 	2 Annual Meeting Fick Center 5:30 pm dinner, 6 pm meeting	3	4	5	6
7	8 Finance & Contracting Comm. 7:30 am 1 West CR MWH	9	10	11	12 Comm. & Educ. Comm. 7:30 am Dial in only	13
14	15	16	17	18 IT Comm. 9 am FH Suite 200	19 	20
21 	22	23	24	25	26	27
28	29	30				

May 2019

Sun	Mon	Tue	Wed	Thu	Fri	Sat
			1	2	3	4
5	6	7	8	9	10 Comm. & Educ. Comm. 7:30 am Dial in only	11
12 	13	14	15	16 Brd. Of Managers 7 am Exec. BR IT Comm. 9 am FH Suite 200	17	18
19	20	21 Quality Comm. 7 am 1 West A MWH	22	23	24	25
26	27 	28	29	30	31	

June 2019

Sun	Mon	Tue	Wed	Thu	Fri	Sat
						1
2	3	4	5	6	7	8
9	10 Finance & Contracting Comm. 7:30 am 1 West CR MWH	11	12	13 Brd. Of Managers 7 am Exec. BR	14 Comm. & Educ. Comm. 7:30 am Dial in only 	15
16 	17	18	19 Business Relations Cncl 7:30 am FH BR	20 IT Comm. 9 am FH Suite 200	21	22
23	24	25 Quality Comm. 7 am 1 West A	26	27	28	29
30						