CASE STUDIES IN EXCELLENCE

2024

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WELCOME to the 2024 edition of America's Physician Groups' *Case Studies in Excellence*!

These case studies profile how APG's member organizations are improving the quality and addressing costs of health care through various means, ranging from care restructuring to technology-based solutions.

APG's 360 physician-led member organizations take accountability for the health care of nearly 90 million Americans across 47 states, the District of Columbia, and Puerto Rico. These organizations represent 200,000 physicians and other clinicians caring for patients of varying age, race, ethnicity, and socioeconomic status. APG members lead the way in improving patients' care experience and health outcomes while also being accountable for costs.

The case studies in this volume highlight 12 APG member organizations' initiatives that advance high-value care in five key areas:

- **Addressing health disparities and social determinants of health (SDOH):**
  - Culturally competent care strategies improve blood pressures in older, minority adults
  - Multimodal SDOH-targeted interventions resolve care barriers and reduce costs
  - Site of service transitions bridge SDOH needs and promote health equity
- **Timely access to mental health supports and services:**
  - Primary care mental health integration improves care access for children in Medicaid
  - Multilingual app facilitates on-demand patient screenings, education, and follow-up
- **Optimizing care access and spend:**
  - Value-based partnership offers personalized, noninvasive alternative to knee replacement for osteoarthritis
  - Acute primary care clinic improves access and overcomes workforce challenges
  - Enhanced care coordination team reduces avoidable emergency room visits
- **Pharmacist integration in primary care:**
  - Pharmacist-led refills unburden physicians and staff while improving quality
  - Pharmacist collaborative care optimizes hypertension control
- **Technology solutions for high-value care:**
  - Unified customer relations management strategy personalizes patient call experience, promotes engagement, and improves care gaps
  - Real-time pharmacy benefits decision support improves medication adherence and lowers prescription costs for both patients and providers

Sharing these success stories is one of the many ways that APG supports our members as they accelerate the movement from volume to value, transform care through alternative payment models, and improve the health care outcomes and experience millions. We hope that these case studies inspire physician practices, health care organizations, policy makers, payers, and purchasers to adopt and support these and other avenues to attaining value-based care.

Susan Dentzer, MS
President & Chief Executive Officer
America's Physician Groups

Susan M. Huang, MD, MS
Chief Medical Officer
America's Physician Groups

Astrana Health

Astrana Health is a leading provider-centric, technology-powered healthcare company enabling providers to deliver accessible, high-quality, and high-value care to all. Leveraging its proprietary end-to-end technology solutions, Astrana operates an integrated healthcare delivery platform that enables providers to successfully participate in value-based care arrangements, thus empowering them to deliver high quality care to patients in a cost-effective manner. Headquartered in Alhambra, California, Astrana serves over 10,000 providers and 1.0 million Americans in value-based care arrangements.

> "In 2023, nearly 30% of Astrana Health's ethnic minority older adults had uncontrolled BP"

Enhancing Blood Pressure Control for Medicare Beneficiaries: Culturally Inclusive Strategies to Close HEDIS® Gaps

INTRODUCTION

In the Medicare population, hypertension (HTN) contributes to adverse health outcomes and high health care costs. In 2021, nearly 80% of U.S. adults aged 65 and older had high blood pressure (BP), and this condition was associated with nearly 700,000 deaths.[1] Asian and Hispanic older adults have higher rates of uncontrolled BP, due in part to markedly lower rates of HTN awareness in these populations.[2,3] Social determinants of health (SDOH), including socioeconomic status, education, healthcare access, language barriers, and cultural beliefs, play crucial roles in HTN control among ethnic groups. Low-income individuals are 30% more likely to have uncontrolled BP. Cultural beliefs around traditional medicine lead to a 25% lower adherence to antihypertensive medications among Asian Americans. Hispanic older adults with limited English proficiency are 42% less likely to have regular BP checks, and even though HTN awareness among Hispanic Americans exceeds 60%, less than 35% have their BP under control.[4,5,6,7,8]

CHALLENGE

Of all members with identified ethnicities at Astrana Health, 81% are of minority backgrounds. In Astrana's Medicare population, 93% are ethnic minorities, and in 2023, nearly 30% of these older adults had uncontrolled BP, mirroring disparities shown in published literature. In the HEDIS® Controlling Blood Pressure (CBP) measure, Astrana sees higher care gaps in its Hispanic Medicare population than in its overall older adult population. In the adult population with diagnosed HTN, only 44% of Astrana's Hispanic and 53% of its Asian patients have controlled BP.

In order to reduce the burden of HTN-related complications in its Medicare population, Astrana needed to recognize and tailor BP interventions to meet the needs of its older minority populations.

INTERVENTION

With oversight from nurse practitioners (NPs), Astrana Health implemented a new BP management outreach program for Medicare Advantage beneficiaries that is grounded in culturally competent care. Driven by member demographics, the team included staff with Chinese, Filipino, Black, Vietnamese, and Hispanic backgrounds. These staff were trained to communicate with empathy and patience across cultures, on how to take

accurate BP readings, and on how to educate patients in effective HTN self-management. Compliant BP readings (<140/90 mmHg) were documented, and NPs submitted claims to close HEDIS® CBP gaps. The team also followed up with the patients' primary care physicians to ensure continuity of care.

Astrana implemented strategies such as language-concordant pairings and targeted cultural competency trainings, which addressed cultural norms, diets, customs and traditions, in readying staff to provide optimally relatable and impactful support to patients in managing their BP control. For example, trained staff reviewed foods prevalent in the patient's culture and helped them identify achievable BP control strategies with these foods. Staff conducted language-concordant, virtual and in-person education to help patients use and read their BP monitors. If the patients did not have home monitors, staff helped them get one through their health plans, a process that was previously daunting to many due to language barriers. Patients were also supported with navigation to community resources that addressed social care needs, such as food banks, free clinics, and wellness centers.

RESULTS

Since the beginning of Astrana Health's program, culturally competent communications, especially with year-over-year retention of providers and members, built trust and facilitated engagement. As the program progressed, patients became comfortable with NP calls and taking home BPs. Patients shared their beliefs, cultural myths and misperceptions with the team without being guarded or embarassed. For example, some patients with an aversion to taking HTN medications believed it was better

CBP in action

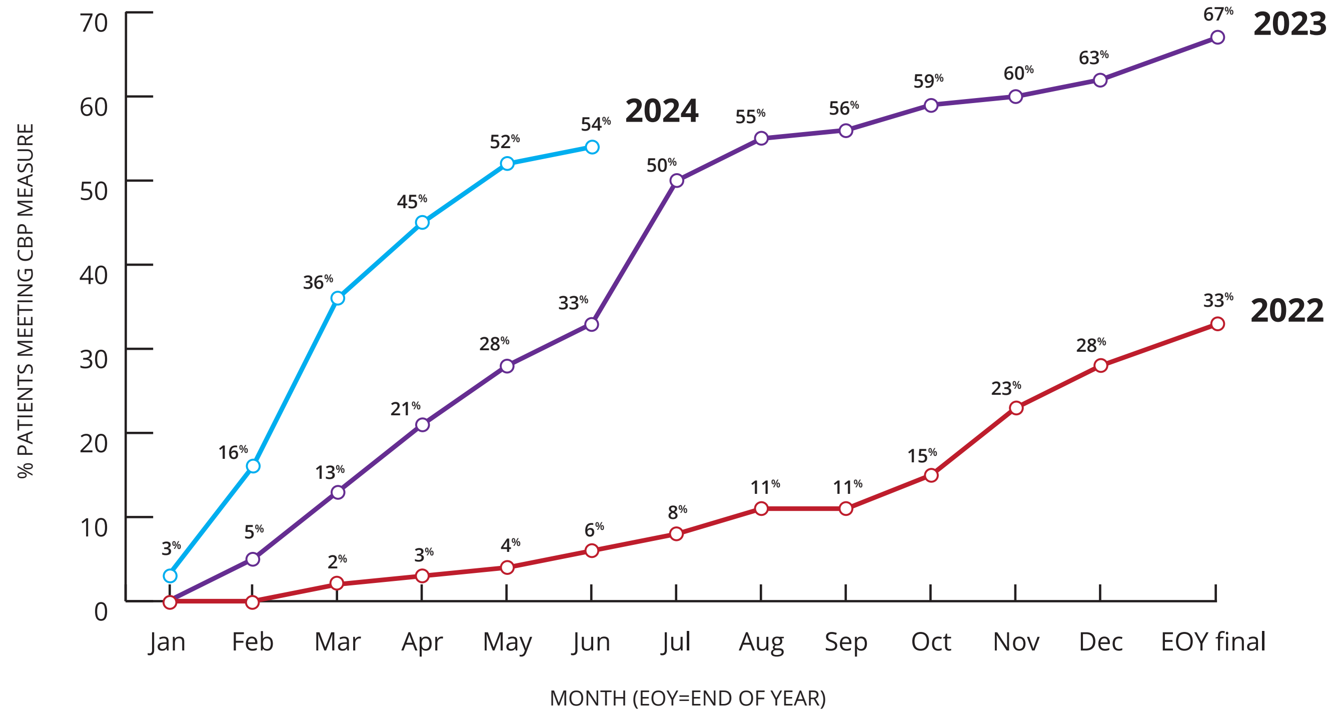
QCO Team

to take a reduced dose or half a prescribed tablet. Culturally competent communications and other trainings helped the Astrana team acknowledge these beliefs and also debunk common misconceptions with appropriate education and support.

During the first full year of the program, measure year 2023, gap closures for the CBP HEDIS® measure more than doubled among minority patients relative to baseline, as shown in the chart. By providing culturally competent care that addresses SDOH and respects cultural norms and language preferences, Astrana Health achieved significant improvements in BP control in its minority Medicare patients. ❖

**HEDIS®: Healthcare Effectiveness Data and Information Set*

INCREASED CBP HEDIS® GAP CLOSURES AMONG ASTRANA'S COMBINED ASIAN, BLACK, AND HISPANIC MEDICARE BENEFICIARIES IN RESPONSE TO CULTURALLY COMPETENT BP CARE, 2022-2024



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Transforming Mental Health

Part of Rady Children's Health Network, Children's Physicians Medical Group (CPMG) is an Independent Physician Association that proudly provides San Diego and Southern Riverside counties with the only integrated delivery network of pediatric primary care, specialty care, and hospital services. Children's Primary Care Medical Group (CPCMG) is the region's largest medical group specializing in health care for kids from birth through adolescence in San Diego and Southwest Riverside counties. CPMG and CPCMG's mutual mission with Rady Children's Hospital – San Diego is to restore, sustain, and enhance the health and developmental potential of children through excellence in care, education, research, and advocacy.

> "The U.S medical system has…historically bifurcated mental and physical healthcare"

Developing an Innovative Pediatric Mental Health Integrated Care Program

INTRODUCTION

Between 2007 and 2018, there was a 57% increase in suicide among Americans aged 10-24.[1] By 2021, the interplay among the COVID-19 pandemic and the longstanding impacts of structural racism, health care inequality, and lack of mental health providers led to a national emergency in child and adolescent mental health in the U.S.[2] Although many people who receive treatment for mental health conditions recover, lengthy wait times, insurance network barriers, and stigma contribute to persistent access barriers.[3] The U.S. medical system has also historically bifurcated mental and physical healthcare,[4] resulting in silos that fail to address the whole child.

CHALLENGE

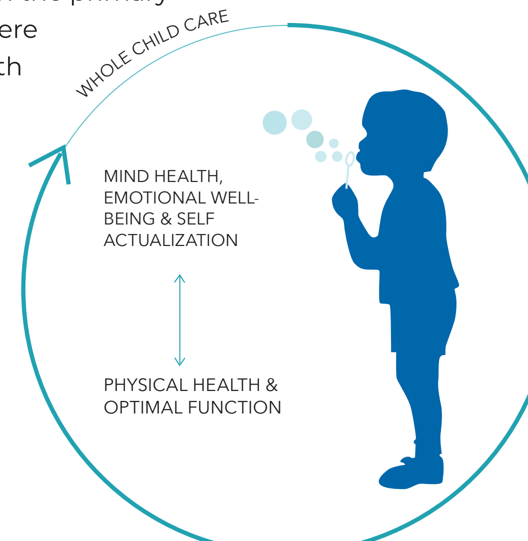
At Rady Children's Hospital San Diego (RCHSD), childhood mental health concerns were increasing prior to the COVID-19 pandemic.[5] Between 2011 and 2019, RCHSD had a 1700% increase in child and adolescent emergency department (ED) visits for mental health concerns. Although integrated care models are effective in reducing stigma and addressing access barriers,[6] there are system-, clinic-, and provider-level implementation challenges, including the following[7]:

- Limited evidence-based research on integrated care
- Institutional and infrastructural adaptations required for integrated care culture
- Difficulty recruiting therapists with integrated care experience
- Insufficient reimbursement rates, fiscal system changes, and difficulty establishing long term financial sustainability.

INTERVENTION

In 2020, RCHSD, CPMG, and CPCMG partnered to launch a Primary Care Mental Health Integration (PCMHI) Program. This initiative blends elements of Primary Care Behavioral Health and Collaborative Care models to provide evidence-based, accessible, and cost-effective mental health care to children and youth across San Diego and Riverside Counties.

PCMHI begins in the primary care setting where integrated health therapists are embedded. These therapists are introduced to patients



through warm handoffs from primary care physicians and provide brief, evidence-informed therapies over 1-6 sessions. PCMHI employs a "hub and spoke" model, where "spokes" represent the primary care pediatric sites with embedded therapists. The "hubs" are free standing mental and behavioral health clinics where higher acuity, long-term cases can be treated. Patients at the hub may receive therapy, psychiatry, or both services. Care coordinators provide support to patients who receive care at spoke or hub sites.

Administrative leadership across RCHSD, CPMG, and CPCMG identified these shared objectives:

- Increase access to evidence-based mental health care for children
- Foster early identification and prevention of common childhood mental health conditions
- Increase mental health education for participating PCPs
- Commit to clear, open communication across all providers
- Ensure a fiscally sustainable model.

PCMHI developed communication protocols to help clinicians and office staff optimize patient care:

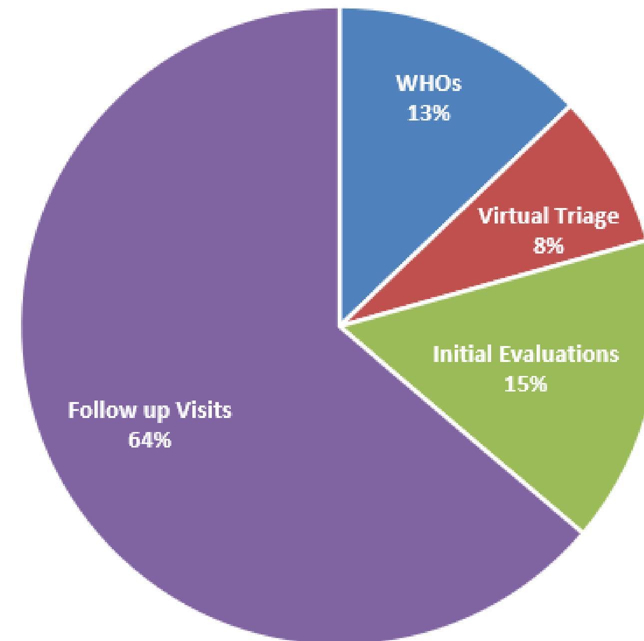
- Warm handoffs that utilize the PCMHI "Convene, History, Assessment, Triage, and Safety" framework (CHATS), as described in the diagram below

C Convene	Team members all meet with patient and guardian together
H History	PCP gives background with patient and guardian present
A Assessment	PCP gives assessment of patient and explains MHI role in treatment
T Triage	IHT triages (assigning track, expected length of treatment)
S Safety, Supplementals, Schedule	Safety assessment/plan(refer to ED/BHUC if necessary Supplemental information Schedule initial evaluation

PCMHI CHATS mnemonic used to describe and standardize elements of the PCP-to-therapist warm handoff at MHI-affiliated pediatric primary care offices.

- Weekly conferences that allow teams to discuss cases and address questions across disciplines
- PCP real-time requests for psychiatric feedback regarding psychopharmacologic care
- Use of a shared electronic health record (EHR).

COMPLETED PCMHI VISITS AS OF JUNE 2024 (TOTAL 39,928 APPOINTMENTS WITH 7,304 PATIENTS)



Virtual triage appointments occur when warm handoffs (WHOs) are not possible. During virtual triages, IHTs meet the patient, assess their concerns, and determine next steps for treatment.

RESULTS

Between June 2020 and August 2023, PCMHI established integrated care teams in nine primary care clinics and four regional hubs. Clinic populations are diverse, range from 2,000 to 15,000 individuals, and most PCMHI patients are insured through Medicaid managed care. As of June 2024, PCMHI completed 39,928 mental health appointments with 7,304 patients, including:

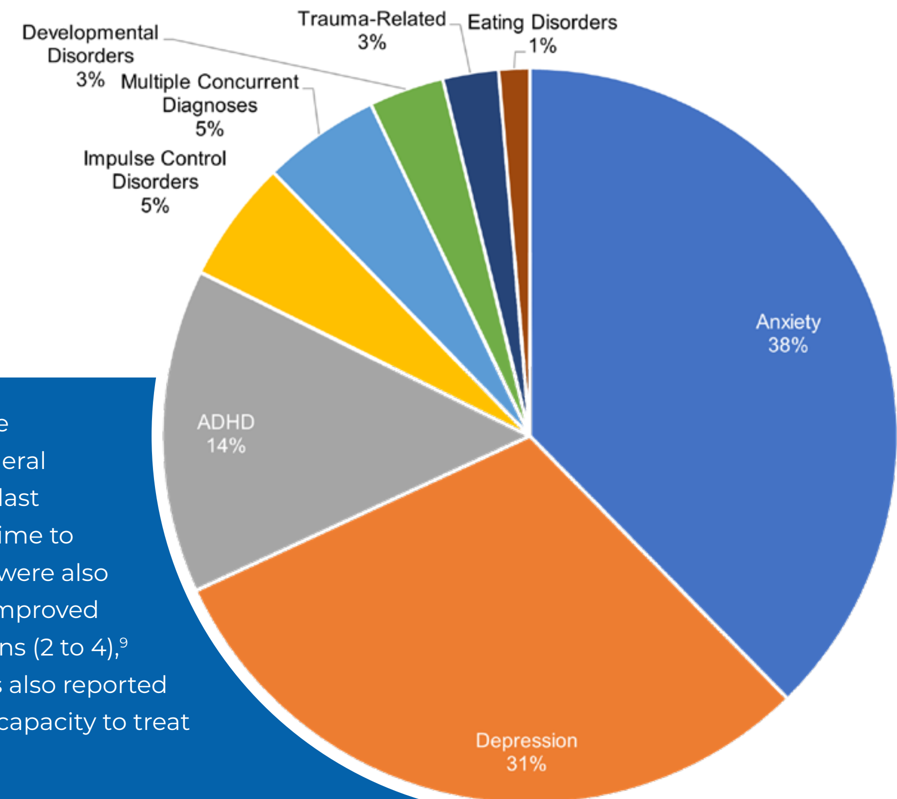
- 5,141 warm handoffs

- 3,108 virtual triage appointments
- 6,208 initial evaluations
- 25,471 follow-up visits.

Of the above visits, psychiatry completed 937 initial evaluations and 4,199 follow-up appointments.

PCMHI currently relies on fee-for-service reimbursement and institutional support. For long-term fiscal sustainability, the program seeks additional revenue sources, more comprehensive payer contracts, and strategies to improve billing paradigms. Future efforts will target sustainability, implementation challenges, billing and funding strategies, and measurement-informed care workflows on a large scale. ❖

BEHAVIORAL HEALTH INTEGRATION PATIENT DIAGNOSES



Preliminary results showed a 62% reduction in the Patient Health Questionnaire (PHQ-9) depression symptom screening scores and a 44% reduction in the General Anxiety Disorder (GAD-7) screening scores between the initial assessment and last documented screening.[8] Between June 2021 and June 2024, the average wait time to initial appointment decreased from 10.4 to 9.3 days, or 11.1%. PCPs at IHT clinics were also surveyed before and 8-months after PCMHI implementation. Results showed improved scores in PCPs' perceptions about patient access to behavioral health evaluations (2 to 4),[9] access to therapy (1 to 4), and psychiatric medication consultation (2 to 4). PCPs also reported strong beliefs in early mental health integration and its ability to increase their capacity to treat patients more effectively and ease their workload.

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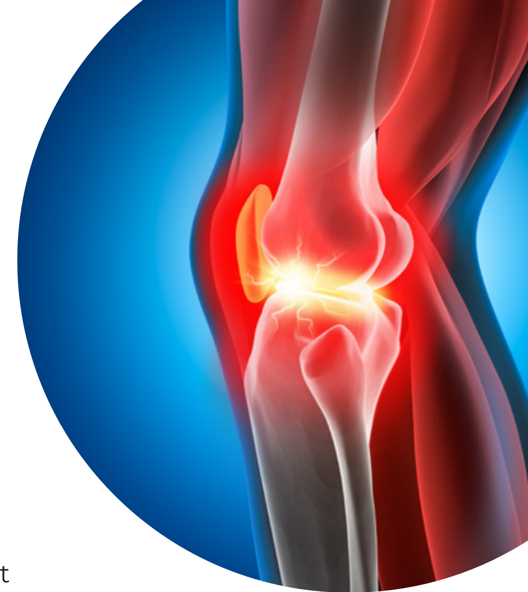
Formed in 1981 as a multi-specialty medical group to provide the twin cities of Lancaster and Palmdale, CA with the highest quality healthcare experience, High Desert Medical Group (HDMG) is an affiliate of Heritage Provider Network—a California leader in healthcare delivery networks for more than 40 years. The medical group's founding principles hold true today, and HDMG is proud to be Lancaster and Palmdale's preferred provider of healthcare by offering patients a broad range of preventative and other healthcare services and focusing on the physician-patient relationship as foundational to high quality care.

> "So thankful that HDMG is able to offer me an alternative to surgery, I can walk much better without pain"

Value-Based Approach to Non-Invasive Osteoarthritis Treatment Improves Patient Outcomes



INTRODUCTION

One in seven U.S. adults has knee osteoarthritis (KOA). The prevalence of KOA is rising rapidly, leading to associated increases in disability and burdens on the healthcare system, caregivers, and other stakeholders. In the U.S., the estimated lifetime cost of a patient diagnosed with KOA is $140,300, and the economic burden of KOA is $27 billion annually. Approximately 54% of patients with KOA will have a total knee replacement, and the number of these procedures is expected to rise with the increase in KOA prevalence and the aging of the U.S. population.[1] In 2021 at HDMG, 2,689 patients were diagnosed with KOA, and the costs related to knee replacement surgeries that year exceeded $1 million.

CHALLENGE

Traditional KOA treatment modalities can be invasive, of variable efficacy, and financially burdensome. Despite knee replacement and preceding treatment modalities, including medications, intra-articular injections, surgical debridement procedures, etc, KOA patients are often troubled by non-resolved symptoms, functional limitations, and complications of their surgeries. However, HDMG's full risk Medicare Advantage contracts in Northern Los Angeles County enabled the practice to identify innovative ways to help manage patients with KOA in an effective, nonsurgical, cost-effective manner and offer more treatment options with fewer complications. For HDMG, the solution was partnering to provide patients with a non-invasive, personalized medical shoe device and support option. The collaboration also represented the first time a US-medical group examined the utilization and cost outcomes of the device, in addition to clinical quality and patient-centric outcomes.

INTERVENTION

In October of 2021, HDMG partnered

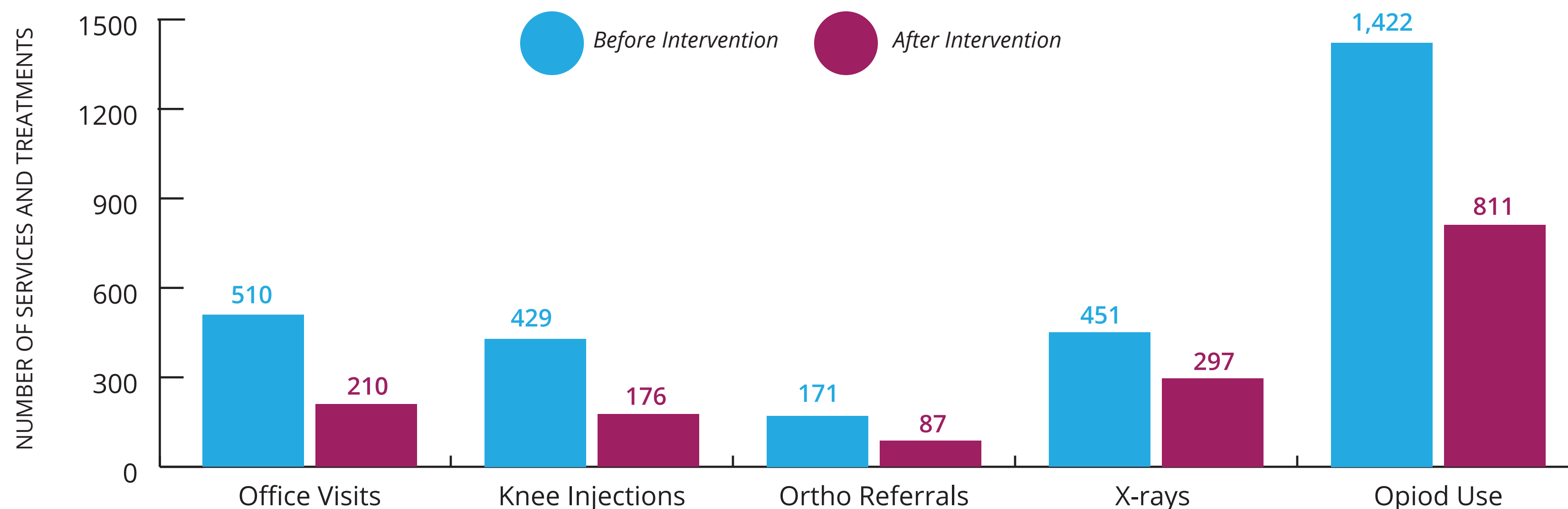
with AposHealth® to offer a home-based, noninvasive, biomechanical intervention that was found safe and clinically effective for alleviating knee pain and retraining gait using a biomechanical shoe device.[2] As part of the partnership, HDMG physical therapists are trained to calibrate the corrective shoe device, customizing the placement and size of pods attached to the heel and forefoot of individual patient's shoes, in order to reduce their gait-associated knee or back pains. Calibration is determined based on the patient's symptoms, physical examination, and computerized gait assessment.

Patients are requested to return for follow-up appointments to reassess clinical outcomes and gait patterns and adjust the calibration of the device and treatment plan, as needed. Having been educated via in-service, flyers and presentations, providers at HDMG may refer patients to this treatment by submitting documentation of the diagnosis along with X-rays confirming KOA. Because of the progressive nature of KOA, patients are best served as soon as they complain of knee pain and should ideally be referred at least six months prior to referring to orthopedic surgeons, to allow sufficient time for this therapy to provide pain relief and decrease progression of KOA. Should a patient fitted with this device continue on to Total knee replacement, AposHealth® reimburses HDMG a portion of the fee for the device, thereby mitigating HDMG's risk in offering the treatment.

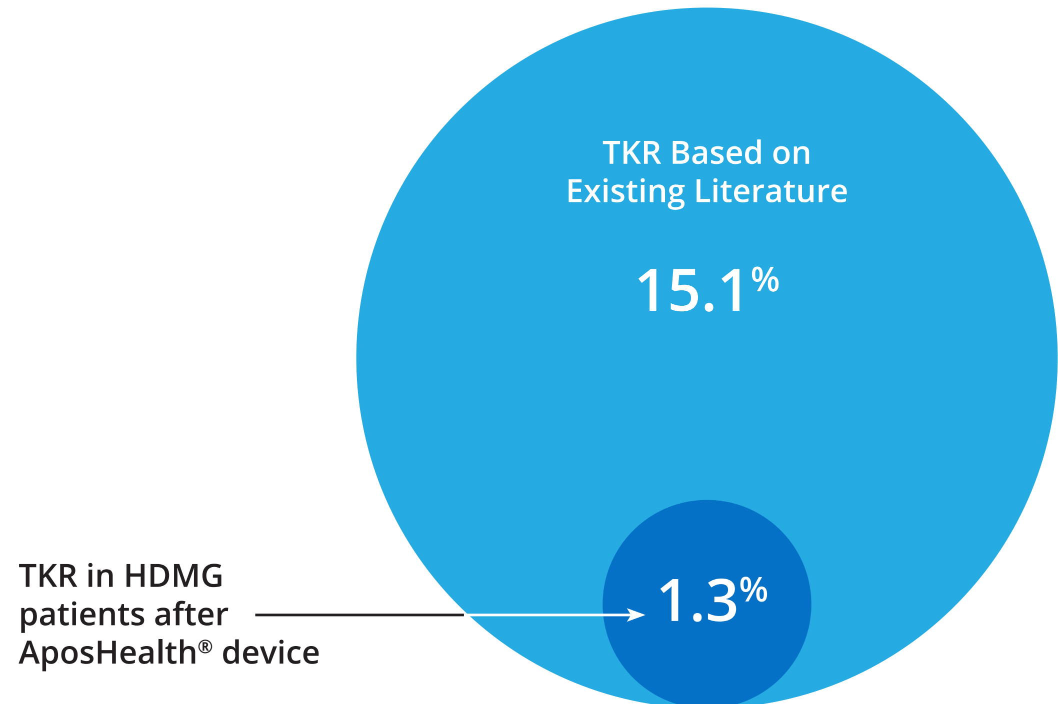
RESULTS

HDMG started 317 patients with KOA on the noninvasive biomechanical shoe device and related follow-up protocol.

KOA RELATED SERVICES AND TREATMENTS BEFORE AND AFTER INTERVENTION



Among these patients, the intervention resulted in a 56% decrease in diagnostic claims, 59% decrease in outpatient services, 59% decrease in non-operative treatments, 43% decrease in opioid pain medication use, and 59% decrease in intra-articular injections. Published literature indicates that Total knee replacement rates are 15.1% in people with KOA[2] , but we have seen a rate of only 1.3% following our intervention. HDMG plans to provide AposHealth® device to all members needing KOA treatment by expanding the program to include home visits with virtual physical therapists. ❖



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Hoag Clinic, the medical foundation under Hoag Memorial Hospital Presbyterian, delivers care to 286,000 patients through medical groups and independent physicians with approximately 75,600 patients in value-based care arrangements across Orange County, California. Hoag's provider organizations, Hoag Medical Group and Hoag Physician Partners, were recognized by IHA Excellence in Healthcare in 2023. In addition, Hoag Medical group received IHA's Top 10 Percent Performance in Clinical Quality. Hoag Clinic was also recognized in 2023 as a Recipient of APG's Standards of Excellence™, SOE®.

> "Our enhanced customer relations managment strategy increased quality and patient experience"

Call Center Infrastructure to Optimize Value-Based Care and Patient Experience

INTRODUCTION

In 2019, Hoag Clinic initiated risk-based payor relationships and centralized primary care call management in Orange County, CA. However, with daily patient interaction volumes reaching into the thousands, meeting the basic standard of 'exceptional patient experiences' posed a significant challenge. The clinic recognized the need for transformation, aiming to create an environment where patient trust and satisfaction could be cultivated through timely, efficient, and personalized interactions that extended beyond initial inquiries. Thus, Hoag Clinic embarked on a mission to enhance the patient experience while optimizing holistic care.

CHALLENGE

Despite implementing centralized performance management tools and an interactive voice response system, Hoag faced persistent challenges delivering personalized, high-touch care during unsolicited calls and chat inquiries. Inbound calls required a multi-step process: verifying the patient's identity, discerning the purpose of the request, navigating various applications to access the patient's record, and taking the appropriate action. Agents often lacked contextual information such as details about specialty visits, historical call data, and care team specifics. Opportunities for preventative measures such as screenings, annual health assessments, and wellness checks were being overlooked, resulting in patients missing out on care aimed at enhancing their quality of life. Consequently, agents' interactions were transactional, falling short of comprehensive, whole-person care.

Centralized staffing also made some patients feel disconnected due to lack of continuity in support staff, and high- and lower risk patients were processed through the same call queues, with inadequate pairing with staff's expertise. Subpar call experiences that did not align with Hoag's standards were typically identified through individual call audits, post-visit surveys, sporadic administrative or physician feedback, or formal complaint mechanisms. Assessment of Contact Center quality was primarily based on patient surveys focusing on the ease of scheduling and was constrained by the limited scope of call recording audits.

INTERVENTION

Our enhanced customer relations management (CRM) strategy increased

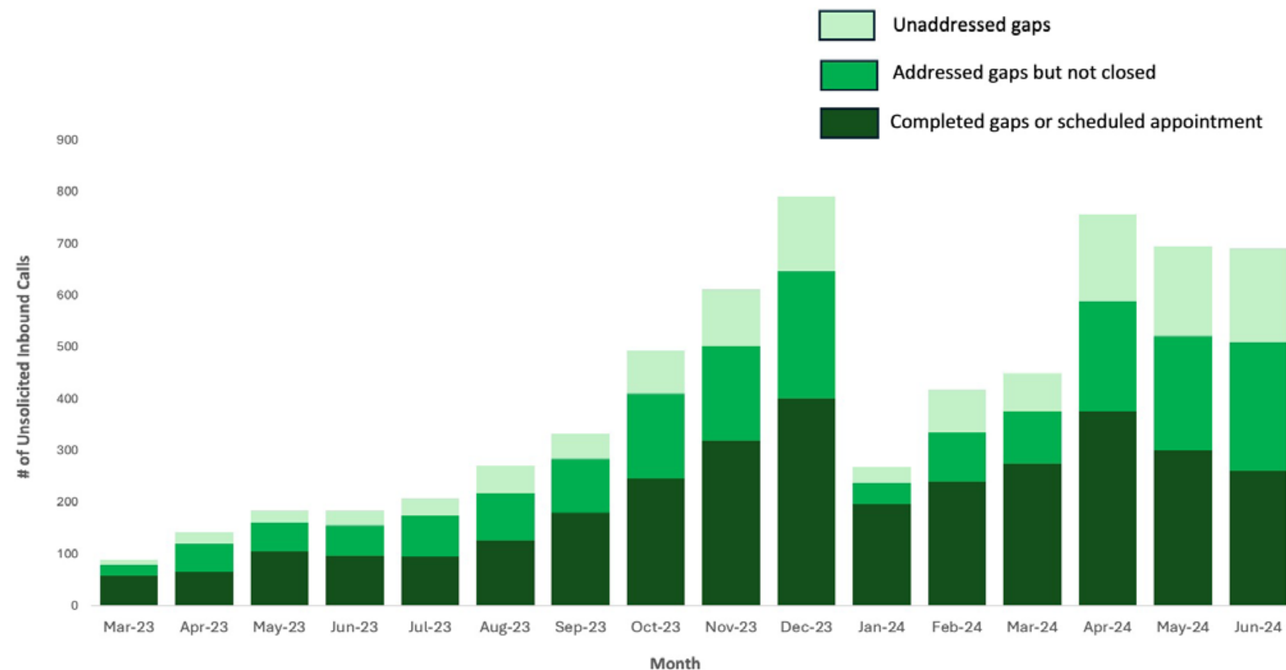
quality and patient experience by integrating communication channels and data into a single platform. The system connects callers with appropriate staff by recognizing patient histories and data, allowing the call to be routed accordingly. It also directs calls based on need, such as pharmacy inquiries to medical prescription support or Spanish speakers to bilingual staff, and it implements prioritization strategies for high-risk patients. The CRM facilitates rapport and personalizes call experiences by providing patient details such as an upcoming birthday, call histories with recordings, patient language and communication preference, and links to their assigned care manager. The CRM has a single portal that centralizes information, reduces application toggling, and enhances service delivery. It optimizes each call as a quality improvement opportunity by mining visit histories and claims for actionable insights, highlighting care programs and prompting staff to inform callers about available services. The CRM prompts staff to address preventative measures, standardizes scripts for patient engagement, and provides weekly reports on bookings and health measure closures. By serving as a centralized hub for information and tools, the CRM enables staff to focus on exceptional patient service.

To maximize each patient engagement, Hoag conducts multiple trainings and actively supports collaborations among staff that are overseen by hands-on leadership. Onboarding involves comprehensive training in a live environment, along with access to a robust knowledge repository. Staff feedback is actively sought and used to inform enhancements aimed at reducing workload, such as the recent addition of a Microsoft Power BI® Provider Lookup tool that provides extensive details on any provider associated with Hoag.

RESULTS

By 2022, Hoag Clinic's platform was overseeing 2,000 to 4,000 calls and chats daily, reflecting its commitment to accessible patient services. Between January and June 2024, Hoag observed increases in patient satisfaction, appointment bookings, and Medicare Wellness visits, and a corresponding decrease in care gaps. These outcomes came with no increase in call

IMPACT ON HEDIS® CARE GAPS



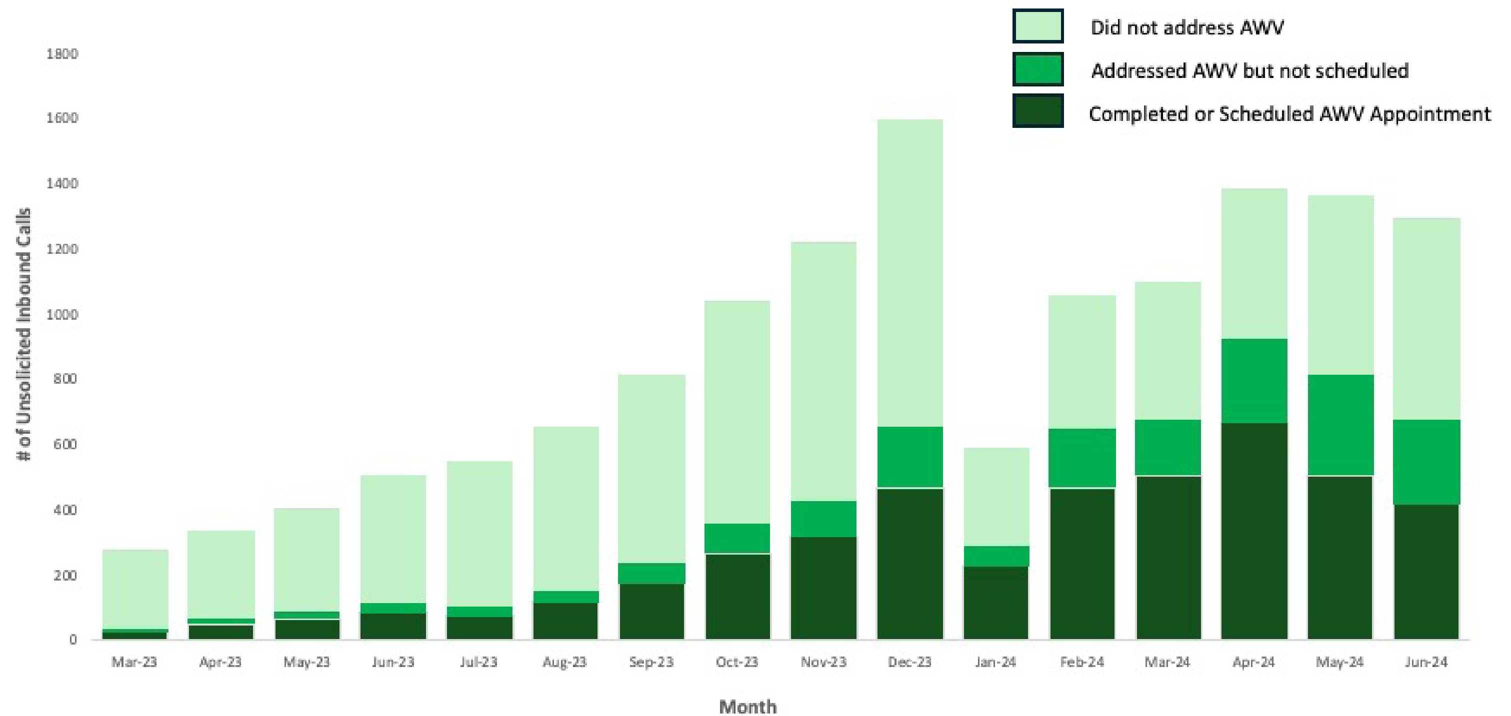
Total of 50.3% of unsolicited inbound calls between Jan 2024 – June 2024 resulted in completion of care gaps or scheduled appointments. Of the calls that did not result in gap closure or a booked appointment, 56.3% still discussed the importance of addressing any open care gaps.

handling times.

Post-call survey data showed that Hoag's Net Promoter Score increased steadily from 82 to 85 between January and June of 2024. An NPS above 70 signifies excellent customer experience and strong loyalty.

The CRM strategies improved patient engagement and operational efficiency. After a brief stabilization period, the CRM tool did not increase call handling times and has enhanced the call experience by addressing multiple aspects of the patient's care beyond the reason for the call.

IMPACT ON MEDICARE ANNUAL WELLNESS VISITS (AWVs)



Total of 41.1% of unsolicited inbound calls between Jan 2024 – June 2024 resulted in completion or scheduling of Medicare Annual Wellness Visits.

The CRM platform's gaps in care alert functionality supplemented existing outreach and in-office patient care management strategies. In the first half of 2024, the team booked 1,650 appointments (50.3% success rate) from unsolicited calls. Among calls that did not result in an appointment, a notable 56.3% involved staff informing the patient about the importance of the quality measure and offering a pathway to address the care gap *(see Impact on HEDIS® Care Gaps graph)*.

Similar results were observed with Medicare Annual Wellness Visits (AWV). In the first half of 2024, we booked 2,795 appointments (41.1% success rate) on unsolicited patient calls *(see Impact on AWVs graph)*.

The touchpoint with inbound callers provides an opportunity to engage more eligible members qualifying for the measures, driving performance improvement. Overall, the CRM has provided a platform that enables more meaningful exchanges. Future integrations and AI tools will continue to enhance the call experience and contact center operations. ❖

Founded in 2015, Integrated Health Partners of Southern California (IHP SoCal) is a clinically integrated network serving 400,000 mostly Medicaid recipients whose medical home is one of nine Federally-Qualified Community Health Centers in three Southern California counties: San Diego, Riverside, San Bernardino. IHP SoCal holds five primary care contracts, two of which are value-based. IHP SoCal is within a family of companies, Health Center Partners of Southern California, which also includes Health Quality Partners (Health Center Controlled Network) and CNECT (Group Purchasing Organization).

> "I am much less stressed knowing I can get [care] in the comfort of my home and don't have to get a ride"

Achieving the Triple Aim by Addressing SDOH in Patients with Multiple Sclerosis

INTRODUCTION

As IHP SoCal, a clinically integrated network (CIN), advances in value-based care from primary care capitation to full professional risk, it has re-engineered its processes to deliver on the Triple Aim: high quality medical care delivered at a reasonable cost with a focus on patient experience and equity. The primarily MediCal-insured patients seen in the CIN's community health clinics are highly vulnerable and face an array of social and economic conditions—such as food and housing insecurity and transportation barriers—that affect their ability to access care. However, the CIN's new value-based care (VBC) contracts catalyze care innovations through a delegated utilization management model and financial flexibility to invest in non-traditional care models. The VBC contracts also provide increased access to data that help the provider network craft tailored solutions for stubborn challenges with key patient populations. One such population at IHP SoCal is a small cohort of patients with Multiple Sclerosis (MS) who receive twice yearly, hospital-based infusions.

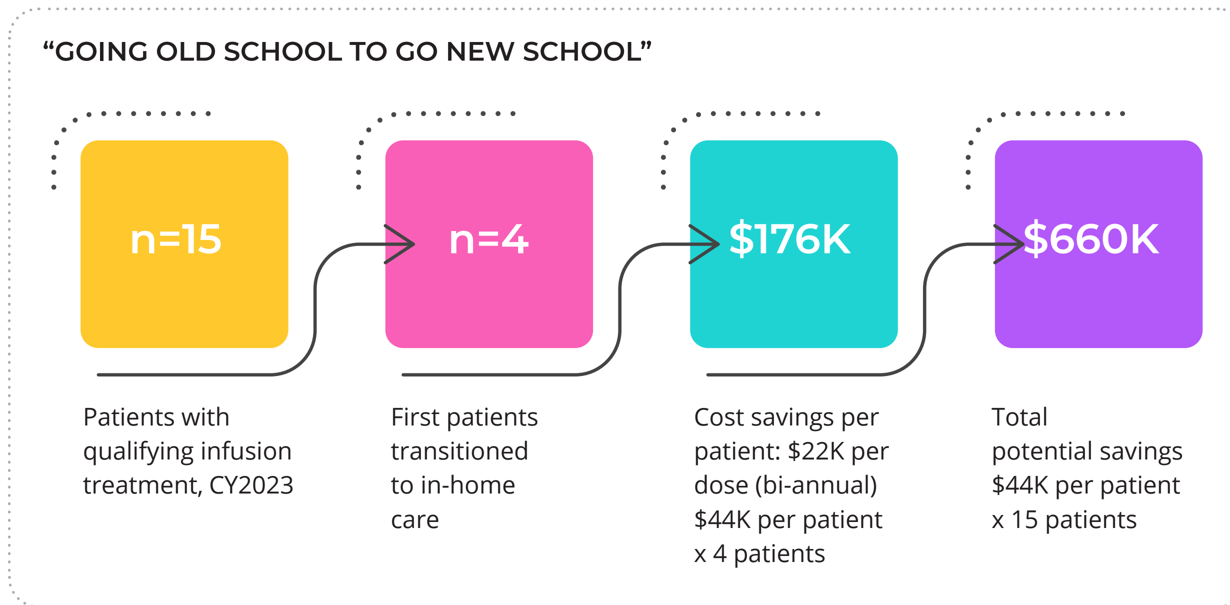
CHALLENGE

IHP SoCal's MS patients experienced significant transportation and family support issues resulting in missed appointments and medication non-adherence that had direct implications for achieving the Triple Aim. To address the unique challenges of this patient cohort and create a patient-centric service model for MS infusions, IHP SoCal asked, "What if their socioeconomic barriers, such as transportation, were directly addressed, and these patients received more personalized care? Was it feasible to leverage data through the CIN's VBC partners to go 'old school'—to provide home-based care—in meeting the Triple Aim for patients with MS?"

INTERVENTION

Community health centers are uniquely organized to achieve health equity as many are located in health professional shortage areas. In addition to medical services, community health centers also support dental and behavioral health, social case management, housing navigation, and food pantries. Based on claims data, IHP SoCal identified 15 MS patients who

received hospital-based ocrelizumab infusions using diagnosis codes cross-matched to J codes for potential home infusions. Through partnerships across multiple organizations, a workflow was developed that allowed patients to receive infusions in their homes from a contracted home health vendor, or at an ambulatory infusion center near their home. Patients and primary care physicians received outreach from a centralized case management team to facilitate dialogue about transitioning MS patients from tertiary hospital to home or standalone outpatient infusion center. The case management team worked across settings to ensure patients received care in the right place, at the right time. Patients were educated on the model and once consented, IHP SoCal worked with the hospital system-based subspecialist to ensure infusion care was well-coordinated. This included ensuring orders were properly in place, medication was delivered from specialty pharmacy to home/infusion center, and patient/family were updated about changes to care delivery. Robust communication and regular check-ins ensured that new processes remained free of errors and met all stakeholder needs. Primary care physicians were engaged in care plan changes to ensure care was anchored in a primary care medical home model.



RESULTS

To date, four MS patients successfully transitioned their infusions from hospital to home, and these transitions have been associated with progress on Triple Aim metrics and achieving health equity.

High Quality: Compared to those continuing hospital-based infusions, patients who transitioned treatment to home were more likely to receive infusions on time. Physicians also felt more confident that critical treatments reached their patients. By improving coordination across delivery systems and settings, patients were receiving care closer to or in their homes with minimal to no barriers.

Patient Experience: The intervention improved patients' quality of life and addressed non-clinical needs such as transportation. A patient shared, "I didn't know it was possible for me to receive medical care in my home. Not only am I able to get the treatment I need but I am much less stressed knowing I can get it in the comfort of my home and don't have to get a ride."

Reasonable Cost: The treatment costs were reduced by administering infusions outside of the hospital, by partnering with home health, and by leveraging the MediCalRx program. Cost

savings for the four patients were $176,000 with a projected total cost savings of $660,000 when all patients are transitioned. Other elements of return-on-investment included fewer emergency department visits for those receiving home infusions compared with usual care. Within a value-based care and payment model, IHP SoCal was able to reinvest the savings into care team support and additional patient support models to address additional needs of patients and providers.

By finding a pathway for home infusions, IHP SoCal has been able to meet the Triple Aim: quality medical care delivered at a reasonable cost with a keen focus on patient experience and equity. IHP SoCal's VBC contracts allowed this pilot program to innovate care, meet vulnerable patients where they are, address social determinants of health, reduce disparities, and build strong community partnerships. Utilizing patient feedback as well as claims and encounter data, the network clinical team has identified additional opportunities for community-based care models. These include a community-based cancer care management model, enhanced care management for high-risk/high-acuity patients, sub-specialty value-based care and payment models inclusive of community providers and ancillary service providers, and addressing food insecurity and medication adherence through community-based organizations. ❖

Staff at Integrated Health Partners of Southern California

For over 75 years, Mercy Medical Group (MMG) has been engaged in its mission of delivering healing with humankindness in Sacramento, California. From humble beginnings in 1948 as a 4-physician group, MMG has grown into the largest multispecialty group within Common Spirit Health. It is a medical group that leads with highly engaged providers who leverage team-based care to deliver high-quality, value-centric services. Mercy Medical Group engages patients efficiently and effectively to improve overall outcomes while managing total cost of care.

> Our approach engages a team of APPs with physician supervision who work a standard 12-hour shift

A Value-Driven Initiative Targeting Primary Care Access

INTRODUCTION

Health care delivery systems face rapidly growing demand for primary care services that exceed their capacity. The Health Resources and Services Administration's National Center for Health Workforce Analysis estimates that there will be a shortfall of 68,000 full-time physicians by 2036.[1] With a rapidly growing Medicare-eligible population and many primary care providers (PCP) approaching retirement age in the next 10 years, the need for novel care delivery models has never been greater. This challenge disproportionately impacts patients with social determinants of health (SDOH) by hindering care access, thereby driving persistent inequities in healthcare outcomes. Lack of access to primary care leads to higher emergency department (ED) utilization, hospital admissions, and avoidable adverse health outcomes.

CHALLENGE

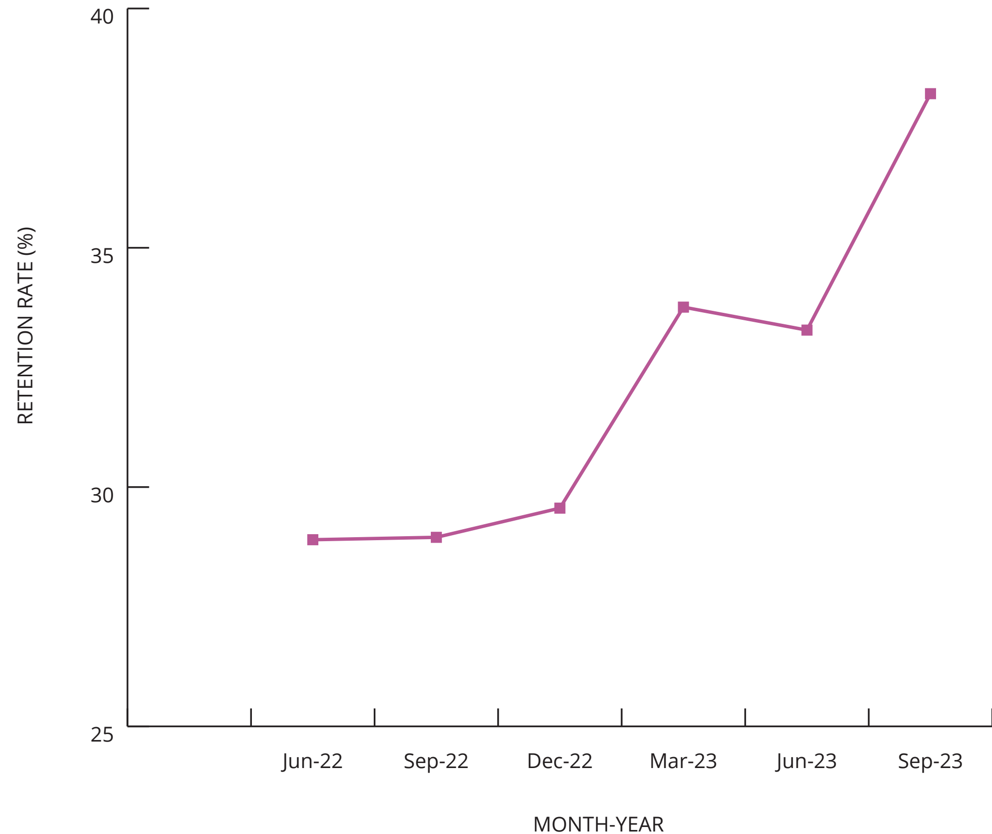
Mercy Medical Group provides care in 27 ambulatory locations and five Dignity Health hospitals in the Sacramento region.

Thirty percent of MMG's patients are capitated, and of these, 11% are Medicare beneficiaries, with the balance commercially insured. MMG holds professional risk with multiple plans, including both dual and shared risk products, and MMG's partnership with Dignity Health Medical Foundation includes a risk-sharing agreement with incentive components for lowering total cost of care, bed days, and ED utilization. Despite MMG's broad regional footprint, high out-of-network (OON) ED utilization rates and hospitalizations were identified in the Roseville area where MMG does not have a medical center. Like other healthcare organizations in the area, MMG has encountered difficulty hiring adequate numbers of qualified PCPs in traditional clinic settings. These circumstances offered opportunities to improve value-based care by addressing several challenges:

- Access barriers to primary care services
- Difficulty recruiting and retaining physicians and advanced practice professionals (APP) for primary care roles
- Total cost of care associated with potentially avoidable ED usage at OON facilities.

INTERVENTION

MMG's solution to these challenges was development of the "Express Primary Care" (EPC) clinic model. This approach engages a team of APPs with physician supervision who work a standard 12-hour shift. APPs are paid a competitive hourly salary with bonus potential to deliver acute primary care visits with same day or next-day scheduling only. Care is delivered in person and virtually on demand. Patients requesting same-day or next day access are offered an appointment if none is available in their primary care provider's schedule. The EPC clinic is payer agnostic and, in accordance with MMG's Core Values, has no access restrictions. Care delivery focuses on acute illness and moderate to low acuity diagnoses, allowing rapid care delivery and reducing pressure on surrounding primary care practices. Higher risk cases like chest pain, chronic disease management, pain management, and illnesses requiring a higher level of care are directed to PCPs. The initiative also delivers value by performing Medicare Annual Wellness Visits for many patients, thereby freeing PCPs to deliver more complex care while helping to achieve improved incentive targets.



RESULTS

Implementation of EPC has been highly successful, with target staffing levels achieved within six months. Despite regional recruitment challenges, the shift model was very attractive to applicants. While other traditional primary care clinic positions remained unfilled, MMG recently had six qualified applicants for just two positions at the EPC clinic. This appears to be related to shift-based scheduling, which offers 3 X 12-hour weekly shifts. For patients, this approach also provides extended access for those who are unable to schedule

visits during normal business hours. Among capitated patients, the EPC's impact on ED utilization was substantial, with 18% and 26% reductions in OON ED visits within six miles of the EPC. Another positive finding was that 1,846 new capitated patients entered MMG's care system through the EPC clinic in the first year, and MMG had a 10% increase in retention among capitated patients *(see graph)*. Staffing cost effectiveness surpassed MMG's urgent care clinic after seven months, and EPC costs MMG 20% less per day in provider staffing costs than the urgent care clinic. Mercy Medical Group plans to open six additional sites over the next five years across the region. ❖

> Was able to schedule same day appointment, staff was very friendly and did a good job at accommodating to me. I really appreciate the effort to make sure I am healthy. Will be referring this facility to family and friends.

> I had a wonderful experience here. The whole staff was pleasant and helpful. The doctor was very compassionate and listened to all my concerns. It was thorough and scheduled any other services I needed. I will use them again as I felt very cared for.

> My primary physician's first available appointment was more than a week out. Learned about this place and was able to walk in, get assessed, and get a referral! Incredibly helpful!

> Cannot say enough for these folks. I came in as a walk-in, got a same day appointment. Everyone was friendly, attentive, and kind. I felt like I was heard and cared about every time I interacted with the staff, both clinical and reception.

REFERENCES

[1] Health Resources and Services Administration. Workforce Projections. Available at: https://data.hrsa.gov/topics/health-workforce/workforce-projections. Accessed August 27, 2024.

Founded in 2007, the MSO of Puerto Rico is a full-service health, clinical, and administrative management organization focused on independent physician associations (IPAs) and PCPs, with a wraparound network of specialists and clinics. The MSO works with one of the largest Medicare Advantage (MA) insurers in Puerto Rico, MMM Healthcare. Its mission is to enable partners, clients, and providers to achieve better results through lasting, productive, professional partnerships. The MSO of Puerto Rico currently manage 13 MMM Multiclinics and 22 IPAs and have a contracted network of 2,800 PCPs and 6,000 specialists in over 11,000 locations around Puerto Rico impacting more than 500,000 Medicare Advantage and Medicaid beneficiaries. MSO Holdings also owns two of the largest MA IPAs on the Island–Castellana Physician Services LLC and PHM Multihealth–which have over 100,000 MA members and more than 900 physicians.

> "...barriers often delay treatment, sometimes up to 10 years from onset of symptoms"

Breaking the Stigma and Facilitating Timely Access to Mental Health Care with My Emotions© Member App

INTRODUCTION

Traditionally, most managed care organizations subcontract managed behavioral health care organizations to manage their mental health benefits, but this often leads to fragmented care and suboptimal outcomes. That is why, in 2012, MMM through the MSO of Puerto Rico, became the first organization in Puerto Rico to insource management of mental health benefits through our Integrated Mental Health Department (IMHD). The initiative aimed to improve access to care, develop integrated clinical programs, enhance patient outcomes, and strengthen provider relations. IMHD offers a 24-hour call center for care coordination, emergency management, psychiatric crisis interventions, and case management. It also handles discharge planning, interdepartmental referrals, and utilization reviews. The IMHD improves care delivery by emphasizing quality, compliance, regulatory oversight, and integration of mental health services within our broader healthcare network. These initiatives enhanced mental health population management programs, integrated referral processes, and innovative provider contracting and utilization management strategies. From 2013 to 2023, visits by the MSO's IMHD mental health specialists (psychiatrists, psychologists, and clinical social workers) increased by 60% percent, reflecting improved access to care. Despite these advances, the MSO faced persistent challenges supporting mental health services and integration due to a series of catastrophic events that hit Puerto Rico in recent years: Hurricane Maria (2017), earthquakes (2020), and the Covid-19 pandemic, each compounding the strain on residents' mental health.

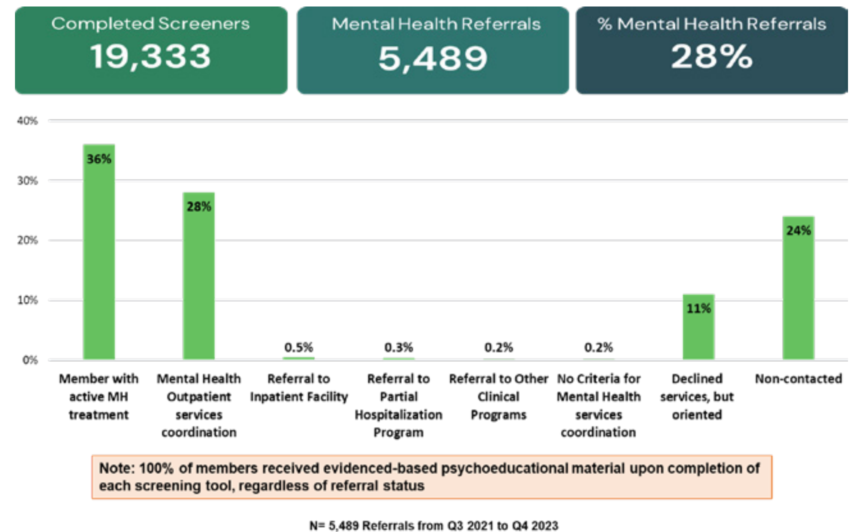
CHALLENGE

In addition to natural disasters and the Covid-19 pandemic, other significant challenges in mental health care faced by the Puerto Rican population include stigma, a shortage of specialists, and a lack of mental health literacy among patients and families. These barriers often delay treatment, sometimes up to 10 years from the onset of symptoms. To address these issues, the IMHD developed the innovative My Emotions© app. Although many mental health apps and websites with screening tools are available, most of these are not available in Spanish and they do not allow patients to connect directly with a mental health professional who is available 24/7. These gaps represent challenges for our patients to connect with the help they need in a timely manner, and in their preferred language.

INTERVENTION

My Emotions© is available to Medicare Advantage and Medicaid members on MSO's mobile apps. Engagement with the app was promoted through brochures, social media, closed circuit videos at clinics, and provider education. The app provides self-assessment tools for mental health conditions such as major depression, bipolar disorder, generalized anxiety disorder, post-traumatic stress disorder, drug and alcohol use disorders, the emotional impact of COVID, and smoking cessation. To promote usability and adoption, the tools are user-friendly and available in English and Spanish. Upon completing each screening tool, users receive scoring information that helps them understand their mental health status, and relevant, evidence-based psychoeducational resources.

A key feature distinguishing My Emotions© from other mental health applications is functionality that connects users directly with the IMHD's 24/7 clinical call center. Staffed by licensed professionals, the call center offers additional mental health assessments, referrals, and timely care coordination at the appropriate level, thereby improving access to services in a non-intimidating manner. This feature has been particularly important in coordinating emergency services and crisis management in cases of active suicidal ideation. Another key feature of My Emotions© is how it helps to bridge the gap between primary care and mental health services by sharing the patient's screener results with their primary care physician.



RESULTS

Launched in the third quarter of 2021, My Emotions© has demonstrated significant effectiveness and reach. Of the 610,073 eligible patients, 62,044 (10%) engaged with the MSO's Member app. Of these patients, 16,661 (27%) also used the My Emotions© App. By December 2023, the latter patients completed 19,333 screeners, of which 5,489 or (28%) were positive or resulted in a assessment and/or care coordination. The PHQ-9, GAD-7, and MDQ were the most frequently used mental health condition screening tools. The average user was aged 60 years, with a female-to-male ratio of almost 2:1. Of the 28% of screens that resulted in a mental health service referral—0.5% received coordination to inpatient treatment, 0.3% were triaged to partial hospitalization, and 28% to outpatient mental health services.

Additionally, 36% of referrals were for individuals already actively receiving mental health treatment, reflecting the app's use and value for both new and established patients.

Integration of My Emotions© with MSO's IMHD facilitated timely access to care and improved care coordination, while providing valuable data to drive population health management strategies. By offering accessible, immediate, and stigma-free mental health support, this work yielded measurable benefits in quality of and access to mental health care for the MSO's Medicare Advantage and Medicaid members. ❖

Actual examples of how My Emotions© prevented a potential suicide and facilitated care coordination while enhancing our members' experience.

- 60 year-old male with history of mental health treatment who completed PHQ-9 depression screener.
- PHQ-9 score 14 (moderate symptoms of depression); Q9 (suicidal ideation) = affirmative.
- Upon the MSO's IMHD* Call Center evaluation, symptoms were validated (including active suicidal ideation and intention). Patient lacked support network and reported family problems as a stressor.
- Case was presented to an inpatient facility for admission.
- After completing inpatient treatment, patient was stepped-down to a partial hospitalization program and later continued with outpatient services.

- 46 year-old female with history of mental health treatment with psychiatrist and clinical social worker who completed a GAD-7 anxiety screener.
- GAD-7 score 23 (severe symptoms of anxiety).
- Upon IMHD* Call Center evaluation, symptoms were validated (including active death wishes without active suicidal intention). Patient's symptoms were exacerbated due to health condition of her youngest son.
- Patient refused coordination support to partial hospitalization. However, she allowed the IMHD* Case Manager to discuss with her MH providers. The patient, her psychiatrist, and her clinical social worker, all agreed to increase her visit frequencies until her symptoms improved.

Suicide prevention | Enhanced member experience | Care coordination

*IMHD = Integrated Mental Health Department

Ochsner Health is the leading nonprofit healthcare provider in the Gulf South, delivering expert care at its 46 hospitals and more than 370 health and urgent care centers. In 2023, Ochsner Health cared for more than 1.5 million people from every state in the nation and 65 countries. Ochsner's workforce includes more than 38,000 dedicated team members and over 4,700 employed and affiliated physicians.

> "Prescribers make the final decision on whether a recommended alternative is appropriate for the patient's plan of care"

Empowering Physicians to Lower Patient Out of Pocket Costs with Real-Time Pharmacy Clinical Decision Support

INTRODUCTION

Navigating the complex world of health insurance coverage is extremely difficult under the best of circumstances. This situation becomes more problematic at the point of care when physicians evaluate the benefits of various treatments against the cost, both to the patient and insurer. Patient cost—along with efficacy and safety— drive successful care plans, and high-cost medications can lead to primary non-adherence, prescription abandonment, and medication rationing.

Understanding actual patient costs of various therapeutic alternatives within a pharmaceutical class would allow physicians to provide best choices for their patients. Historically, collecting cost information required a substantial time investment on the part of the physician, yielding vague estimates that were not patient- or pharmacy-specific. Complexities associated with benefits design, prescription tiering status, and medication formulations exacerbate these difficulties for prescribers. For example, medications with the same active ingredients but different formulations may be covered as preferred generic or restricted to specialty tiers. Ochsner Health, like many health care organizations across the country, is looking to technology, innovation, and automation to decrease reliance on manual processes for care delivery. Our Primary Care service line has a strategic goal to ensure all workflows are user friendly, improve joy of practice, and return time to the physician for direct patient care. Addressing pharmacy-related issues at the point of care consistent with these goals is of strategic importance to our organization and has the potential to improve patient experience and reduce out of pocket costs.

CHALLENGE

Prior to this program, Ochsner's electronic medical record (EMR) system had manual benefit checks for prescriptions when a physician signed an electronic order, but it was hidden in the background and required multiple clicks to activate. The system could investigate one prescription at a time and was utilized approximately once each month. However, allocating additional labor or physician time to identify preferred formulary agents would have been inefficient and cost prohibitive.

Unlike retail pharmacies, health systems such as Ochsner Health cannot communicate in real-time with patients' pharmacy benefit managers (PBM) through electronic prescription interfaces that facilitate prescription adjudication. Prescribers therefore lack critical information on coverage, reimbursement, and the patients' out of pocket costs for their medications. Addressing persistent prescribing challenges at the point of care would require a means to provide this information to the prescriber through the EMR. Such a system would also optimize lost opportunities for quality improvement and provide relevant outcomes data.

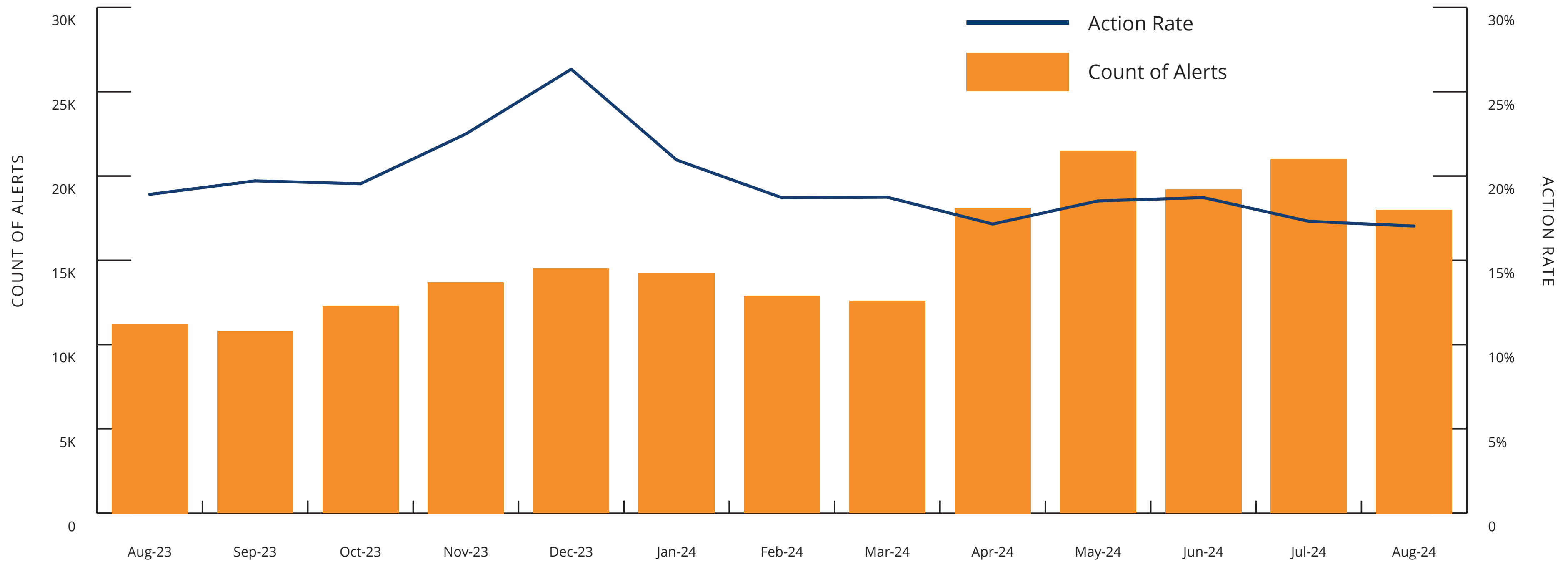
> "Using Real-Time Pharmacy Benefits has transformed my practice," says Lee Montgomery, MD, a family physician in Baton Rouge. "It's easy to use and patients appreciate the effort to make their care more affordable. I highly recommend adding this tool to your practice to boost patient satisfaction and improve outcomes." Dr. Montgomery has an alert acceptance rate of 39% for the prior 12 months, which accounts for 92% of total possible savings for his patients. "I love being able to tell my patients that they can get the same effective medication at a fraction of the cost."

INTERVENTION

Ochsner Health thus created a Real-Time Pharmacy Benefits tool, an automated process with background data aggregator to provide physicians with clinical decision support when relevant, stay silent when irrelevant, and minimize disruption in the physician's care delivery. The program team worked with our Physician Leadership and Informational Service teams to create a tool which provides the prescriber with patients' actual out of pocket costs prior to transmission to a pharmacy, along with multiple alternative products that could save the patient money. Physician leaders within affected service lines were contacted to discuss prescribing practices and treatment algorithms. All recommendations were within the same therapeutic clinical category. Evaluations were performed regularly, with questions about appropriateness escalated to our PBM contacts. Ultimately, prescribers make the final decision on whether a recommended alternative is appropriate for the patient's plan of care, and the effectiveness of the program will be determined by the safety and efficacy of the medications being recommended.

Ochsner evaluated and aligned its EMR interfaces to maximize showing the number of prescriptions that would have assigned patient out of pocket costs, and the new EMR tool aimed to provide cleaner information for consideration to prescribers. An alert would trigger in a physician's prescribing workflow if an alternate medication in the same therapeutic class could save a patient more than $0.75 per day or $22.50 for a 30-day supply. The interface program would otherwise remain silent to minimize alert fatigue for physicians. The patient savings threshold has since been decreased to $6.00 per 30-day supply. Converting to the alternative agent is executed using a single click within the alert.

A data warehouse and dashboard were created to collect and track not only alerts but also PBM formulary status and clinical recommendations for the most frequently prescribed medications. The dashboard also reports physician activity and quantifies patient savings when a physician converts to an alternative. The alert reflects agents covered by the patient's insurance, resulting in minimal upkeep for the organization. As PBM formulary statuses change, the tool will remain updated, minimizing health system or IT labor.



This tool was piloted in a single clinic, followed by a single disease state system-wide. After educating prescribers, the tool was activated across the system. No physician complaints were received during the go-live period of the first twelve months, an important measure of success.

RESULTS

Since 2021, Ochsner Health Network physicians have saved patients in value-based contracts >$5.1 million in pharmaceutical copays using the new Real-Time Pharmacy Benefits tool. Ochsner's physicians have embraced the system, which generates small incremental savings at high volume over time. Alerts are triggered ~10,000 times/month, a small fraction of all prescriptions.

Physician acceptance of recommended alternative agents averages 19% per month. Physicians report decreased prescription abandonment at the pharmacy counter due to cost or prior authorization and less rework after patient visits.

Although this "patient-first" initiative improves affordability of the care Ochsner Health provides, its halo effect reduces overall costs of care in the organization's value-based contracts. Savings are driven by converting higher cost brand name medications to equally efficacious generic alternatives. The impact of these selections compounds over time because many chronic medications are reordered after the patient is established on therapy. Savings to Ochsner's value-based plans sum to between $20 million—$42 million since program initiation. ❖

SHARP

Sharp Community Medical Group (SCMG) is the largest private practice, independent physician association (IPA) in San Diego, CA. With a network of over 1,000 primary and specialty care physicians practicing in 350 locations, SCMG offers families convenient access to care in their own communities. SCMG's physicians represent over 30 specialty areas, with partnerships including Sharp HealthCare, Palomar Health, and Rady Children's Hospitals. The SCMG Pharmacy team supports quality metric performance, utilization management, and ambulatory care services.

> "The program has been remarkably successful, enhancing efficiency for providers and staff"
> –DR. AZAM

Centralized Pharmacist-Based Refill Clinics Improve Refill Completions and Reduce Primary Care Physician and Staff Time

INTRODUCTION

Physicians have finite resources to respond to escalating demands on their time. Independent physicians must prioritize clinical care and respond to the demanding executive, billing, and staffing obligations that are required to manage a private office.

Pharmacy administrative tasks intensify these burdens, leading to lower quality of care, higher costs, and physician burnout. Family physicians suffer from particularly high rates of exhaustion, with 51% reporting burn out in 2022.[1] Pharmacist-driven care models involving comprehensive medication management (CMM) can positively impact patient outcomes and physician well-being.

CHALLENGE

Refill requests account for >10% of annual messaging to physicians at SCMG's two selected pilot practice sites, incurring >12,200 requests per year. Addressing these may seem inconsequential, but the cumulative impact of multiple, refill-related issues can be significant:

- Too many refill requests were screened and completed by physicians and other care team staff, directing time away from direct patient care
- Pharmacists were underutilized for screening and completing refill requests, thereby missing opportunities for pharmacy-related quality improvement

Another substantial challenge was centralizing one process across two autonomous practices with differing workflows. To build consensus, SCMG integrated program outcomes and prioritized stakeholder feedback throughout the pilot period.

A multi-disciplinary approach was used (including teams specializing in practice transformation, data, and electronic medical record (EMR) system) to leverage all available tools in facilitating program uptake and optimizing outcomes.

Above: PCP and care team staff at an SCMG pilot practice for pharmacist-based refills

INTERVENTION

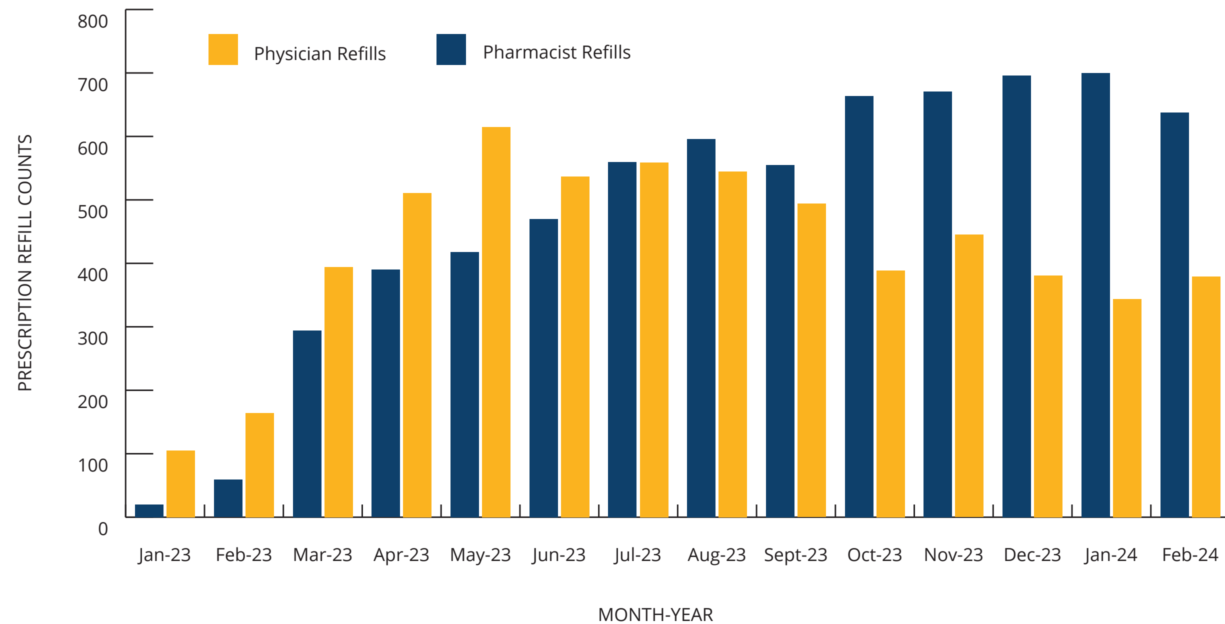
The SCMG Centralized Refill Clinic program enables the clinical pharmacy team to perform thoughtful drug reviews and authorize refills through a collaborative practice agreement (CPA) designed to meet practice needs and support clinical care for ten common chronic conditions (e.g. diabetes, hypertension, dyslipidemia, osteoporosis, etc.). Therapies not meeting established criteria or conditions (e.g. antibiotics, pain therapy, etc.) are flagged for physician follow-up while drug requests that have financial or polypharmacy barriers undergo CMM review. Pharmacists aim to improve medication adherence by optimizing medication supply and continuity for common chronic diseases. Medications or conditions not covered by the CPA are reassigned to the physician or other clinical care team staff for review. Pharmacy quality metrics (e.g. medication adherence, statin use, hypertension control) also inform refill criteria. The Refill Clinic launched in the two selected pilot clinics in January and March 2023.

The workflow relies on the use of a common EMR system. As drug refill requests are communicated to the provider's EMR from either the pharmacy or patient:

- Pharmacy technician screens:
  - Medication dose, instructions, duration
  - Visit dates
  - Labs

  Pending findings, the pharmacy technician assigns the request to the pharmacist, physician, or care team staff.
- Pharmacist reviews:
  - Medication allergies, interactions, contraindications, duplicative therapy
  - Treatment notes
  - Labs

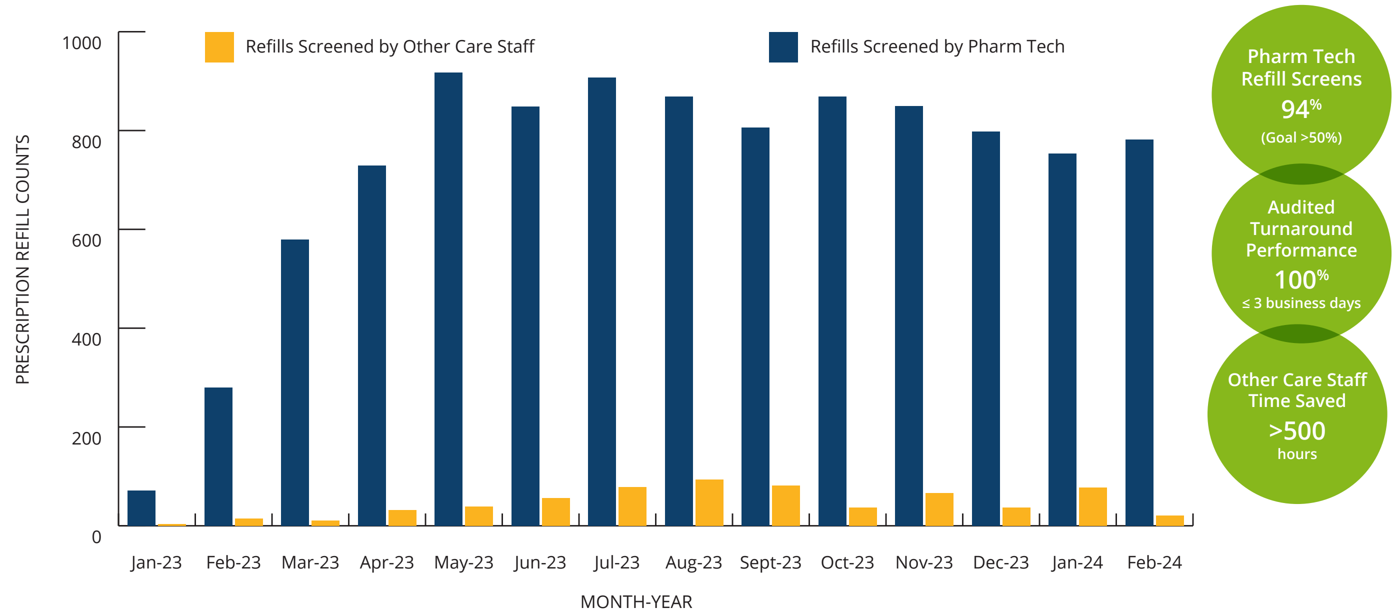
  Pending findings, the pharmacist renders decision of approval, transitional fill, or physician to review.



By October 2023, a central workflow was established for both practices piloting the intervention.

RESULTS

Pilot results exceeded expectations. The Centralized Refill Clinic achieved an overall volume of 52.6% (goal > 30%) refill completion. From December 2023-February 2024, pharmacist completion rates increased steadily, reaching 64.8%. During this period, pharmacist-completed refills reduced physician time on this task by approximately 336 hours. The Refill Clinic screened 94% of all refill requests, exceeding the 50% goal. Pharmacy technicians reduced other care team staff time for refill screening by >500 hours.



All clinic reviews and screenings were completed in the established timeframe (≤3 business days), with the majority being finished on the same day as the request. The 830 hours saved by physicians and other care team staff allowed resources to be redirected to patient care.

Quality metrics also showed an overall 2% composite improvement compared to prior year on target chronic conditions like asthma, diabetes, dyslipidemia, and hypertension. The improved pharmacy quality metric composite scores were linked to maximizing drug days' supply, lab completion, and annual visits.

In November of 2023, the service was added to an additional practice. ❖

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[1] American Academy of Family Physicians. Family physician burnout, well-being, and professional satisfaction (position paper). Accessed August 15, 2024. https://www.aafp.org/about/policies/all/family-physician-burnout.html

VANCOUVER CLINIC

Vancouver Clinic is the largest physician-owned, multispecialty medical practice in the Northwest, with more than 500 clinicians and 1,800 employees offering comprehensive primary, specialty, surgical, and urgent care at 18 locations in Oregon and SW Washington. Vancouver Clinic's Pharmacy Services Department provides direct care to patients for a variety of chronic conditions and provides expertise to other departments including the Infusion Center and Transitional Care Clinic.

> "The pharmacists made me feel listened to and well cared for; their knowledge… was impressive"

Pharmacist-Driven Medication Management Improves Hypertension Care

INTRODUCTION

Approximately 50% of U.S. adults have hypertension, and about 60% of these patients are on antihypertensive therapy. However, only about 1 in 4 adults have controlled hypertension.[1] Hypertension is one of the most costly health conditions to treat, with patients facing up to $2,500 higher annual medical costs compared to those without high blood pressure (BP).[2] In 2021, Vancouver Clinic launched an initiative with a goal to have 85% of patients with diagnosed hypertension achieve blood pressure targets of < 140/90 mmHg.

Clinical pharmacists are relatively new to the Vancouver Clinic and are slowly integrating into existing population health and primary care teams to provide Comprehensive Medication Management (CMM) for a growing patient population. CMM is relevant to value-based care because of strong evidence linking it to favorable downstream clinical and economic benefits.[3,4] Pharmacists joined the hypertension intervention team in 2022 and identified opportunities to enhance the program's impact through CMM among hypertensive patients.

CHALLENGE

Vancouver Clinic employs close to 500 clinicians in many primary care and medical specialties, and these providers care for over 53,000 patients on the hypertension registry, 10,000 of whom take at least one antihypertensive medication. Guidelines and medications for treating hypertension have changed over the years, and clinical inertia has challenged many established primary care clinicians especially when managing patients with a longer history of hypertension. The 2017 ACC/AHA hypertension guidelines provided clear support for current blood pressure goals[5]; our challenge was to gain acceptance across all departments to help patients achieve these goals. Initial work to improve blood pressures focused on capturing accurate blood pressures but did not address therapeutic improvements. Initially, pharmacists were not incorporated into the hypertension improvement project nor had they worked with PCPs to optimize medication

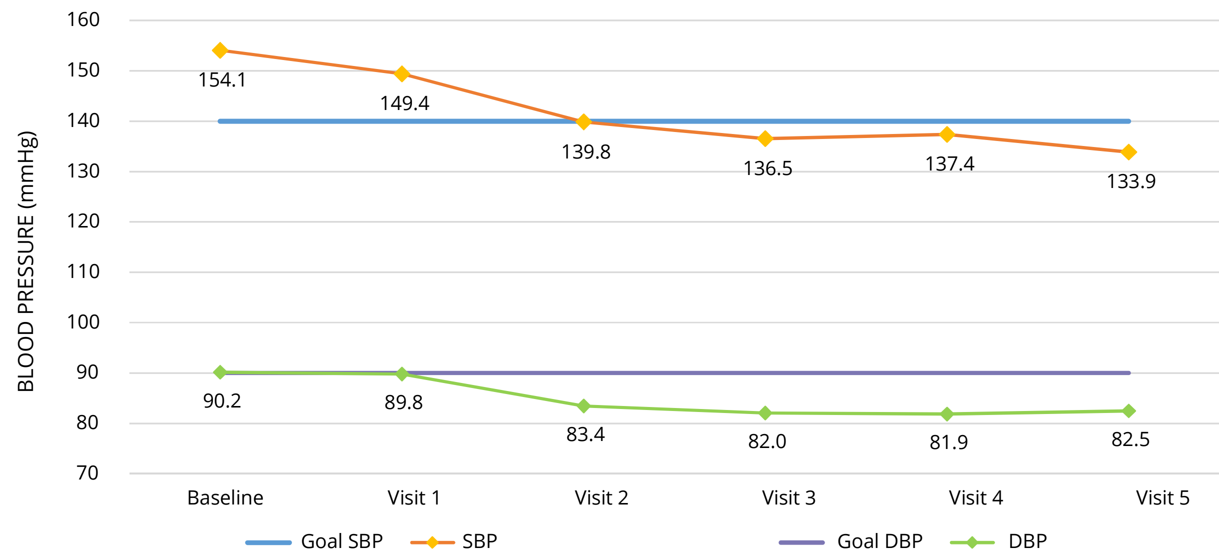
therapy through direct patient care visits and CMM.

Pharmacists reviewed patients on the hypertension registry who were on at least one medication to treat hypertension, and they identified clear opportunities to improve medication management in this population. A challenge was to find ways to optimize the 0.8 pharmacist FTE to make a positive impact on the more than 50,000 patients that needed to reach BP targets. If a significant improvement in outcomes could be realized, the Pharmacist Services Department could establish a significant return on investment (ROI) and provide more CMM in the future.

INTERVENTION

Vancouver Clinic implemented a multipronged approach to improve hypertension treatment.

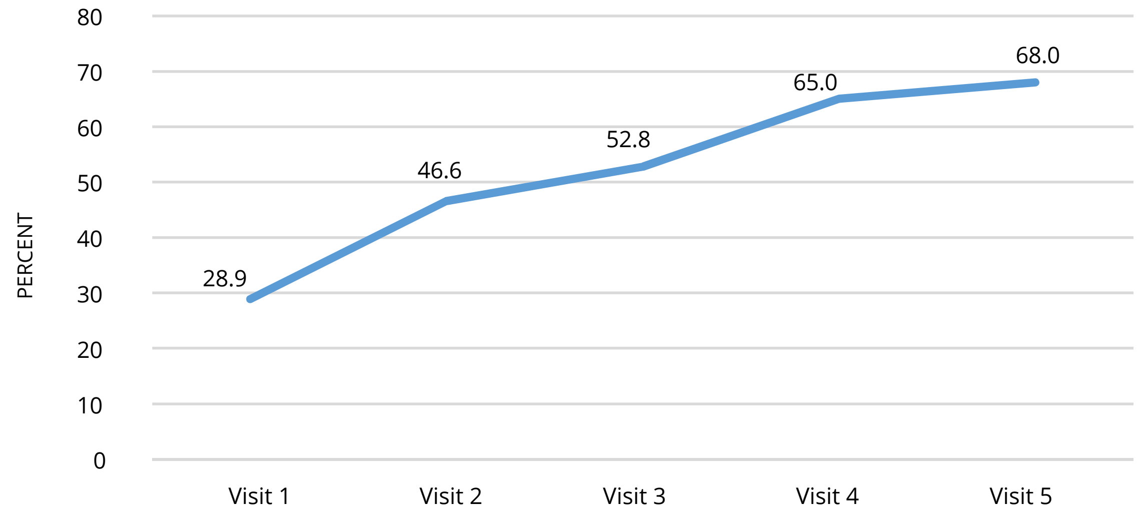
- **Education:** Clinician-focused education on hypertension guidelines was presented at multiple venues, including all provider meetings.
- **Guideline Adherence:** Treatment algorithms were developed to guide clinicians through the decision-making process for antihypertensive drug selection and dosing. These guidelines were incorporated into our *Epic* electronic medical record system's clinical decision support prescribing tools.
- **Enhanced Pharmacist Engagement:** Pharmacists prescribe and adjust medications through collaborative drug therapy agreements in Washington and Oregon State. The pharmacist sets up a referral process for patients who might potentially benefit from a CMM visit, and it was up to the primary care clinician to refer these patients to the pharmacist. Pharmacists saw patients for an initial consult and follow-up visits to optimize medications. They also encouraged use of home blood pressure flow sheets integrated within *Epic* to account for white coat blood pressure elevations.
- **Automatic Referrals:** Six months after pharmacist visits began, the panel coordinator team began to identify Medicare Advantage patients from the registry who had elevated blood pressures. The panel coordinators then initiated automatic referrals to the pharmacist for blood pressure checks and evaluation.



RESULTS

The combination of pharmacist-led visits, education, and guideline-driven

prescribing tools have improved blood pressure control for Vancouver Clinic's patients.



- Pharmacists have seen >200 patients for hypertension management and have completed >350 visits.
- By the end of 2023, most hypertensive patients seen by a pharmacist had one new antihypertensive medication added to their regimen.
- Patients who saw a pharmacist had an average BP of 137/79 mmHg, and 79.2% achieved their goal blood pressures.
- Before CMM visits, only 66% of Medicare Advantage patients and 61% of all patients were at their goal blood pressure. As of July 2024, 76% of our Medicare Advantage patients are meeting blood pressure goals, and we are on track to reach our target of 85% in the upcoming year.

These program successes and positive ROI accelerated clinician support for incorporating pharmacists on the primary care team. This project highlights the valuable role that pharmacists can play optimizing medication management in value-based care contracts.

Vancouver Clinic continues to look for ways in which pharmacists can help expand access to care and improve the health of its community. In August of 2024, an additional 1.0 FTE pharmacist was added to provide CMM. Pharmacist-led CMM visits have now also expanded to medication management for diabetes and other high-risk health conditions. ❖

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Valley Organized Physicians (VOP), an independent physician association in South Texas, consists of over 400 primary and specialty care physicians across Laredo and the Rio Grande Valley. The group was formed to provide community-based coordinated care under the uniting mission that care should be convenient and cost-efficient for patients. VOP is managed by CareAllies, and the two organizations collaborate closely on numerous value-based initiatives to improve quality, affordability, and health outcomes for the VOP community.

> "We are committed to providing high-quality, personalized care to our patients"
> –DR. WILLIAM TORKILDSEN

Redefining Care: Prioritizing SDOH to Improve Well-Being, Reduce Utilization, and Lower Costs

INTRODUCTION

Socioeconomic factors, health behaviors, and physical environment account for more than 80% of modifiable contributors to health[1], making it essential for physician practices to address these social determinants of health (SDOH). Doing so is especially true for VOP, an independent physician association in south Texas that serves a catchment area characterized by a high prevalence of health inequity. Across the three counties that VOP serves, 24% of residents live in poverty, 18% are food insecure, and 24% have severe housing problems.[2]

CHALLENGE

Despite a desire to address the population's SDOH, VOP's leadership acknowledged the difficulties of doing so. Challenges included resource availability and linking patients to resources that they could trust and use.

Addressing SDOH barriers required several steps, some of which could not be accomplished in a physician's office. First, an obstacle needed to be identified by the patient or by utilizing available data. Next, a tailored solution needed to be found based on the patient's needs. Lastly, the patient would have to be willing and able to engage in addressing the SDOH barrier. If a step was overlooked or poorly implemented, it would be difficult for an SDOH program to succeed. VOP needed the time, resources and ability to:

- Encourage patients to be open and honest about their personal lives, beyond clinical topics
- Utilize available information and ask the right questions to uncover hidden SDOH barriers
- Find appropriate solutions for each patient's unique situation
- Ensure patients have the knowledge, ability, and willingness to follow through with recommended solutions.

To create a sustainable program, VOP partnered with CareAllies, its value-based care management services company. Together, they tackled these stubborn SDOH implementation challenges.

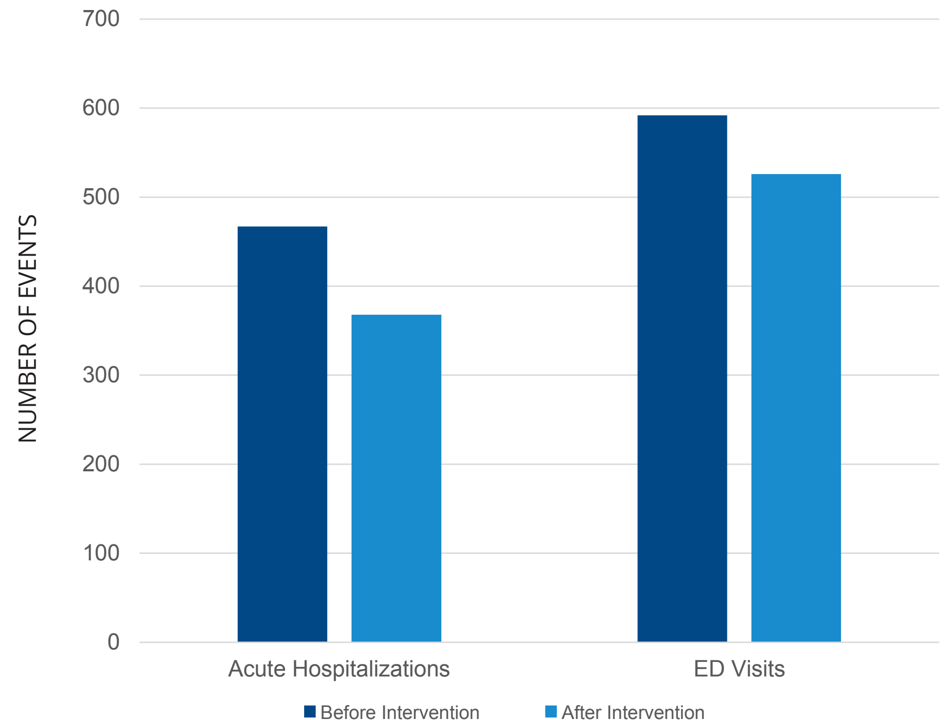
INTERVENTION

VOP and CareAllies' SDOH program goes beyond merely educating patients about resources. It uses clinical and claims data, along with physician referrals, to identify patients with unaddressed SDOH needs, and employs a team of social workers to

connect patients with community-based organizations, refer them to programs, and track outcomes. The team has local knowledge and speaks Spanish to optimize service for VOP's predominantly Hispanic population.

A physician who suspects additional patient support is needed makes a referral to the SDOH team and informs the patient to expect a phone call from their office, understanding that patients are more likely to answer calls from their doctors. The SDOH team then calls the patient on the same, or the next, business day (from the physician's phone number) to perform a detailed assessment while the visit is still top-of-mind. These calls enable deep conversations, enhanced education, and a greater ability to link to appropriate resources. Teams always follow up to ensure recommended resources are meeting patients' needs and offer additional support if they are still encountering obstacles.

Typically, at-risk patients have multiple SDOH needs. For example, a 62-year-old male with multiple chronic conditions was missing appointments and had several fall-related emergency department (ED) visits. A social worker called and learned he had home safety concerns, no vehicle, and food insecurity, among other needs. She helped him secure transportation, food delivery, home services, a low-income subsidy, an emergency alert button, a walker, a shower chair, and other necessities. The patient is now showing up for appointments, filling prescriptions, and has not fallen again at home.



When comparing the 12 months preceding and 12 months following SDOH interventions, the number of hospitalizations decreased by 21.2% and the number of emergency department visits also decreased by 11.1%.

RESULTS

Now in its fifth year, VOP and CareAllies' SDOH program has grown in volume, awareness, and impact. Through proactive outreach and referrals:

- 1,051 patients were identified in 2022, of whom 73% accepted support. The team resolved 93% of their SDOH gaps.
- 1,798 patients were identified in 2023 (a 70% increase in volume over 2022), of whom 77% accepted support. The team resolved 94% of their SDOH gaps.

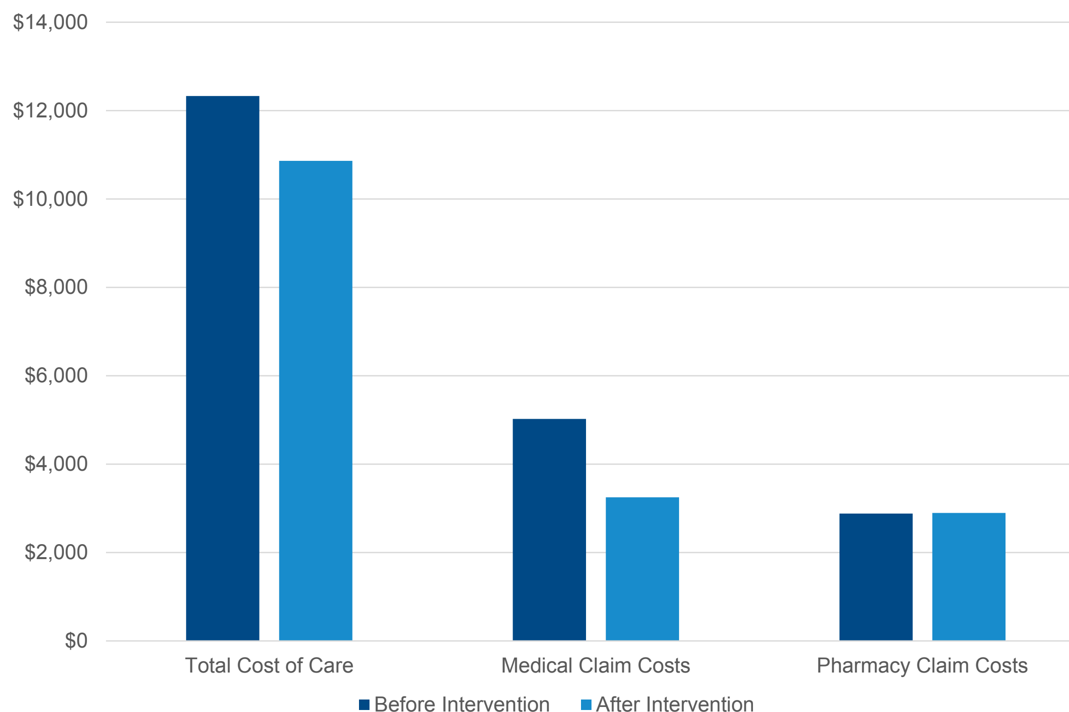
To understand how the program impacted utilization and cost, VOP leadership contracted with a third-party vendor to conduct an in-depth study to assess whether addressing SDOH barriers had an impact on these metrics.

Analyses showed[3]:

- 21.2% reduction in hospitalizations
- 11.1% reduction in ED visits
- 11.9% reduction in total cost of care
- 35.3% reduction in medical claim costs

Program data continue to be collected and analyzed because there is still much to learn about the connection between SDOH, utilization, and outcomes. In the meantime, VOP and CareAllies are encouraged by the program's growth and success. Countless stories have demonstrated the program's impact on individual lives, highlighting the value of combining data analytics, targeted outreach, relationship-building, and regular follow-up to address SDOH. ❖

MEDIAN COSTS BEFORE AND AFTER SDOH INTERVENTION



The median total cost of care for patients following intervention was 11.9% lower than before. To determine if cost differences were consistent across claims sources, medical and pharmacy costs were also compared. Medical claim costs were 35.3% lower after interventions.

Left: Staff at Port Isabel Health Clinic, a VOP practice, where Dr. William Torkildsen cares for patients

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Dignity Health. Woodland Clinic
A Service of Dignity Health Medical Foundation

Woodland Clinic Medical Group (WCMG) is a 150-member, multispecialty medical group that works in Northern California with Dignity Health, its operational partner. Incorporated in 1911, WCMG's efficient practice design and culture of collaboration have resulted in clinical and financial success in value-based health care. Dignity Health has cared for the Greater Sacramento area for more than 125 years, offering access to personalized, community-based care with all the benefits of being one of the largest nonprofit health systems in the nation. Its local managed care populations include 16,948 Medi-Cal patients, 2,338 Senior patients, and 17,433 Commercial patients.

> "CC teams have the potential to increase the value proposition associated with PAV ED visits"

Care Coordination for Reducing Potentially Avoidable Emergency Department Visits

INTRODUCTION

A health care system that agrees to manage a population shares responsibility with patients to improve quality and lower the cost of health care, while optimizing satisfaction for both patients and clinicians. This value proposition includes reducing emergency department (ED) utilization for non-urgent, potentially avoidable visits (PAV). In the United States, PAV account for 16-30% of all ED visits, with costs approaching $38 billion annually. Reasons why patients present to the ED for PAV include limited access to primary care, to save time, to get an earlier appointment, pain, perceived urgency, and convenience.[1-6]

WCMG's efforts to increase its value proposition center around redesigning primary care into care teams. This redesign includes formation of Continuing Care (CC) teams to provide enhanced care coordination for patients with complex care needs. These CC teams, consisting of nurses, social workers, navigators, and community health workers, blend multidisciplinary expertise in reviewing and addressing root causes of ED utilization. By reducing ED PAV, the CC teams have the potential to increase the value of care for patients and WCMG.

CHALLENGE

WCMG aimed to reduce the rate of ED PAV in the dual-risk managed care population--Medicaid, Medicare, and commercially insured patients who are assigned under capitation to WCMG for professional and facility services. When appropriate, WCMG's CC teams contacted, educated, intervened, and supported these managed care patients in navigating from the ED back to primary and urgent care.

INTERVENTION

Data was gathered on dual-risk patients' ED visits between June 2023 and March 2024. It was determined which—given adequate primary care access—were PAV according to a published algorithm.[6] The CC team contacted patients with a PAV and delivered one of five escalating tiers of interventions *(see Escalating Interventions table)* to redirect them to primary care or urgent care, and for some, enroll them in Continuing Care. All patients received letters and "Know Where to Go" fliers, and if they had a recurrent PAV, a licensed vocational nurse evaluated the ED clinicians' notes and used clinical judgment to determine the next appropriate intervention. RNs were involved in complex care assessment and planning, and navigators contacted patients to

ESCALATING INTERVENTIONS

INTERVENTION	LETTER	FLIER	NAVIGATOR	CC REFERRAL	CC FOLLOW UP*	CALL
1	✓	✓				
2	✓	✓	✓			
3	✓	✓		✓		
4	✓	✓			✓	
5	✓	✓	✓	✓		✓

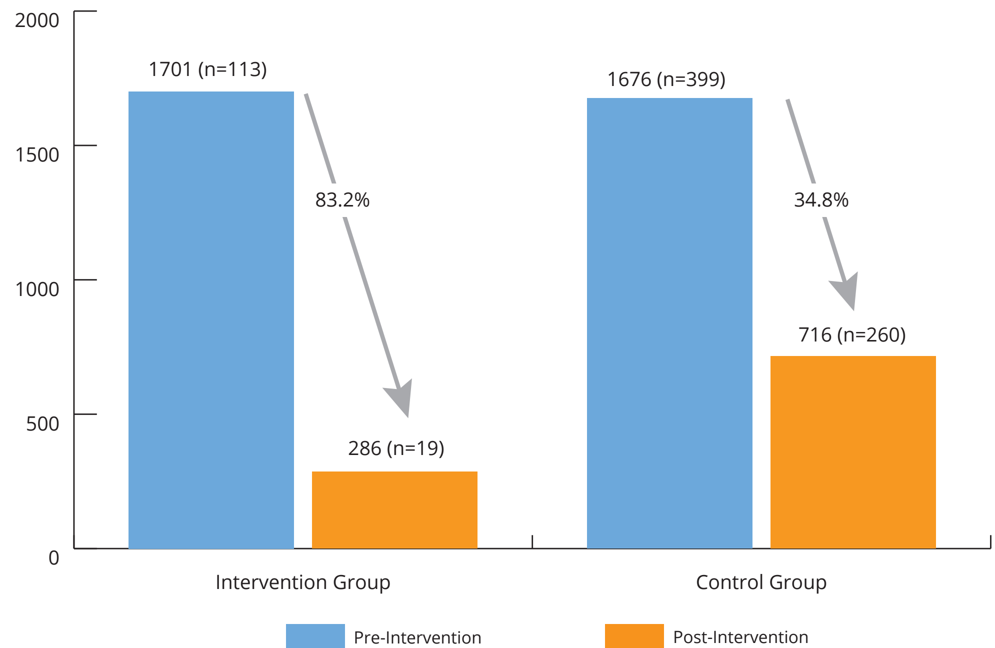
*CC = Continuing Care enhanced care coordination program; *For patients already enrolled in CC*

schedule primary care follow up. Patients with greatest need were called, proactively enrolled in both CC and other interventions.

Approximately 20% of eligible patients participated in the intervention. While WCMG does not have comparative data from other programs, we identified some barriers, including wrong phone numbers, patient disinterest, limited staff, manual processes, and reticence for cold calling. This was balanced by having a passionate customer service driven staff that helped drive the acceptance rate.

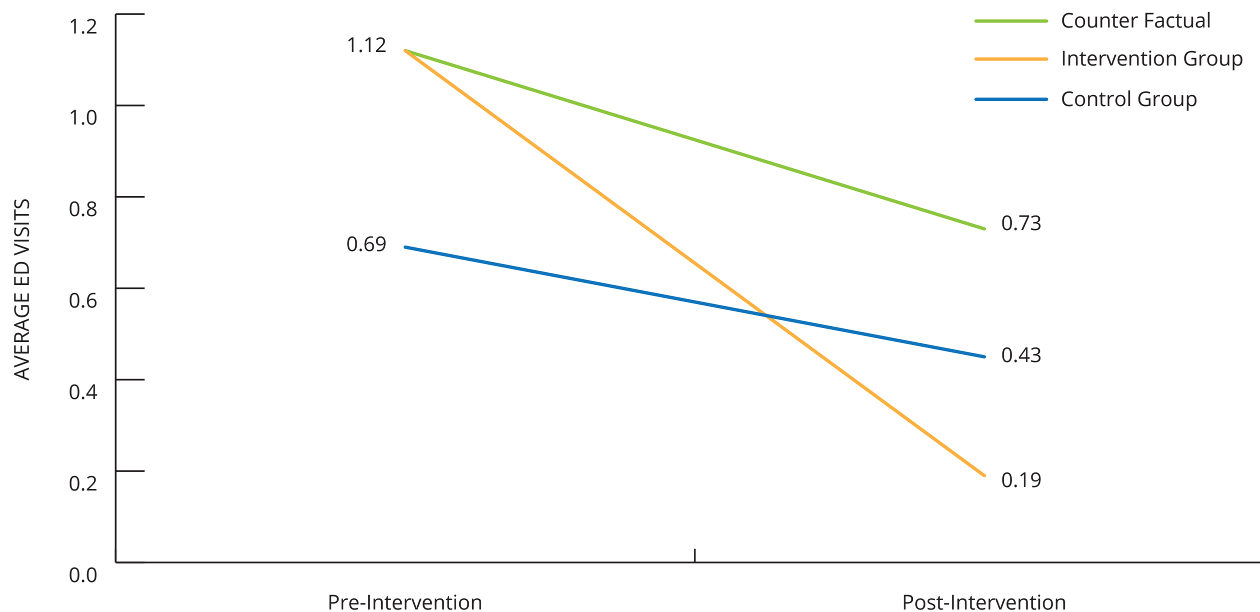
RESULTS

For patients in the CC intervention group who had a recurrent ED PAV, we counted the number of months post intervention and pulled historical ED PAV utilization for an equal number of months before the intervention, defining the pre and post periods for each patient. The pre and post periods for intervention patients without a recurrent PAV were determined by the number of months between intervention and March 2024. The control group was defined as dual-risk patients who visited the ED for a PAV, and their pre and post periods were defined as 12 months before and after March 31, 2023.



The three most common discharge diagnoses were headache (23%), orthopedic pain (18%), and rash (10%). The number of PAV in the intervention group dropped by 83.2% (113 vs. 19 encounters and 1,701 vs. 286 visits/1,000 member months, *(see ED PAVs bar graph)*. However, we also saw a 34.8% decrease in PAV among control patients (399 vs. 260 encounters, and 1,676 vs. 716 visits/1,000 member months). Additional analyses showed the intervention decreased PAV by 48.4% compared to what would have occurred without an intervention *(see Difference-in-Difference graph)*.

DIFFERENCE-IN-DIFFERENCE ANALYSIS OF AVERAGE ED VISITS BETWEEN INTERVENTION AND CONTROL GROUPS



Although our intervention reduced ED PAV, understanding cost savings was challenging because of the array of considerations around quantifying total cost of care. Undoubtedly, there are cost savings associated with avoiding PAV ED visits, and reducing these visits is good for value-based models. However, savings will depend on number of PAV, overhead, labor associated with CC teams and an array of other factors that were beyond the scope of this project. Future work will expand the program to all WCMG's value-based populations, including shared-risk HMO and MA patients, PPO-ACO patients, and patients attributed through MSSP. We will also continue to examine the cost implications of this program. ❖

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