AMERICA'S PHYSICIAN GROUPS







CASE STUDIES IN EXCELLENCE

2018

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President's Introduction

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™ (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 13th annual Standards of Excellence™ 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

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

> "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™ (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 12th 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® program and results, visit www.apg.org/soe.

Closing Care Gaps With Technology, People, and Process

> "WHEN THE REPRESENTATIVE CALLED ME, I THOUGHT, 'THANK GOD! SOMEONE IS CALLING TO HELP ME WITH IDEAS FOR MANAGING MY DIABETES.'"
>
> *—Teresa, Vantage Medical Group patient*

INTRODUCTION

As part of agilon health's formation in mid-2016, we assumed control of Vantage Medical Group. Vantage is an independent practice association (IPA) that has served the "Inland Empire" region of Southern California and our partner market health plans for over 34 years. For 2017, the new agilon health management team committed to improving Vantage's Medi-Cal quality metrics—infusing new leadership and technology and providing operational support and additional resources. By the end of the year, Vantage had closed 20 percent more gaps in preventive and chronic care for patients.

CHALLENGE

The diffuse nature of the providers and geography in the Inland Empire makes scaling quality initiatives costly and operationally challenging. Vantage Medical Group includes over 750 primary care providers across more than 350 practices that span over 27,000 square miles. Not only is it critical to engage and support these providers, but the network must also provide access to laboratory, radiology, obstetrics, and select specialty care services across the geographic region.

The new agilon health leadership recognized this challenge and provided Vantage with the technology, human capital, and operational support needed to execute against an aggressive Quality Plan. Corporate leadership, including agilon health CEO Ron Kuerbitz, made the organizational objectives and management expectations clear: Vantage would become a quality-focused medical group.

INTERVENTION

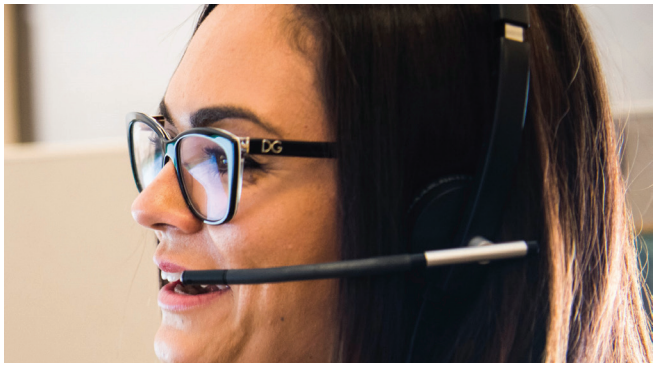
During 2017, the Quality team at Vantage Medical Group collaborated with agilon health leadership to execute a comprehensive plan to improve Medi-Cal quality. The plan included the following:

- **Hiring a team of 10 dedicated quality professionals,** including two who were fluent in Spanish. This represented an annual investment in excess of $1.1 million. The Vantage Quality team actively worked with individual patients to schedule mammograms, glucose and cervical cancer screenings, and immunizations.
- **Implementing proprietary technology** that integrates claims data, supplemental data, eligibility files, and primary care physician (PCP) attribution logic. This technology facilitates detailed tracking and reporting of closed gaps in care against goals, by PCP, geography, and other metrics—supporting targeted interventions and a quantitative understanding of the effectiveness of specific outreach activities against others.

  For example, the team executed outreach for HbA1c screening and persistent medication monitoring by sending patients handwritten lab slips—similar to what they receive in the doctor's office. This resulted in a 20 percent conversion rate to compliant patients. This outreach mechanism was also incorporated into our breast cancer screening efforts in 2018.

  The map on page 7 highlights the insights gained from viewing gap closure by geography—illuminating potential access issues or other sub-geography trends.
- **Offering $25 Target gift cards** as member incentives, resulting in over 2,400 closed gaps in care.
- **Securing direct access to electronic health records (EHRs)** for over 100 primary care providers. This facilitated the gathering of supplemental data to close over 14,000 gaps in care.
- **Collaborating with network specialists,** including OB-GYNs for cervical cancer screenings and ophthalmologists for retinal eye screenings, resulted in over 1,100 incremental closed gaps in care. For

Vantage Medical Group Ophthalmologist Andrew Strand, MD



Quality Specialist Anja Santiago, one of 10 representatives who helped more than 5,500 patients undergo preventive screenings in 2017

example, Vantage collaborated with Acuity Eye Group & Retina Institute of California to reach out to 2,639 members, resulting in 195 additional members undergoing retinal eye exams in the last three months of 2017.

- **Acquiring two retinal eye screening cameras,** which allowed us to bring screenings for our diabetic members to network PCP offices, community centers, and other convenient locations. Nearly 100 patients were screened over a six-week period in November to December 2017.

  Going forward, on an annualized basis, we expect our retinal eye cameras to contribute to a 25 percent increase in diabetic patients undergoing eye screening. In addition, significant pathology has been identified through this program.

- **Paying more than $1 million to PCPs** for achievements against the 2017 Vantage Quality Program.

RESULTS

As a result of over $60,000 in member incentives, Quality team outreach, specialist collaboration, and supplemental data collection efforts, as well as encounters submitted by network PCPs, Vantage Medical Group closed 65,800 quality gaps in 2017. That represented 61 percent of total gaps in care and a 20 percent increase over 2016.

This increase was not only attributable to a focus on encounter submission, but also to member engagement and supplemental data extraction efforts. Notably, 67 percent of members eligible for breast cancer screening were adherent, placing us in the 75th percentile nationally for Medicaid plans. In addition, nearly 90 percent of Vantage members requiring monitoring for persistent medications were adherent.

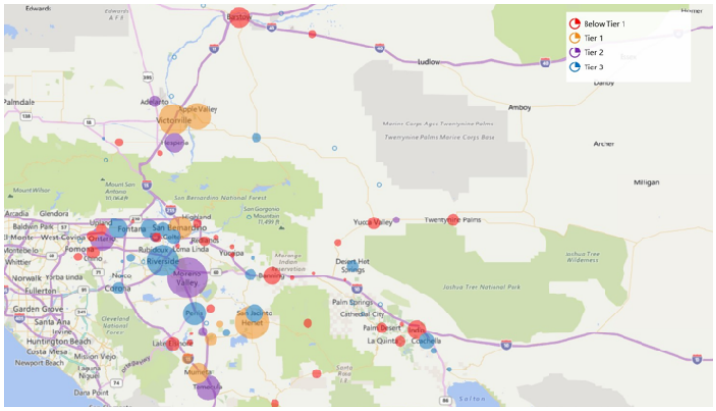
Quality measures related to care for diabetic patients also improved dramatically over 2016:

- Eye screening adherence rose from 38 percent to over 50 percent.
- Glucose-level screening and compliance increased from a 42 percent screening rate in 2016 to over a 50 percent control rate in 2017.

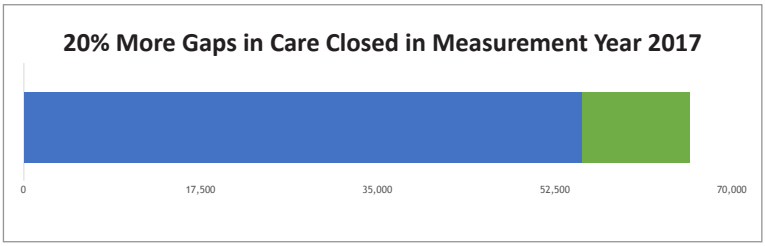
What do all these numbers mean for patients' lives? Here is what one patient, Teresa, wrote to us:

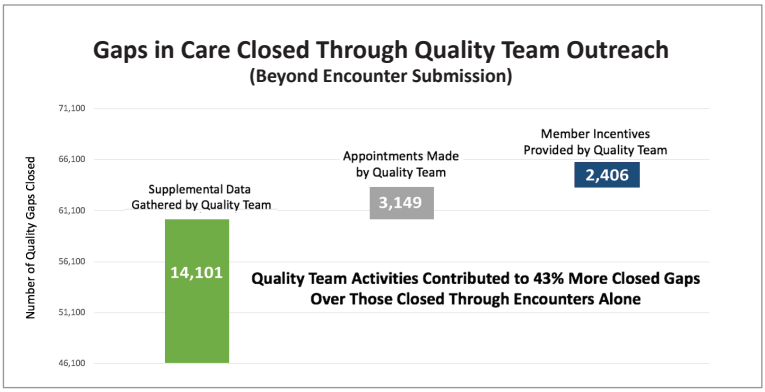
"I'm writing to express my appreciation for the representative from Dr. Cardona's office, who recently called me to schedule a retinal screening. Just two years ago, at age 45, I was diagnosed with diabetes and I am still really new at this.

When the representative called me, I thought, 'Thank God! Someone is calling to help me with ideas for managing my diabetes.' She also helped me schedule an OB-GYN appointment. It was so nice to have someone just call to follow up so gently."



Map highlights geographic areas with lower adherence rates for breast cancer screening, facilitating targeted interventions





In 2017, three Quality Team interventions resulted in 19,656 closed care gaps (on top of 46,100 gaps closed by encounters).

WHO WE ARE

agilon health was formed in mid-2016 with the promise of re-imagining quality, efficiency, and patient experience for healthcare delivery in underserved communities. We provide primary care physicians with the organizational and operational tools necessary to allow them to spend more time with patients, identify gaps in patient care, and more proactively communicate with specialists.

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™ 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.

Improving Quality in a Medicare Shared Savings ACO

"THE HYPERTENSION CONTROL AND DEPRESSION SCREENING PROCESS SHINED A SPOTLIGHT ON ASPECTS OF MEDICAL CARE THAT OFTEN GET PUSHED INTO THE SHADOWS."

—-Richard Fossen, MD, FACP, internal medicine physician at MCHS

INTRODUCTION

How do you move a large, multicenter, ambulatory, and inpatient system with a broad geographic footprint from fee-for-service to value-based care—while maintaining or improving quality of care? That is the challenge that Marshfield Clinic Health System (MCHS) has been facing—and meeting.

Since 2013, MCHS has participated in the Centers for Medicare & Medicaid Services (CMS) Medicare Shared Savings Accountable Care Organization (ACO) program. By using a multidisciplinary team approach, combined with robust electronic medical records tools and ongoing communication, we successfully improved the population health quality measures—and patient care.

CHALLENGE

MCHS is committed to closing gaps in care for all patients. As part of the ACO program, we must report on specific quality measures—a blend of process, outcome, and patient experience metrics focused on wellness and management of chronic disease.

During our participation, the quality measures have changed in number and definition. It's an ongoing task to keep providers updated and correlate definitions with changes in the medical literature. Course correction can be difficult because results are not received until more than 20 months after the start of the measurement period.

Given our 50,000-square-mile service area and the many centers and providers involved, we needed an efficient way to share quality outcome results at the system, center, and individual provider levels. We created a dashboard reporting mechanism that captured data from the electronic health record (EHR) system. Annual reviews of CMS quality definitions and evidence-based guideline recommendations form the basis of the dashboard.

We also developed an infrastructure to perform analytics, develop data display mechanisms, provide access to information for stakeholders who were driving quality improvement, and educate staff and providers across our large and rural healthcare system.

INTERVENTION

MCHS participated in a Medicare Shared Savings Program ACO pathway from 2013 to 2015, and from 2016 to the present. Using a multifaceted approach, we paired clinical quality nurses with currently practicing physician counterparts to bring forth the quality measures, develop ideas for intervention, and implement practice changes. The goal was to improve care for all patients, not just the Medicare population.

Clinical quality nurses, quality medical directors, and local teams met regularly to exchange ideas on how to improve processes of care delivery. We also shared information from the ACO annual results with executive and operational leadership and individual providers.

Through these meetings, we identified two key focus areas: improving blood pressure control in patients diagnosed with hypertension, and screening for depression using a standardized, validated screening tool.

- **Hypertension improvement initiative.** This initiative involved three components:
  - System training in blood pressure monitoring (accuracy and competency)
  - Provider hypertension management education
  - Equipment maintenance and replacement

Staff education began in 2015 as an annual computer-based training module, combined with a formal hands-on competency assessment. The initiative also included a provider salary component, and clinical quality coordinators reached out to patients who were not at their blood pressure goal.

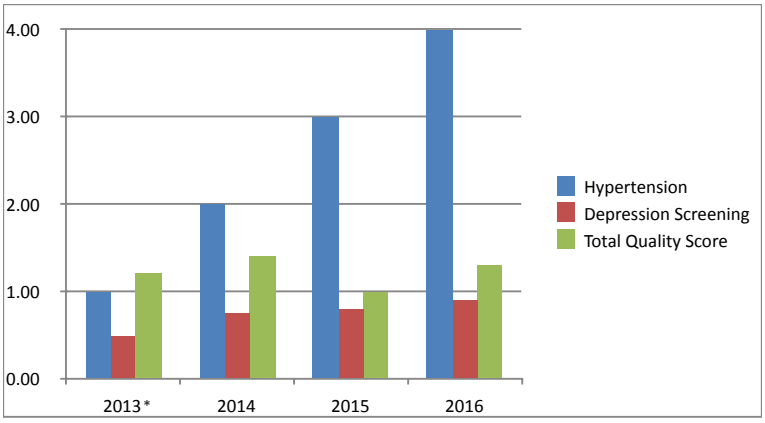
MCHS engaged all specialties in this training and in developing processes to connect patients not at their goal back to their medical home if the specialty was not actively managing their hypertension. These process and education changes laid the foundation for rapid cycle quality improvement initiatives—producing a significant benefit to patient outcomes.

- **Depression screening.** This effort included a new technical component in the EHR to trigger a patient health questionnaire (PHQ-2) assessment annually. If that assessment is positive, the record automatically prompts a PHQ-9 assessment.

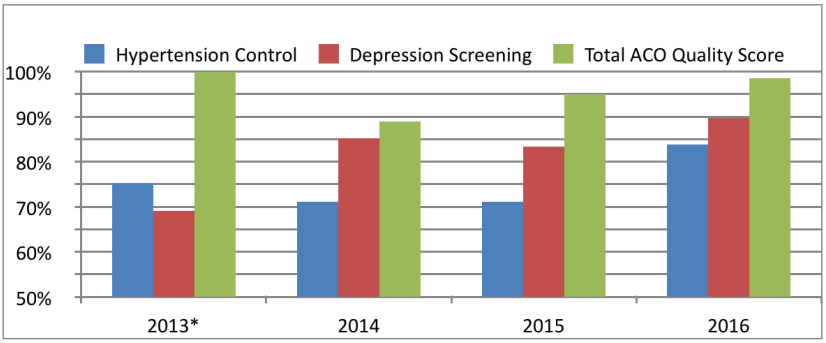
  Further work on process and workflows for depression occurred in 2014. If a PHQ-9 is positive, the provider determines if there is an acute risk (suicide). If not, the provider can start therapy, and/or an integrated care coordinator helps with a referral to behavioral health, via a tool built into the EHR.

  This point-of-care triggering to identify needs for screening—and an infrastructure to address issues around depression and suicide—paved the way for improved, expedited care for patients.

ACO Quality Results by Domain



Quality Results: Hypertension & Depression



** 2013 was a pay-for-reporting year*

RESULTS

MCHS has shown steady improvement in the quality measures. 2013 was a bit of an anomaly, as it was a pay-for-reporting year. A great deal of learning has occurred concerning integrating teams across a large and mostly rural area.

A key driver of success has been to keep communication effective and flowing across multidisciplinary teams to achieve improvements, despite quality measures that change in volume and definition. All efforts are performed in a patient-centered manner—with input from providers, staff, the MCHS Quality department, and direct input from patients through an ACO patient advisory council.

Communication includes:

- Quarterly face-to-face meetings between primary care providers and quality improvement staff.
- Annual one-on-one provider practice reviews.
- E-mail communications to update changes in tools and workflows. An online toolkit for each metric contains such resources as evidence-based workflows, process maps, frequently asked questions, resources for referral, and screenshots and directions for using the tools. The Quality team answers questions via a shared email box or by email contact.

The success of these projects is reflected in improved metrics—and patient experiences. One patient wrote:

"My doctor has been treating me for blood pressure for years. I went in for my eye exam, and the nurse told me my blood pressure was high. The next day I got a call and was asked to come in for a recheck. My blood pressure was still high, and my medication was changed. My blood pressure is now back to normal. THANK YOU!"

WHO WE ARE

MARSHFIELD CLINIC HEALTH SYSTEM (MCHS) is one of the nation's largest rural healthcare providers, with more than 55 clinical locations across 34 Wisconsin communities and 3.5 million patient encounters annually. A fully integrated system of care, MCHS has nearly 10,000 employees, 1,100 providers, more than 80 specialties, a health plan, a research institute, and education programs.

Reducing Rehospitalizations: There's an App for That

> "WE HAVE THIS GREAT TOOL, A SECRET WEAPON REALLY, THAT ALLOWS US TO MAKE SURE EVERY ONE OF OUR PATIENTS HAS THE BEST CHANCE TO AVOID A REHOSPITALIZATION."
>
> *—Laolu Fayanju, MD, Senior Medical Director, Ohio Region*

INTRODUCTION

Oak Street Health is a globally capitated medical group focused on adults living in medically underserved communities. Our mission is to rebuild healthcare as it should be, and our organization has a core objective to keep patients happy, healthy, and out of the hospital. That means preventing avoidable hospitalizations—and especially avoidable rehospitalizations.

To achieve this, our team developed Canopy, a proprietary suite of web-based applications that deliver insights to care teams at the point of care and support evidence-based workflows. One app in the suite, called Inpatient Review, assists care teams in ensuring that all Oak Street inpatients receive all evidence-based interventions that have demonstrated an impact in reducing the chances of rehospitalization. This app is the foundation to our transitions-in-care process.

CHALLENGE

One in four patients who are hospitalized are readmitted within 30 days of being discharged. With each rehospitalization, thousands of dollars are spent on care. Meanwhile, the risk of patients getting sicker grows, and patients often suffer preventable setbacks.

There is high-quality, peer-reviewed evidence for what works for these high-risk patients, but few practices are able to get it right. This isn't because it's impossible, but because it requires teamwork and a choreographed response to deliver what we know patients need. A 2011 meta-analysis from Northwestern University researchers (published in the *Annals of Internal Medicine*) showed that patients require many interventions—not one single intervention—during their transition from hospital to home to have the best chance of avoiding a rehospitalization.

Those interventions should include, but aren't limited to, the following:

- Educating patients about health status
- Developing a plan for discharge
- Managing medication reconciliation
- Scheduling follow-up visits with primary care providers
- Following up with patients on the phone (or with other remote support, including home visits)

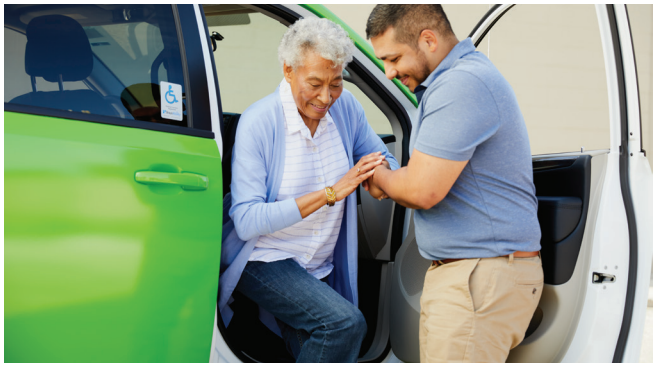
INTERVENTION

Within its Canopy suite, Oak Street Health developed the proprietary Inpatient Review application specifically to help prevent hospital readmissions.

Canopy integrates 1,300 data fields across several platforms, including electronic health record (EHR), inbound/outbound calls, the Centers for Medicare & Medicaid Services (CMS), customer relationship management (CRM), utilization management, and care management. It also integrates with external data platforms like eligibility, revenue, claims, prescriptions, and provider charts to track patients from hospital to home and better personalize their post-hospitalization care.

The Inpatient Review app guides teams through evidence-based interventions that consensus shows improve outcomes. This is the foundation of Oak Street Health's transitions-in-care process, which provides patients the highest quality of care from hospital to home and every facility in between. In this process, the responsibilities of transition nurses (TRNs) include, but aren't limited to:

- Updating the Inpatient Review app daily based on discussions with the patient, hospital staff, and/or the facility's electronic medical record (EMR)



- Maintaining up-to-date discharge planning information
- Scheduling post-discharge visits
- Requesting discharge summaries from the facility and completing post-discharge calls
- Driving referrals to a house call nurse practitioner, if appropriate
- Facilitating medication therapy management by a pharmacist

The Inpatient Review app serves as a virtual roundtable where care teams meet to discuss their highest-risk patients. It's the venue for communication, and it includes all the relevant information to deliver evidence-based support.

RESULTS

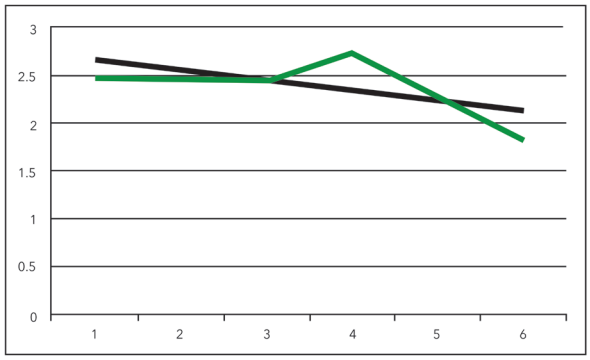
Since the development and launch of the Inpatient Review app, Oak Street Health has seen a 26 percent reduction in risk-adjusted rehospitalization. This illustrates the integral role technology plays in supporting the consistent delivery of evidence-based care to complex, chronically ill patients in multiple care settings.

All Oak Street Health centers have access to the Canopy Inpatient Review app, and more than 100 employees across the organization regularly use it to coordinate care for admitted patients. On average, users log into the tool 3.3 times a day, and 85 percent of users would recommend it to a colleague. The app captures and tracks 22 percent more hospitalization events than what is reported through payer census files.

Canopy ensures Oak Street Health patients are getting the patient-centered, evidence-based care they require, regardless of where they go for inpatient services or which Oak Street Health team member they spoke with last. Canopy is an example of the type of platform that value-based models of the future will need to deliver evidence-based care in a complex care ecosystem. It integrates all available data and simplifies the process for care teams to keep patients happy, healthy, and out of the hospital.

Inpatient Review App: Impact on Readmissions

Number of readmission events standardized per 1,000 patients, adjusted for risk score*



Months from Application Roll Out

Risk-adjusted readmissions per 1,000

Trend line

** "Risk Score" is the Hierarchical Condition Categories (HCC) Risk Adjustment Factor (RAF)*

"Now we have this great tool, a secret weapon really, that allows us to make sure every one of our patients has the best chance to avoid a rehospitalization," says Laolu Fayanju, MD, Senior Medical Director, Ohio Region. "We as a team feel like we're actually doing our very best for patients who deserve our very best."

Inpatient Review App: User Satisfaction	
On a scale of 1-10 (10 – great improvement) how much of an improvement is the Canopy Inpatient Review application compared to the previous tool?	**7.6**
On a scale of 1-10, how user-friendly is the Canopy Inpatient Review applicaton?	**7.7**
Would you recommend Canopy Inpatient Review application to other regions?	**22 - Yes** **3 - Maybe** **1 - No**

Responses from 26 transition nurses and social workers across all sites

WHO WE ARE

Founded in 2013, **OAK STREET HEALTH** is a growing organization of value-based primary care centers serving adults on Medicare. We serve more than 45,000 patients in nearly 35 globally capitated care centers located in Illinois, Michigan, Indiana, Pennsylvania, and Ohio. The Oak Street Health model is payer-agnostic and focused on optimizing social determinants for patients through evidence-based primary care, neighborhood-based community centers, transportation, behavioral health services, and a host of delegated managed care functions.

Transforming Practices Into Patient-Centered Medical Homes

> "PATIENTS COME TO TRUST AND RELY ON THEIR NURSE CARE MANAGER AS SOMEONE WHO HAS THEIR BEST INTERESTS AT HEART, PROVIDES BIAS-FREE COMMUNICATION, AND WILL POINT THEM IN THE RIGHT DIRECTION."
>
> —-*Deborah Andrade, RN, BSN, CDOE, Nurse Care Manager*

INTRODUCTION

From July 2016 through July 2018, Prospect Medical Systems (PMS) deployed an integrative approach to managing a Medicare population in its newest market: Rhode Island (RI). The goal was to quickly and dramatically reduce utilization and total cost of care—in practices where many providers were relatively new to managed care.

Our approach included transforming a majority of owned and affiliated practices to patient-centered medical homes (PCMHs), coordinating provider activities with a centralized care and utilization management team, and boosting provider engagement. The results were dramatic, with marked reductions in hospital admissions, total skilled nursing facility (SNF) days, SNF length of stay, hospital 30-day readmissions, and total cost of care.

CHALLENGE

Rhode Island has been a leader in healthcare innovation in such areas as rate caps, practice transformation, and payment reform. But the state still has very high costs and utilization compared with many other U.S. markets. And while some medical groups in the state have organized to be managed care entities—including independent practice associations (IPAs) and accountable care organizations (ACOs)—others remain unorganized. The challenge for PMS was to enter the market with our California-based managed care experience and rapidly transform it with a newly developed delivery system.

Gilbert Teixeira, DO, and Nurse Care Manager Linda Salvatori, RN, BSN, consult with patient Maria Lemos.

INTERVENTION

In 2014, PMS completed the acquisition of two Rhode Island hospitals and created an IPA of providers who were primarily "naive" to managed care. Throughout the next year, we began to boldly take downside risk on managed care services while building our local infrastructure.

- **Care management.** However, it wasn't until January 2017 that we fully instituted our care management teams, while simultaneously working with owned and affiliated practices to undergo practice transformation and PCMH certification. By mid-2018, 80 percent of our practices had on-site nurse care managers, as well as the systems needed to improve their quality measures.

  "It is so good to have a nurse care manager who cares about my practice and patients as much as I do," one physician notes.

- **Building engagement.** Network managers have enhanced the efforts of our geographically and administratively separate and disparate practices, facilitating education and communication between practices and the central team.

  To share data and best practices and build engagement, we divided the enterprise into four geographic regions of providers, called PODS (Physician Organized Delivery Systems). At bimonthly PODS meetings, we update providers on data around quality performance, patient satisfaction, and utilization metrics. The group decided early on to share unblinded data. This made it easier to discuss best practices and barriers to success and accelerate cycles of improvement.

- **Reducing readmissions.** PMS implemented several programs to reduce readmission rates, including:
  - Anticipatory discharge planning
  - A centralized transition-of-care (TOC) team including coordinators, nurses, and clinical pharmacists
  - A receiving practice team comprising staff, a nurse care manager, and a primary care physician
  - A visiting nurse practitioner position

All hospital patients now have an inpatient care manager who coordinates their discharge and post-discharge activities with the TOC team—ensuring they have necessary medications, durable medical equipment, and home care.

Once home, patients receive a phone call from the TOC coordinator to ensure that they carried out their discharge instructions and scheduled a follow-up PCP appointment within five days. A clinical pharmacist also contacts patients to perform medication reconciliation, and patients receive a 24-hour number to reach a nurse. A nurse practitioner is available to provide home visits if needed.

"When patients are discharged from hospitals, we are able to assist them right away, secure an appointment for them, and meet with them face-to-face," explains PMS Nurse Care Manager Shanthi Pavanasam, RN, BSN. "This increases our ability to engage our most medically complex patients while setting goals and working with patients to achieve them."

RESULTS

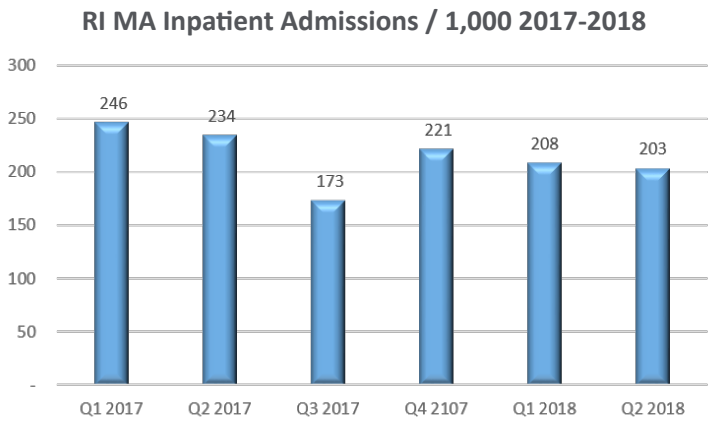
The results of this coordination between our practices and the centralized functions at PMS have been highly impactful. The data presented are for the Medicare population, but we have seen similar trends in our other populations under management.

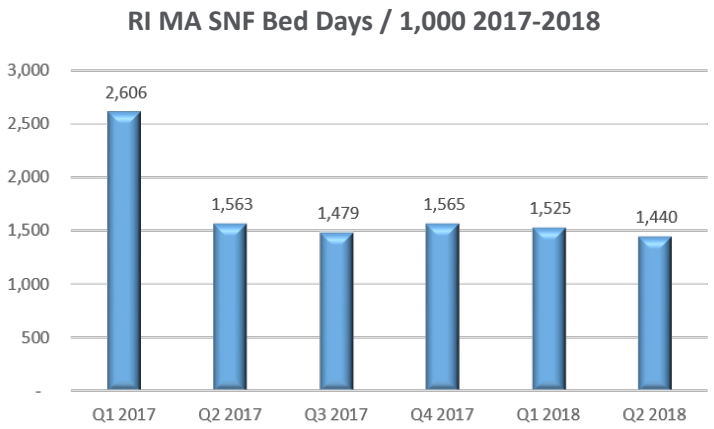
For our Medicare population, PMS saw the following results over an 18-month period:

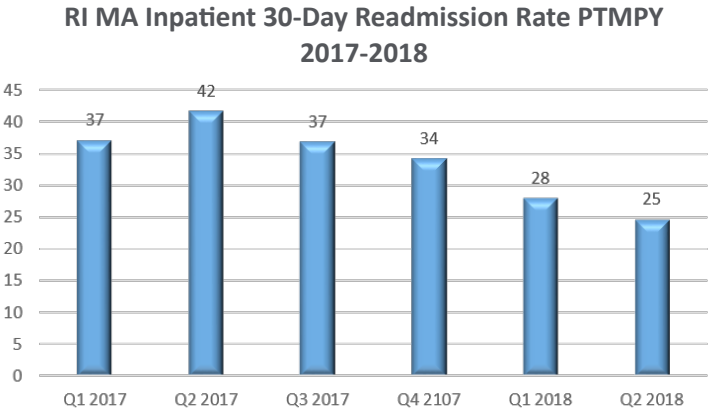
- 16 percent reduction in admissions
- 42 percent reduction in SNF days
- 20 percent reduction in SNF length of stay
- 33 percent reduction in 30-day readmission rates
- 7.7 percent reduction in total cost of care

We also have major efforts and systems in place to drive quality performance and patient satisfaction. Longer data collection cycles for those domains make it difficult to show year-over-year comparisons at this time. But Nurse Care Manager Deborah Andrade, RN, BSN, CDOE, explains how patients feel about our services:

"They count on us to resolve a variety of healthcare needs, including navigating insurance plan benefits, community resources, transition-of-care needs, and advanced care planning," Andrade says. "Patients come to trust and rely on their nurse care manager as someone who has their best interests at heart, provides bias-free communication, and will point them in the right direction."







WHO WE ARE

PROSPECT MEDICAL SYSTEMS (PMS) is the management service organization for Prospect Medical Holdings, a growing integrated delivery system. Prospect owns 20 hospitals with approximately 3,800 licensed beds and operates hundreds of clinics and outpatient centers. We arrange for the provision of care to nearly 500,000 members in our networks of more than 11,000 doctors and specialists. PMS offers a full range of management services, including IPAs, claims, and care and utilization management.

A High-Touch Approach for High-Risk Patients

"OUR HIGH-RISK PROGRAMS SPAN THE CONTINUUM OF PATIENT NEED, AND WE CAN SEAMLESSLY MOVE PATIENTS FROM ONE PROGRAM TO ANOTHER AS THEIR NEEDS CHANGE."

—Kenneth D. Goldblum, MD, FACP, Chief Medical Officer

INTRODUCTION

Tandigm Health is a value-based care organization that provides primary care physicians with innovative resources that enhance their ability to deliver proactive, high-quality care—so patients get healthy and stay healthy.

Several of Tandigm's programs are designed specifically to help physicians provide clinical and care management support for high-risk patients. The needs of these patients are especially complex, and our high-touch programs assess and provide appropriate care as patients move along the risk continuum—improving health outcomes while lowering costs and reducing the amount of time spent in acute care facilities.

CHALLENGE

According to the Kaiser Family Foundation, just 5 percent of patients account for approximately half of healthcare expenditures. The care for these high-risk patients is often fragmented, as primary care providers typically do not have the resources to adequately serve their unique and complex medical and psychosocial needs.

To improve healthcare outcomes and reduce expenditures for this population, Tandigm needed to design a sustainable, flexible suite of programs that could nimbly provide care across the risk continuum and meet patients' rapidly changing needs. Our challenge was to match the most expensive resources to the patients who would experience the greatest benefit. As patients moved down the risk continuum, we needed to use less expensive resources to continue to meet their needs.

To accomplish this, we designed four distinct but interconnected programs that provide varying levels of high-touch care. Primary care physicians refer high-risk patients to our programs, and we utilize a proprietary risk algorithm to identify the most beneficial programs for each patient's diagnoses, utilization patterns, and social determinants.

We leverage this algorithm monthly to account for patients' changing needs and levels of risk. We also rely on Tandigm clinicians to refer patients to higher- or lower-acuity programs based on their clinical assessment and predefined criteria.

"Our programs span the continuum of patient need, and we can seamlessly move patients from one program to another as their needs change," explains Kenneth D. Goldblum, MD, FACP, Chief Medical Officer at Tandigm. "This enables us to titrate the intensity of intervention to patient need and make the programs more effective both clinically and financially."

INTERVENTION

After a patient is discharged from an acute hospital setting and either referred by a primary care physician or identified by the risk algorithm, Tandigm evaluates the patient's risk level. We then provide appropriate levels of clinical services, support, and education through one or more of our high-risk programs:

- **Skilled Nursing Facility (SNF) visits.** Our clinicians work closely with patients and their families at more than 20 preferred SNFs. The daily visits ensure a clear understanding of the treatment plan and a seamless transition to the patient's home.
- **House calls.** Tandigm's clinicians and nurse practitioners visit the highest-risk patients at home to address health needs, order tests, and adjust medications—aiming to prevent readmissions back to the hospital.
- **MVP (Most Valuable Patients) program.** Our community-based nurse navigators provide high-risk

patients with ongoing support and education. The nurses accompany patients to medical appointments and help them with next steps, including medication management, symptom recognition, and risk assessments.

- **Telephonic transitions of care.** This protocol connects telephonic nurse navigators with Tandigm's "rising risk" patients immediately after they are discharged from a facility. Through these phone conversations, nurses provide education, coordinate needed follow-up appointments, determine the need for house calls, and help patients stay connected to their care managers.

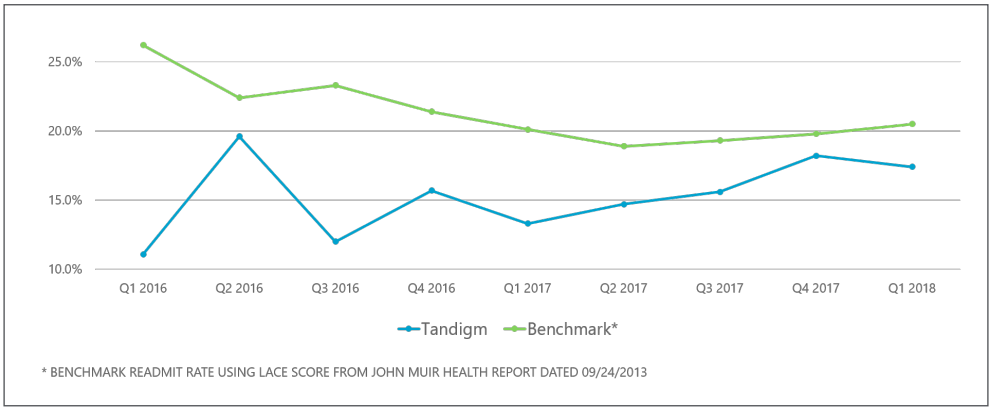
RESULTS

In 2017, Tandigm enrolled over 5,000 patients in our high-risk programs. These patients represented 15 percent of our membership and 50 percent of our overall medical costs—a significant improvement over the national average.

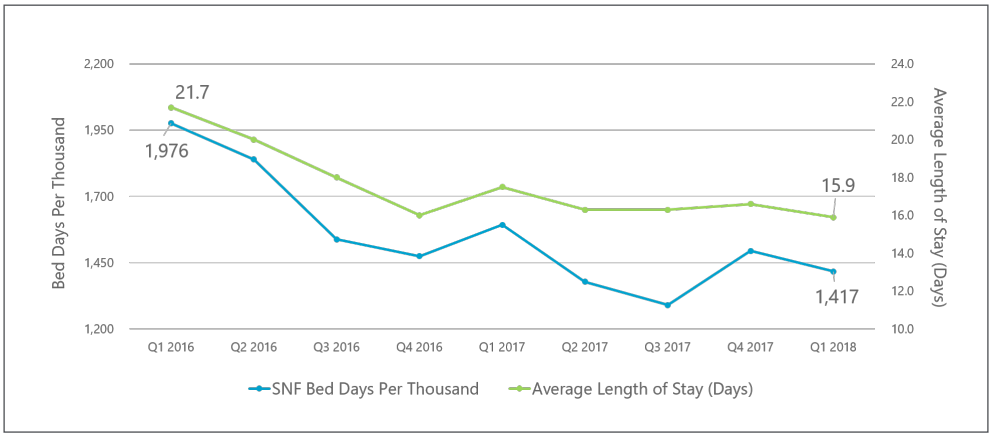
In the last two years, Tandigm's coordinated care programs have prevented approximately 220 hospital readmissions among high-risk patients. Notably, from Q1 2016 to Q1 2018, our risk-adjusted 30-day readmission rate was 4 percent lower than the benchmark.

Furthermore, our SNF Program has helped reduce the time patients spend in these facilities. From Q1 2016 to Q1 2018, the number of SNF bed days per thousand fell by 28 percent. Our patients' average number of days spent in a SNF also dropped from 22 to 16—a 27 percent decrease. Over the course of a year, our patients spend 1,000 fewer days in a SNF.

Medicare High-Risk Programs: 30-Day Readmission Rate



Medicare Length of Stay in Skilled Nursing Facilities



In addition, the average length of stay is just 13 days in Tandigm preferred facilities, compared with 20 days at other SNFs—a 35 percent difference. Our patients at preferred SNFs are also 20 percent less likely to be discharged into acute hospital admission.

"Being physically present and available to our patients' needs and concerns—while improving access to care through house calls and other high-touch medical programs—significantly improves the quality of life for our patients and reduces utilizations," says Jill Schwartz-Chevlin, MD, Tandigm Medical Director. "Our clinicians enjoy high levels of job satisfaction, knowing they change patients' lives on a daily basis."

WHO WE ARE

TANDIGM HEALTH is dedicated to enhancing the ability of primary care physicians to provide the finest possible care while lowering costs through a more coordinated, proactive model. By providing greater tools and resources to its network of doctors, Tandigm puts primary care physicians back at the center of patient care. We work with over 420 primary care physicians, reaching more than 110,000 patients.

'A Foot in Both Canoes': Bridging Volume and Value

> "WE SLOWLY AND METHODICALLY CHANGED HOW WE DELIVER PRIMARY CARE, WITH AN EYE TOWARD PROVIDER SUSTAINABILITY AND BUDGET NEUTRALITY."
>
> *—Jeremy Chrisman, DO, Medical Director of Care Transformation and Primary Care*

INTRODUCTION

Over the past seven years, Vancouver Clinic has been slowly carving out a value-based delivery system in the Pacific Northwest—while also successfully delivering on fee-for-service contracts. With uncertainty in the future of payment reform, we made the decision to deliver on total cost of care first, and then use the power of market-leading quality and cost to drive changes in contracts. To succeed, we had to develop key competencies in population health, delivery of care in—and avoidance of—high-cost settings, and differing payment methodologies.

CHALLENGE

The term "a foot in both canoes" has been used to describe the precarious position of having both fee-for-service and value-based contracts. Our challenge was to bridge the gap between volume and value in a manner that was financially responsible. "We slowly and methodically changed how we deliver primary care with an eye toward provider sustainability and budget neutrality," explains Jeremy Chrisman, DO, Medical Director of Care Transformation and Primary Care for Vancouver Clinic.

We had several specific and obvious barriers to success. Vancouver Clinic had an access problem; the average wait time to see a primary care provider was one month. We ran lean in the physician support department, and the increasing burden of documentation and coding related to Medicare Advantage reporting was becoming untenable. In addition, we did not have a functional hospitalist program to care for our patients when they were sickest.

INTERVENTION

- **Personalizing panel size and ensuring access for impaneled patients.** We overhauled how we approach panel size and personalized it based on each provider's historical behavior. Panel size is now calculated as "Patients Seen Per Day" multiplied by "Days Worked Per Year," and then divided by the "Panel Visit Rate."

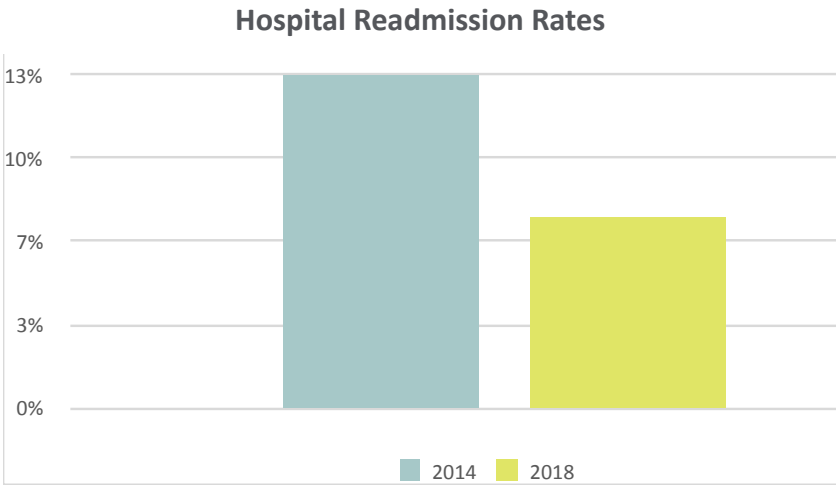
- **Investing in infrastructure so that coding and care gaps are not wholly the provider's responsibility.** Vancouver Clinic recognized that the increasing burden of documentation and coding was becoming untenable for our physicians. We decided to add support to our primary care panels in the form of a panel coordinator. The coordinator is responsible for identifying and closing care gaps as patients come through the office, and for providing outreach to patients who need to be seen.

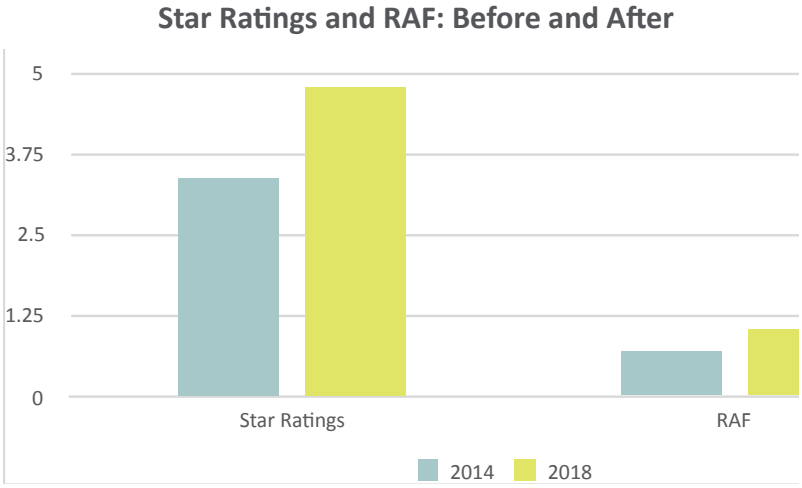
- **Investing in hospitalists who are well-compensated, available for admission/readmission avoidance, and dedicated to quality care.** As an ambulatory multispecialty group, Vancouver Clinic struggled with the financial implications of developing a hospitalist program. We initially made the mistake of attempting to drive the program toward a revenue-positive position as a standalone service. This mistake was catastrophic to the program, chasing away the physicians who were dedicated to quality and keeping only those motivated by volume.

  We made a fundamental reset and overhauled our expectations. We limited the interactions each hospitalist could have, with a hard cap of 14 and an average under 12. We asked that hospitalists take the time to focus on preventing the next admission during the patient's stay in the hospital. We were able to attract top-tier hospitalists who launched an ambulatory transitional care clinic the following year. This clinic allows them to care for their highest-risk patients post-discharge, and it provides an alternative to admission in some cases.

RESULTS

- **Panel size and continuity.** After developing the analytics to understand and reliably report metrics like third next available appointment (TNA), visit rate, and patients seen per day, we were able to move from a TNA measured in weeks to a TNA measured in hours.
- **Support for primary care.** The addition of panel coordinators helped us raise our Star ratings from 3.4 in 2014 to 4.8 in 2018. Panel coordinators have also been fundamental in moving our risk adjustment factor (RAF) score from 0.69 in 2014 to 1.02 in 2018.
- **Building a hospitalist program.** From 2014 to 2018, our readmission rate fell from 13 percent to 7.4 percent—a 43 percent reduction. Admits per thousand, meanwhile, have declined from 240 in 2014 to 189 in 2018.





WHO WE ARE

At **VANCOUVER CLINIC**, caring for people is our first priority and the driving force behind everything we do.

We have served the community of Southwest Washington since 1936 and have the largest private multispecialty clinic in Clark County, along with five locations across Vancouver, Battle Ground, and Washougal. We offer 40-plus medical specialties and have over 300 providers.

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* Indicates 2017–2018 Board Members

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New West Physicians, P.C.*
Ruth Benton, CEO
Ken Cohen, MD, CMO

Northwest Physicians Network of Washington, LLC
Rick MacCornack, CEO
Scott Kronlund, MD, CMO

Oak Street Health
Terry Olsen, MD, SVP, Accountable Care
Drew Crenshaw, VP, Population Health

OhioHealth
David Applegate, MD, VP Medical Affairs
Carmela Hartline, Director Clinical Services

Ohio Integrated Care Providers
Cindy M. Baker, CEO
Patrick Goggin, MD, Quality Improvement Medical Director

Omnicare Medical Group
Toni Chavis, MD, President
Ashok Raheja, MD, Medical Director

One Medical Group
Tom Lee, MD, Founder & CEO
Brendhan Green, VP Contracting & Reimbursement Strategy

OptumCare Network of Connecticut
Karen Gee, SVP & COO
Rob Wenick, MD, VP & Medical Director

Pacific Medical Administrative Group
Donna Mah, MD, President
Michael Chang, MD, Executive Director

Pediatric Associates
Peter Shulman, MD, CEO
Scott Farr, COO

Peoples Health Network
Warren Murrell, President and CEO
Brent Wallis, MD, Medical Director
Groups: Health Prime, L.L.C.; Independent Physician Association of New Orleans, Inc.; Memorial Independent Physician Association, Inc.; North Shore Independent Physician Association, Inc.; Pontchartrain IPA, Inc.; South Louisiana Independent Physician Association; University Medical Group, L.L.C.

PHM MultiSalud, LLC.
Roberto L. Bengoa Lopez, President
Lynnette Ortiz, MD, Medical Director
Groups: Advantage Medical Group; Advantage Medical Group; Alianza de Medicos del Sureste; Centro de Medicina Familiar del Norte; Centro de Medicina Primaria Advantage del Norte; Centros Medicos Unidos del Oeste; G.M.D.C., Inc.; Grupo Advantage del Oeste; Grupo Medico de G.M.B., Inc.; Grupo Medico de Orocovis

Physicians DataTrust
Kathi Toliver, VP of IPA Administration
Lisa Serratore, COO
Groups: Greater Tri-Cities IPA; Noble AMA IPA; St. Vincent IPA

Physicians of Southwest Washington, LLC
Melanie Matthews, CEO
Gary R. Goin, MD, President

PIH Health Physicians
Rosalio J. Lopez, MD, SVP & CMO
Andrew Zwers, VP of Group Operations

Pioneer Medical Group, Inc.*
John Kirk, CEO
Jerry Floro, MD, President

Preferred IPA of California
Mark Amico, MD, Medical Director
Zahra Movaghar, Administrator

Premier Family Physicians
Kevin Spencer, MD, CEO and President
Mat King, CFO

Primary Care of St. Louis, LLC
Joy Strathman, Executive Director
Bruce J. Berwald, MD

Prime Care Managers
John Ford, CEO
Ted Trimble, MD

PriMed Physicians
Mark Couch, MD, President
Robert Matthews, VP of Quality

Privia Medical Group LLC
Keith Fernandez, MD, National Chief Clinical Officer
Graham Glaka, VP, New Product Development

ProHealth Physicians, Inc.
Jack Reed, President & CEO
Rich Guerriere, MD, SVP & CMO

Prospect Medical Group*
Jeereddi Prasad, MD, President
Martin Serota, MD, Chief Medical Officer, California & NE Market
Groups: AMVI/Prospect Medical Group Prospect; Genesis Healthcare of Southern California, Inc., a Medical Group; Nuestra Familia Medical Group, Inc.; Pomona Valley Medical Group, Inc.; Prospect Health Source Medical Group, Inc.; Prospect Medical Group, Inc.; Prospect NWOC Medical Group. Inc.; Prospect Professional Care Medical Group, Inc.; Prospect Provider Group RI, LLC; Prospect Provider Group CTE, LLC; Prospect Provider Group CTW, LLC; Prospect Provider Group NJ, LLC; Prospect Provider Group PA; Prospect Health Services TX, Inc.; StarCare Medical Group, Inc.; Upland Medical Group, a Professional Medical Corporation

Providence Health & Services
Groups: in Alaska, California, Montana, Oregon, Washington

Providence Medical Management Services
Phil Jackson, Chief Integration and Transformation Officer
Groups: Korean American Medical Group; Providence Care Network

Renaissance Physician Organization
Clare Hawkins, MD, IPA Board Chair
Whitney Horak, President

River City Medical Group, Inc.
Keith Andrews, MD, Medical Director
Kendrick T. Que, COO

Riverside Medical Clinic
Steven Larson, MD, Chairman
Judy Carpenter, President and COO

Riverside Physician Network
Howard Saner, CEO
Paul Snowden, CFO

St. Joseph Heritage Healthcare*
Kevin Manemann, President and CEO
David Kim, MD, Medical Director
Groups: Hoag Medical Group; Mission Heritage Medical Group; St. Mary High Desert Medical Group

St. Vincent IPA Medical Corporation
Jeffrey Hendel, MD, President
Leesa Johnson, Director of IPA Operations

San Bernardino Medical Group
James Malin, CEO
Thomas Hellwig, MD, President

Sansum Clinic*
Kurt Ransohoff, MD, CEO & CMO
Chad Hine, COO

Santa Clara County IPA (SCCIPA)
J. Kersten Kraft, MD, President of the Board
Janet Doherty Pulliam, CFO

Santé Health System, Inc.
Scott B. Wells, CEO
Daniel Bluestone, MD, Medical Director

SeaView IPA
Lynn Haas, CEO
Kooros Samadzadeh, DO, Medical Director

Scripps Coastal Medical Center
Anthony Chong, MD, CMO
Tracy Chu, Assistant VP of Operations

Scripps Physicians Medical Group
Joyce Cook, CEO
James Cordell, MD, Medical Director

Sharp Community Medical Group*
Paul Durr, CEO
Kenneth Roth, MD, President
Groups: Graybill Medical Group • Arch Health Partners

Sharp Rees-Stealy Medical Group*
Stacey Hrountas, CEO
Alan Bier, MD, President

Signature Partners Network*
Matthew Poffenroth, MD, CMO
Anne Rieger, COO

SOMOS Community Care
Marcus Zachary, DO, Medical Executive
David Steinman, MBA, Chief Operating Officer

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Southern California Permanente Medical Group*
Diana Shiba, MD, Director of Government Relations
Veronica Dela Rosa, Assistant Medical Group Administrator

Southwest Medical Associates
Robert B. McBeath, MD, President & CEO
Greg Griffin, COO

Starling Physicians, PC (formally Connecticut Multispecialty Group)
Jarrod Post, MD, CEO
Tracy King, Chief Administrative Officer

Steward Health Care Network, Inc.
Mark Girard, MD, MBA, President
Douglas Costa, COO

Summit Medical Group, PA*
Jeffrey Le Benger, MD, Chairman & CEO
Jamie Reedy, MD, Chief of Population Health

Sutter Health Foundations & Affiliated Groups*
Larry deGhetaldi, MD, Division President, Palo Alto Medical Foundation
Kelvin Lam, MD, MBA, Chief Medical Officer, Sutter Health Bay Area
Groups: Central Valley Medical Group; East Bay Physicians Medical Group; Gould Medical Group; Marin Headlands Medical Group; Mills-Peninsula Medical Group; Palo Alto Foundation Medical Group; Palo Alto Medical Foundation; Peninsula Medical Clinic; Physician Foundation Medical Associates; Sutter East Bay Medical Foundation; Sutter Gould Medical Foundation; Sutter Independent Physicians; Sutter Medical Foundation; Sutter Medical Group; Sutter Medical Group of the Redwoods; Sutter North Medical Group; Sutter Pacific Medical Foundation

Swedish Medical Group
Meena Mital, MD, Medical Director
Bela Biro, Admin Director, Accountable Care Services

Synergy HealthCare, LLC
James Jones, MD, Chairman of the Board
Austin Burrows, Sr. Administrator, CareAllies

Tandigm Health, LLC
Anthony V. Coletta, MD, MBA, President & CEO
Kenneth Goldblum, MD, FACP, CMO

The Everett Clinic, PLLC*
Al Fisk, MD, Chief Medical Officer
Adrianne Wagner, Associate Administrator for Quality Improvement

The Permanente Medical Group, Inc.*
Stephen Parodi, MD, Associate Executive Director
Traci R. Perry, Director, TPMG, Advocacy and Political Affairs

The Portland Clinic
Dick Clark, CEO
Jeffrey Cleven, MD, CMO

The Southeast Permanente Medical Group, Inc.
Michael Doherty, MD, Executive Medical Director and Chief of Staff

The Vancouver Clinic, Inc., P.S.*
Mark Mantei, CEO

Torrance Hospital IPA
Norman Panitch, MD, President

Tri Valley Internal Medicine Group
Jonathan H. Dinh, MD, CEO
Kaila T. Pollock, COO

Triad HealthCare Network, LLC*
Steve Neorr, VP, Executive Director

UC Davis Health
Michael Hooper, Medical Director, Care Services & Innovation
Ann Boynton, Director, Care Services & Innovation

UC Irvine Health
Manuel Porto, MD, President & CEO
Natalie Maton, Executive Director of Operations

UCLA Medical Group*
Sam Skootsky, MD, CMO

UniPhy ACO, LLC
Rene J. Valverde, President & CEO
Maria Labarga, MD, CMO

USC Care Medical Group, Inc.
Donald Larsen, MD, CMO

USMD
Richard Johnston, MD, CEO & Chief Physician Officer
Michelle Speck, CAO

Valley Care IPA
Sonya Araiza, CEO
Michael Swartout, MD, Medical Director

Valley Organized Physicians
William Torkildsen, MD, Chairman of the Board
Sarah Wolf, Senior Administrator

Verity Medical Foundation
Eric Marton, CEO
Dean M. Didech, MD, CMO

VillageMD
Clive Fields, MD, CMO
Paul Martino, Chief Strategy Officer

Washington Permanente Medical Group
Steve Tarnoff, MD, President & Executive Medical Director
David Kauff, MD, Medical Director

WellMed Medical Group, P.A.*
Carlos O. Hernandez, MD, President
Richard Manning, President, Enterprise Clinic Operations

Corporate Partners

AbbVie
Anthem Blue Cross of CA
Evolent Health
Humana, Inc.
Merck & Co.
Nestle Health Science
Novo Nordisk
Patient-Centered Primary Care Collaborative
Pfizer, Inc.
Sanofi, US
SCAN Health Plan

Associate Partners

Arkray
Astellas Pharma US, Inc.
Avanir Pharmaceuticals, Inc.
Bristol-Myers-Squibb
Easy Choice Health Plan, Inc.
Genentech, Inc.
HealthAxis Group, LLC
Incyte Corporation
Johnson & Johnson Family
Kaufman, Hall & Associates
Kindred Healthcare, Inc.
Lumara Health
Mazars USA, LLP
Novartis Pharmaceuticals
Ralphs Grocery Company
Relypsa, Inc.
Soleo Health Inc.
Sunovion Pharmaceuticals Inc.
The Doctors Company

Affiliate Partners

Acurus Solutions Inc.
Alignment Healthcare
Altura
ArborMetrix
Care Angel
Children's Hospital Los Angeles Medical Group
CVHCare
Dermira Inc.
Financial Recovery Group Inc.
Mills Peninsula Medical Group
Nifty after Fifty Monarch LLC
Partners in Care Foundation
Pharmacyclics, Inc.
Pinnacle Brokers & Insurance Svc, LLC
Redlands Community Hospital
SullivanLuallin Group
Ventegra, LLC

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AMERICA'S PHYSICIAN GROUPS

apg.org

915 Wilshire Boulevard
Suite 1620
Los Angeles
CA 90017
213.624.2274

1215 K Street
Suite 1915
Sacramento
CA 95814
916.443.2274

1501 M Street NW
Suite 640
Washington
DC 20005
202.212.6891