# AMERICA'S PHYSICIAN GROUPS =



CASE STUDIES NEXCELLENCE

2018



Welcome to America's Physician Groups' Case Studies in Excellence 2018, which highlights the work of selected physician organizations that are pushing the limits and exceeding expectations when it comes to quality of care. These seven examples show what risk-based coordinated care is all about: improving systems to drive better quality and a better care experience for patients.

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

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

More than 120 physician groups across the country responded to this year's survey, and 71 percent of these participants received the coveted Elite SOE® status. That is an increase of almost 10 percentage points compared with last year's survey, and it speaks to our members' unrelenting pursuit of quality in delivering healthcare.

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

I encourage you to participate in the  $13^{th}$  annual Standards of Excellence<sup>TM</sup> survey, which takes place in spring 2019. Either for the first time or as a returning participant, you will gain a clear picture of your organization's capabilities and competencies on the path to risk-based arrangements.

Meanwhile, I hope that you will enjoy—and gain valuable insight from—APG's Case Studies in Excellence 2018. I know that I personally am impressed by how our members' commitment to quality, coupled with innovative thinking, can result in major improvements in coordinated care delivery and patient outcomes.

Thank you to all our contributors for sharing your ideas and experience with us.

Don Crane President and CEO America's Physician Groups

## Message From APG's CMO

It's been nearly two years since the Medicare Access and CHIP Reauthorization Act (MACRA) was implemented in January 2017. And at America's Physician Groups, our members continue to succeed with risk-based models of accountable, coordinated care.

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

In this 2018 edition of *Case Studies in Excellence*, we showcase seven APG organizational members who are excelling at delivering integrated care while meeting the challenges of the quadruple aim. Their stories of coordinated and patient-centric care are compelling—and show how they are using innovative delivery models to optimize care to patients.

In these pages, you'll learn how our physician groups are:

- Improving quality and moving into value-based care at a large, multicenter, ambulatory, and inpatient system that was historically embedded in a fee-for-service payment model.
- Creating a fully employed clinical model that brings an intensive, 24-hour house call practice to the sickest and frailest patients.
- Using a proprietary suite of web-based applications to help manage the health of Medicare patients—and reduce rehospitalizations.
- Bridging volume and value models by changing the approach to primary care and developing key competencies in population health.
- Creating high-touch programs to support high-risk patients—while lowering costs, hospital readmissions, and days spent in skilled nursing facilities.
- Rapidly transforming a new Medicare market through patient-centered medical homes, nurse care managers, and provider engagement.
- Closing 20 percent more Medicaid care gaps—in one year—through leadership, technology, and quality improvement.

Sharing these stories is just one more way that APG is working to support physician groups in improving the quality and value of healthcare for patients. It is my sincere hope that you find *Case Studies in Excellence 2018* both valuable and informative—and that our members' stories will help inspire you to transform your own organization's delivery of care.

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



"SEEING SO MANY OF OUR MEMBERS RECEIVE THE HIGHLY COVETED ELITE STATUS CONFIRMS WHAT WE KNOW—PHYSICIAN GROUPS ACROSS THE COUNTRY ARE LEADERS IN THE ONGOING VALUE MOVEMENT."

—Amy Nguyen Howell, MD, Chief Medical Officer, APG

Earlier this year, America's Physician Groups announced the results of its 2018 Standards of Excellence<sup>TM</sup> (SOE®) member survey. This rigorous, voluntary self-assessment documents APG members' coordinated care infrastructure and preparedness—setting a bar for consumers to evaluate the quality and value of their healthcare delivery.

The 12<sup>th</sup> annual SOE® survey was offered to more than 300 APG members in 43 states, the District of Columbia, and Puerto Rico—with 122 medical groups, health systems, and independent practice associations (IPAs) participating. In all, these groups cover 12.9 million commercial lives, 3.2 million Medicare Advantage lives, and 3.7 million Medicaid lives.



APG's Clinical Quality Leadership Committee analyzes the survey performance each year, adding new measures for technical quality, responsive patient experience, and affordability. This year included continued enhancements based on regulatory changes with the Medicare Access and CHIP Reauthorization Act (MACRA) and critical additions for pediatric populations. The changes reflect the rising standards and expectations of purchasers, payers, and government agencies and elevate the survey to the performance level reflected by our members.

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

The 2018 Standards of Excellence™ is composed of the following domains, with the first five publicly reported:

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

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

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

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

#### Domain 5—Group Support of Advanced Primary Care:

Patient-centered medical home model and its use in revitalizing the discipline of primary care

### Domain 6—Administrative and Financial Capability:

Management of complex relationships, diverse revenue streams, innovative payment alignment, and risk-based payments



Physician groups that reach the quality threshold in each domain are awarded a "star." Groups achieving a star in all five publicly reported domains are designated as Elite.

In 2018, 71 percent of SOE® participants achieved the Elite designation and were recognized at the APG Colloquium in Washington, DC.

The Star achievement levels are:

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

For more information on the SOE  $^{\! \otimes}$  program and results, visit www.apg.org/soe.



## **Bringing Back Intensive House Calls**

"THESE PEOPLE ARE LIKE A TRAVELING EMERGENCY ROOM. THEY COME DAY OR NIGHT—
WHENEVER I NEED THEM. THEY ARE HELPING ME NOT GO TO THE HOSPITAL AS MUCH."

---Landmark patient

#### INTRODUCTION

The sickest and frailest patients typically have mobility limitations, as well as challenging social and behavioral determinants of health. As a result, they are often unable to make it to their doctors' offices, and they utilize the emergency department as their main source of primary care.

To meet this need, Landmark Health—a physician-led, multidisciplinary, risk-bearing mobile medical group—created a fully employed clinical model that brings back an intensive house call practice. The goal: provide comprehensive and coordinated care to the highest-utilizing patients right in their homes, 24 hours a day.

#### **CHALLENGE**

The average Landmark patient is 78 years old, has eight chronic conditions, and takes more than 12 medications. About half struggle with social and behavioral comorbidities that are frequently unaddressed. These socially isolated patients manage only 2.5 primary care office visits per year.

When they do get to the office, the traditional healthcare system's constraints often limit the ability to fully care for their multiple conditions or to adequately address advanced care planning, palliative services, and end-of-life care. The results are very high emergency department and hospital admission rates—and needless suffering for patients and their families.

#### INTERVENTION

Landmark's clinical model features four pillars designed to directly address the most pressing challenges facing these highly vulnerable patients:

 Complexivist<sup>™</sup> Care. Landmark provides high-touch, high-intensity care for patients in their homes, 24/7.
 We treat patients both proactively and urgently, and we educate them and their families. Home visits occur monthly on average but can be daily or weekly for those with the highest acuity. This customized in-home care



helps avoid unnecessary emergency department visits and hospitalizations. Care includes:

- Real-time blood draws
- IV catheter insertions
- Administration of IV fluids and medications
- Foley catheter insertions
- Wound care
- Minor procedures

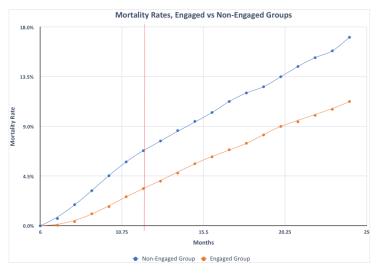
Visits from interdisciplinary and behavioral health team members average another three touches per month. This ensures health literacy and vigilant surveillance of medical, behavioral, and social determinants of health to address exacerbations earlier—when they are more easily treated.

In addition, our pharmacist plays a crucial role in training the team in optimal medication reconciliation, assisting with de-prescribing, and notifying providers about adverse drug reactions, cost-effective alternatives, medication assistance programs, and medications to avoid in specific patient populations.

- Behavioral Health. We employ our own dedicated behavioral health team, including psychiatrists, addictionologists, psychiatric advanced practice providers, and social workers. Landmark uses a proprietary and mandatory Behavioral Health Risk Assessment Tool to screen all patients for mood disorders, psychosis, dementia, and alcohol and substance use disorders. Meanwhile, our social workers identify social determinants of health and leverage community and plan partner resources to holistically address them.
- Palliative Focus. We are highly skilled at advanced care planning, palliative care, and early and appropriate hospice utilization. All clinicians undergo intensive training on how to have challenging conversations with







MEASURE	PRE- LANDMARK PROGRAM	POST- LANDMARK PROGRAM
Controlling High Blood Pressure – Cardiovascular	4 stars (71%)	5 stars (91%)
Nephropathy Screening – Diabetes	1 star (88%)	5 stars (98%)
HbA1C Controlled < 9	3 stars (66%)	5 stars (87%)
Retinal Exam – Diabetes	3 stars (70%)	5 stars (82%)
Adult BMI Assessment	3 stars (85%)	5 stars (99%)
PHQ-9 Annual Screening	85%	92%
Member Satisfaction	75%	97%

patients and families, introduce palliative and hospice care, and document patients' therapy goals.

They are also trained in aggressive palliative symptom treatment and hospice eligibility criteria. Local hospice medical directors are invited to attend our weekly in-person interdisciplinary team meetings to reinforce hospice awareness and accept real-time referrals.

 Risk-Based Financial Model. Landmark enters into total cost of care risk contracts with health plans. We are paid a per member, per month amount to care for the identified cohort—allowing for investment into comprehensive teams, proactive care, and around-the-clock availability.

If net savings are not generated on the cohort, Landmark reimburses downside risk—holding the health plan harmless from a financial standpoint. This aligns incentives to provide the highest-quality and most cost-effective care.

#### **RESULTS**

- Reduction in admissions. A propensity matched cohort
  analysis demonstrated a 28 percent reduction in Medicare
  Advantage hospital admissions for Landmark patients.
  And our ability to see patients in their homes within 72
  hours of hospital discharge—to ensure they are stable
  and the discharge plan is effective—has resulted in up
  to a 32 percent reduction in the 30-day all-cause hospital
  readmission rate.
- Lower medical loss ratio (MLR). The Landmark eligible cohort has a historical Medicare Part C medical loss

ratio of over 100 percent. Through intensive in-home interventions to avoid hospitalizations, as well as a focus on reducing unnecessary spend in pharmacy, home health, specialists, and end-of-life costs, Landmark decreased MLR for both engaged and non-engaged patients. By the program's third year, MLR fell to less than 80 percent.

- Improved quality. By bringing care and testing to the home, we have demonstrated significant improvement on HEDIS and Stars quality metrics for engaged patients with contracted partner health plans.
- Lower mortality. By treating patients earlier, avoiding unnecessary hospitalizations, and leveraging early and appropriate palliative and hospice services, we demonstrated a measurable impact on mortality.
   Compared with similarly matched non-engaged patients, mortality rates for Landmark patients were 50.5 percent lower at 12 months and 34.1 percent lower two years post-engagement.
- Higher patient satisfaction. Our Net Promoter Score (NPS) has been 90 or greater for three years running. In our most mature markets, health plan retention rates are 10 times higher for Landmark patients than typical Medicare Advantage members—suggesting they stay with the plan to retain our services.

The bottom line? Receiving essentially no-cost "concierge-level" care 24/7 is tremendously satisfying for patients and their caregivers. "If I call at 2 in the morning, I know that Landmark is there for me," one patient explains. "It's very reassuring."

#### **WHO WE ARE**

Founded in 2013, LANDMARK HEALTH partners with health plans to provide intensive 24/7 in-home medical care to the sickest and frailest patients across multiple lines of business, including Medicare Advantage, Medicaid, dually eligible, and commercial. We contract with 12 health plans across 24 markets and manage total cost of care risk on about 77,000 complex, chronically ill patients.

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