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

Chairman of MWHA Board

Message from Dr. Thomas A. Janus

It is well known that there are few, if any, mom and pop type stores in business anymore. The Wal-Mart corporate model has driven them out of existence. With this, we have lost the "personal touch" provided by these smaller entities and have traded it off for discounts and more convenient hours of operation. This of course is the fault of no individual, but a gradual acceptance of corporate gigantism monopolizing the industry.

How close health care is to following this business model is more than just a rhetorical question. It is a frightening proposition. I can think of no industry that is more dependent on intimate human interaction than health care. It is difficult enough to tolerate the concept health care decisions made by providers must be approved by insurance company employees, who are far less trained in health care and are perhaps thousands of miles away. Imagine a world where policies as to how one would interact with patients would be dictated not by the physicians in the office, but by some corporate handbook created again perhaps thousands of miles away, if not in another country. But this is indeed a major pressure facing our health care providers. Not just physicians but hospital systems as well. In the 28 years I have been practicing in Fredericksburg, never have I felt the potential our hospital system might be required to lose its independence based on financial necessity. Mergers and acquisitions might be a necessity to survive, but I believe will lead to the demise of what health care truly is, personal, passionate caring for those in need.

The question is how are we poised to prevent us from being the mom and pops of health care? I believe the Alliance is a vehicle that can permit a counter attack against corporate onslaught. By having our network work together, using proven protocols and measures, we can improve care, decrease cost and demonstrate value to the market. This of course is the essence of clinical integration. But the Alliance will only be as successful as we as providers are in changing how we practice medicine. It will take collaboration, an investment of time and finances, and a commitment to change practice patterns where quality and cost containment suggest change is necessary for the greater good.

Over the next several weeks, the Clinical Quality Committee will be asking each specialty to identify what specific parameters we wish to emphasize in our first year of operation. This will be our first step towards demonstrating value and delivering what we promised to the patients we serve. I urge you to take this process seriously, get involved in selecting the measures you feel are important, and then incorporate those new measures into your practice.

Larger sized corporations may perhaps have the upper hand on cost due to economies of scale, but they certainly do not have a monopoly on quality, and I would suggest we can be more efficient by knowing our market and reacting to the needs of the market specifically rather than a one size fits all model. The mom and pop shops never had the ability to clinically integrate, but we do, and by doing so we can stave off the potential of corporate acquisition and at the same time improve how we care for our patients.

Thomas A. Janus, DO

Inside this Issue:

2300 Fall Hill Avenue, Suite 234 Fredericksburg, VA 22401 **P** 540.741.1557

Committee Corner….

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

As the Alliance begins its first year of operations, attention turns to the technology solution chosen assist with the integration of our practices into a true network. Last month the MWHA Board of managers received a status report on the progress of the Orion / MedeAnalytics Project and previewed the planned services through the community health record, Rappahannock Health Connect (RHC). Discussion focused on the short term goals for clinical integration and data analytics. While concerns were raised surrounding the potential outside integration costs to practices from their own vendors, the Alliance board received reassuring news from the RHC indicating that both basic and premium level integration would be included in Alliance Membership dues. Understanding that the success of the Alliance depends on practice integration, all efforts are being made to reduce financial barriers to practice integration with Orion.

Over the next year the Information and Technology Workgroup will be overseeing efforts in several key areas that will impact Alliance members.

1. Paid Claims Data for the MWHC members of the health plan has already been imported into MedeAnalytics and will serve as the starting point for performance benchmarking.
2. The Alliance will begin to engage practices and MedeAnalytics to formulate a project plan to collect the practices' Submitted Claims Data which will enable the generation of broader performance benchmarks.
3. All practices will be given access to the Orion Clinical Portal. Initial functionality will include secure messaging, event notifications, results, and demographic lookup. A rollout and training plan is currently being developed.
4. The Patient Portal will be activated and used to coordinate post discharge transition of care, beginning with Stafford Hospital.
5. Practices will be screened for readiness, placed in queue for premium level integration. A maximum of 14 practices could be integrated the first year depending on vendor resources and capability. (Premium integration allows practices to begin contributing information from their own EMR to the community health record, thus building a more complete record of each patient's health history.)

Be on the lookout for communications that will help your practice get plugged into RCH and get the most benefit from Alliance participation.

Greg, Szlyk, MD

MWHA Board of Managers
MWHA Chair of IT Committee
MWHC Medical Director of Informatics
Urology Associates of Fredericksburg

Committee Highlighted

	Jan	Feb	Mar	Jun	Sep	Dec
Communications and Education-Dr. Kurian Thott	●					●
Clinical Quality Committee-Dr. Susan Holland		●				
Information Technology Committee-Dr. Gregory Szlyk			●			
Finance and Contracting Committee-Dr. Jeffrey Frazier				●		
Membership and Operations Committee-Dr. Patrick McManus					●	

Message from Dr. Rick Lewis
MWHA Medical Director

There were a number of "hot topics" discussed and debated at the MWHA Board of Managers meeting that took place on March 20, 2014. Of interest, none of these were on the official agenda but arose out of pointed comments reflecting what was on the minds of various physician board members. The quality of the associated discussions was high and reflected the breadth of experience and interest of those present. Those of you who weren't there would have been proud of the contributions of your chosen representatives. In fact, our DHG representative, Mike Strilesky, was prompted to remark (and I'm paraphrasing) "That was the best meeting you have had so far - it really shows how far this organization has come in a relatively short time". I wanted to take this opportunity to expand on one of those "hot topics" as it affects all of us in the Alliance collectively but some of us more specifically - that is our primary care contingent.

Clearly, our primary care base is a key component of the Alliance as it strives for clinical integration and population health management. Historically, primary care physicians have not been rewarded appropriately (especially from a financial reimbursement standpoint) for their efforts in the care of an increasingly aged, sick and complex patient population. This largely reflects our present fee-for-service system which disproportionately rewards procedure-based care versus cognitively based care. We can end up getting paid more for what we do **to** a patient than **for** a patient. As you are aware, this disparity is starting to be addressed (though admittedly slowly as we are in an era of revenue neutral payment adjustments) and will probably be accelerated as we move toward a population health management model and are rewarded on the basis of how well we take care of large groups of people. Whether we're talking about Accountable Care Organizations or Patient Centered Medical Homes or something that hasn't even been thought of yet, primary care providers will play key roles as we are rewarded not only for healing the sick but maintaining the health of those who are well and lowering the risk of those whose characteristics and habits place them in jeopardy for losing the relatively good health they may be enjoying now.

So your Alliance wants to know how our primary care providers feel, what they are thinking, as we develop our clinical integration model. What quality metrics are important to you? (These metrics are the practices and outcomes that the Alliance will be tracking to demonstrate our commitment to quality and to provide a means for us to reward good clinical performance and identify those who need remediation and education). What can the Alliance do to make your practice lives easier and more rewarding? We are actually starting to think about requesting an ACO application. As ACO's are essentially primary care based (at least as I understand them) finding out how our primary care physicians feel about this is crucial.

As such, your Board has decided to set up a meeting specifically to seek primary care input and provide a forum to seek and address primary care concerns. Of course, this kind of thing only works if we get good participation from our membership. We are thinking about having an early evening meeting on a weekday in a central location (e.g. The John Fick Auditorium on the campus of Mary Washington Hospital) at which dinner is provided. Primary care members will put together the agenda and lead the meeting. We will be asking that at least one member of each primary care group attend. As opposed to specialty groups which tend to be relatively large, there are a lot of one and two person primary care groups (out of the 32 primary care practices in the Alliance, 22 are comprised of one or two physicians) so we would look forward to broad and robust participation.

The success and legitimacy of other organizations has been hampered by poor attendance at meetings and other expressions of apathy. Let's demonstrate that the Alliance is not going to be one of these. Look for the announcement in the near future that will let you know when and where this meeting will be taking place. If you have any particular issues which you feel should be addressed at this meeting. please contact one of your primary care board members (Drs. Janus, McManus, Amory, Holland, Madiraju or Bigoney).

Rick Lewis, MD

Communications and Education

SAVE THE DATE

Town Hall Meetings
For Primary Care, Internal Medicine and Pediatric Physicians

Join Alliance Board: Drs. Amory, Bigoney, Holland, Janus, Lewis, Madiraju and McManus for...

Two Information Sessions

- Wednesday, April 16
- Tuesday, April 29

Fick Conference Center ■ 6:00 - 7:30 p.m.

Details include:

- Quality Metrics
- Care Coordination
- Data Acquisition

RSVP by the Friday prior to the events to Pamela Johns (540) 741-2118 or pamela.johns@mwhc.com so we can coordinate appropriate number of meals

Second Membership Payment Due

Thank you to those physician owners who have made their second payment. A number of payments are still outstanding. The remaining $2,250.00 and interest payment of five dollars ($5.00) of the subscription price is already overdue. To avoid a late penalty, please submit your payment to the Alliance today!

Dues Deadline Extended

Our dues deadline has been extended to June 1, 2014 as a result of the late invoicing. Please send your check before this date to avoid a late payment penalty.

Look For Us Quarterly

We're committed to providing you with relevant news and information. Moving to a quarterly newsletter will allow us to deliver pertinent communications to you and your practices. Future newsletters will be published on the first of June, September and December. Between the March and June newsletter, any significant updates will be relayed through our other channels of communication such as Facebook, Twitter and email.

Facebook and Twitter

Your Facebook and Twitter invitation should have arrived this week. Please accept the invite to help us stay connected with you and you with us.

Visit us on the web at http://MWHealthAlliance.com

Watch for exciting enhancements to the MWMD website in 2014 as we work to make the site more user friendly and resourceful.

MWHC Health Plan - 3 Objectives for the Alliance

#1. The Alliance is committed to providing more effective care to MWHC, our partner and first contracted employer by adopting the principles of 'Better Care Better Health for populations and Lower per capita costs of healthcare.' No ONE specialty is responsible for all three dimensions. It is true of many populations that it is the 20% that incur 80% of the spend and MWHC is no different. By focusing on a percentage of manageable patients within this 20% rule; we will begin to make a difference.

#2: Emergency Room Utilization

ER Visit Utilization Rate	2012	2013	Norm
ER Visits per 1000	303	358	218

*Norm: UMR Book of business

Top Diagnosis **Chest Pain**

#3. Less expensive alternatives to top selling brand name drugs hit the market every year, driving generic rates in many markets into the 80-85 percentiles. This remains to be an opportunity for the Alliance is to improve upon the current Generic Utilization which equates to direct savings. The goal is to increase the use of clinically appropriate generic medications in the outpatient setting and begin to focus on

#1 Focus on High Risk/Cost Patients

MWHC High Risk/Cost Patients	2012	2013
Complex Cases	149	150
High Cost >$25,000	228	260
Movers*	643	595

*High Risk today but not a high Cost...Yet.

#2. Mary Washington healthcare associates have been steadily increasing Emergency Room utilization and this is not unique to MWHC; coverage does not equal access. Access is an national issue as well as a local one and the efficiency and culture of going to the ED is only growing. Early 2014 numbers show Associates utilization continue to trend upward even with the increased co-pays of $200. This will remain to be an objective for the Alliance to improve upon for MWHC Associates.

#3: Pharmacy Generic Utilization

Pharmacy Generic Utilization	2012	2013
Overall Generic Fill Rate (GFR)	72.5%	75.5%

(3) Highest Cost Medications in both 12' & 2013
1. Nexium, 2. Humira, 3. Cymbalta

2300 Fall Hill Avenue, Suite 234 Fredericksburg, VA 22401 **P** 540.741.1557

April 2014 Calendar

Mon	Tue	Wed	Thu	Fri
	1	2	3	4
7	8	9	10 MWHA Finance & Contracting Committee	11
14	15 MWHA Membership & Operations Committee	16 *PCP Town Hall	17 MWHA Board of Managers Meeting	18
21	22	23	24 MWHA Clinical Quality Committee	25 MWHA Communications & Education Committee
28	29 *PCP Town Hall	30		

* **PCP Town Hall Meetings** 6:00—7:30 pm Fick Conference Center

- Qualtiy Metrics
- Care Coordination
- Data Acquisition