Case Studies in EXCELLENCE 2023

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Welcome to the 2023 edition of America's Physician Groups' *Case Studies in Excellence*!

We are delighted to showcase 10 profiles of patient-centered, coordinated, and accountable care that exemplify how APG's physician-led organizations are "taking responsibility for America's health."

APG's approximately 360 member organizations span 47 states, the District of Columbia, and Puerto Rico. Their roughly 170,000 physicians care for nearly 90 million Americans. They strive to improve patients' care experiences and health outcomes while also being accountable for costs.

In this volume, 10 of these organizations have shared their best practices, insights, and lessons learned in adopting new approaches to providing care. Their case studies comprise innovations in four major areas:

- **Team-based care** (embedded pharmacists, integrated behavioral health, engaged and empowered office staff)
- **Patient engagement and activation** (falls prevention program, financial incentives to bridge health and social needs)
- **Advanced primary care and beyond** (Lean practice transformation, nurse-driven population health clinics, outpatient extensivist centers)
- **Specialty care integration** (evidence-based orthopedic back and joint care, medical home model for chronic kidney disease)

Sharing the hard-won expertise of our members is a primary way that APG not only supports other organizations seeking to learn about value-based care but also fuels the broader movement away from volume to value. We hope that readers will find the case studies to be an important resource that can inform health care organizations, policymakers, payers and purchasers, and even patients about the multiple strategies that organizations can undertake in pursuit of value-based care.

We congratulate and thank the APG member organizations that contributed to the 2023 edition of *Case Studies in Excellence.*

Susan Dentzer, MS, President & Chief Executive Officer
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CareAllies
Patient-Centric Initiative Dramatically Improves Practice's Readmissions Rate

Introduction

Process improvement is a key aspect of CareAllies' work helping physician organizations succeed in value-based care. Our Process Improvement Team continually analyzes data to identify opportunities for improvement and then works closely with providers to understand the root causes of challenges and how to address them.

Through this ongoing analysis, we identified an opportunity to lower the plan all-cause readmissions rate for a busy primary care practice in Harlingen, Texas. The practice, led by Stephanie Garcia, MD, is part of Valley Organized Physicians—an independent physician association supported by CareAllies. At the time, from 2018-2020, the practice's average readmissions rate for Medicare patients was 11%. We created a patient- and practice-centric initiative that lowered this rate by more than 70%.

Challenge

An 11% readmissions rate is concerning for any patient population. But for this particular practice—which was high-performing in other areas—it served as a bellwether for underlying social determinants of health (SDOH) that were preventing many patients from getting the best possible care.

Dr. Garcia's practice is located in South Texas' Rio Grande Valley, one of the nation's most economically disadvantaged areas. The region's population has a relatively high prevalence of multiple chronic conditions and persistent socioeconomic challenges, such as food insecurity, lack of housing and transportation access, health illiteracy, and language barriers. Nearly 90% of area residents are Hispanic,[1] and for many, Spanish is their primary language. Many patients lack insurance or are dual-eligible for Medicare and Medicaid.

Our Process Improvement Team partnered with Dr. Garcia to:

- Determine the root causes of unplanned readmissions
- Identify existing processes that required more consistency and reliability
- Gauge where new practice processes or tools were needed
- Obtain buy-in for proposed interventions

We also wanted to keep our objectives attainable. Together, we aimed to achieve a readmissions rate below 8%—with the ultimate goal of improving overall care. This target was chosen based on the 2019 targets needed to achieve a four-star Medicare Stars Rating.[2]

Left: A CareAllies Process Improvement Team member with two family nurse practitioners at Dr. Garcia's office in South Texas

Intervention

Our team worked with Dr. Garcia, along with her nurse practitioners, medical assistants, and front desk staff, to apply Lean Six Sigma principles (define, measure, analyze, improve, and control) to reduce readmissions.

We then launched several initiatives that targeted SDOH factors impacting patients and adjusted processes within the practice to improve overall care. These initiatives included:

1. **Improving post-discharge planning.** One root cause of readmissions was that high-risk patients weren't being flagged in the electronic medical record. Under the new process, a staff person flags these charts after discharge—prompting the practice to provide next-day appointments and additional support. A script helps the team gather relevant information from hospitals to inform these alerts.
2. **Closing the loop with specialists.** Previously, patients often had difficulty seeing specialists within 30 days post-discharge. A non-legal "care collaboration contract" now defines how primary care and specialty physicians can better communicate, develop care plans, and partner to ensure timely and high-quality care.
3. **Addressing transportation roadblocks.** We created flyers to help patients understand their available insurance benefits for transportation. The practice also connects patients with other community-based transportation resources.
4. **Increasing medication adherence.** A "cheat sheet" uses pictures and simple phrases to help patients remember which medications they've been prescribed and why—as well as when, how, and how much of each medicine to take.

CareAllies is a Houston-based organization providing management services—and the people, processes, and technology—that physician organizations need to succeed in value-based care. CareAllies has over 20 years of experience supporting providers in commercial, Medicare Advantage, and original Medicare value-based arrangements, including the Medicare Shared Savings Program and ACO REACH. We currently support 67 provider organizations, with more than 6,000 physicians in 11 states, caring for more than 400,000 patients in value-based arrangements.

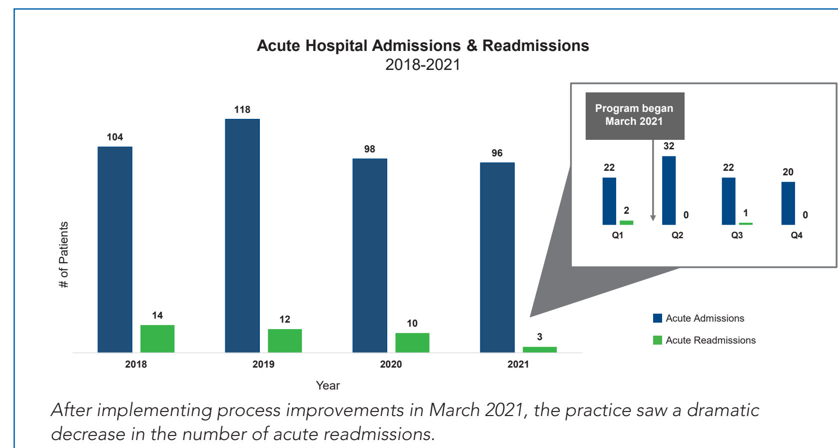
5. **Helping patients know where to go.** Patient knowledge gaps were one of the identified causes of high readmission rates. Now, educational materials inform patients when to use after-hours and urgent care centers. "Call Us First" materials encourage them to call the practice—even after hours—for non-emergencies.
6. **Simplifying chronic condition management.** A series of flyers uses red/yellow/green "stoplight" graphics with condition-specific symptoms and action plans. These help patients understand how to manage their symptoms appropriately.

Results

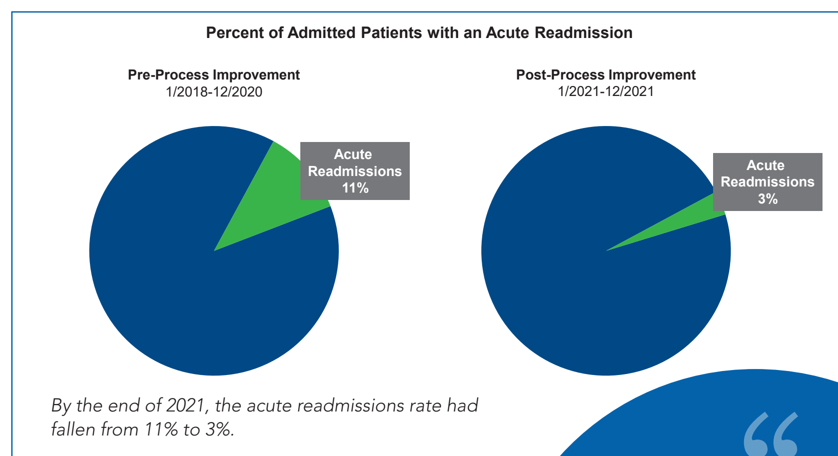
Reducing avoidable readmissions tends to increase patient satisfaction and improve health outcomes, while lowering unnecessary costs ($15,500 per readmission, on average).[3] Our process improvement and patient engagement strategies helped lower this practice's readmission rate to 3%—a 72% reduction and far beyond our initial goal *(See Figure 1)*. This rate continues to remain stable.

These results demonstrate the meaningful difference a collaborative process improvement initiative can make to patient care. Our strategies used scripts, flyers, and other low-cost, easy-to-create documents that are repeatable and scalable. However, success is dependent on a few key factors:

- **Avoid overburdening teams.** Data and technology play an important role in recognizing opportunities, but utilizing experts who can apply findings to your organization and workflows can help narrow your focus.
- **Emphasize leadership and empowerment.** Buy-in starts with leadership. Including stakeholders in process design/redesign creates a sense of ownership that contributes to long-term sustainability.
- **Create reliable processes.** Consistency and repeatability require steps that every person can implement—every time, at every touchpoint.



After implementing process improvements in March 2021, the practice saw a dramatic decrease in the number of acute readmissions.



By the end of 2021, the acute readmissions rate had fallen from 11% to 3%.

Fig. 1

CareAllies and Valley Organized Physicians continue to enhance existing process improvement work and expand it to other practices across the organization. It takes time for change to start showing an impact, but ultimately, the results—and improved patient care—are worth the effort.

> Bringing my clinical team together with CareAllies' process improvement experts made a meaningful difference in our ability to empower our community to achieve better health.
>
> *— Stephanie Garcia, MD*

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Cedars-Sinai Medical Network
Comprehensive Medication Management Improves Migraine Care and Outcomes

Introduction

Status migrainosus is a continuous, relentless migraine attack, consisting of a headache lasting more than 72 hours. First-line treatment is a combination of medications known as a migraine cocktail, which can be administered in outpatient care. And yet, severe and sudden headaches account for 3.5 million emergency room (ER) visits per year in the United States—with migraines representing a third of those visits.[1]

At Cedars-Sinai Medical Network, one barrier to optimal outpatient migraine care was that our neurologists were booked out for several months. This made it difficult for patients to get timely care and follow-up, as well as treatment for status migrainosus outside of the ER. To increase access to migraine treatment providers, optimize care for patients, and reduce ER visits, we created a comprehensive medication management program for migraine care—integrating pharmacists directly into our neurology clinics.

Challenge

Prior to creating this program, our physicians were spending over two hours per migraine patient at initial appointments to collect migraine histories and provide counseling and medication therapy. Follow-up appointments were also at least one hour long. To remedy this, we developed a comprehensive medication management program to involve pharmacists in migraine management.

Under this program, pharmacists can adjust, discontinue, and initiate medications for migraine, including management of status migrainosus. They can also follow up with patients in between their visits with neurologists, address medication-related questions, provide counseling and prompt treatment of status migrainosus, and offer appointments before patients go to the ER.

One challenge is that pharmacist-led disease management programs are more common in primary care and have traditionally been independent of—and in different locations from—referring physicians. We needed to integrate a neurology-trained clinical pharmacist within our neurology offices. Our goals were to:

- Improve migraine clinical outcomes
- Decrease patient barriers and increase access
- Prevent ER visits
- Reduce overall health care costs
- Generate self-sustaining revenue from the neurology clinical pharmacist's services
- Maintain high patient and provider satisfaction

Cedars-Sinai Medical Network pharmacists

Intervention

We developed the Migraine Pharmacy Protocol—which involves a post-graduate year two (PGY2) neurology specialty-trained pharmacist—in 2016. During solo visits with patients, the pharmacist was initially involved in intake of migraine history, education, and selection and management of migraine pharmacotherapy.

In 2018, we added pharmacist initiation of status migrainosus medications to the protocol. Patients with migraine attacks now contact the pharmacist via phone or the electronic medical record (EMR), and the pharmacist prescribes a migraine cocktail if indicated. The ease of electronic communication enables prompt migraine treatment and can prevent ER visits.

In 2019, we developed a novel, team-based approach to utilize the pharmacist embedded within the neurology office to co-manage patients via co-visits. This model provides a patient-centered approach while allowing the physician to see a greater number of patients—which improves access. Each co-visit works in the following way:

- The patient meets with the pharmacist, who provides education and medication management.
- The pharmacist briefly reviews the plan with the physician.
- The physician then performs a physical/neurologic exam and finalizes the plan.

Cedars-Sinai Medical Network includes more than 1,000 physicians and 330,000 unique patients in multiple specialties throughout Los Angeles County and oversees Cedars-Sinai's ambulatory surgery centers, joint venture imaging, and physical therapy centers. We have approximately 100,000 patients in value-based contracts, including Medicare Primary Care First, commercial accountable care organizations (ACOs) and HMOs, and Medicare Advantage. Our Pharmacy Services Department provides patient care in primary care and specialty drug therapy management programs, as well as transitions of care, refills, and drug utilization and distribution services. We have a PGY1 pharmacy residency program and student training program.

Migraine Cocktail Treatments Ordered by Pharmacists – Average Per Month

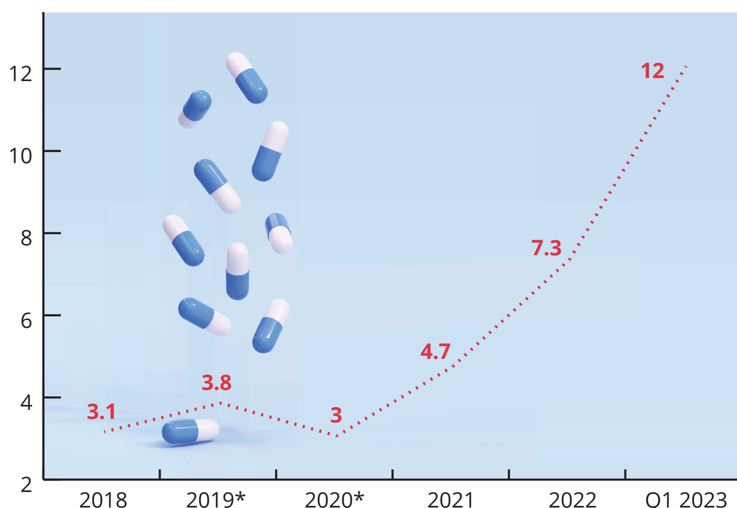

Fig. 1. Pharmacists began ordering migraine cocktail treatments under the protocol in 2018. Since then, the average number they prescribe per month has increased by four times. Each treatment ordered is a potential prevented ER visit.

**2019 includes only four months of data, while 2020 data includes February through December. For parts of those years, a pharmacist was not available in the program, and changes were made to data collection processes.*

Average Number of Headache Days Before and After Program: Jan. 1, 2017 – March 31, 2023

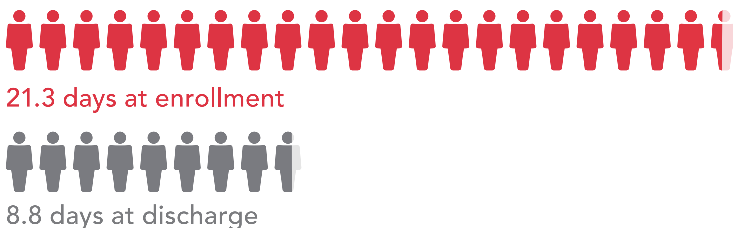

Fig. 2. Patients' average number of headache days have fallen 59% after participating in the program.

To test this model, we created an initial pilot phase with one neurologist, one pharmacist, and office staff—who all participated in program design using lean process methodology. With the help of the Pharmacy and Operations teams, office staff, and physician leaders, we created standard processes for scheduling, rooming, and documentation, as well as best practices for establishing provider and patient buy-in, handing off patients, and setting agendas.

The pilot was used as a proof of concept and to further refine best practices. Based on its success, we expanded the co-visit model to all neurologists in our network.

Results

One metric we measured was the number of pharmacist-ordered migraine cocktail treatments. Each treatment ordered is potentially a prevented ER visit.

In 2018, pharmacists ordered an average of 3.1 migraine cocktail treatments per month. By 2022, this number had doubled to 7.3 treatments per month—and by the first quarter of 2023, pharmacists were ordering an average of 12 treatments a month *(See Figure 1).*

Meanwhile, co-visit volumes skyrocketed from one to 10 migraine management co-visits at the program's start to a current volume of 40-50 a month. This has improved access and led to more appropriate use of limited neurology specialist resources. The revenues generated from these co-visits have also helped with specialist engagement, care model sustainability, and growth.

Most importantly, the program has helped patients achieve better control of their migraines *(See Figure 2)*. Between January 2017 and March 31, 2023, patients' average number of headache days fell 59%—from 21.3 days per month at program enrollment to 8.8 days per month at program discharge. Both patients and providers have reported high satisfaction with the program.

The current staffing ratio is one pharmacist to 12 neurologists, and they utilize the shared space and staff within the Neurology offices and the Pharmacy department. Our neurology pharmacy programs also include epilepsy, multiple sclerosis, restless legs syndrome, and Parkinson's disease, and they utilize both co-visits and solo pharmacist visits. This model is translatable to other specialty settings as well.

> "Having a clinical pharmacist in our office has allowed us to see acute migraine patients on the same day, which has saved countless emergency and urgent care visits."
>
> *— Neurologist, Cedars-Sinai Medical Network*

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Central Ohio Primary Care
Extensive Care Centers: A Novel Way to Reduce ED Visits and Observation Stays

Introduction

Patients often seek care in an emergency department (ED) for non-emergent conditions. This is a well-known source of unnecessary health care costs,[1] but the use of observation stays after ED visits is a less-studied area of potential waste. Our internal data suggests that 15%-40% of ED visits result in a hospital observation stay—often for lower-acuity complaints that did not require inpatient hospital resources. External research confirms elderly patients are admitted to observation stays at increasingly high rates.[2]

At Central Ohio Primary Care (COPC), claims data from our partnership with Agilon Health revealed that our senior patients were being transferred from the ED to observation stays at a significantly higher rate than expected. To reduce these unnecessary costs and improve care for patients, we created a novel alternative: the Extensive Care Center (ECC).

Challenge

Our attempts to work with major hospital systems to reduce unnecessary acute care and observation stays were met with limited success, due in part to differing incentives for value-based care. However, COPC has dedicated hospitalists, nurses, advanced imaging centers, and laboratory services—giving us the ability to treat lower acuity conditions that are beyond the scope of a PCP office.

Still, we faced several barriers, including a care delivery infrastructure that is spread out over 90 offices across Central Ohio, as well as fee-for-service (FFS) reimbursement limitations for extended care in an outpatient setting.

Intervention

In 2017, COPC introduced the ECC as an outpatient alternative to ED and hospital observation units—with office visit pricing. The ECC features a COPC hospitalist working with a registered nurse (RN). This team provides visits without time limits and offers advanced diagnostics and treatments, including:

- Point-of-care and advanced complexity labs
- CT scans
- Ultrasound
- Cardiac monitoring
- IV treatments

In 2022, we opened a second ECC to support demand, and a third location will open in 2024. Although only about 20% of our patients are in downside risk contracts, ECC services are available to all adult COPC patients, regardless of insurance, and are open Monday through Friday, 9 a.m. to 8 p.m., with limited weekend access.

Our internal data suggests that almost 90% of our ED visits for patients over age 65 occur between 10 a.m. and 6 p.m. Staffing is also significantly more costly after 8 p.m. and on weekends. We have found little demand for ECC services after 8 p.m., but our data suggests unmet demand over the weekends. Cost is the biggest barrier to providing full ECC weekend care.

PCP offices drive ECC utilization—identifying potential patients and notifying ECC staff. The ECC RNs contact patients, confirm they can be treated safely at the ECC, and schedule them at the most appropriate location based on geography, ECC capacity, and projected patient needs.

Ongoing communication between patients, PCPs, and the ECC is critical to success and focuses on:

- Building awareness of ECC services
- Educating providers on when to refer patients to the ECC versus the ED
- Educating patients on available options for acute care
- Providing PCPs with patient-specific information about episodes of care

Results

The ECC has been a tremendous success with patients, providers, and payers. In 2022, our ECCs saw 3,075 patients; we expect this to grow to 4,000 in 2024. About half of these patients are over age 65 and in full-risk contracts.

Based on case reviews, 50% to 75% of ECC visits would have otherwise gone to the ED. In 2022, around 20% of those patients would have been discharged to observation care. Using conservative cost estimates, our ECCs resulted in a savings of $800,000 to $1.2 million in avoided unnecessary care for our Medicare

Central Ohio Primary Care (COPC) is the largest independent physician-owned primary care group in the U.S. Founded in 1996, COPC has grown to approximately 500 physicians in 90 offices and serves over 450,000 patients in the greater Columbus region, with 75,000 seniors in full-risk contracts—including more than 41,000 in Medicare Advantage. COPC is a leader in physician-driven high-value care, with most physicians receiving 20% to 50% of their income from value-based payments. COPC offers patients access to internal specialists, hospitalists, same-day care for acute needs, palliative care, lab services, imaging, diagnostic testing, and several disease management programs and services.

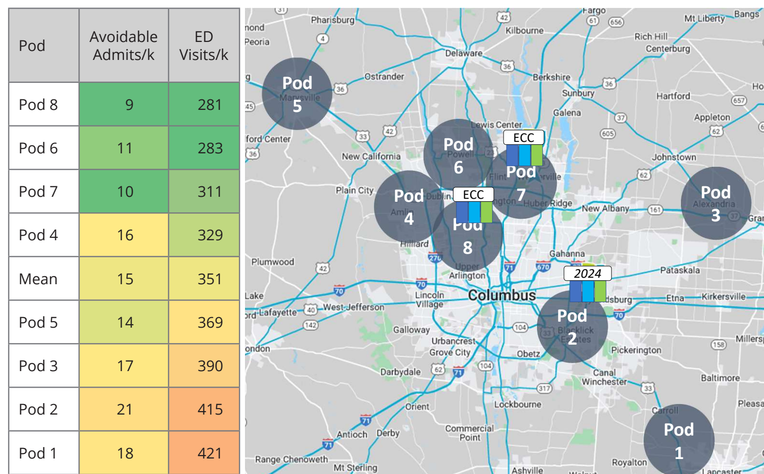
patients in risk-bearing contracts. If we include commercial patients in traditional fee-for-service (FFS) contracts, it represents savings of $2.8 million to $4.1 million.[3] These estimates do not assume any reduction in inpatient admissions. In addition:

- Among ECC patients, 98% were satisfied with the overall care they received.
- Our two ECCs see a combined 18-24 patients a day.
- Only 6% of ECC patients required an ED visit within 72 hours of their ECC encounter.
- For PCP offices, ECC proximity is linked to lower avoidable hospital admissions and ED visits *(See Figure 1).*
- Higher ECC visit volume is associated with fewer observation stays for our patients at a nearby hospital *(See Figure 2).*

The greatest challenge for our ECC program is the relatively low fee-for-service revenue that it generates. No facility fees are charged, limiting reimbursement to traditional ambulatory evaluation and management (E&M) codes. For patients in risk-bearing contracts, projections show that downstream savings from avoided ED and observation stays pay for the ECC, but future savings can be a difficult way to fund expansion.

For commercial patients in traditional FFS contracts, the ECC operates at a deficit. The potential savings per episode for these patients are greater because commercial ED and observation costs are significantly higher than in Medicare. Two of our commercial payers recognize this and created a special payment for ECC visits that is substantially lower than a typical ED visit. If all our commercial payers paid a similar amount per visit, the ECC would be completely self-sustaining from a financial standpoint.

Proximity to ECC is Correlated with Lower ED and Avoidable Admission Rates



Pod	Avoidable Admits/k	ED Visits/k
Pod 8	9	281
Pod 6	11	283
Pod 7	10	311
Pod 4	16	329
Mean	15	351
Pod 5	14	369
Pod 3	17	390
Pod 2	21	415
Pod 1	18	421

Fig. 1

Opening of New ECC Location is Inversely Related to Observation Admissions at Closest Hospital

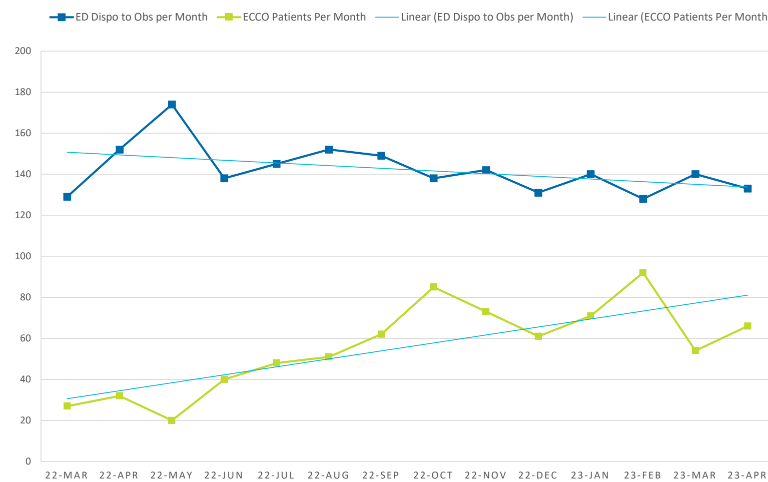


Fig. 2

> Based on case reviews, 50% to 75% of ECC visits would have otherwise gone to the ED.

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Desert Oasis Healthcare
Value-Based Approach Prevents Falls While Improving Financial Performance

Introduction

Every year, more than 1 in 4 adults ages 65 or older fall—an event that can be life-changing and can lead to long-term disability.[1] At Desert Oasis Healthcare (DOHC), 10,412 of our members had at least one fall in 2021, with nearly half experiencing two or more falls. These incidents resulted in nearly 16,000 utilizations—with costs for ED visits alone estimated at over $14 million. In response, we teamed with Altura to implement a value-based program aimed at not only preventing repeat falls—but also a first fall.

Challenge

Like many provider organizations, DOHC faced challenges with preventing older patient falls, including inconsistent screening—especially when patient encounters cover multiple chronic conditions—as well as difficulty reaching members and a lack of tools to engage those at risk. While our prior focus had been on avoiding repeat falls, the literature suggests that preventing a first fall is critical. Falling once doubles the chances of falling again.[2]

DOHC has many disease management and population health programs, but education and resources related to strength, balance, and mobility were limited to passive referrals to in-person and online "Matter of Balance"™ classes—which had low participation. STAR and other quality measures address asking patients about falls, but this does not engage and activate the patient to improve strength and mobility.

Intervention

In September 2021, DOHC partnered with Altura, which provides specialized patient activation services. Altura's UpRight™ program is a home-based, virtual, and bilingual (English and Spanish) intervention that improves strength and mobility for older adults while reducing fall risk.

The program was white-labeled for DOHC and named Stable Steps™. DOHC identifies and refers patients to Altura via the electronic health record (EHR). These include not only patients who have already fallen, but also new senior members deemed at high risk, those with conditions such as Parkinson's disease, patients referred by a provider, and patients discharged from a skilled nursing facility.

For the core high-touch portion of the program, participants receive:

- Telephone coaching sessions. An Altura patient activation specialist calls the member at least once a month to provide medically approved strength and balance exercises and tips. These are targeted to the patient's needs and mobility level.
- A checklist of household fall hazards
- Home installation of grab bars, bed rails, etc.
- A medication review to assess medications that cause dizziness or sleepiness
- Access to a hotline to reach a patient activation specialist

Altura triages specific issues back to DOHC team members and includes important notes in the EHR for PCP visibility. The company also provides a DOHC-branded patient webpage and point-of-care provider tool. In addition, Altura conducts longitudinal risk assessments and patient-reported outcome surveys regarding physical activity status, strength score, stratified fall risk score, stated medical needs, program satisfaction, and mobility and fall frequency self-assessments. This has resulted in a comprehensive database that enables Altura staff to better educate patients about incidents that often lead to falls (e.g., "I was rushing to the toilet").

After six months, patients are moved into a maintenance program, where they receive monthly DOHC-branded emails featuring fall prevention resources and can access the Stable Steps hotline. Patients can reenter the high-risk program if they fall or are referred by a provider.

Desert Oasis Healthcare (DOHC) serves more than 60,000 members, including over 30,000 Medicare Advantage patients, in the Coachella Valley and surrounding desert communities of Riverside and San Bernardino counties in California. DOHC is a full-risk staff model medical group with a wraparound independent physician association (IPA), including 150 primary care providers and more than 300 specialists. Altura provides value-based health systems with configurable and interoperable services and technology, as well as a team of patient activation specialists, to help produce positive financial results and quality scores across strategic initiatives.

Reduction in Utilization and Admissions with Stable Steps Cohort

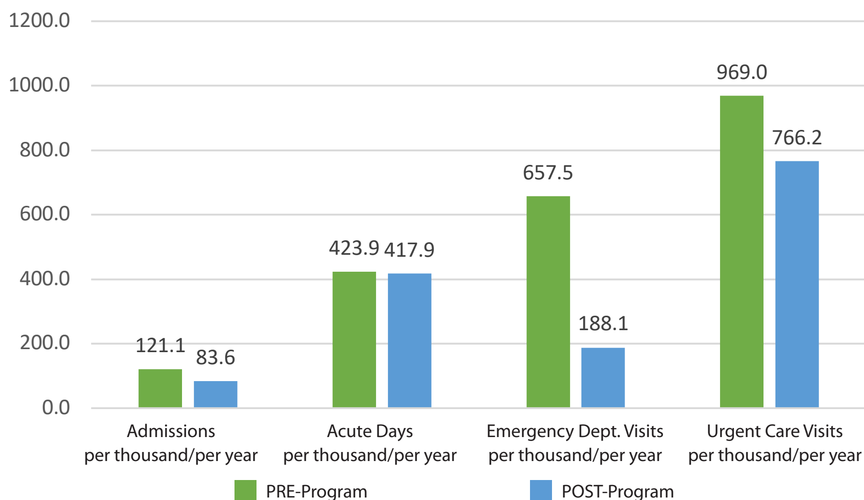

Fig. 1. In an analysis of 146 patients in Stable Steps, acute hospital admissions declined 31%, while ED visits dropped 71%. Patients in the cohort had an average age of 80 years, with an average of 11 conditions.

Fallen in Last Year

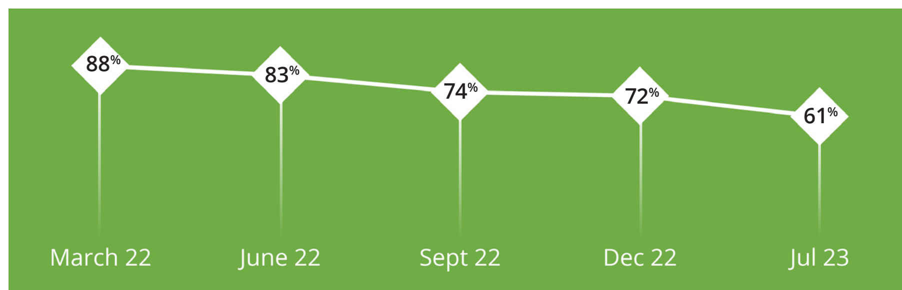

Fig. 2. The percentage of patients in the Stable Steps program who reported a fall in the last year has declined by 30%.

Results

The results of this collaboration have exceeded expectations. DOHC and Altura analyzed urgent care, ED, and inpatient claims data for 146 patients who actively participated in Stable Steps after receiving medical care due to a fall.

The analysis found a 71% reduction in ED visits after referral to the program *(See Figure 1)*. In addition, a patient-reported survey with 129 responses from the same population found that 81% felt the program helped prevent a subsequent fall, while a semiannual fall assessment showed a steady decline in falls *(See Figure 2)*.

Patient satisfaction has also exceeded expectations:

- Stable Steps has regularly garnered a net promoter score (NPS) in the mid- to high-70s.
- DOHC's fall-related Consumer Assessment of Healthcare Providers and Systems (CAHPS) score has risen significantly since the collaboration began.
- The CAHPS score for the Stable Steps cohort has exceeded the overall DOHC score by over 50%—helping DOHC to consistently exceed its target since the first quarter of 2022.

Finally, the program is sensitive to social determinants that may impact mobility and falls. For example, assessment data indicates our Hispanic patients are more concerned about falling, are open to more resources, and have fall-related medical conditions that vary from our general population.

Given the preliminary cost savings and positive patient satisfaction/NPS scores that lead to retention, Stable Steps has a positive return on investment—allowing for a sustainable program with room for expansion.

> "Prior to Stable Steps I rarely walked, and now I'm up to 30 minutes a day. The seated leg exercises really help."
> — *Stable Steps patient*

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Health Care LA, IPA

Health Care LA, IPA
A Mobile App—With Financial Incentives—Addresses Social Determinants of Health

Introduction

Health Care LA, IPA (HCLA) is a nonprofit network caring for underserved communities in Los Angeles County. HCLA patients often experience social determinants of health (SDOH) barriers—driving emergency department (ED) overuse and avoidance of preventive care.

To address these barriers, we partnered with a local hospital in downtown Los Angeles—with whom we have an existing shared risk agreement—to pilot a program using an app-based network called Samaritan. This app, available in select cities around the country, is a social network that helps people experiencing homelessness to meet their housing and life goals.

We used the app to connect high-risk patients experiencing homelessness, as well as patients overutilizing the ED, with direct financial and social supports to address SDOH barriers, lower ED utilization, and improve health outcomes.

Challenge

EDs are treating a greater proportion of patients with complex social needs.[1] There's a demonstrated relationship between SDOH and ED utilization, and patients experiencing homelessness often have substantial barriers to accessing health care that are further exacerbated by other SDOH.

HCLA's population has historically had high ED utilization rates. Despite trials of other interventions (ED navigators, real-time texting to patients, etc.), success in lowering these rates had been limited to patients anchored to our health centers. The Samaritan program created a positive, financial incentive for patients to engage with primary care and establish a connection with our health centers. Five HCLA health centers piloted the program as an enhancement to their current case management programs, leveraging existing staff and resources.

By supporting these members to address SDOH, we aimed to decrease costs for HCLA and our partner hospital, while improving quality of life for members.

Intervention

Primary care providers (PCPs) identify high ED utilizers and/or high-risk patients experiencing homelessness and offer them enrollment in the program. Members who agree to participate receive a Samaritan "smart wallet" from care team partners (who are similar to care managers or patient navigators). Members then create an account and/or public profile.

Care team partners use the Samaritan platform to understand members' social needs and identify mutually agreed upon steps to address those needs (e.g., complete bloodwork, visit their PCP, complete a job application, etc.). Members receive financial incentives once they complete each action step.

Through the public-facing app, members may also receive messages of encouragement and direct financial support from other community members on the Samaritan platform. They can use these donations to pay bills or buy clothes or work boots, for example. These two avenues offer patients greater social support and connection, while simultaneously incentivizing them to engage with primary or specialist care.

It is important to note that members decide what information is provided publicly. Those concerned about privacy may choose to use pseudonyms or not post anything to the public-facing app. For those members, financial incentives come solely from engaging with their care team.

Results

The program aimed to engage 200 members. Since April 2022, HCLA has enrolled 228 members and currently has 195 active members. Members remain in the program for up to 12 months or until they graduate—which occurs when they reach greater stability and improved SDOH.

Since piloting Samaritan, HCLA has documented improved clinical outcomes, member self-sufficiency, and health care engagement. To date, $101,082 (an average of $62.30 per member per month) has been provided to members for completing action steps and from community member donations. Outside of the financial support, community members have delivered more than 5,000 messages of encouragement to members through the Samaritan platform.

HCLA is a nonprofit network of 34 federally qualified health centers (FQHC) and community health centers that has been serving underserved patient communities in Los Angeles County since 1991. The network is managed by MedPOINT Management, a large management services organization (MSO). As of January 2023, HCLA serves over 720,000 Angelenos, virtually all of whom are enrolled in government programs such as Medi-Cal, Medicare, and Covered California. HCLA IPA is governed by a 15-member board of FQHC CEOs.

Based on SDOH assessments completed by members throughout the program, 68% of participants have measurably improved their quality of life—reporting better access to healthy food sources, improved emotional well-being, and increased monthly income.

The pilot has also led to measurable gains in members' health care utilization *(See Figure 1).* Early data shows:

- A 27% reduction in members with ED visits
- A 42% reduction in total ED visits
- An 11.7% increase in primary and specialty care utilization
- HCLA has realized a $14,552 (35%) reduction in total cost of care over the past year for actively enrolled members—an average of $1,325 per member.

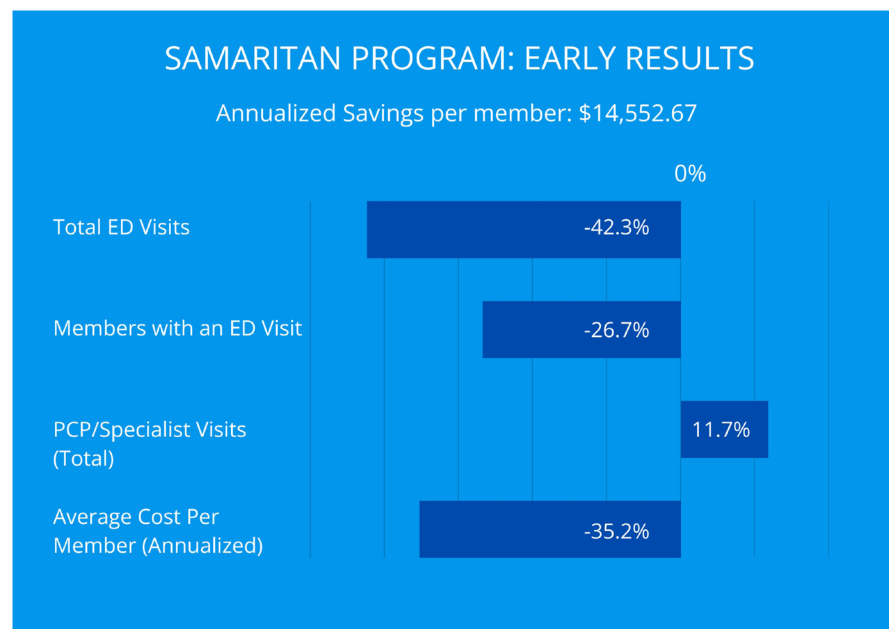

Fig. 1. The pilot program has led to measurable gains in members' health care utilization, including a 42% decrease in emergency department (ED) visits.

In terms of operational takeaways, we found that the program's scalability and sustainability is directly tied to whether an organization has a well-established care management team and process in place.

The ramp-up time was longer than expected—largely due to barriers in trying to implement something new with health centers that could not support it. Once we aligned with existing care management programs, implementation was swift. Member retention is in line with other case management programs—a challenge but not insurmountable.

The most significant challenge was making sure that stakeholders could connect the Samaritan data with their own utilization/claims data to understand outcomes. Samaritan has made critical updates to its application, such as capturing member health plan identification numbers, which support improved data connectivity. We're in the process of a larger program evaluation with the assistance of Kaiser Permanente's Center for Community Health and Evaluation—funded through a California Health Care Foundation grant—which will allow for a deeper impact analysis.

> This makes me feel like there's somebody out there who actually wants to help.
>
> — *Samaritan program patient*

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MSO of Puerto Rico
Empowering Value-Based Care Office Staff With Rewards and Education

Introduction

In 2007, MSO of Puerto Rico LLC created the Office Advantage Program as a strategy to help office staff at our independent primary care physician (PCP) practices adopt clinical, quality, and administrative initiatives. The program rewards staff for supporting our providers in value-based care, particularly for obtaining data in a timely and well-documented format. Offices are ranked by their participation and results, and financial incentives are awarded to staff each quarter.

In 2020, we decided to build on this program's success by establishing the Office Advantage Leadership Academy. A part of the Office Advantage Program, the Academy promotes continuing education and professional growth for physician office staff—specifically around supporting member experience and value-based care.

MSO Office Advantage Leadership Academy graduates

Challenge

Since its creation, the Office Advantage Program has been an effective way to improve the performance of our physician network—with 88% of PCP offices participating, representing 97% of our Medicare Advantage members. Participating offices have demonstrated higher raw quality scores than non-participants *(See Figure 1)* and better performance in key indicators such as annual health assessments and encounter submissions.

However, in this ever-changing health industry, we needed to look for new opportunities to retain office staff and provide them with tools for their development. Although financial rewards are important, it was imperative to create an educational program that fostered professional development and aligned with administrative workflows. This would help staff support the transformation of our practices and continually improve services to our members.

In October 2020, we created the Office Advantage Leadership Academy as a parallel program within the Office Advantage Program. Like the rewards program, the Academy aligns with the pillars of MSO's compensation model: quality and stars, technology adoption, patient experience, and population management.

Intervention

To enroll in the Academy, staff members must be active participants in the Office Advantage Program. Our first cohort was open to staff from offices with at least 100 MMM Healthcare active members. In October 2022, we expanded access to staff in offices with at least 50 MMM members. (MMM Healthcare is the largest Medicare Advantage insurer in Puerto Rico.)

In collaboration with a local university and MSO clinical leadership, we designed a robust curriculum that builds the knowledge and skills needed in value-based care. We targeted courses to patient experience, better care coordination, continuity and coordination of health services, maximization of resources, and improvement of key performance indicators. The Academy aimed to:

- Promote extraordinary care to patients and families
- Expand staff skills in MSO's technological tools
- Recognize staff for acquiring skills in patient experience, quality, and population management
- Emphasize the value of professional growth
- Demonstrate MSO's commitment to establishing an organizational culture that supports patients and staff

Courses were designed in a virtual format and are available to participants during the year they are enrolled. At the end of their Academy year and after completing 45 contact hours (each course is 1.5 to two hours), enrollees earn a university certificate and accumulate reward points that can be redeemed for gifts. Continuing education courses are also available so they can stay up to date with how health care evolves.

Founded in 2009, MSO of Puerto Rico LLC 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. We work with the largest Medicare Advantage (MA) insurer in Puerto Rico, MMM Healthcare. Our mission is to enable partners, clients, and providers to achieve better results through lasting, productive, professional partnerships. We currently manage 14 MMM Multiclinics and 22 IPAs, and have a contracted network of 1,300 PCPs and 800 specialists impacting more than 596,000 Medicare Advantage and Medicaid beneficiaries. MSO also owns two of the largest MA IPAs on the Island: Castellana Physician Services LLC and PHM Multihealth, with over 48,000 MA members and a network of more than 900 physicians.

Leadership Academy Courses

Quality & Stars	Patient Experience	Population Management	Technology Adoption
• Stars Expert Certificate* • Stars Methodology • Quality Audit	• Health Plan Benefits and Services* • The Power of Perception* • Sensibility* • Emotional Intelligence • Cultural Competence	• Population Management* • Coding & Documentation* • Social Determinants* • Care Management and Planning • Guaranteeing Access to the Primary Office • Mental Health Integration	• Compliance* • Microsoft Office (Excel & Teams*) *Mandatory courses*

Results

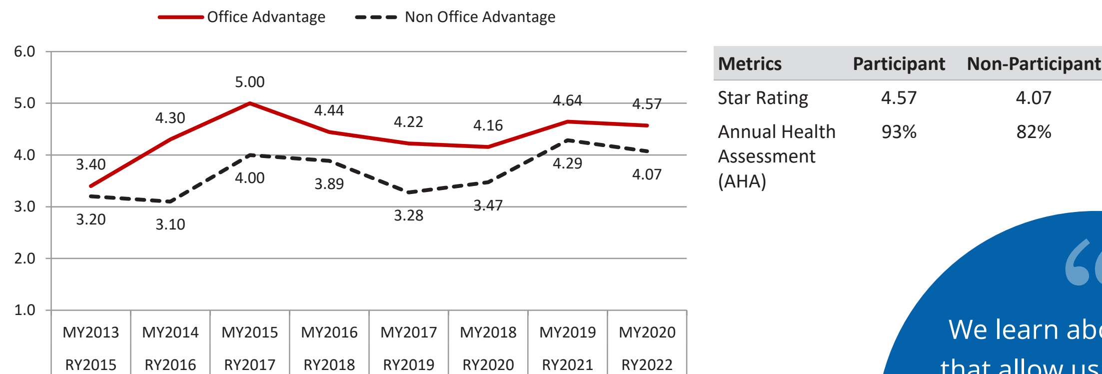
In the first two years of the Academy Program—2021-2022 and 2022-2023—600 administrative staff enrolled, and 522 graduated.

As we did with our original rewards program, we have observed better compliance performance from the offices of our Academy enrollees and graduates, versus offices that have not participated *(See Figure 2)*. Academy participants have also demonstrated:

- More engagement with patients, resulting in a better patient experience
- Improved technological knowledge, allowing them to be more efficient
- A greater commitment to the Office Advantage Program
- A better understanding of the metrics and key indicators used in the Office Advantage Program
- Better engagement and understanding of clinical programs

The Office Advantage Leadership Academy has improved our providers' performance by engaging the entire care team—office staff, providers, and MSO—while also promoting the professional growth of administrative staff. We have enhanced adoption of this program by providing needed tools, aligning outcome metrics, and allowing full transparency.

Overall Raw Quality Rating



Metrics	Participant	Non-Participant
Star Rating	4.57	4.07
Annual Health Assessment (AHA)	93%	82%

Fig. 1

> We learn about tools that allow us to better serve the patient.
>
> *— Myriam De Jesús, Office Advantage Leadership Academy participant*

Office Advantage Leadership Academy

Comparative Performance: Participants vs. Non-Participants

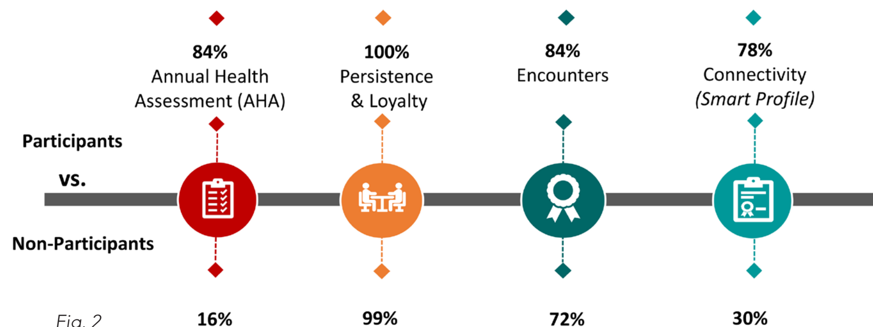


Fig. 2

Oak Street Health
Collaborative Care Model Integrates Behavioral Health Into Primary Care

Introduction

The vast majority of people today agree there is a mental health crisis in the U.S.[1] In 2019-2020, 21% of adults—equivalent to over 50 million Americans—experienced a mental illness. And yet, nearly one-third reported they were not able to receive the treatment they needed.[2]

This may be explained by the relatively low mental health workforce capacity in the U.S., and the fact that U.S. primary care practices are among the least prepared to manage patients with mental illness.[3] To address these challenges, Oak Street Health adopted a Collaborative Care Model (CoCM) for behavioral health in 2018.

Challenge

One challenge that drove us to adopt CoCM was that an external Medicare Advantage mental health provider network lacked the capacity to care for patients in our primary care centers. We quickly learned that we could not depend on external systems to provide timely, high-quality services to our vulnerable patient population.

Even when we were successful in referring patients externally, there was often a lack of integration and communication from these providers. Patients were not receiving high-quality mental health care—a requisite component of our Oak Street Health value-based care model.

Recruiting internal Oak Street Health therapists and psychiatric providers was also a challenge. With the increase in the prevalence of mental illness post-COVID and a therapist pool that has traditionally been limited to licensed clinical social workers (LCSWs) and psychologists in Medicare, it was difficult to provide timely, evidence-based psychotherapy embedded in primary care.

Concurrently, psychiatric providers are scarce and difficult to recruit in many of our underserved communities. With these roles difficult to fill and external referral options limited, we were unable to fully manage the mental health burden among the primary care population. A team- and consultation-based model was needed.

Intervention

The Collaborative Care Model is an evidence-based approach to behavioral health with universal screening and population-based evaluation of patient treatment-to-target goals. Our approach is based on the original IMPACT study,[4] which found that collaborative care more than doubled the effectiveness of depression treatment for older adults in primary care, compared to usual care.

CoCM embeds mental health professionals into primary care centers and encourages collaboration between the patient, primary care provider (PCP), behavioral health specialist, and telepsychiatric consultant to manage the patient's mental health and substance use concerns.

Oak Street Health implements this model through employing 74 behavioral health specialists (LCSWs), 12 telepsychiatry practitioners (psychiatrists or advanced practice nurse practitioners), and 615 PCPs (physicians, nurse practitioners, and physician assistants). Here's how it works:

- **PCPs** identify patients who may benefit from CoCM through universal screening for depression and substance abuse, as well as daily clinical interactions with their patient panel. They then initiate warm handoffs to the behavioral health specialists.
- **Behavioral health specialists** assess patients' mental and behavioral needs, support with case management, make referrals to other behavioral health resources and specialists, and provide brief, evidence-based psychotherapy (including problem-solving therapy, motivational interviewing, or behavioral activation) as indicated.
- **Telepsychiatry practitioners** provide recommendations (medication regimens, clarification of diagnosis, determining level of care, etc.) to the PCP and behavioral health specialist and act as direct providers of care to patients.

Oak Street Health is a network that currently consists of more than 180 value-based primary care clinics in 21 states across the United States. Our growing network includes 615 PCPs (physicians, nurse practitioners, and physician assistants), 74 behavioral health specialists (LCSWs), and 12 telepsychiatry practitioners (psychiatrists or advanced practice nurse practitioners). Together, we serve more than 225,000 Medicare beneficiaries (42% of which are dually eligible for Medicaid), with an average age of 68 years and an average annual income of approximately $17,500. Over 58% of patients identify as African American, Hispanic/Latino, or Indigenous. Over 40% of our patients are identified as having a mental health illness.

The CoCM team shares a defined group of patients, for whom clinical outcomes are tracked within a shared registry. The team can monitor and reach out to patients who are not improving and provide caseload-focused consultation, rather than ad-hoc advice alone.

Results

In 2022, we screened 98% of our patients (171,330) for depression and 88% (169,415) for substance abuse. Among those referred for behavioral health treatment, 65% have enrolled in the behavioral health program, with two-thirds of those patients completing at least six weeks of treatment.

In addition, 13% of patients who tested positive for substance abuse enrolled in treatment, compared with 11% nationally.

Mental health outcomes of patients in the program have improved quickly and consistently *(See Figure 1)*:

- 53% of patients who engaged with CoCM had a five point or greater reduction in PHQ-9 scores (a measurement of depression severity) within six weeks of enrollment.
- 44% of patients showed a 50% or more reduction in PHQ-9 scores after 24 weeks.

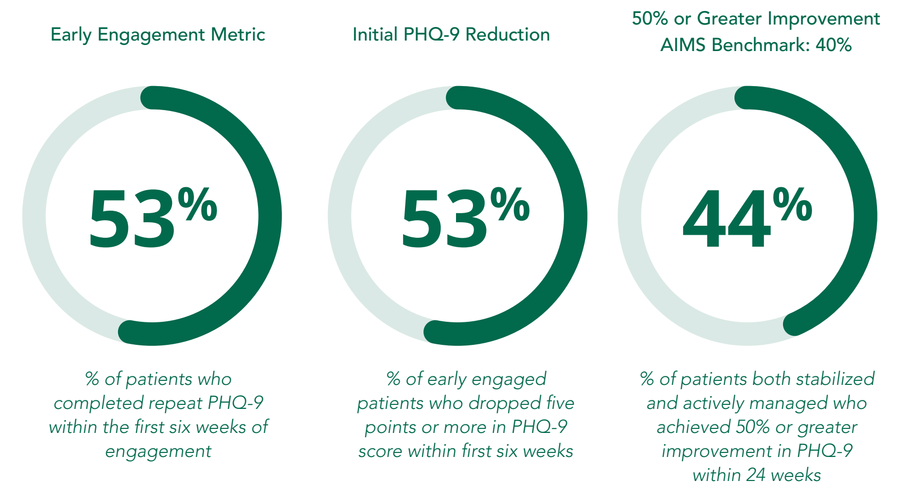


Fig. 1. Nearly half of patients showed a 50% or more reduction in PHQ-9 scores after 24 weeks in the program, exceeding the 40% benchmark from the University of Washington Advancing Integrated Mental Health Solutions (AIMS) Center (based on the IMPACT study).[5]

An initial pre/post quasi-experimental evaluation also suggests that enrolled patients showed a 69% reduction in emergency department utilization, when evaluated eight months after CoCM enrollment.

Through implementing CoCM, we have become aware that many patients have complex symptom presentations, including severe mental illness and multiple diagnoses. As our ability to refer out for specialized care remains hindered due to a lack of this care in the communities we serve, our next steps for this program include scaling our cohort of behavioral health specialists, providing more targeted care for patients with severe mental illness and substance use disorders, and evaluating the health equity implications of our intervention.

> "When I came in, I was really sad … [Now] I feel that I'm thriving, and I had never had that before."
>
> *— Joy, Oak Street Health CoCM patient*

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Optum Washington – The Everett Clinic
Engaging Surgeons and Specialists to Develop High-Value Care

Introduction

Health care costs continue to rise at unsustainable levels, leading to an increased focus on value-based care. However, most value-based care efforts have centered on primary care—even though subspecialty office-based care accounts for the highest office-based spending costs. As a result, surgeons and specialists find themselves unsure of how they fit into this changing paradigm. They often lack participation in creating new care models and can develop concerns that value-based care is detrimental to their practices.

Optum Washington designed a program that engaged our employed surgeons and specialists to develop high-value care practices that would improve quality of care and reduce unnecessary health care costs.

Senior leaders from The Everett Clinic with local elected officials at the opening of the clinic's Arlington, Washington, location

Challenge

Optum Washington has two large multispecialty groups: The Everett Clinic and The Polyclinic. Both care delivery organizations have a significant volume of fee-for-service and value-based care arrangements. We have optimized many areas of patient care and excelled in high-value care because of a culture of continuous quality improvement and coordinated care among our primary care team and specialists.

Nonetheless, many of our value-based quality interventions have been focused within primary care. It has been much more difficult to develop programs that encourage high-value care once patients end up in a specialty or surgical department. The interventions we have seen in some other organizations were more punitive with referral management, but this can lead to disengaged specialists and surgeons.

Our challenge was to develop a program that incentivized specialists and surgeons to optimize and increase high-value care in a setting where they have both fee-for-service and value-based patient arrangements.

Intervention

Some industry attempts to engage surgeons and specialists in value-based care have involved top-down interventions, which can encounter resistance or poor buy-in.[1] We decided to take a different approach—empowering surgeons and specialists themselves to lead the development of high-value care, as part of a focused intervention at our Everett Clinic.

We asked each surgical and specialty area at The Everett Clinic to develop department-specific quality projects that improved high-value care. The projects would:

- Take place over one year
- Involve all clinicians in the department
- Have defined goal metrics—which, if met, would result in a 5% quality incentive being added to the pay of every clinician in the department

By creating a financial incentive, surgeons and specialists felt compensated for their additional work in value-based care. Having the projects developed within the departments increased engagement and empowered local subject matter experts, who are best-positioned to identify specialty-specific areas for care improvement.

The incentive was "all or nothing" for each department. As a result, clinicians readily tracked the performance of their fellow department members to ensure everyone was achieving the expected results. Departments were required to report quarterly not only to the organization, but also to all other department members. This real-time transparent data helped guide performance.

Results

The Orthopedics department focused on reducing viscosupplementation injections, which involve injecting a gel-like fluid called hyaluronic acid (HA) into

The Everett Clinic was founded in 1924. We're a nationally recognized physician group known for offering high-quality health care services while lowering the overall cost of care. The Everett Clinic operates 30 care sites throughout King, Pierce, Skagit, and Snohomish counties and includes approximately 200 surgeons and specialists. Together, we care for more than 330,000 patients, including more than 24,000 lives in value-based care. The Everett Clinic joined Optum in 2019. Optum is a nationwide family of doctors dedicated to connecting every aspect of health and health care and making it simpler.

Cost Savings in Viscosupplementation Use, 2020-2022

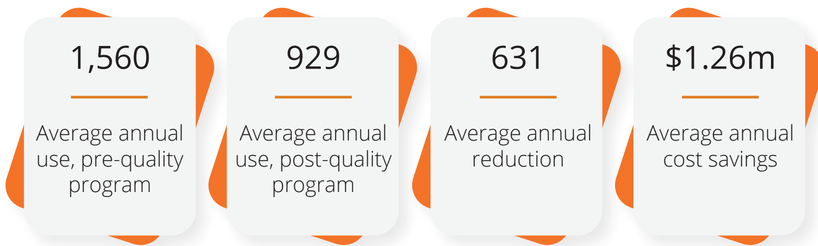

Fig. 1

Reduction in Emergency Room Visits for Acute Back Pain

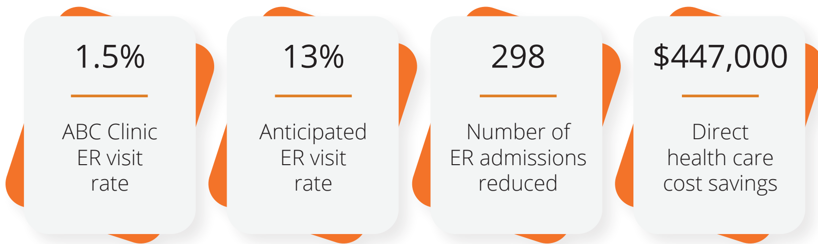

Fig. 2

the knee joint. The American Academy of Orthopaedic Surgeons does not recommend routine HA injections for knee pain related to osteoarthritis,[2] as recent research has not found them effective at significantly reducing pain or improving function.[3,4]

The Orthopedics team set a goal that department members follow the accepted indications for HA injections 90% of the time. Retrospective chart reviews found that the group exceeded its goal—adopting this evidence-based pathway 95% of the time.

Prior to the project, from 2016-2019, the clinic's average viscosupplementation utilization was 1,560 per year (1,349-1,692). After the project, utilization fell 54% to an average of 849 injections per year for 2020-2021. In 2022, even though the quality program had concluded, utilization continued to be 30% lower than the pre-program average.

Based on an average cost of $2,000 per injection, the intervention resulted in an average annual savings of $1.26 million in health care costs between 2020 and 2022. *(See Figure 1.)*

Meanwhile, the Physiatry department developed an acute back pain clinic (ABC Clinic) to reduce predicted emergency room (ER) visits for back pain. The goal was to ensure that patients who had been seen in our acute care facilities were contacted within one business day and offered a clinic appointment within one week.

A nurse practitioner was hired and trained on acute back pain management and protocols by our physiatrists. Between September 2020 and September 2022, the clinic received 2,590 referrals—contacting 98% of patients within one business day of the referral and offering 97% an appointment within one week.

Based on a retrospective chart review, the rate of ER visits in those referred to the clinic was 1.5%, compared with an anticipated 13% or higher rate seen in the literature. The ABC Clinic resulted in 298 fewer patients presenting to the ER for acute lower back pain than anticipated. Given an average cost of $1,500 for an ER visit for low back pain, we calculated $447,000 in direct health care cost savings *(See Figure 2)*.

To help sustain improvements, we now receive regular quality reports on our surgeons and specialists, including viscosupplementation rates for our orthopedic surgeons and ABC Clinic results for physiatrists. Our surgeons and referring primary care physicians will have ongoing visibility to the metrics to ensure continued high-value care performance.

> "Having the projects developed within the departments increased engagement and empowered local subject matter experts."

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Sharp Rees-Stealy Clinics Take a New Approach to Case Management—and Improve Quality Outcomes

Introduction

Created during the pandemic, our innovative Population Health Clinics have fundamentally changed our approach to case management. The clinics provide our medical group with primary care support using embedded RN case managers. These case managers focus on achieving blood pressure control in patients with hypertension and hemoglobin A1C (HbA1C) control for those with diabetes—as well as on closing gaps in care (discrepancies between recommended best practices and the care patients actually receive).

The program's success and sustainability have allowed Sharp Rees-Stealy to surpass our goals around blood pressure and diabetes control, which reduces the risk of heart attack and stroke for our patients.

Challenge

Sharp Rees-Stealy responded quickly to COVID-19 lockdowns, as we saw worsening patient conditions and growing gaps in care. After assessing patients' perceived barriers to care, we developed a pilot Population Health case management clinic. The program was created in collaboration with our medical director, primary care physicians, and senior leadership.

We invited patients to come to the clinic to meet with an RN nurse case manager (CCM) to close gaps in care—without any copay or charge. Our population is 70% HMO, so not charging a fee makes patients much more willing to come for this kind of visit.

Because this was started during the pandemic, patients could choose to be seen in their car or in outdoor sitting areas, or have a telemedicine visit with our CCM. They could also receive a blood pressure cuff for at-home monitoring. These clinics served to provide access and alleviate fears and anxieties in receiving safe care. We also involved patient caregivers, family, and support systems—encouraging them to attend clinic visits and speak to the CCMs to further foster ongoing care.

Left: Nurses and physicians at a Population Health Clinic

Intervention

We adapted our CCM role so that these RN nurse case managers worked in the Population Health Clinics one day per week at their assigned site. This gave our overall clinical sites two days a week when Population Health visits could be scheduled.

The CCMs were the key to this initiative. We specifically wanted to tap into their expertise and skills for engagement—particularly in motivational interviewing, as well as in identifying and responding to patients' ideas and emotions and moving them toward their health goals.

The team collaborated with physicians and clinic staff to develop guidelines and processes, as well as obtain buy-in and enthusiasm for the clinics. Evidence-based guidelines were the foundation for the project and for the protocols for managing elevated blood pressure and HbA1C. CCMs brought any escalations to physicians in real time, working with site care teams.

The initiative began as a pilot at one site, which quickly became two, at the clinics most in need. We involved our data team from the start, designing lists to identify appropriate patients. We also created in-process metrics that were reported out each week, enabling us to track our progress and make changes.

Population Health's nonclinical staff and community health workers took on the outreach and scheduling. Patients easily acquired appointments with our CCMs—often on the same day—greatly improving access. A full site rollout followed in 2021.

Results

Although the pandemic has passed, our Population Health Clinics continue on, stronger than ever. They have proven not only effective, but also sustainable.

For example:

Sharp Rees-Stealy is part of Sharp Healthcare, an integrated, not-for-profit delivery system. We are a foundation model, multispecialty medical group with 607 primary and specialty care physicians and mid-level providers. We serve 3 million residents in San Diego County, California, with 228,000 member lives—including 154,000 commercial, 29,000 Medicare Advantage, and 12,500 ACO lives. Our revenue is 70% prepaid HMO capitated and 30% PPO and fee-for-service. Members can receive on-site laboratory, radiology, physical therapy, and pharmacy services at most of our 15 clinic locations.

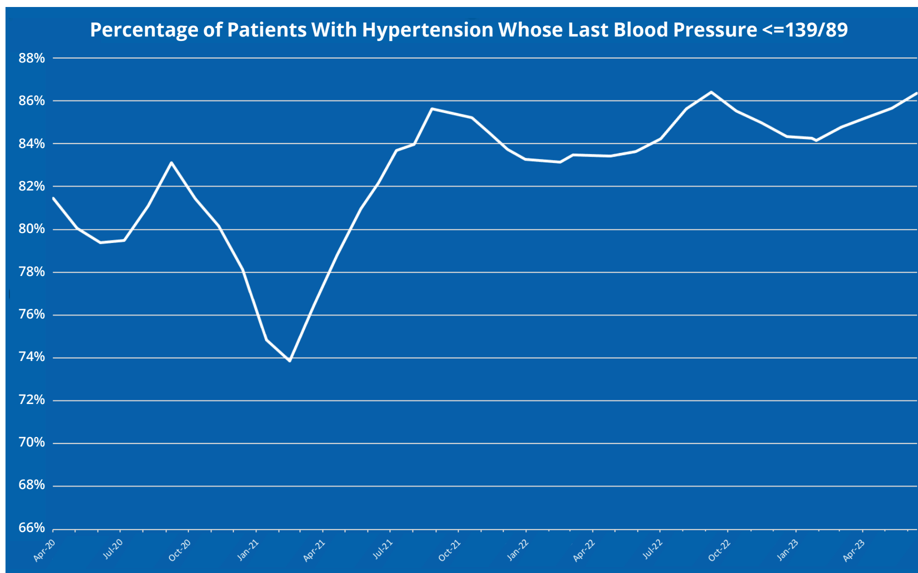

Fig. 1. From the start of the clinics in April 2020, the percentage of patients with hypertension achieving blood pressure control rose from 81% to 86% in June 2023—exceeding our goal of 85%. The drop in compliance in late 2020 to early 2021 coincided with the height of the pandemic in Southern California.

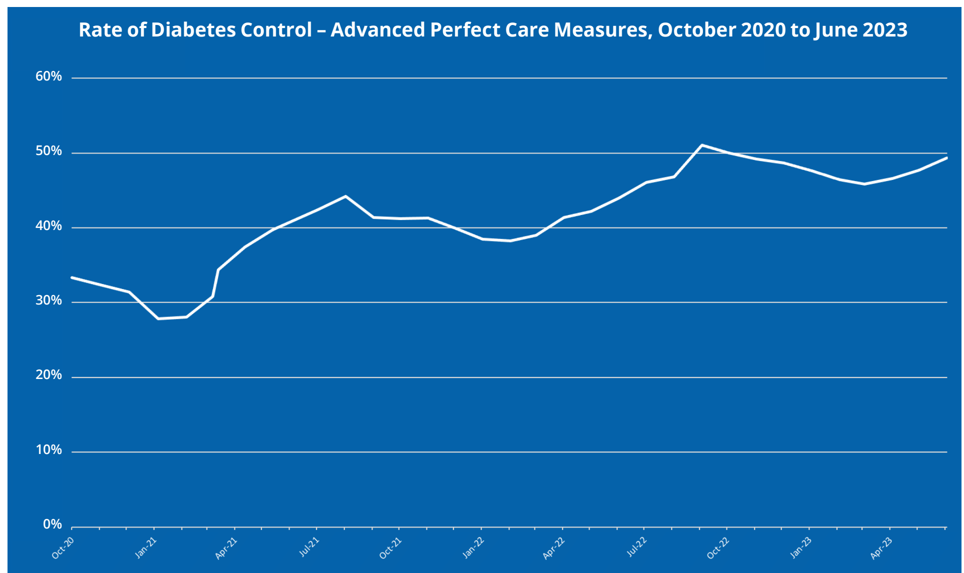

Fig. 2. Diabetes control, as indicated by Advanced Perfect Care (APC) measures, rose from 33% in 2020 to 49% in June 2023. Chart shows the percentage of patients with diabetes who achieved an A1C <8, blood pressure <140/90, and compliance with kidney health evaluations, eye exams, and statin medication.

- **Blood pressure control** in hypertensive patients rose from 81% in April 2020 to 86% in June 2023 *(See Figure 1)*.
- **Diabetes compliance**—including HbA1C, blood pressure control, and RetinaVue eye exams—increased from 33% in October 2020 to 49% in June 2023 *(See Figure 2)*.
- **Total clinic nurse visits** jumped from 418 in 2020 to 2,200 in 2022. We expect to reach 4,400 visits for 2023.

We implemented the program to ensure quality care, not to obtain a return on investment (ROI). However, by exceeding our goals around blood pressure and diabetes control, we are reducing the risk of heart attack and stroke for our patients. This will be reflected over time in our ROI.

One key learning was that this clinic setup was a big change for our CCMs, who had been exclusively working from home during the pandemic. It took about a year for the team to truly buy in to working at the sites one day a week to focus on care gaps—when many of the scheduled patients were not part of their caseloads. In response, we adjusted CCM caseloads and implemented process changes. Site staff also were initially confused about this new role, and CCMs were often asked to perform duties not within the program's scope. A lot of reinforcement—in the form of ongoing education to site staff and leaders—was needed.

Finally, while workforce shortages are impacting many in health care, our Population Health team has not experienced this issue. Our nurses have the flexibility to work from home four days a week, and they like the work they do with patients. Most importantly, our patients trust them. By bringing the CCM team to our sites, our nurses have been able to share their knowledge and their approach to managing our patients' health. This has driven improved clinical quality.

> "I feel like a weight has been lifted off my shoulders after I do these appointments."
>
> *— Population Health Clinic patient*

UCLA Health
Kidney Medical Home: A Model for Specialty Value-Based Care

Introduction

UCLA Health data shows that end-stage kidney disease (ESKD) is one of the highest costing medical conditions, with an annual cost of approximately $100,000 per patient. Delaying the onset of ESKD and managing ESKD care in a cost-efficient manner are important factors for success in value-based care.

UCLA Health has applied a medical home model to specialty care to achieve the goals of value-based care. This Kidney Care Medical Home incorporates team-based care with nurses, social workers, and care coordinators who work alongside physicians to support patients in avoiding unnecessary utilization, enhancing quality, and improving patient experience. The model integrates primary care with specialty care.

Challenge

Kidney care is a high-priority area for population health. Kidney disease affects 1 in 7 adults in the U.S.—with an estimated annual cost of $24,000 for treating each Medicare beneficiary with chronic kidney disease (CKD), and $86,000 for each beneficiary with ESKD.[1] The condition also has a high human cost. Patients with ESKD live 25-30 years less than their healthy counterparts.[2]

ESKD is irreversible kidney failure, and individuals need dialysis or a kidney transplant to survive. One option is peritoneal dialysis, a type of dialysis that can be performed at home. This offers greater convenience and lower costs.[3] *(See Figure 1.)* Yet, the national rate of peritoneal dialysis was only 13.4% in 2020,[4,5,6] indicating a significant opportunity for placing more patients on this modality.

Our Kidney Medical Home Program seeks to increase the number of eligible patients placed on peritoneal dialysis over in-center hemodialysis, as well as prevent avoidable hospitalizations and emergency department (ED) visits. This is important because hospitalization rates are high in patients with CKD (35.0 per 100 person years), and hospitalized patients have a high risk of complications.[7]

Modality	Location	Annual Medicare Payments per Beneficiary	Cost per Quality Adjusted Life Year (QALY)
Peritoneal Dialysis	Can be done at home	$91,000[3]	$87,000[5]
Hemodialysis	Must be done in a dialysis center	$109,000[3]	$109,000[3]

Fig. 1

Intervention

UCLA Health has participated in the Centers for Medicare & Medicaid Services (CMS) Kidney Care First voluntary alternative payment model since the model began in 2022. Using this as a catalyst, we established a transformational "design team" to launch a redesign of our kidney care. The team included primary care physicians, nephrologists, and experts in clinical operations, IT, quality, ambulatory care management, and population health management.

The resulting Kidney Medical Home program is broad in scope and ranges from early diagnosis of CKD to ESKD. It has five features:

1. Early identification and referral of primary care patients with CKD
2. Identification of high-risk patients using a UCLA-developed AI/machine learning predictive model (launched in August 2023)
3. A custom decision-support tool in the electronic health record to prompt nephrologists to prescribe sodium-glucose cotransporter-2 (SGLT2) inhibitors to slow disease progression
4. A complex care management program for patients with both CKD and heart failure. This includes remote patient monitoring and an RN care manager to prevent avoidable hospitalizations and ED visits.
5. A patient education and shared decision-making program to elicit patient values, goals, and preferences

For patients with ESKD, we use a transplant-first approach over dialysis. For those going on dialysis, our program helps patients choose the modality of dialysis that matches their preferences. The UCLA Health Kidney Medical Home also incorporates a whole-person care model that screens patients for depression and engages them in their own care through patient activation.

UCLA Health is among the most comprehensive and advanced health care systems in the world. Our mission is to provide state-of-the-art patient care, generate research discoveries leading to new treatments and diagnoses, and train future generations of health care professionals. We offer a comprehensive network of primary and specialty care services at more than 260 clinics throughout Southern California and at four world-class medical centers. Approximately 43% of our patients are attributed to a value-based risk contract. Year-over-year, UCLA Health has experienced a 21% increase in patients tied to value-based care across risk-based arrangements—including Medicare Advantage, commercial accountable care organization models, and other governmental and commercial alternative payment models.

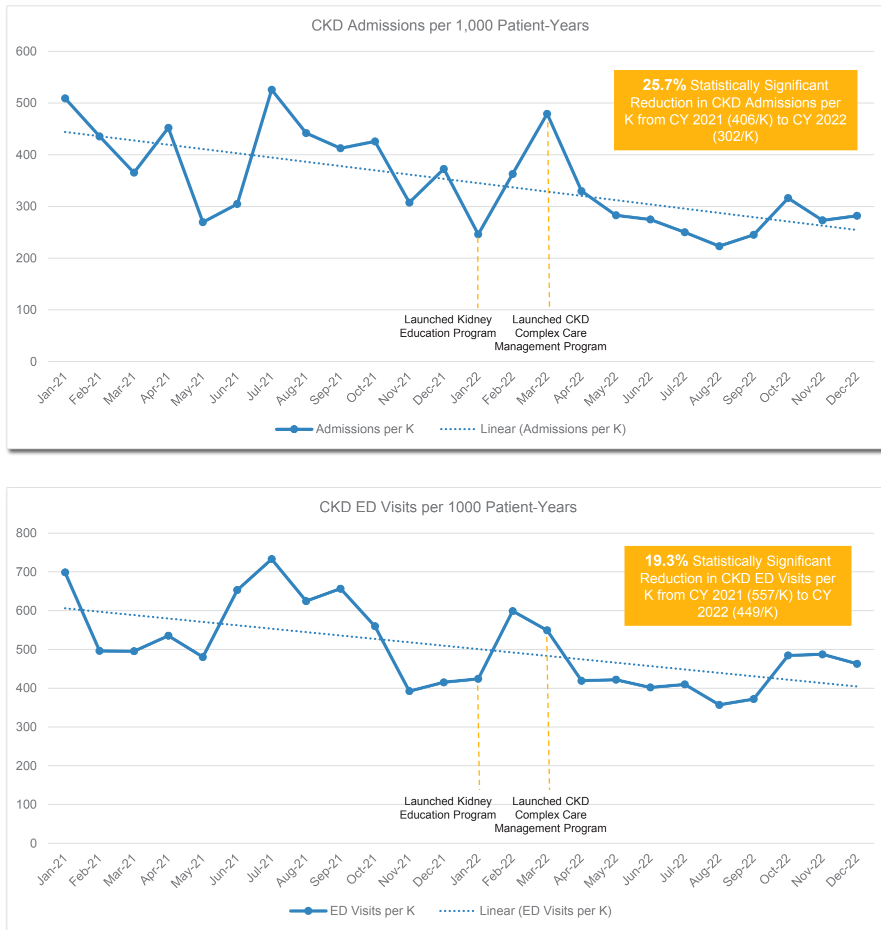

Fig. 2. UCLA Health saw a 25.7% decrease in hospital admissions and a 19.3% reduction in emergency department visits from January 2021 through December 2022.

Results

Since its inception in January 2022, the UCLA Health Kidney Medical Home education program has enrolled 206 patients. Among patients in the ESKD education and shared decision-making program, 64% have chosen home dialysis (instead of in-center hemodialysis) or kidney transplant.

If these patients are placed on peritoneal dialysis by their physicians, it would represent a considerable increase in peritoneal dialysis over our current rate of 11%. This has the potential to decrease costs by up to $2 million per year for our patient population, while enhancing quality of life and improving survival.

Our complex care management program for patients with CKD and heart failure began in March 2022 and has enrolled 31 patients. And since launching our Kidney Medical Home, we have seen the following statistically significant results for patients with CKD, compared with the prior year *(See Figure 2)*:

- A 25.7% decrease in hospital admissions
- A 19.3% reduction in ED visits

Patients and physicians have also expressed strong satisfaction from participating in this program.

While this is early data and we expect to have more complete data over time, the UCLA Health Kidney Medical Home has served as a model for developing the capabilities and infrastructure to manage other high-cost clinical conditions. These programs have helped us achieve success in the CMS Kidney Care First program. In our first year, we achieved a net increase in revenue over fee-for-service revenue in prior years.

> "Since launching the program, we have seen a 25.7% decrease in hospital admissions and a 19.3% reduction in ED visits."

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