2019

AMERICA'S PHYSICIAN GROUPS




CASE STUDIES IN EXCELLENCE



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President's Introduction

Welcome to America's Physician Groups' *Case Studies in Excellence 2019*. These 10 case studies beautifully illustrate the remarkable work of our physician group members, who are constantly pushing traditional boundaries to drive better quality and a better care experience for patients.

In this volume, you will learn about current healthcare challenges facing APG's members and their patient populations, together with detailed solutions and outcomes. These case studies are a testament to the exceptional coordinated care being delivered by hundreds of APG physician groups nationwide.

The quality and effectiveness of their work is also demonstrated by their participation in the nationally recognized Standards of Excellence™ (SOE®) program. This voluntary self-assessment enables APG groups to evaluate their systems and processes for delivering value-based care—providing a roadmap for ongoing quality improvement.

This year, 122 physician organizations across the country responded to the survey, and 66% of participants received the coveted Elite SOE® status. This number remains consistently high and speaks to our members' unrelenting pursuit of quality in delivering healthcare.

From our esteemed membership, APG has selected 10 case studies that exemplify this commitment to improving patient care and that showcase the many benefits of value-based care. Today, more Americans are receiving care through a coordinated delivery model, and a growing body of evidence shows that it offers better value, higher quality, and lower total costs for patients—while delivering tremendous value to physician groups taking financial risk.

I encourage you to participate in the 14th annual Standards of Excellence™ survey, which takes place in spring 2020. Either for the first time or as a returning participant, you will gain a clear picture of your organization's capabilities and competencies on the path to risk-based arrangements.

Meanwhile, I hope that you will enjoy—and gain valuable insight from—APG's *Case Studies in Excellence 2019*. Every year, I am impressed by how our members exceed expectations in delivering high-quality, innovative, coordinated care—and improved outcomes—in low-cost, risk-based models of care.

Thank you to all our contributors for their hard work and dedication.

Don Crane
President and CEO
America's Physician Groups

Message From APG's CMO

As we prepare for another election year in America, we're reminded of how far we have come as a country and a globally revered health system. The Accountable Care Act (ACA) and the Medicare Access and CHIP Reauthorization Act (MACRA) delivered tremendous change to how we had previously delivered healthcare to our patients. America's Physician Groups answered the national call for change and helped propel our members to succeed in risk-based, coordinated care models.

One of the unique opportunities as an APG member is to tap into our organization's vast knowledge base to learn and explore best practices and opportunities. The goal: optimize the quality of patient care and improve upon opportunities to bend the cost curve for America's competitive advantage.

In this edition of *Case Studies in Excellence 2019*, we showcase 10 APG organizational members that are excelling at delivering coordinated and patient-centric care while meeting the challenges of the quadruple aim. In these pages, you'll learn how our physician groups are:

- Empowering pharmacists to deliver safe, high-quality medication management to patients at home via collaborative practice agreements with prescribing providers.
- Activating patient engagement techniques (PETs) to help patients take charge of their healthcare while having fun.
- Combating physician burnout and boosting physician joy by reducing work after work.
- Reducing hospital readmissions for Medicare and Medicaid beneficiaries by implementing a new transition-of-care workflow.
- Creating a dedicated hospital unit to improve transitions of care for Medicare Advantage patients.
- Partnering with paramedicine allies to address overutilization of emergency department services by economically vulnerable populations.
- Developing a new speech care coordination program for the Medicaid pediatric population amidst skyrocketing demand for services.
- Leveraging a practice transformation team to improve quality and performance of primary care physicians.
- Designing a pay-as-you-go rewards program to sensitize physicians to their role in risk adjustment.
- Addressing medication adherence barriers by tracking data and promoting enhanced patient-provider communication.

Sharing these stories is just one more way APG is working to support physician groups in improving the quality and value of healthcare for patients. I hope that you find *Case Studies in Excellence 2019* both valuable and informative—and that our members' success inspires you to unlock new opportunities to approach healthcare delivery transformation within your organization.

Amy Nguyen Howell, MD, MBA, FAAFP
Chief Medical Officer
America's Physician Groups

Standards of Excellence™: A Roadmap to High-Quality Care

Earlier this fall, America's Physician Groups announced the results of its 2019 Standards of Excellence™ (SOE®) member survey. This rigorous, voluntary self-assessment documents APG members' coordinated care infrastructure and preparedness—setting a bar for consumers to evaluate the quality and value of their healthcare delivery.

The 13th annual SOE® survey was offered to more than 300 APG members in 44 states, the District of Columbia, and Puerto Rico—with 122 medical groups, health systems, and independent practice associations (IPAs) participating. In all, these groups cover 15.3 million commercial lives, 3.2 million Medicare Advantage lives, and 3.8 million Medicaid lives.

APG's Clinical Quality Leadership Committee analyzes the survey performance each year, adding new measures for technical quality, responsive patient experience, and affordability. For the past two years, the survey included display questions on social determinants of health (SDOH). Results from those surveys showed a major provider focus on addressing SDOH, and this year, the committee voted to add point value to this section. This shows APG's support for addressing SDOH, gives credit to physician groups doing this work, and encourages others to make this commitment.

> "Physician organizations that see the value of the Standards of Excellence™ survey understand that it takes commitment, vision, and leadership to deliver sustained value to their patients."
>
> *—Amy Nguyen Howell, MD, Chief Medical Officer, America's Physician Groups*

Notably, this year the committee voted to maintain the thresholds for each domain at a high bar, aligning with the program's mission to drive enhanced performance and quality of care. It also collaborates with the National Committee for Quality Assurance (NCQA) to ensure the highest accuracy and standards for the survey and its scoring and review.

The 2019 Standards of Excellence™ is composed of six domains, with the first five publicly reported:

Domain 1
Care Management Practices
Clinical system supports for quality and efficiency on a population scale

Domain 2
Information Technology
Funnel for accurate, actionable information to support clinical decisions and coordinate team care

Domain 3
Accountability and Transparency Response to the public demand for objective information regarding performance, patient service, and regulatory compliance

Domain 4
Patient-Centered Care Critical components of access, convenience, cultural responsiveness, and customized individual care

Domain 5
Group Support of Advanced Primary Care
Patient-centered medical home model and its use in revitalizing the discipline of primary care

Domain 6
Administrative and Financial Capability
Management of complex relationships, diverse revenue streams, innovative payment alignment, and risk-based payments

Physician groups that reach the quality threshold in each domain are awarded a "star." Those achieving a star in all five publicly reported domains are designated as Elite. In 2019, 66% of SOE® participants achieved the Elite designation and were recognized at the APG Colloquium in Washington, DC.

The Star achievement levels are:

- 5 stars = Elite
- 4 stars = Exemplary
- 3 stars = Meritorious
- 2 stars = Admirable
- 1 star = Commendable
- 0 stars = Participant

For more information on the SOE® program and results, visit apg.org/soe.

Improving Access to Speech Therapy Amid High Demand

INTRODUCTION

In 2014, changes in California regulations resulted in a dramatic increase in demand for pediatric speech services via our medical group. This came without any commensurate increase in capitation or an ability to significantly increase the infrastructure and staffing of our capitated providers, and it rapidly overwhelmed our network capacity.

In response, Children's Physicians Medical Group (CPMG) worked with the Developmental Services department at Rady Children's Hospital-San Diego—as well as local educational agencies (school districts)—to develop, pilot, and broadly implement a new Speech Care Coordination program to ensure that member families receive the services they need.

CHALLENGE

Prior to 2014 in California, school districts were primarily responsible for providing speech therapy to children over age 3 who had Medi-Cal (Medicaid) coverage. The network of speech providers in our area was built on this assumption. So when a new state regulation shifted this responsibility to Medi-Cal managed care plans, it unleashed a flood of requests for services upon an already busy system.

Our internal capitated services were limited in capacity by personnel and facility constraints. We had an established network of external contracted fee-for-service vendors, but we had built this network based entirely on geographic access issues. Not all of these providers were willing to see the new volume of Medi-Cal members. In addition, we had concerns about the quality of services provided by some vendors in our area. This made us reluctant to simply increase the size of our network.

> "We had his speech evaluation with Stephanie, and it was an eye-opening experience. Just 30 minutes with her showed me that someone finally understood my son's challenges. I am grateful beyond words."
>
> *—Mother of Consultative Evaluation Clinic patient*

Initially, we provided extensive education and guidance to our primary care and specialty communities on multiple occasions and in multiple formats. We outlined which needs could most appropriately be met by the school districts, and which should be referred directly to Rady Developmental Services. This effort did not result in a statistically significant change in referral patterns.

Our next step was to create a dedicated Speech Care Coordination program—working with local school districts to meet our group's obligations and the needs of our member families.

INTERVENTION

Stakeholders in developing the program included Rady Developmental Services leadership, partner health plan medical directors, school district medical directors, and leadership of several special education local plan areas (SELPAs), which oversee the provision of special education. We also had regular communication with the districts' special education departments.

Here is how the program works:

- Authorization requests are modified for children over 3 on Medi-Cal—providing families with the direct phone number for the school district office responsible for speech therapy services.
- After the child's records are reviewed, a speech care coordinator at CPMG contacts the family within five business days. If needed, our coordinators assist the family in contacting the school district.
- If there will be a delay in accessing school services (such as over the summer), an authorization is issued for a shorter course of therapy to bridge this gap.
- If children are already receiving services via their district—but the family or provider believes they would

benefit from additional services—the coordinator securely obtains the child's individualized education program (IEP) and schedules the child for CPMG's Consultative Evaluation Clinic (held at Rady Children's Hospital).

- At these Saturday clinics children are seen by a speech language pathologist (SLP), who performs a speech evaluation, assesses the child's needs, establishes appropriate goals, and determines if needs or goals are not being addressed by the school district. The SLP then makes recommendations for services to address these needs.
- When children are not eligible for services via their school district, CPMG provides services through our medical network.

RESULTS

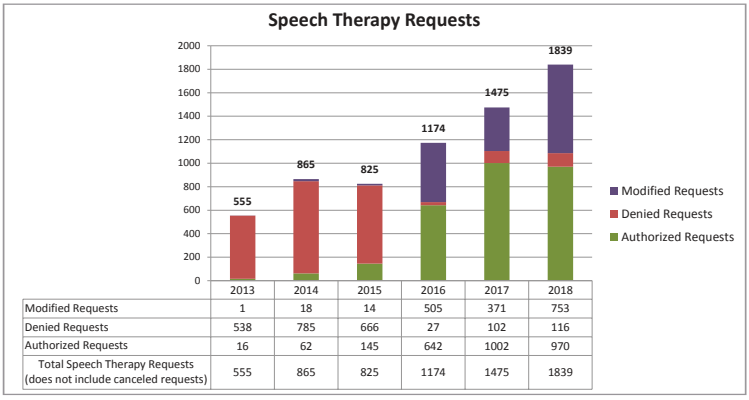
Of the children enrolled in speech care coordination whose cases were closed in the first six months of 2019, the needs of 65% are being fully met by their schools. Another 16% received short-term bridging services, and 19% are receiving services via the school and supplemental therapy. These numbers are remarkably consistent with the results of our initial 2016 pilot.

There have been several unexpected benefits of this project:

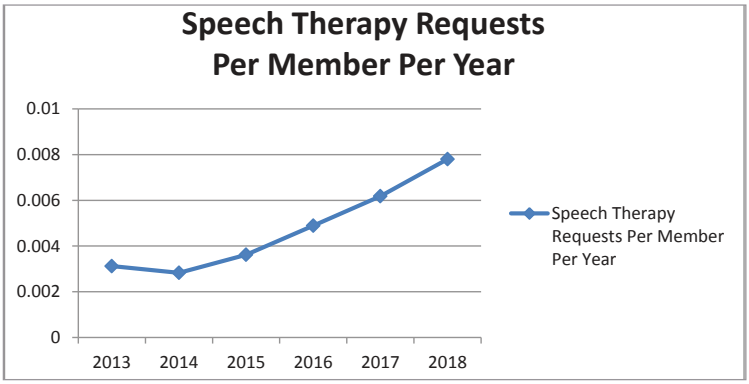
- We've created written guidance on our expectations for assessments, standards, and documentation for our contracted vendor network. We are now working on similar guidelines for occupational and developmental physical therapy.
- Collaborating with the leadership team of our largest partner federally qualified health center (FQHC)—and our regional SELPAs and school districts—has helped align understandings and expectations.
- Establishing the weekend Consultative Evaluation Clinics improved access for members who require a higher level of care than what is available via the schools.
- Perhaps most exciting, we are currently piloting a novel model of intermittent speech services. We are assessing whether children receiving therapy on an every-other-month basis—with both a home program and telehealth access during the "off" months—make equivalent progress to those in ongoing services. This could potentially double the capacity of our internal team.
- We are projecting savings in speech therapy services of more than $3.8 million in 2019.

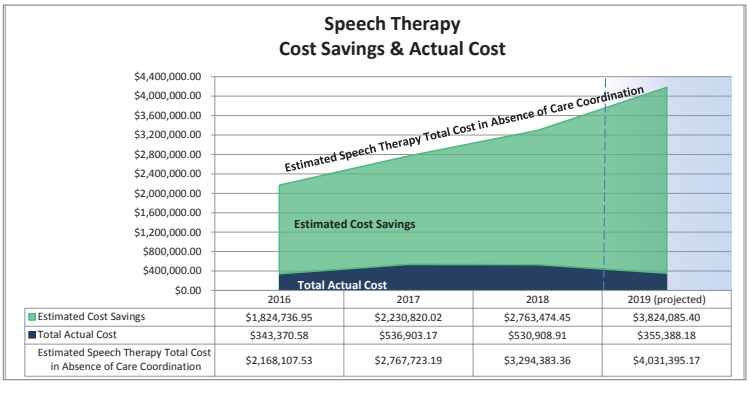
Despite our success in ensuring that most children can access appropriate care from their local schools—generally closer to home and with access to additional services—the volume of requests has continued to skyrocket. This remains an ongoing challenge. Without this program, the increase in our costs would have been astronomical.

The obvious solution is for providers to appropriately direct children whose needs can be best met by community organizations to those organizations—thus preserving medical group access for younger children and for those who require more specialized care.



	2013	2014	2015	2016	2017	2018
Modified Requests	1	18	14	505	371	753
Denied Requests	538	785	666	27	102	116
Authorized Requests	16	62	145	642	1002	970
Total Speech Therapy Requests (does not include canceled requests)	555	865	825	1174	1475	1839





	2016	2017	2018	2019 (projected)
Estimated Cost Savings	$1,824,736.95	$2,230,820.02	$2,763,474.45	$3,824,085.40
Total Actual Cost	$343,370.58	$536,903.17	$530,908.91	$355,388.18
Estimated Speech Therapy Total Cost in Absence of Care Coordination	$2,168,107.53	$2,767,723.19	$3,294,383.36	$4,031,395.17

WHO WE ARE

Children's Physicians Medical Group (CPMG) was founded in 1998 by a collaboration of pediatric primary care and specialty providers to enable more effective and coordinated care for San Diego's children. Today, our independent practice association (IPA) has evolved into a pediatric integrated system of care that includes Rady Children's Hospital-San Diego. CPMG is responsible for utilization management, quality improvement, and case management services for approximately 75,000 assigned members. We also perform these services on behalf of Rady Children's Hospital for other health plan contracts—ultimately totaling 300,000 children in San Diego and southern Riverside counties.

BINGO! Improving Quality Through Patient Engagement

INTRODUCTION

IntegraNet Health is committed to the health and well-being of the patients we serve. It is our goal to work closely with our patients, contracted providers, and health plan partners to ensure our patients achieve optimal health outcomes. We believe the best way to improve quality metrics and clinical outcomes is to keep patients focused and engaged in their care. To do this, we use patient engagement techniques (PETs). These techniques empower our patients to take charge of their healthcare—and to have fun at the same time.

CHALLENGE

Primary care physicians are held accountable for quality measures, yet they often have little to no control over clinical outcomes. Issues they face include:

- Providers are occasionally assigned patients they have never seen.
- Patients seek treatment from emergency rooms or urgent care centers when they do not have an established relationship with a medical home.
- Many patients will not follow up with their primary care physicians for preventive health screening.
- Health literacy among patients is generally low, and many patients lack knowledge of the importance of preventive care.
- The only time many patients see their physician is for treatment of an illness—not wellness-related preventive screening.

Recognizing these challenges, IntegraNet Health has made it a priority to implement initiatives that empower patients to be more involved in their care. We believe patient engagement is the key to improving quality metrics and achieving optimal healthy outcomes.

> "The BINGO card helped me to remember to follow up with my doctor and to remember what I had taken care of."
>
> *—Emily, IntegraNet member*

INTERVENTION

IntegraNet Health first implemented patient engagement techniques in 2012, and we have continued to develop this approach over the years. Our efforts include:

- **Healthcare BINGO.** We developed a BINGO (Being Involved Never Gets Old™) card for Medicare Advantage members to help them understand which annual preventive screenings they need. The quality metrics are listed in the BINGO squares; in each square, providers record when the screening occurred and by whom.

  When the patient receives a black-out—with all squares completed—the card is mailed to IntegraNet Health for review. In return, the patient receives a $15 gift card in accordance with guidelines and approval from the Centers for Medicare & Medicaid Services (CMS). We are currently compiling data to determine the card's overall effectiveness.

- **Community health worker visits.** Community health workers (CHWs) are used in the patient's home as the "boots on the ground" for the company. Their primary focus is to foster patient engagement, promote access to available community resources, and provide educational resources to prevent or decrease exacerbations of chronic disease.

During the home visit, CHWs screen patients to determine their level of health literacy. Education is then geared toward the patient's level of understanding, and we identify barriers to care and develop treatment goals. CHWs then contact patients to help schedule preventive health screenings in their PCP medical home.

In addition, CHWs assist physicians with closing open HEDIS measures through active patient engagement. CHWs contact the patient by phone or conduct a home visit. The primary objective is to educate the patient on the importance of preventive screening and routine follow-ups. They also complete a functional status assessment and pain assessment as needed.

- **HEDIS Health Fairs.** IntegraNet conducts HEDIS Health Fairs to help physicians achieve optimum quality metrics. Members are invited to attend and receive preventive screening tests, including mammograms, blood draws, and blood pressure checks. Qualified staff assess many of the HEDIS measures, and results are submitted to the physician for review.

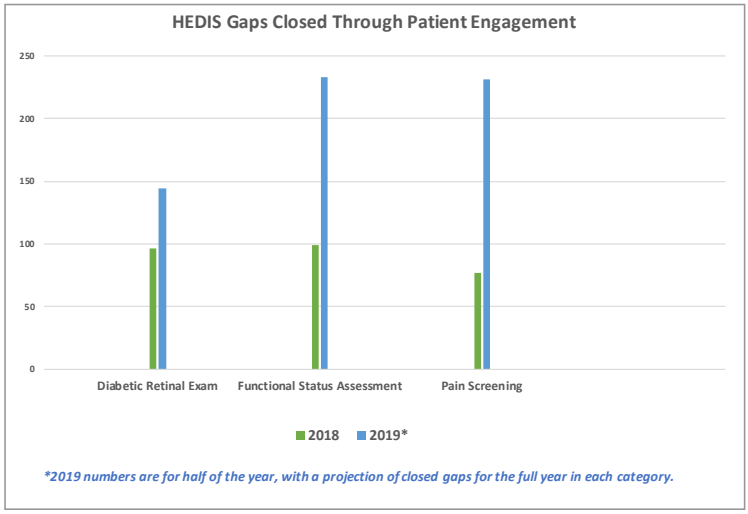
RESULTS

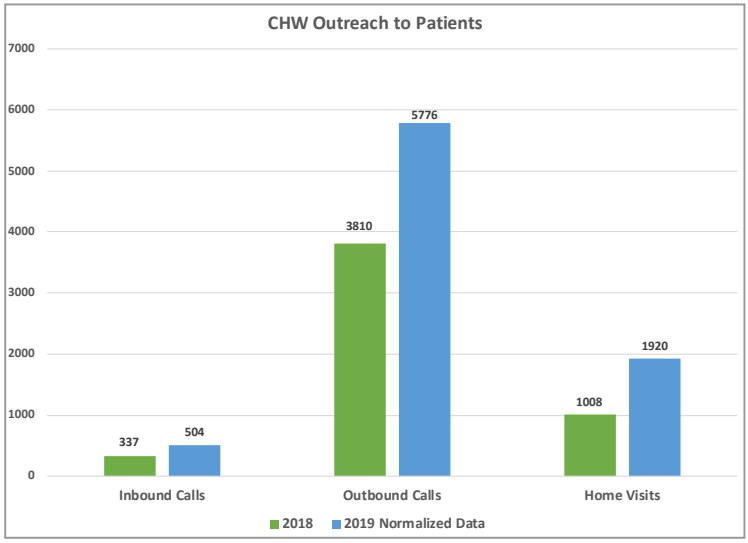
In 2018, total outreach from CHWs helped PCPs close 810 gaps. From Jan. 1 to June 30, 2019, CHWs have assisted with closing an additional 822 quality measures—representing a projected increase of 100% year to year.

One of the key gaps closed involved diabetic retinal exams (DRE). IntegraNet purchased a diabetic retinal camera so our trained CHWs could capture photographs of the retina in patients' homes. The photos are then sent to an ophthalmologist to review, and results are sent to the PCP.

As a result of this intervention, we increased the number of DRE gaps closed by 50% from 2018 to 2019 (using projected data for the second half of 2019). In 2019, we're also projecting a 135% increase in the number of functional assessment gaps closed, and a 200% increase in pain assessment gaps closed. Additional gaps in care have been closed as a result of CHW education.

In addition, we have expanded the BINGO card program to include all Medicare Advantage members under risk-sharing in 2019. We are seeking approval from CMS to extend the BINGO card to ACO beneficiaries as well.





WHO WE ARE

IntegraNet Health was established in 1997 as an independent practice association (IPA) and management services organization (MSO). One of the largest IPAs in Texas, IntegraNet offers shared-risk population health management services with more than 1,600 contracted primary care and specialty physician practices. We also provide contracted physicians with office-based business services. Our attention to preventive care and disease care initiatives helps physicians meet required quality standards and achieve healthier patient populations.

Empowering Pharmacists to Manage At-Home Medications

INTRODUCTION

Intermountain Healthcare has been expanding its home-based services to incorporate more complex medical treatments and technologies, add primary care visits and checkups, and provide more complete care beyond brick-and-mortar facilities. Called Intermountain at Home, this expansive program is supported by physicians, advanced practice providers, nurses, pharmacists, care managers, life care managers, and other practitioners to keep patients comfortable and cared for in their own homes.

One elemental piece of this program is safe, high-quality medication management. To support this, Intermountain at Home is empowering pharmacists to fulfill more active clinical roles by enabling them to enter into collaborative practice agreements (CPAs) with prescribing providers.

CHALLENGE

In 2017, Intermountain Homecare and Hospice incorporated its first CPA. CPAs denote that authorized pharmacists have the appropriate training to provide clinical care in the related practice. The agreements give pharmacists permission to:

- Write and order laboratory tests
- Write, order, and change the dosage or frequency of medications

This first CPA allowed homecare pharmacists to manage dosing levels for patients on vancomycin, an antibiotic given by infusion to treat severe infections.

Vancomycin is a complex medication to manage because it requires blood draws every other day until the patient is therapeutic—and then weekly labs thereafter. These labs have to be ordered, reviewed, and managed by the prescribing provider to appropriately dose this medication at therapeutic levels and avoid toxicity.

For community physicians, this can be an extraordinary amount of work in addition to their other patient care responsibilities. To further complicate matters, a community physician may see a very small percentage of patients on this medication. Inexperience with vancomycin could lead to poor outcomes and adverse events, such as kidney damage.

> "Empowering pharmacists to make informed decisions on behalf of busy physicians allows for immediate responses, which translates to a safer and more cost-effective healing environment for our patients."
>
> *—Erin Stahl, PharmD, BCPS-Infectious Disease Clinical Pharmacist, Intermountain Homecare and Hospice*

INTERVENTION

To make the CPA available to physicians, Intermountain first established a special committee led by our Infectious Disease team. The committee created a protocol for our homecare pharmacists to practice within, based on Infectious Diseases Society of America (IDSA) clinical practice guidelines for managing vancomycin.

The established team of pharmacists at Intermountain Homecare and Hospice went through extensive training on vancomycin management, again led by our head of Infectious Disease. The protocol and training were rolled out to pharmacists via a series of in-person and online advanced education modules.

All pharmacists were expected to participate to be a resource for our community physicians. Each pharmacist also had to pass a practical, case-based test to demonstrate the skill level needed to safely manage vancomycin. Every year, pharmacists in the program must recertify via a practical test.

Another key step included recruiting physicians who would allow the pharmacist to manage vancomycin for them. Such management had been commonly done only in the hospital within the care team circle. A community CPA was new, and many physicians were hesitant at first.

However, over time, this has evolved into a trusted relationship between physician and pharmacist—and ultimately, better management of patients in general.

RESULTS

Vancomycin management, which included a pharmacist as part of the community healthcare team, significantly improved the touch points needed to effectively manage home-based patients on this medication.

In 2018, 410 patients obtained vancomycin from the homecare pharmacy. Of these, 209 were managed by the pharmacist, versus 201 by the provider.

The onset of a therapeutic level (as determined by our infectious disease providers) was measured to ascertain the success of the treatment. Data has shown that as a patient spends more time within the therapeutic range, outcomes are improved, with fewer associated side effects for patients. This ultimately leads to less antibiotic resistance, fewer emergency room visits, and less time spent in the hospital.

In 2018, homecare pharmacists were able to obtain therapeutic troughs within seven days 88% of the time—compared with 65% of the time when managed by a provider.

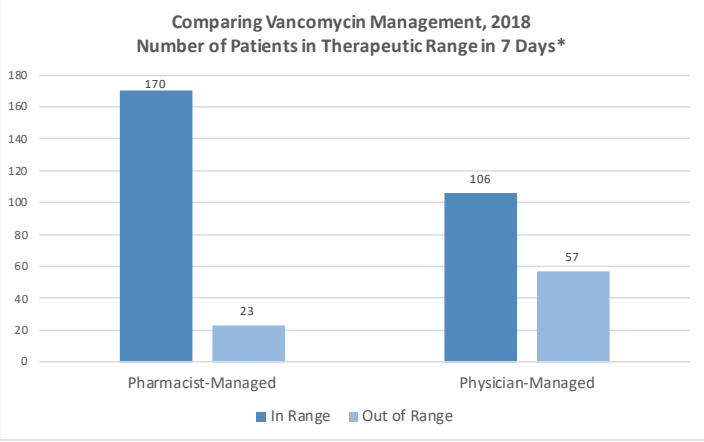
Our pharmacists are now managing many vancomycin patients every day. There is a lot of concentrated experience that we hope will show better outcomes and fewer side effects. This has been a satisfier for both pharmacists and physicians—allowing the pharmacist to move quickly to provide the best care for a patient without waiting for a physician to sign off on orders—and freeing the physicians to focus on the patients they need to see.

"When a homecare pharmacist can manage vancomycin for a patient, it allows for a more seamless transition from the inpatient setting to homecare," says Erin Stahl, PharmD, BCPS-Infectious Disease Clinical Pharmacist, Intermountain Homecare and Hospice. "It can also impact patient safety

immensely because the pharmacists are able to act quickly by ordering the necessary labs and making safe dosage adjustments. These labs and dosage changes often occur outside of regular business hours."

We're currently finishing the education and competency evaluations for pharmacists and dietitians to enter into a CPA for home-based parenteral nutrition for adults, and recently we've identified a need to expand parenteral nutrition to pediatrics/newborns.

CPAs are empowering both pharmacists and providers to perform the roles they're meant to—getting patients rapid access to the care they need in their own homes. We believe that this, in turn, will support care safety, quality, and patient experience; prevent unnecessary hospitalizations; improve operational efficiencies; and minimize costs.



WHO WE ARE

Intermountain Healthcare is a not-for-profit system of 24 hospitals, 215 clinics, a medical group with 2,500 employed physicians and advanced practice clinicians, a health insurance company called SelectHealth, and other health services in Idaho, Utah, and Nevada. Intermountain is widely recognized as a leader in transforming healthcare by using evidence-based best practices to consistently deliver high-quality outcomes and sustainable costs.

Relieving Physician Burnout by Reducing 'Work After Work'

INTRODUCTION

Across the United States, physician burnout is an epidemic, with 44% of physicians reporting feelings of burnout or depression. The consequences of this burnout—including lower empathy for patients, reductions in practice, early retirement, substance abuse, and even suicides—are devastating to physicians, patients, families, and our communities.

To reverse this trend, Iora Health focused on reducing the amount of work our physicians take home ("work after work"). By studying this problem and experimenting with solutions, Iora improved the most time-consuming workflows, including those related to policies, processes, training, and technology.

CHALLENGE

Iora Health's mission is to restore humanity to healthcare. Along with our high-impact, relationship-based care model (which particularly benefits Medicare patients), we have an explicit commitment to develop and sustain joy in practice.

To date, remedies for physician burnout have mostly examined individual physician behavior, with a focus on building resilience and implementing coping strategies. Rather than giving physicians ways to cope, we decided to tackle the issue of burnout at its root. Unsurprisingly, we found that physician burnout increases as the number of work hours increases.

> "Shortening the consult review process has allowed us to practice more at the top of our license and has reduced time wasted on review of routine and mostly uninformative notes. More time is now spent on patient care, and work after work has been reduced significantly."
>
> *—Iora practice medical director*

Our challenge: Continue to build joy in practice while maintaining high expectations for care in an ever-changing clinical environment. In addition, Iora was addressing this problem at a time when overall provider workload was increasing by 30%—due to growth in our patient population.

INTERVENTION

We began by investing in understanding exactly what was contributing to provider burnout—or lack of joy in practice—in our organization. This investment was substantial, and importantly, began at the top.

Our efforts were initiated by Iora Co-Founder and CEO Rushika Fernandopulle, MD, MPP. Fernandopulle spent three months on a listening tour with every provider in our group. Iora also conducted a Culture Amp engagement survey for all employees and the American Medical Group Association (AMGA) satisfaction survey for providers.

Based on these results, it was clear that work after work had a major impact on provider well-being. We defined after-hours work as work outside of an 8 a.m. to 5 p.m. day.

In June 2018, Iora created a focused campaign to boost physician joy—beginning with reducing work after work. A lean team interviewed and observed 40 providers, 150 care team members, and every market medical director at Iora. We created a way to measure work after work for each care team member, and we developed quantitative tools to understand the work care teams do in delivering comprehensive primary care to seniors.

Our goal: Reduce work after work for 90% of our providers to a manageable five hours a week or less (to allow for on-call activities). At that time, only 65% of our providers met this goal.

Iora's strategy was simple: to "hotspot" the providers and teams that were struggling the most with work after work. Through one-on-one coaching, we aimed to fix core care activities via three to four experiments per practice. Over six months, we coached 14 practice location teams

on process improvements and ran 60 experiments on 15 different workflow improvements. These improvements led to enhancements in training, management guidance, and Chirp, Iora's collaborative care technology platform.

For example, we centralized the review of faxed-in specialist consult notes. Under the new process, consult notes are now reviewed and summarized by a nurse; the provider then reviews the summary and adds it to the patient's chart as needed. In just two weeks, we noticed a significant boost in efficiency in this activity (Table 1). In addition, total work after work was reduced by three hours for the providers in the pilot program.

Other experiments included dedicated provider task time, visit flow standardization, medication refill process improvements, and technology and process improvements in visit documentation. We gave practice managers weekly actionable progress reports. Finally, we introduced a rapid improvement framework, where teams discussed the process changes daily during the morning huddle and made incremental improvements.

RESULTS

After working with 20 providers, 87% of our providers worked less than five hours after work each week. Although we saw a 30% increase in overall provider work in the six months of this study (due to growth of Iora's patient population), average work after work was still reduced by 35%. In January 2019, average provider work after work was only three hours a week.

Through this program, we learned that:

- Just 20% of Iora providers contributed to 80% of provider work after work.
- Iora providers spend 80% of their time on five core activities: seeing patients and completing documentation, reviewing labs and imaging, extracting data from past medical records, interpreting consult notes, and completing refill requests.
- Providers who could complete their work while at work had three differentiating characteristics:
  - They had high-performing teams to support them.
  - They were hyper-intentional about effectively managing their time during the day.
  - Their teams were more adaptive to change.

In just six months, process improvements allowed us to reinvest an estimated $1.2 million to $2 million in provider time for our patients—and significantly improve "joy in practice."

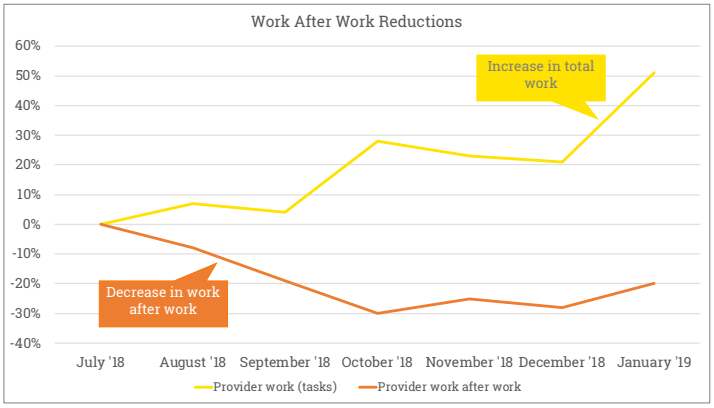
We still have more to do. We continue to improve daily practice activities to make teams more effective for our patients. Our commitment is ongoing as we monitor engagement, time use, clinical results—and most importantly, joy.

Table 1

Impact of Centralizing Consult Note Review

	Before Pilot	After Pilot
Turnaround time	12 days	5 days
Provider review time	6-7 minutes	1-2 minutes

Turnaround time and provider review time reduced by about 60% and 80%, respectively, as a result of centralizing consult note review.



REFERENCES

1. CA Sinsky et al. In Search of Joy in Practice: A Report of 23 High-Functioning Primary Care Practices. Ann Fam Med May/June 2013 vol. 11 no. 3 272-278
2. Medscape's 2019 National Physician Burnout and Depression Report, Medscape.com/slideshow/2019-lifestyle-burnout-depression-6011056-1.

WHO WE ARE

Founded in 2010, **Iora Health** is a national, globally capitated, risk-bearing provider group that is building a different kind of health system to deliver high-impact, relationship-based care. Our care model provides extraordinary service to patients, ensuring improved health outcomes while lowering overall costs. Patients enjoy better access to care, office- and non-office-based encounters, an accessible and transparent medical record, and robust educational offerings. Teams and providers enjoy smaller panel sizes, closer relationships with patients, and the opportunity to lead systemic change in healthcare delivery while working with a true team.

Reducing Readmissions and Post-Discharge No-Shows

INTRODUCTION

Reducing readmissions is one of our key initiatives at MedPOINT Management (MPM). Achieving a reduction would strengthen our utilization management program, improve our HEDIS performance in the all-cause readmission measure, strengthen our relationship with our partner hospitals, and most importantly, help patients attain a higher quality of care.

Our readmission rate varies across the 13 independent practice associations (IPAs) we manage, but at the end of 2017, it averaged 14.2% for Medi-Cal members and 13% for Medicare members. Despite a very devoted and hard-working inpatient utilization management (UM) team, we knew there was an opportunity for improvement.

CHALLENGE

Structuring a program to reduce readmissions was a significant undertaking. We identified that patients return to the hospital within 30 days of their initial stay for a few main reasons, most commonly related to:

- The initial hospitalization
- A secondary condition
- Poorly managed transitions of care
- An unrelated admission

To add to the challenge, many of our patients have negative social determinants of health (SDOH)—including homelessness, transportation issues, and lack of a support system.

It is important to note that most of MPM's IPAs support the hospitalist model. While it can be argued this strategy is more efficient, the disruption of primary care physician (PCP) continuity of care can't be overlooked. This was also a consideration when structuring the workflow.

Despite significant investments in inpatient utilization infrastructure, we recognized that staff alone could not improve engagement. The process needed to be revised.

> "Several health centers are very excited to see that the new process has resulted in more patients showing up for their appointments. Our team is now getting access to some of the live scheduling systems, which is optimizing this process further."
>
> *—Jorell Ludovico, In-Patient UM Team Lead*

INTERVENTION

Transition-of-care (TOC) strategies are key to program success. Built on the premise that more-effective handoffs and improved provider communication can have a positive effect on lowering readmission rates, MPM has clinical and nonclinical staff focused exclusively on TOC.

Our initial TOC workflow consisted of the following:

1. E-fax the face sheet to the PCP upon admission notification. A report of "patients in house" was e-faxed to the PCP on a daily basis.
2. Upon discharge, the PCP received the history and physical, consult notes, list of procedures, radiology, lab results, and the discharge medication list.
3. Once discharged, the patient was called by MPM's TOC staff to schedule a PCP visit, preferably within seven days of discharge.
   a. The follow-up PCP visit included medication reconciliation and addressed all diagnoses documented in the discharge summary.

While this workflow seemed like a good process on paper, the results were poor. Only 37% of members kept their appointment, which further burdened the overloaded scheduling at provider offices.

After recognizing our metrics were stagnant, we knew change was required. In 2018, we revised the workflow—adding two important steps (No. 2 and No. 5). Here is the new process:

1. E-fax the face sheet to the PCP upon admission notification.
2. Once notified of a medical/surgical admission, the TOC staff calls the patient—while the patient is still hospitalized—to establish a rapport and begin discharge planning and SDOH discovery. This includes scheduling a PCP visit within seven days following discharge.
3. A report of "patients in house" is e-faxed to the PCP on a daily basis.
4. Upon discharge, the PCP receives the history and physical, consult notes, list of procedures, radiology, lab results, and the discharge medication list.
5. The member outreach team places a reminder call to the patient and provider the day before the scheduled PCP visit. This also gives MPM an opportunity to discuss HEDIS gaps and encourage the provider to schedule these services.

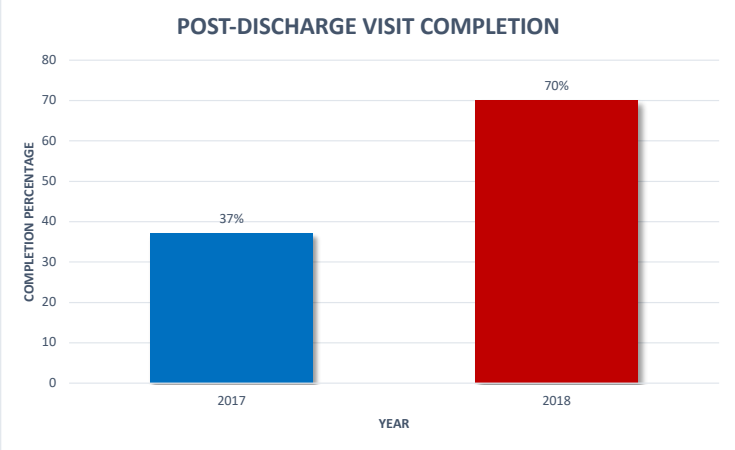
RESULTS

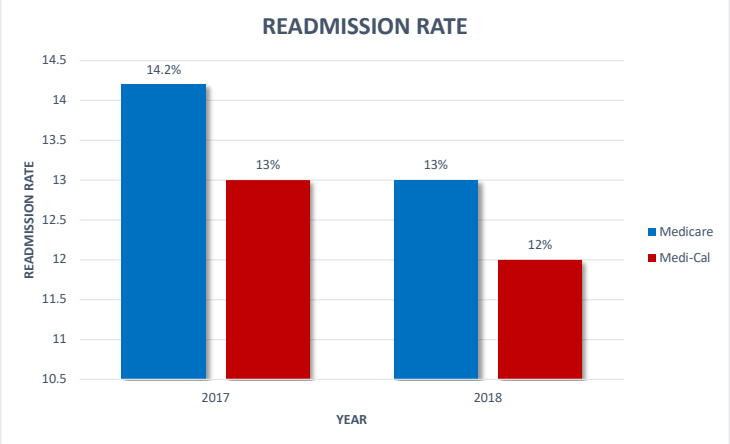
These program adjustments have resulted in steady improvements—both direct and indirect. Holding true to the premise that readmission rates can be reduced by focusing on quality discharge information, well-coordinated care, and timely communication with PCPs, readmission rates improved from 13% in 2017 to 12% in 2018 for Medicare members. For Medi-Cal members, rates fell from 14.2% in 2017 to 13% in 2018.

We have also seen a reduction in patient "no-shows" for post-discharge visits. Overall, 70% of patients contacted now complete the post-discharge visit—an 89% increase from before. Another benefit has been improved physician engagement in transitions of care.

One important aspect of the new TOC process is the scripted call while the patient is in the hospital. Obvious questions about transportation, social support, and home needs are asked, but perhaps most importantly, the call allows patients to express their individual needs. The "caring" element goes a long way with healing.

We are still tweaking the program to achieve even greater success. Our TOC and case management teams remain very involved with the discharge planning process and participate in daily huddles with the medical director and hospitalists. We are striving for a 12% or lower readmission rate for all lines of business and have made a significant investment in human capital. We look forward to more success in the future.





WHO WE ARE

Founded in 1987, **MedPOINT Management** is a management services organization (MSO) that serves more than a million members in California—92% Medi-Cal, 2% Covered California, 2% Medicare and/or Medicare-Medi-Cal, 3% commercial, and 1% point-of-service (POS). We provide all aspects of managed care management services to IPAs and hospital clients. Our customized approach allows us to successfully manage single physician practices, large networks of federally qualified health centers, and all practice models in between.

A 'Golden' Hospital Unit Improves Transitions of Care

INTRODUCTION

The complexity of hospital admissions in chronic disease impacts health plans and the provider community. Over the years, unique interventions have been implemented to maximize outcomes and improve patient experience. Historically, inpatient management teams (hospitalists and case management) have had the most impact on the cost of inpatient care. But as inpatient management programs have evolved, other issues have impacted the alignment between health plans, provider groups, and hospitals.

At InnovaCare, we have a health plan (MMM Healthcare) with a large MSO (MSO of Puerto Rico) and a strong relationship with the provider community. We looked at improving transitions of care for patients in a way that benefited each of our stakeholders. This unique project impacted our Medicare Advantage (MA) membership.

CHALLENGE

Many clinical and quality outcomes are negatively impacted by ineffective transitions of care (TOC) during hospitalizations. Ineffective transitions can result in lower quality of care, financial drain, and potential compliance liability to stakeholders. Research has also shown that they can lead to higher admissions and readmissions, higher medical costs, lower member satisfaction, and increased disenrollment.

Root causes of ineffective transitions include poor communication and ineffective patient education. Examples include patients and caregivers receiving:

- Unclear instructions concerning follow-up care
- Conflicting recommendations of treatment
- New medication schedules

"Unidad Dorada is an excellent concept where support and services are integrated. They also think about the comfort of the caregivers."

—Granddaughter of Unidad Dorada patient

It became clear to us that communication among discharge planners, hospitalists, and others interacting with inpatients was not as effective or coordinated as it could be. We needed a mutually agreeable strategy, where the three stakeholders (health plan, providers, and hospitals) benefited from a program that improved quality, financial efficiency, and member satisfaction and retention.

The solution: Create a dedicated hospital unit controlled by our key stakeholders. We used our health plan's leverage to lease a hospital floor—which allowed our MSO to then optimize levels of care and coordinate all aspects of the admission for patients on that floor. The goal was to achieve better alignment among all groups, and most importantly, better outcomes.

The unit was initially a challenge to all stakeholders:

- **For the health plan**: Would the medical groups provide enough redirected admissions to keep the prepaid floors busy year-round? Would members accept redirected admissions? How would it impact member retention?
- **For the medical groups**: How would the other health plans receive this intervention? Could the IPAs redirect enough patients to this health plan-exclusive unit to impact their full-risk contracts to create savings—while improving overall quality of care and service?

INTERVENTION

MMM Healthcare leased entire hospital floors at three tertiary hospitals. We called these dedicated units "Unidad Dorada" (Golden Unit). The key to success was the alignment by the IPAs and medical groups to use these MMM-exclusive floors—and redirect potential MMM admissions from surrounding hospitals to our exclusive floors.

The intervention began with our contracted hospitalists seeing the patient in the emergency room after the patient was triaged by the ER. MSO-specific clinical protocols had an immediate impact. Enhanced multidisciplinary communication and active clinician participation positively changed cultural dynamics on the hospital floor. Thanks to standardized practices, the Unidad Dorada (UD) multidisciplinary team produced health and psychosocial assessments, care plans, and discharge plans in less than 48 hours of admission.

Admission to UD for each patient includes:

- A UD welcome kit
- Proprietary web portal access
- 24/7 call center support
- Bedside medication reconciliation and distribution upon discharge
- Coordination of follow-up PCP visits
- Follow-up phone calls
- Home visit programs
- Transportation

Patients also receive access to other MMM and MSO services, such as our Vita Care chronic care clinics; mental health, case management, and disease management programs; and follow-up visits.

RESULTS

The program began in 2016 but had to weather through the hurricanes of 2017. The results have been positive and continue to be very promising. We have broken down the results into three areas:

1. Utilization of services

Our results (Table 1) include our Medicare Advantage membership between 2016 and 2018 at UD-participating hospitals:

- Admits per thousand dropped from 184 to 175.
- Our 30-day readmission rates fell 18%.
- Average length of stay fell by 12%.
- Redirected admissions to the UD-preferred hospitals increased regional market share for those hospitals by 30%.

2. Health plan and member engagement

Patients and caregivers were significantly satisfied with services and quality of care (Table 2). Patient satisfaction was 99%, and overall membership retention increased to 98.7% among members who used the program.

The most improved areas for the health plan were medication adherence and reconciliation on the discharged UD patients, as well as increased PCP follow-up appointments after UD discharge. Medication adherence performance improved our Star rating from 4 to 5.

3. Financial impact

Using partner hospitals that allowed us to coordinate medical care and manage transition of care issues resulted in significant financial improvements. The measurement years 2016 to 2018 showed improvement in regions where we had a UD hospital using most utilization metrics.

More importantly, in one of the regions, the IPAs redirected more than 35% (38% in 2019) of all their admissions to UD. This resulted in a 22% reduction in inpatient costs and a 10% improvement in overall savings between 2016 and 2018.

Table 1: Utilization Management

UM of Services	2016	2018	% Change
Admits/K	184	175	-4.9%
Length of Stay	5.8	5.1	-12.1%
30-day Readmit %	12.3%	10.1%	-17.9%
Redirects to UD*	23%	30%	30.4%

The table shows utilization management improvements after two years of Unidad Dorada.

** Indicates regional market share for hospitals participating in the UD program.*

Table 2: Member Engagement

Metric	2018	2019	% Change
Member Retention	93.7%	98.7%	5.3%
Bedside Rx (prior to DH)	17%	65%	282.4%
Post-DH Appointment	10%	62%	520%
Member Satisfaction	99%	99%	No change

Unidad Dorada improved member engagement in multiple areas. Although UD began in 2016, these initiatives were not measured until 2018. (DH = discharge home)

WHO WE ARE

MSO of Puerto Rico, LLC (MSO), is a full-service health management organization in Puerto Rico. We focus on efficiency and high-quality delivery of care through innovation and tools that allow excellent clinical, administrative, and financial results. We manage 21 independent practice associations (IPAs) with a network of more than 5,000 PCPs and specialists impacting 255,000 Medicare Advantage members, and 88 IPAs impacting 275,000 Medicaid patients. MSO also owns the largest Medicare Advantage IPA on the island: Castellana Physician Services, LLC, with 80,064 Medicare Advantage members and a network of 800 PCPs and specialists.

Using EMTs to Reduce Low-Acuity Emergency Room Visits

INTRODUCTION

Accessing readily available non-acute care is often difficult for the most vulnerable and socioeconomically challenged patients (Medicaid population). This navigation and care chasm leads to overutilization of emergency department (ED) services for conditions that could otherwise be treated in a lower acuity care setting.

Like so many other integrated health systems across the country, Ochsner Health System was struggling to offer our large Medicaid population a reliable ED alternative for low-acuity care. For many of our vulnerable patients in the greater New Orleans region, the ED was perceived as the default care setting—not only for acute needs, but also for general wellness and low-acuity needs. In response, Ochsner partnered with Ready Responders to give this population a new alternative for low-acuity care and reduce patients' unnecessary use of the ED.

CHALLENGE

With a large portion of our lower-acuity ED visits taken up with our indigent Medicaid populations, Ochsner Health System was spending a large portion of our finite labor and space resources on nonemergent needs.

Over the years, we had tried several interventions, including building closer relationships with our local federally qualified health centers (FQHCs) and sending patients post-ED-visit mailers explaining alternative care settings for lower-acuity needs. But these efforts met with little success. This

patient population continued to have challenges with transportation and with accessing FQHCs and urgent care clinics. These care settings often required large financial deposits that patients had a hard time providing. Thus, they ultimately ended up back in the ED to seek care.

It became obvious that bending the curve of low-acuity ED utilization—and creating a lasting change in these behaviors—would require a radical change to our traditional mindset of only providing peripheral interventions (i.e., teaching about the FQHC and alternative care settings). But the big question was whether this population would truly embrace a change in care settings to one that included a clinical intervention inside their own home.

> "A parent advised me that she was truly happy with Ready Responders. Without the program, she would have gone to the emergency room, and she could not have made the appointment with her son's new doctor."
>
> *—Report from post-visit call with patient*

INTERVENTION

The advent of paramedicine in many communities across the country has been seen as a way to solve overutilization at an episodic level. At Ochsner, we believed we needed a multi-pronged approach that included episodic interventions as well as longitudinal care management.

In March 2019, we partnered with Ready Responders, a home-based EMT company in the greater New Orleans area that essentially operates on an Uber-based platform. EMTs pick up shifts and are then deployed either in an urgent care on-demand model or on scheduled visits.

In our initial collaboration, we sent Ready Responders a list of patients who had had multiple low-acuity emergency room visits in the prior 90 days. This list was a starting point so Ready Responders could reach out and

enroll patients for a scheduled in-home visit with a medic. The medic could then educate patients on their condition, arrange for a telehealth visit with a provider if an exacerbation in condition was present, and make sure the patient received prescriptions and transportation to and from a pharmacy to pick up medications.

The initial visit and needs assessment were centered around educating patients about their current condition and setting up care in alternative settings, such as the local FQHC. If the EMT deemed the patient at continued risk for a return non-emergency ED visit, Ready Responders would follow the patient for up to 60 days.

Phase two of the program used Ochsner's 24/7 nurse advice line to deploy EMTs into the homes of patients who were calling about their symptoms. The deployment was based on the triage disposition of "other than ED now." This added an urgent care on-demand program, as well as longitudinal care management of this population once the on-demand visit has taken place.

RESULTS

Initial results have been nothing short of groundbreaking. With more than 400 patients enrolled in the longitudinal community care management program, we are seeing a 43% reduction in overall ED utilization from this population 90 days post-intervention (compared with the 90-day period before the intervention).

Even more promising is the reduction in low-acuity ED visits in the same population: a staggering 60% in the same 90-day post-intervention period.

These are the first results we have been able to sustain for both total ED utilization and redirection of lower-acuity visits. The urgent care on-demand program is also showing promising results in patient satisfaction. After an in-home urgent care visit, more than 95% of patients say they are satisfied and would use the service again to seek care.

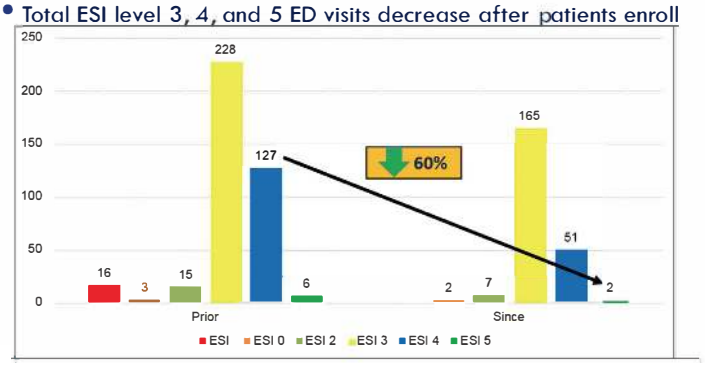
In addition, patient education about the local FQHC and other community resources has led to more than 95% of EMT-identified social needs being addressed.

We are so pleased with these results that we are continuing to seek new ways to collaborate with Ready Responders to expand our portfolio of home-based options for our most vulnerable populations. We are in the process of building an in-home follow-up visit program for low-acuity discharges from our hospitals. This program will focus on patients who historically have been challenged with maintaining follow-up care due to transportation issues, access to specialty care, or caregiver support gaps.

Low-Acuity ED Utilization

CURRENT PERFORMANCE

- ED Utilization prior and since enrolled in Ready Responders
- Total ESI level 3, 4, and 5 ED visits decrease after patients enroll



READY RESPONDERS ED PROJECT

KEY HIGHLIGHTS

Key Highlights:

1. **43% reduction** in overall ED visits for enrolled patients
2. **60% reduction** in unnecessary ED visits for enrolled patients

WHO WE ARE

Ochsner Health System is Louisiana's largest nonprofit academic healthcare system. Driven by a mission to "Serve, Heal, Lead, Educate, and Innovate," Ochsner provides coordinated clinical and hospital patient care across the region through our 40 owned, managed, and affiliated hospitals and specialty hospitals, as well as more than 100 health centers and urgent care centers.

A Team-Based Approach to Practice Transformation

INTRODUCTION

Last year, as Sharp Community Medical Group (SCMG) approached our 30th anniversary, our Board made a strong commitment to become a group synonymous with outstanding quality—despite the fierce independence of our varied and unique practices. The goal—part of our Vision 2020 initiative—was to raise overall quality and performance. This meant that every physician would be required to achieve a minimum standard of performance.

To support our PCPs and their practices in raising performance, SCMG developed the Primary Care Performance Initiative and leveraged our Practice Transformation department to help implement it. The initiative focused on improving the following quality measures in both overall and access rank: blood pressure control, diabetes mellitus control, medication adherence, preventive cancer screenings, and patient experience.

CHALLENGE

Our physician practices are diverse, with each serving a unique community. SCMG physicians want to have quality and patient experience scores they can be proud of, but the demands of running their practices often prevent them from being able to focus on efforts that would improve these scores.

Many of our practices:

- Lack office systems to support care management and systematic tracking for optimal process and outcomes

- Operate on a narrow financial margin, with minimal flexibility in resource use
- Are often not equipped to manage the fundamental practice changes needed to improve care

> "Practice transformation was sometimes a difficult road to travel, but it was well worth the journey. The team-based concept has been our most powerful tool in the process: one team, one purpose."
>
> *—Kimberly Byers-Lund, DO, Primary care physician, Sharp Community Medical Group*

INTERVENTION

SCMG created the Primary Care Performance Initiative—a voluntary participation program that focused on improving select quality and patient experience measures. Outcomes for each measure were tracked using a 4.0 scale, and unblinded performance scores were provided to all physicians.

Participating physicians had to meet the following requirements:

- **Performance improvement plan.** Create a well-documented plan to focus improvement efforts on a priority measure.
- **Medical director 1:1s.** Meet with the group's medical director to help track progress and ensure goals are clear.
- **Performance excellence physician meetings.** Attend CME meetings to ensure awareness of evidence-based guidelines and in-depth discussion of quality and patient experience measures.
- **Learning collaborative participation.** Share best practices to help providers and staff improve on patient care delivery and outcomes.

To assist physicians in this practice transformation, SCMG support teams meet internally to discuss progress on

performance improvement plans, address practice challenges, and celebrate wins. This multidisciplinary team consists of a medical director, the program manager, program coordinator, and key staff members from Patient Experience, Electronic Health Records, Network Management, Case Management, Population Health, and Practice Transformation.

We identified a need to develop practice-level organizational change to accelerate improvement. This included the creation of more effective clinical teams, better coordination of care, improved information management, and office systems that enhance patient experience.

To achieve this change, we took a team-based approach. SCMG leveraged our Practice Transformation department, including a program manager, three performance improvement specialists, and a program coordinator. This team assisted the practices in incorporating principles of the patient-centered medical home and Lean Six Sigma.

Implementation began by selecting practices that could potentially show the greatest improvement and have the highest physician buy-in. Based on practice readiness and level of engagement, our Practice Transformation team members worked with the individual offices and provided one of three levels of support:

- **Focused** – Performance improvement plan on one focused quality measure
- **Moderate** – Performance improvement plan on multiple quality measures and some operational improvement efforts
- **Extensive** – Performance improvement plan on all quality measures and clinical and operational improvement efforts

RESULTS

In all, 96% of our physicians participated in the initiative. They were able to take advantage of the services provided by our practice transformation specialists and other SCMG support team members to implement changes in their care delivery workflows and processes. Below are a few examples:

- **Hypertension blood pressure control.** By providing blood pressure training and competency to practice staff, we improved our performance on this measure by 13.5% from 2017.
- **Breast and colorectal cancer screening (commercial).** By implementing team-based care and converting data into actionable reports, practices that received Moderate and Extensive support achieved the 75th percentile in this measure—performing more than 10% above those who received Focused support.
- **Overall quality performance.** Overall quality scores showed a significant improvement among physicians using Moderate and Extensive support for practice transformation. Physicians using Focused support had a more modest improvement in their quality performance.

Based on this success, we have decided to expand the Practice Transformation team by hiring additional performance improvement specialists. This will enable us to provide greater assistance to our practices.

Practices that received Moderate or Extensive support from SCMG's Practice Transformation Team achieved higher quality scores.

WHO WE ARE

Sharp Community Medical Group is the largest group of physicians in private practice in San Diego. With a network of over 800 primary and specialty care physicians working in 350 locations in San Diego County, we offer families convenient access to care and the ability to get most of their care in their own community. Our physicians represent over 30 specialty areas and admit to 10 local hospitals, including all Sharp HealthCare and Palomar Health hospitals and Rady Children's Hospital-San Diego. We celebrated our 30th anniversary in September 2019.

Engaging PCPs in Risk Adjustment With Immediate Rewards

INTRODUCTION

In 2015, Summit Medical Group recognized that 3,000 to 4,000 of its 300,000 patients were aging into Medicare each year. In response, the Board endorsed a new approach to managing the group's Medicare population. That approach emphasized four elements: quality, expense management, participation in education sessions, and risk adjustment.

At the time, risk adjustment was relatively new in our market. We needed to sensitize physicians to their role in risk adjustment—and to how risk adjustment affected overall contract performance. To do this, Summit designed and implemented a one-year, pay-as-you-go Rewards & Engagement Program that featured bonus payments in the month immediately after a performance threshold was achieved.

> "The training and presentation offered many gold nuggets that I will try to incorporate in my daily workflow. I learned a lot. Thank you."
>
> *—Kevin Campbell, MD, Summit Medical Group physician*

CHALLENGE

While risk adjustment has been part of Medicare Advantage (MA) since 2004, it was a relatively new concept in Tennessee in 2015. Summit Medical Group physicians were not familiar with the Centers for Medicare and Medicaid Services Hierarchical Condition Category (HCC) model. They did not understand how it could impact contract performance with the MA plan—or how it could positively impact patient care. Most importantly, they did not understand their own role in risk adjustment.


Kevin Campbell, MD

While education can provide information, our goal was to go beyond that and engage physicians with clear-cut expectations and timely rewards. Accomplishing that goal is complicated in MA because shared savings performance is typically finalized 19 months following the close of the performance year. For physicians used to fee-for-service, in which they are paid *20 days* after performing a service, waiting *20 months* redefined delayed gratification.

Using the basics of behavioral economics—such as immediacy, goal gradients, mental accounting, and social ranking—Summit Medical Group designed and implemented a one-year, pay-as-you-go Rewards & Engagement Program for physicians. Importantly, the program featured bonus payments in the month immediately after a physician's achievement was recognized.

INTERVENTION

A physician-only committee established the following basic rules for the Rewards & Engagement Program metrics:

1. Align incentives for contract success.
2. Be transparent, timely, credible, and quantifiable in provider-facing reports.
3. Be fair (weighted by panel size or flat dollar amount).
4. Calculate incentives in time for inclusion in that year's income.

Summit made the significant investment of $5 per member, per month (PMPM) into these incentives. Bonuses were allocated as follows:

- 20% – Quality management
- 25% – Expense management
- 20% – Participating in HCC education
- 35% – Readdress prior-year chronic HCCs

The largest portion of funds rewarded physicians for readdressing prior-year chronic HCCs (providing proper clinical documentation if the condition was still present). The program recognized physicians for each appropriately and adequately documented prior-year chronic HCC.

A tiered approach tied the amount of the incentive to attaining specific performance thresholds. Physicians who achieved over 50% completion received a set dollar amount per documented HCC. If they achieved over 75% completion, their bonus was 1.5 times higher per HCC. At over 90%, they earned twice as much per HCC as at the 50% threshold.

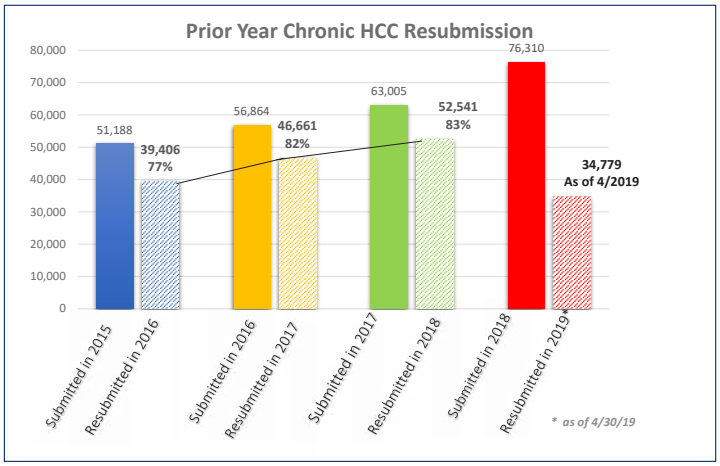
Lump sum payouts were made in the month following achievement of each threshold. On a weekly basis, we reported the readdress rate of all PCPs with full transparency to generate friendly competition.

In addition, in 2015 we offered two educational sessions to help physicians understand the importance of documenting prior-year chronic HCCs. We offered multiple time options, included electronic medical record "super users," and made sure that at least one physician champion attended each offering. We have continued to offer this education once a year, including extra support for new providers.

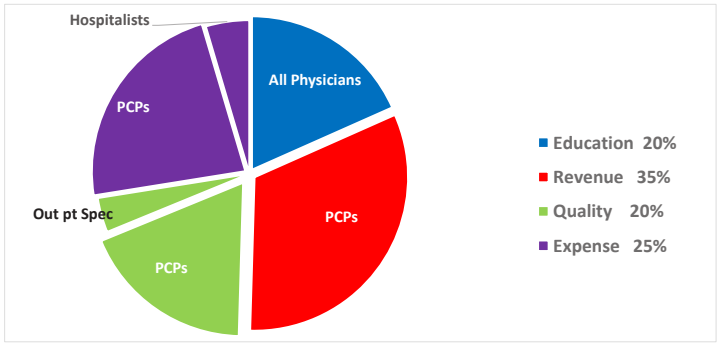
RESULTS

The program helped Summit's physicians gain an appreciation for proper HCC documentation. This has manifested in year-over-year performance results.

Between 2014 and 2019, the percentage of prior-year chronic HCCs that were readdressed and adequately documented increased 5% year-over-year. Note that this 5% improvement was achieved on an ever-increasing denominator because more patients join Medicare Advantage every year as the population ages. Between 2017 and 2018, the increase was 3%—representing a readdress rate of 83% out of 73,102 prior-year chronic conditions.



The program resulted in an increased resubmission rate, year over year, on an ever-increasing denominator.



Program incentives were allocated across four areas and multiple physician types.

WHO WE ARE

Summit Medical Group, PLLC, is an independent physician-owned and physician-directed primary care group based in Knoxville, Tennessee. Summit's 300 primary care providers serve approximately 280,000 active patients in 13 counties. All 60 of Summit's practice sites have achieved NCQA Patient Centered Medical Home recognition under the 2017 standards. Summit's scope of service includes a fully licensed lab, advanced imaging, physical therapy, urgent care centers, a sleep lab, and integrated behavioral health services.

Improving Outcomes and Patient Experience Through Medication Adherence

INTRODUCTION

Medication adherence plays a vital role in ensuring that patients achieve desired health outcomes. But despite its importance in keeping patients well, adherence remains a challenge in South Texas. External factors, which are often out of the care team's control, add an additional level of complexity to keeping patients adherent.

As part of the effort to move away from a service-based model of care to a more proactive outcomes-based model, Valley Organized Physicians (VOP) needed a solution that would address medication adherence barriers. A key part of this solution was to increase engagement with patients after they leave their physician's office.

CHALLENGE

Patients with chronic conditions such as diabetes, hypertension, and hyperlipidemia are at a higher risk for complications. Unfortunately, ensuring that patients are filling and taking their medications has been an ongoing obstacle. Barriers to medication adherence include:

- Medication affordability
- Lack of transportation
- Lack of treatment understanding
- Fear of side effects

To address these needs and concerns, VOP worked with CareAllies, a company focused on helping provider groups transition to value-based care, to develop a Medication Adherence Tracker (MAT). The tracker uses available data to identify high-risk, nonadherent patients to target for interventions.

Access to data and patient identification are essential for success—but they only resolve a portion of the issue.

William Torkildsen, MD

Medication adherence is highly dependent on provider-patient communication. With this in mind, this initiative was also aimed at changing VOP's culture to promote enhanced communication, collaboration, and engagement.

Patients place great trust in their physician; therefore, physician-led initiatives have proven to have a significant impact on changing patient behavior. By placing the reigns in physicians' hands and altering processes to ensure two-way communication, the MAT initiative allows VOP to better understand patients' needs, explain the importance of medications, and problem-solve together.

> "I think it's appropriate that we should be expected to take both a leadership and an ownership position in a patient's medication adherence. As we help improve adherence, outcomes also improve."
>
> *—William Torkildsen, MD, Chairman, Valley Organized Physicians*

INTERVENTION

VOP worked with CareAllies to design a detailed report that highlights lack of "fill" activity for patients prescribed a set of targeted, quality metric-focused medications. These include drugs for diabetes, hypertension, and cholesterol.

The report is then disseminated through CareAllies' embedded care coordinators (ECCs), who support individual practices with quality initiatives. ECCs play a vital role by managing the process and guiding practices to ensure success.

Since patients are more likely to respond to their physician or their physician's staff, a representative from the practice connects with patients to understand their reason for not filling their medication. Interventions include activities such as:

- Providing medication education
- Scheduling an office visit
- Calling the pharmacy to refill the medication
- Switching to a 90-day supply
- Rescheduling multiple refills for the same day
- Setting up home delivery

In addition, providers now place more focus on medication discussions because of the impact these conversations can have on adherence. By identifying concerns that could affect adherence during all office visits, physicians can proactively address medication barriers before a patient appears on the MAT report.

After outcomes from medication interventions are documented, ECCs relay these outcomes to the pharmacy team. Claims analysis can then confirm whether efforts were successful—in other words, whether the patient filled the prescription. An updated report is then created. This continuous cycle utilizes existing data in new and innovative ways and allows for ongoing improvements to the process.

"Patients often look to their doctor to guide them in making care decisions," says Esteban Gallardo, PharmD, Clinical Program Manager, CareAllies. "As a pharmacist, I help develop the data to identify patients who may need medication guidance. By sharing this information with VOP physicians, they can connect with these patients to understand and address any barriers they may be facing."

RESULTS

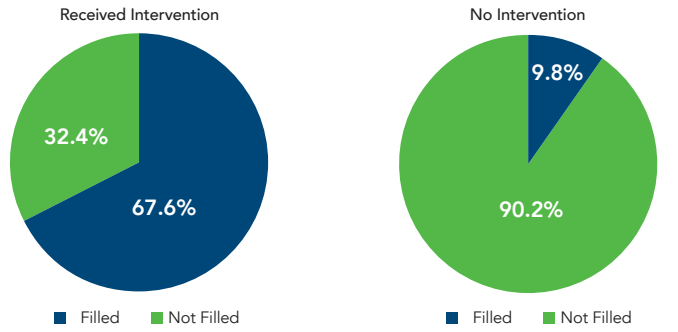
Through the MAT initiative, patients are educated on the importance of filling their medications, and more convenient methods to fill prescriptions are implemented when available. These efforts and adjustments have been welcomed by VOP patients, many of whom were likely unaware that their problems could be solved.

The initiative not only improved patient satisfaction, but a data analysis of 3,539 patients after year one showed that patients who received physician intervention were 20 times more likely to have a prescription filled than those who did not. Patients were also three times more likely to be adherent (per the Centers for Medicare & Medicaid Services standards[1]) by the end of the year.

The MAT initiative has continued to prove successful in closing medication adherence gaps and helping patients adhere to their care plans. This has led to an improvement in VOP's Medicare Advantage and Part D Star Ratings year over year since these process changes were implemented.

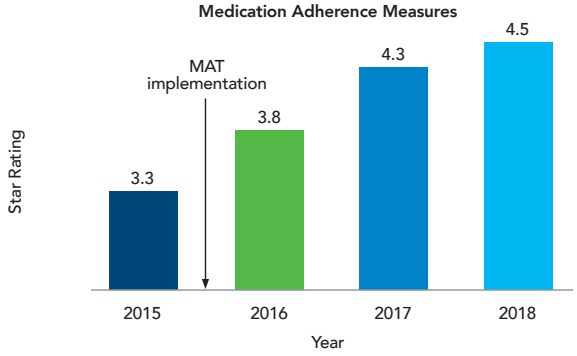
VOP and CareAllies continue to work together to evaluate data and processes to find new ways to enhance the MAT. The more that providers, payers, pharmacists, and other stakeholders can collaborate with each other—and with patients—the bigger the impact on outcomes and satisfaction for all involved.

Percentage of MAT-identified patients who filled medications in year 1*



Based on 3,539 patients identified for Medication Adherence Tracker initiative in 2016.

Medicare Advantage Part D Star Ratings*



VOP Cigna-HealthSpring MA Part D Star Ratings for medication adherence measures: Medication Adherence for Diabetes Medications, Medication Adherence for Hypertension (RAS Antagonists), Medication Adherence for Cholesterol (Statins) and Statin Use in Persons with Diabetes (SUPD). SUPD measure added in 2017.

REFERENCES

1. https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/Downloads/2019-Technical-Notes.pdf

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Valley Organized Physicians (VOP) is an independent physician association located in the Rio Grande Valley region of South Texas. Established in 2011, VOP is composed of a network of primary care physicians and specialists dedicated to driving better health. VOP's unique model unites patients, providers, employers, and payers to advance care delivery—improving outcomes and offering patients high-quality, affordable care.

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