













AMERICA'S PHYSICIAN GROUPS

Case Studies *in* EXCELLENCE

2026

APG.ORG

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Welcome to the 2026 Edition of APG's

CASE STUDIES *in* EXCELLENCE

APG is delighted to feature ten narratives describing patient-centered, coordinated, and accountable care that exemplify how its physician-led organizations are "taking responsibility for America's health." In these case studies, organizations share best practices, insights, and lessons learned from implementing new approaches to care delivery or refining existing ones. The accounts are emblematic of how APG member groups improve patients' care experiences and health outcomes while also accounting for the costs of care.

APG's more than 300 member organizations support patient care and population health in 47 states, the District of Columbia, and the U.S. territory of Puerto Rico. These organizations comprise roughly 260,000 physicians and other clinicians who care for nearly 90 million, or one in four, Americans, including one in three Medicare Advantage enrollees. These patients reflect the full spectrum of age, race, ethnicity, and socioeconomic status.

This year's case studies describe high-value care delivery in four thematic areas:

- **Right Care, Right Test, Right Time**:
  (Kelsey-Sebold Clinic, Sharp Rees-Stealy Medical Group)
  These programs focused on improving diagnostic accuracy and appropriateness through evidence-based testing, standardized follow-up, and timely clinical intervention.
- **Expanding Access Through New Care Models**:
  (Hoag Clinic, Starling Oncology)
  These programs extended care to more patients by reducing treatment barriers, improving patient outcomes and experience, and supporting more efficient use of health care resources.
- **Earlier Identification and Proactive Management**:
  (Central Ohio Primary Care, Desert Oasis Healthcare, MedPOINT Management)
  These programs identified health risks and emerging conditions earlier through screening, data-driven insights, and coordinated interventions that enabled prevention of complications and avoidable hospital utilization.
- **A Refocus on the Fundamentals of Value-Based Care**:
  (MemorialCare Medical Foundation, Sutter Medical Group, UCLA Health)
  These initiatives strengthened core programs and processes in home-based primary care, clinician peer review, and clinical quality improvement.

Documenting and sharing the hard-won expertise described in these case studies is one way that APG helps to support its members and other organizations to thrive in value-based care delivery environments. These case studies are also a resource for policymakers, payers, purchasers, and patients in understanding the strategies that health care organizations can undertake in pursuit of high-value and clinically impactful care.

APG congratulates and thanks the member organizations whose programs are featured in the 2026 edition of *Case Studies in Excellence*.



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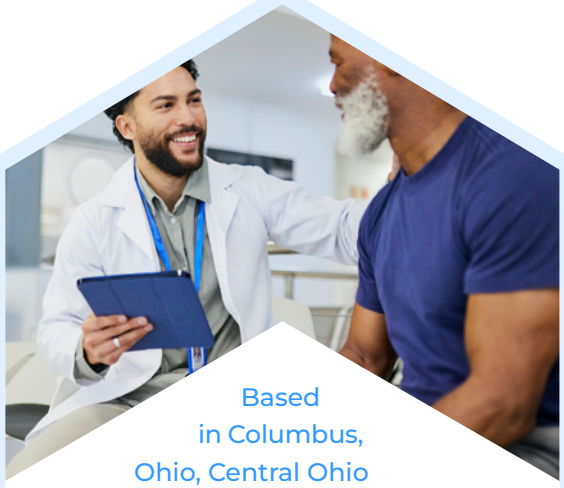
CENTRAL OHIO PRIMARY CARE



Based in Columbus, Ohio, Central Ohio Primary Care is one of the largest physician-owned primary care groups in the United States. Founded in 1997, COPC includes 450+ physicians and 115 advanced practice providers across 80+ sites, serving 450,000 patients with 1.5 million outpatient visits in 2025. Through a value-based partnership with agilon health, COPC combines population health infrastructure and primary care-led workflows to lower total cost of care for chronic conditions such as congestive heart failure.

> *"The pathway brings together screening, documentation, decision support, and treatment recommendations in one EHR workflow.*

From Population Insight to Clinical Action: A Primary Care-Led Approach to Earlier Congestive Heart Failure Diagnosis and Readmission Reduction

Introduction

Congestive heart failure (CHF) is a leading cause of hospitalization and diminished quality of life among older patients,[1] yet it is frequently underdiagnosed in primary care until the patient decompensates and requires emergency or inpatient care.[2] New guidelines from the American College of Cardiology, the American Heart Association, and the Heart Failure Society of America recognize Stage B (structural or functional heart disease without symptoms) heart failure,[3] creating an opportunity for primary care to intervene before symptoms and hospitalization occur. As a physician-led group managing Medicare Advantage and ACO populations in value-based arrangements, Central Ohio Primary Care (COPC) built a pathway to identify CHF patients earlier and to better support those with later stage disease after a hospitalization.

The Challenge

A 2023-2024 actuarial and claims review conducted with agilon health found elevated medical spending patterns that were inconsistent with COPC's CHF prevalence. COPC's clinicians recognized this disconnect as a diagnostic blind spot: COPC appeared to have a cohort of patients who met criteria for Stage B heart failure but had never received a formal diagnosis to guide monitoring or treatment. Left unrecognized, many of these patients' first clinical encounter for heart failure was an emergency department visit or hospitalization, the most acute and avoidable entry point into care. In addition, COPC's diagnosed, hospitalized (Stage C and D) CHF patients cost more than risk-adjusted models predicted. This situation was driven in part by high 30-day readmissions, a signal that too many patients were decompensating after discharge due to gaps in post-discharge support. COPC therefore had two distinct CHF gaps: patients diagnosed too late, and patients readmitted too often. COPC set out to close both gaps by (1) increasing identification of Stage B disease before decompensation, and (2) reducing readmissions among patients hospitalized for acute CHF exacerbations.

The Intervention

In 2025, COPC implemented a primary care physician (PCP) led CHF care pathway with tactics tailored to each of its CHF clinical gaps. To increase earlier diagnosis, population health



registries flagged patients with CHF risk factors and routed them through structured pre-visit symptom screening ahead of their PCP visit. Clinical decision support tools were embedded directly into the primary care workflow, triggering guideline-aligned evaluation, documentation support, and treatment-initiation prompts at the point of care. COPC also conducted a retrospective review of five years of echocardiograms to identify previously unrecognized Stage B disease for clinical reassessment. These reviews allowed identification of patients who had been missed by historical workflows.

To reduce CHF readmissions, COPC layered a structured post-discharge CHF monitoring program onto the care pathway for patients hospitalized with a primary CHF diagnosis. These patients were enrolled at discharge for a minimum 30-day engagement that included proactive care management outreach, structured symptom monitoring, daily weight tracking to catch early fluid overload, and longitudinal touchpoints with a centralized care team.

These interventions targeted different points on the CHF care continuum — pre-diagnosis and post-hospital discharge.

The Results

The pathway produced meaningful results across both target outcomes. There was a 163% increase in patients with diagnosed CHF between 2024 and 2025 (4,026 to 10,595 patients), with an additional 27% increase projected for 2026 (13,447 patients) as the pathway matures *(Figure 1)*. This growth reflects earlier identification, with the share of initial CHF diagnoses made in an acute/inpatient setting falling from 18% in 2023 and 14% in 2024 to just 2% in 2025 and year-to-date 2026 *(Figure 2)*. Additionally, the proportion of CHF patients on guideline-directed medical therapy increased from 80% in January 2025 to 85% in June 2026, reflecting earlier, proactive intervention.

Figure 1

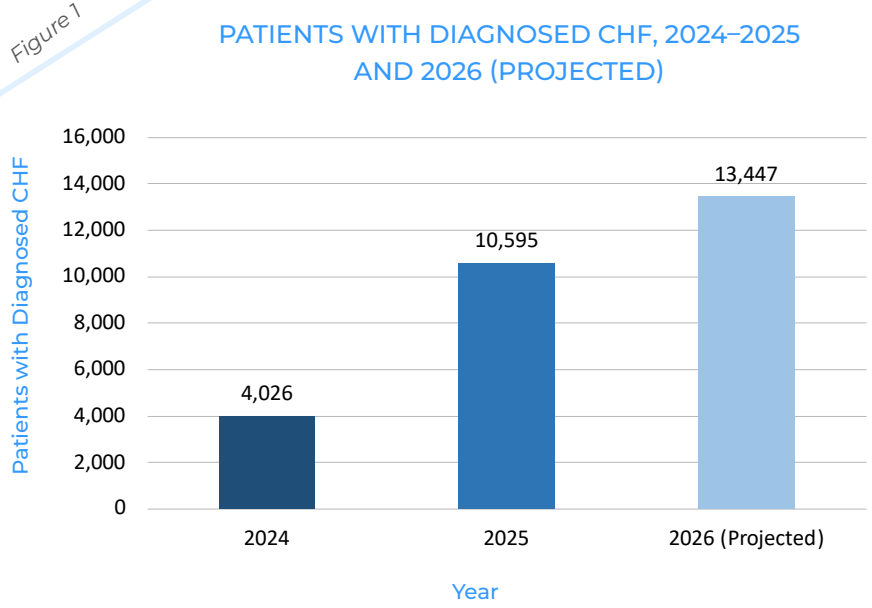
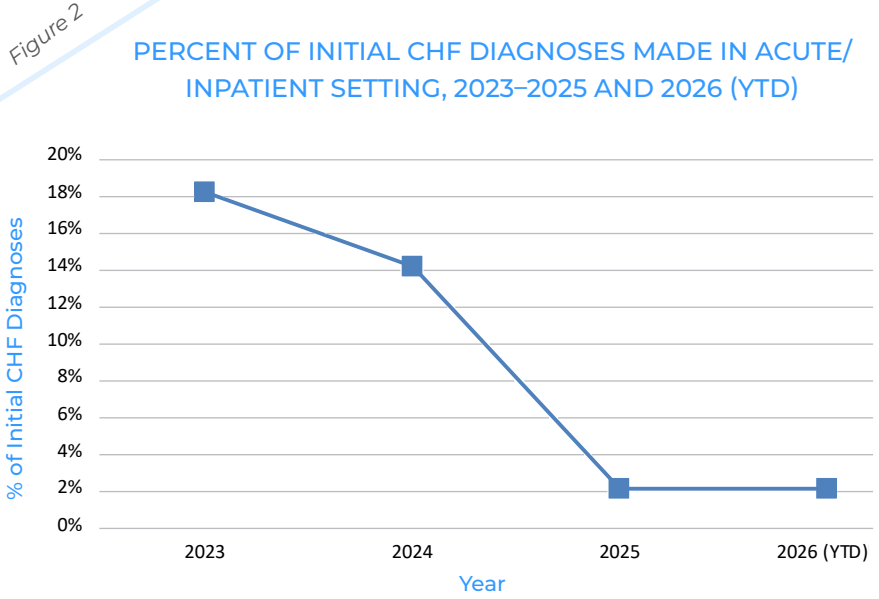


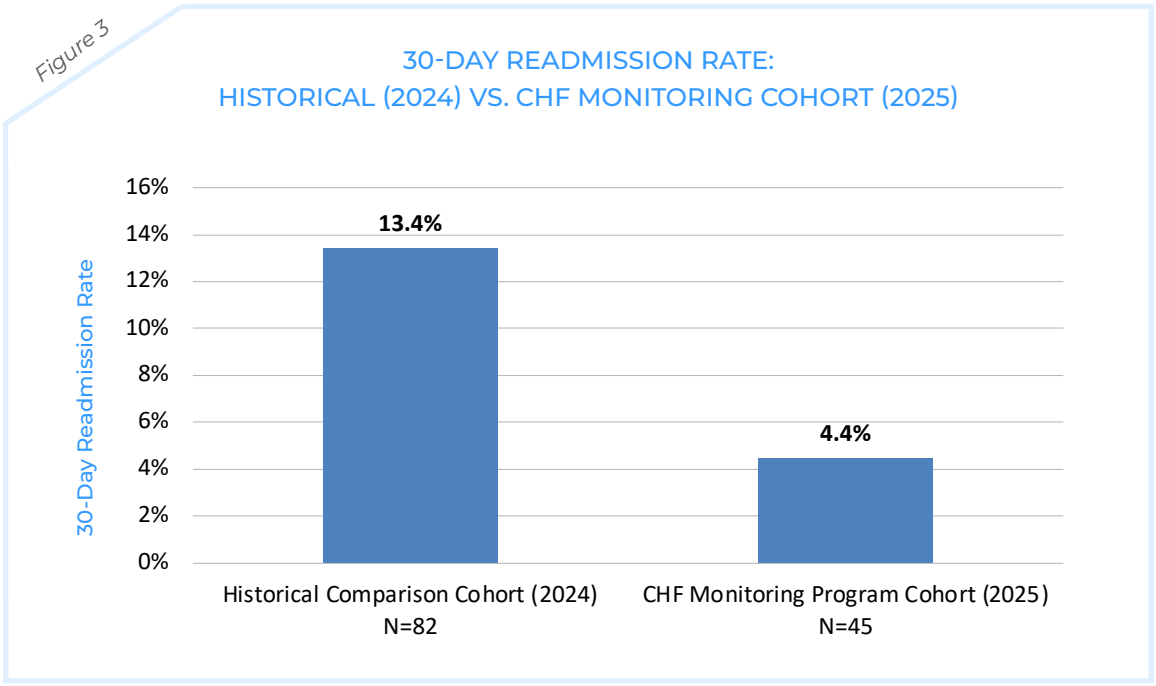
Figure 2



Concerning readmissions, COPC's CHF monitoring program evaluation found patients enrolled in structured, post-discharge monitoring in 2025 (N=45) had a 67% lower 30-day readmission rate compared to a historical comparison cohort (N=82) discharged from an inpatient hospital stay with a primary CHF diagnosis in 2024 *(4.4% vs. 13.4%; Figure 3)*. These monitoring program results are encouraging but not yet conclusive, given the small size of the intervention cohort. COPC plans to repeat the analysis at year-end as enrollment grows.

In a separate, related analysis, a risk-adjusted readmission model covering all CHF patients admitted between January 2024 and April 2026 showed directional improvement in the 30-day observed-to-expected ratio, falling from 1.09 in 2024 to 0.96 in 2025 and further to 0.71 through April 2026. The risk-adjusted analysis is also preliminary because the 2026 data reflect only four months of claims run-out. COPC will continue to monitor findings with a full year of claims data at year-end.

Figure 3



The Conclusion

By pairing earlier CHF Stage B identification with structured post-discharge monitoring, COPC changed how it manages CHF patients. Early results also suggest this two-pronged approach may lower total cost of care from both ends of the disease continuum, an outcome that COPC plans to formally quantify as enrollment matures.

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DESERT OASIS HEALTHCARE

Your Health. Your Life. Our Passion.



Desert Oasis Healthcare, an affiliate of Heritage Provider Network, advances health care by providing integrated primary care and related services to more than 70,000 members and patients across the greater Coachella Valley and the Morongo Basin in Riverside and San Bernardino counties of California. Its multidisciplinary, innovative care programs focus on optimizing health outcomes and promoting wellness, reflecting DOHC's motto: "Your Health. Your Life. Our Passion."

> *"This shift enabled earlier therapeutic intervention for neuropsychiatric symptoms and strengthened family support.*

Closing the Gap Between Dementia Diagnosis and Care

Introduction

Dementia is among the most complex and clinically challenging neurologic conditions facing the United States health care system. Including Alzheimer's disease and related disorders, dementia affects more than seven million Americans, and cases are projected to more than double by 2050. The medical and social burdens of dementia care—including hospitalizations, long-term care, and out-of-pocket caregiver expenses—exceed $300 billion annually.[1] However, underdiagnosis of dementia can mask the extent of the need for condition-related management and supports. Improving dementia diagnosis will increase demand for care coordination and support services and drive the improvement of the overall care landscape for these patients.

The Challenge

Desert Oasis Healthcare (DOHC) provides care for one in three older adults in California's Coachella Valley. Through its collaboration with Alzheimer's Coachella Valley (ACV), DOHC learned that 19,000 of the Greater Palm Springs area's 105,000 adults age 65 and older, were living with dementia or significant cognitive impairment. ACV also reported that DOHC members accounted for more than half of its cognitive screenings and services. In 2024, DOHC's dementia prevalence rate, based on ICD-10 diagnoses among more than 31,000 Medicare-eligible older adults, was 5.2%—slightly below the estimated national prevalence rate of 5.3% and well below Riverside County's rate of 8.7%.[2,3] These findings underscored the importance of supporting timely diagnosis in primary care and the need to connect patients with appropriate resources after a diagnosis is made.

The Intervention

In 2024, DOHC launched a two-part initiative to improve dementia diagnosis and strengthen connections to existing and emerging community dementia resources for patients and families once a diagnosis has been made. First, traditional cognitive assessment methods were replaced with Neurotrack.™ This AI-enabled technology supports DOHC primary care providers (PCPs) by standardizing testing across DOHC's Senior Wellness Clinics, shortening screening time for patients without cognitive dysfunction, helping to identify patients likely to have dementia, and providing population-level analytics to guide ongoing clinical care process improvements. Importantly, the three-minute cognitive screen fits well into patients' yearly checkup workflow. Combined with provider education focused on simplifying diagnosis consistent with DSM-5 criteria and patients' impacted instrumental activities of daily living (IADLs), the new technology supported DOHC's initial program focus on early diagnosis and management *(Figure 1)*.

Second, in fall 2025, DOHC adapted and launched the UCLA Alzheimer's and Dementia Care (ADC) model in its Dementia Care Clinic. This model served as a guide to DOHC as it expanded access to comprehensive dementia care, streamlined confirmation of dementia diagnoses and subtypes, supported early pharmacologic therapy when appropriate, and connected patients and families with local community-based support resources. DOHC uses a clinical pharmacist as the "dementia care specialist." The specialist works under established protocols and with a neurology physician's supervision to evaluate IADLs, review neuropsychological testing and diagnostic laboratory and imaging results, optimize medication regimens, and link patients and families to community resources and social services as the patient's condition and needs progress. DOHC selected the ADC model because it has been shown to decrease hospitalizations, emergency department visits, and custodial care placement *(Figure 2)*.[4-7]

Figure 1

DEMENTIA CLINIC WORKFLOW

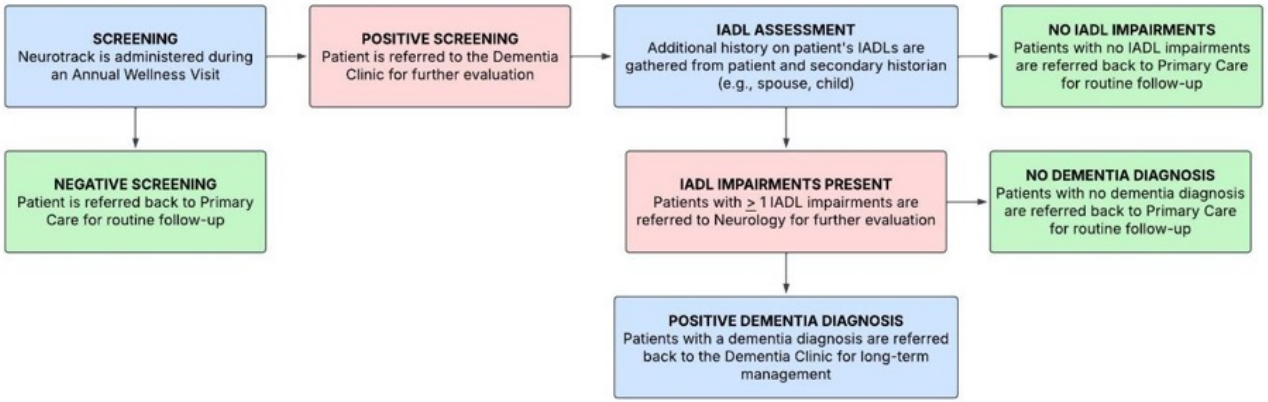


Figure 2

DEMENTIA CLINIC SERVICES

MEDICAL	• Medication Reconciliation • Initiation of dementia medications (e.g. donepezil, memantine) • Assist neurology in starting Alzheimer's infusions (e.g. lecanema • Deprescribing, especially Beers criteria medications (e.g. anticholinergics) • Routine assessment of cognitive and functional status (e.g. SLUMS, FAST) • Prompt emergency room, hospital, and skilled nursing facility stay follow-ups • Advance care planning • Referrals to palliative care and hospice as appropriate
BEHAVIORAL	• Non-pharmacotherapy recommendations for behavioral disturbances • Initiation of antidepressants and antipsychotics as appropriate • Referral to behavioral health services as appropriate
SOCIAL	• Referrals to community-based resources (e.g. support groups) • Referrals to placement services and respite care scholarships • Referrals to social services to assist with Medi-Cal and in-home supportive services applications • Adult protective services reports as appropriate



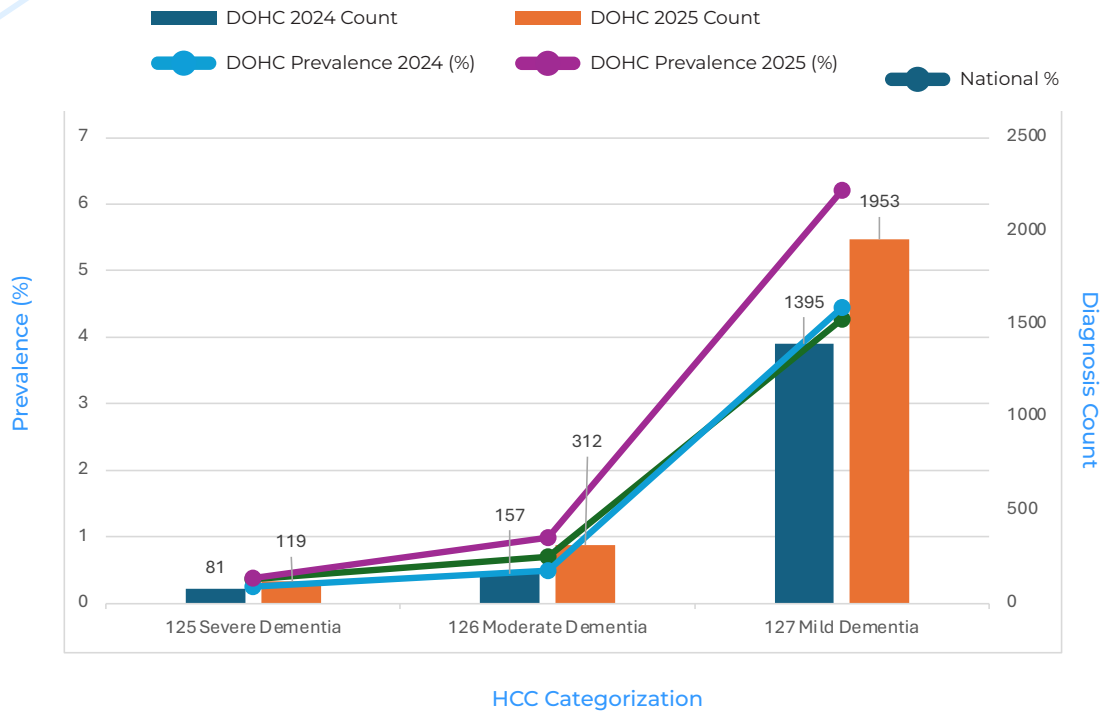
The Results

Initially, increased referrals to the Dementia Care Clinic created a 300-patient backlog that necessitated workflow changes. Many patients were redirected to their PCPs for focused visits to first establish the dementia diagnosis. PCPs at DOHC were historically reluctant to assess and diagnose despite their critical role in longitudinal observation and deep knowledge of, and relationships with, their

patients. However, with workflow changes including proactive and consistent screening protocols and supports, dementia diagnoses at DOHC (defined by hierarchical condition categories (HCC) documented at the time of diagnosis) increased by approximately 46% between 2024 and 2025. End-of-year data from 2025 showed that DOHC's dementia prevalence was 7.6%, a 46% increase over the pre-intervention prevalence of 5.2% *(Figure 3)*.

The Clinic evolved from a purely diagnostic center to its current model, primarily serving newly diagnosed patients with dementia referred from PCP offices. This shift enabled earlier therapeutic intervention for neuropsychiatric symptoms and strengthened family support and caregiver access to community resources. In the past year, these interventions included 131 referrals for social and behavioral support services, health education, home health, occupational, speech, and physical therapies, palliative care, and the provision of durable medical equipment such as wheelchairs. The impact of the new clinic model on reducing acute care utilization is being measured, with results expected in fall 2026.

Figure 3



The Conclusion

Earlier dementia diagnosis/detection in a team-based primary care model that is aligned with a post-diagnosis, pharmacist-led care program can improve patients' access to needed resources and assist them in navigating the dementia care journey.

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Employing a Digital Health Solution to Improve Access and Cost in Physical Therapy



Hoag Clinic, the medical foundation under Hoag Memorial Hospital Presbyterian, delivers care to more than 300,000 patients through medical groups and independent physicians with more than 100,000 members in value-based care arrangements across Orange County, California. Hoag's provider organizations, Hoag Medical Group and Hoag Physician Partners, were recognized by IHA Excellence in Healthcare in 2025. In addition, Hoag Medical group received IHA's Top 10 Percent Performance in Clinical Quality.

> *"Access to care improved significantly through the VPT model, with patients being seen virtually by a therapist within one week of referral*

Introduction

Musculoskeletal (MSK) conditions are the leading cause of disability in the United States and one of the most expensive cost categories in commercial and Medicare populations.[1] Physical therapy (PT) is the recommended first-line treatment for most non-emergent MSK conditions, including low back pain, knee osteoarthritis, shoulder impingement, and chronic neck pain.[2] Yet, a substantial share of patients referred to PT never begin treatment or are faced with long wait times for treatment. The gap between guideline-recommended care and actual PT utilization creates an opportunity to optimize this care pathway.

The Challenge

Within Hoag's HMO value-based care population, MSK conditions are among the most common drivers of outpatient referrals. Although PT contributes significantly to overall costs, it represents a relatively low-cost upstream intervention that can help avoid worse clinical outcomes that come with substantially higher downstream costs. Hoag referral data indicate that fewer than half of patients referred to traditional outpatient PT go on to receive treatment. This situation constitutes a significant clinical care gap and a missed opportunity to manage spending on MSK conditions at the lowest-cost, evidence-based level.

Access constraints also contribute to this gap, with traditional clinic-based PT appointments averaging a 3–4 week wait time from referral to first visit among those who seek treatment.

The Intervention

Beginning in January 2024 and in partnership with LainaHealth, a web-based clinical care platform, Hoag launched a Virtual Physical Therapy (VPT) program for HMO patients ages 12 and older. Each care episode starts with an initial telehealth evaluation conducted by a licensed physical therapist to confirm clinical appropriateness for virtual care. This assessment ensures that patients requiring hands-on, specialized, or in-person assessments are redirected to the appropriate, in-person care pathway.

Following the telehealth evaluation, VPT-eligible patients receive a personalized care plan with a portfolio of home-based exercises. The platform works on all personal devices with a front-facing camera and browser. Motion-tracking technology sees the patient's movements and

the system provides real-time guidance and feedback to ensure the patient performs exercises correctly. Patient-reported outcomes (pain, experience) and functional tests (VPT clinician assessment aided by computer-vision technology on range of motion, balance, and physical performance) are collected continuously throughout the episode and reported back to Hoag on a regular cadence *(Figure 1)*.

The Results

Between January 2024 and September 2025, 1,036 HMO patients were referred to the VPT program and 13,470 were referred to traditional PT. Of those referred to VPT, 494 initiated treatment.



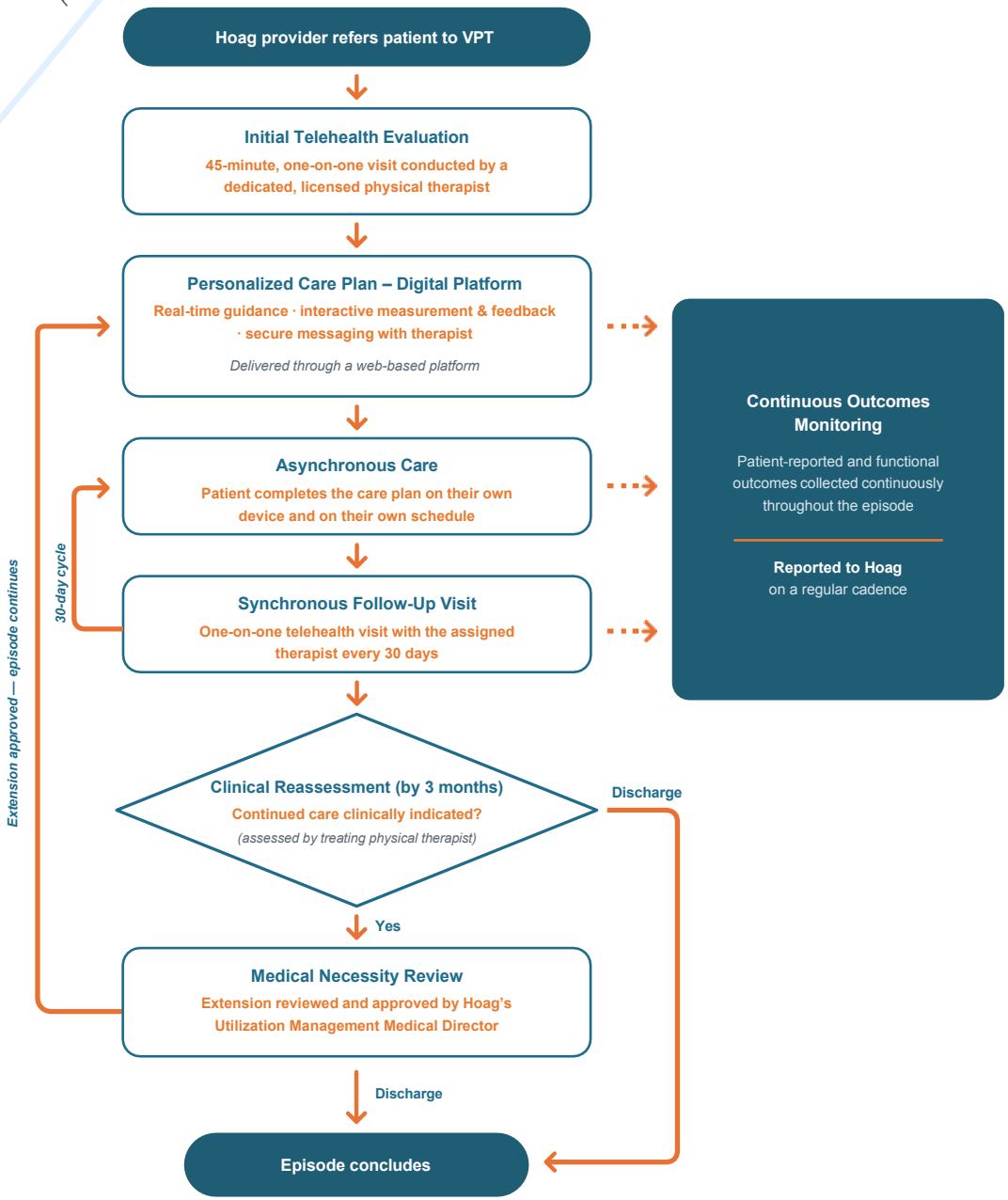
The VPT initiation rate of 48% was similar to the 47% observed in traditional in-person PT for referrals during the same period, indicating that VPT did not discourage initiation of treatment *(Figure 2)*.

However, access to care improved significantly through the VPT model, with patients being seen virtually by a PT within one week of referral, a 75% reduction in average wait time compared to traditional in-person PT.

VPT also demonstrated meaningful savings. Over a six-month period following the initial referral, VPT participants incurred 47% lower PT spending per member per month (PMPM) compared to those receiving traditional in-person PT. Additionally, VPT patients experienced 21% lower orthopedics and orthopedic surgery-related PMPM

Figure 1

HOAG VIRTUAL PHYSICAL THERAPY (VPT) PROGRAM— AN EPISODE OF CARE



costs within six months after referral, indicating reduced downstream utilization of higher-cost services *(Figure 3)*. At the population level, total PT expense decreased by 9% between January and May 2026 compared to 2025.

The Conclusion

Virtual Physical Therapy (VPT) demonstrated substantial clinical and financial value by improving access and reducing PT and orthopedic-related costs. VPT is a viable alternative to meeting patients' MSK treatment needs. But with fewer than half of patients initiating treatment with PT following referrals in both virtual or in-person PT, more work is needed to address challenges with patient engagement, treatment initiation, and completion with either VPT or in-person offerings.

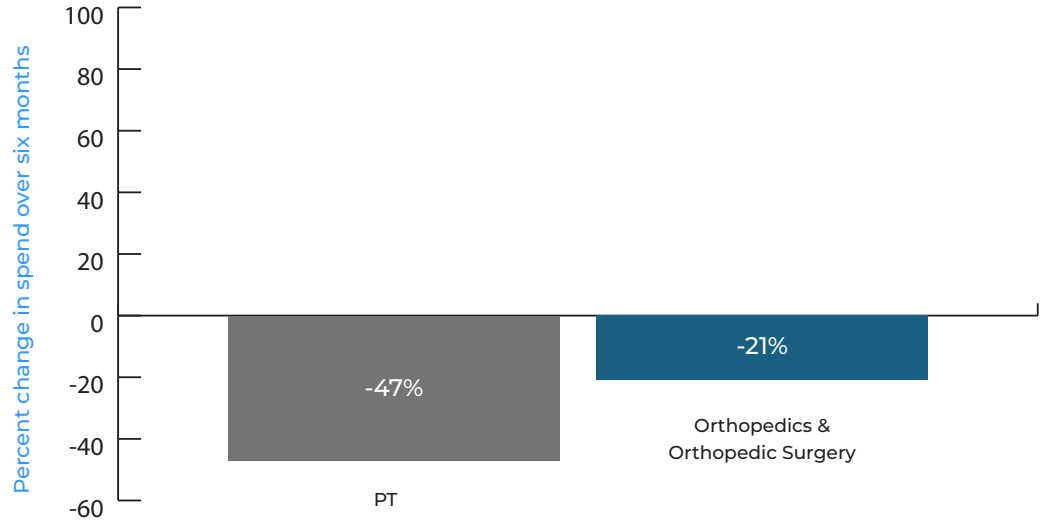
Figure 2

REFERRAL COUNTS JAN 2024 THROUGH SEP 2025

Physical Therapy Type	Total Referral	Enrolled	% Enrolled
Virtual PT	1,036	494	48%
Traditional PT	13,470	6,332	47%

Figure 3

CHANGE IN PT AND ORTHOPEDIC SPENDING AFTER IMPLEMENTATION OF A VIRTUAL PHYSICAL THERAPY PROGRAM



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Kelsey-Seybold Clinic
Changing the way health cares.



Kelsey-Seybold Clinic is a large, physician-led, multispecialty medical group based in Houston, Texas. Founded in 1949, it provides coordinated outpatient care across a broad network of clinics throughout the Greater Houston area. Its physicians represent primary care and numerous medical and surgical specialties supported by diagnostic, imaging, pharmacy, and other ancillary services. Kelsey-Seybold is part of Optum, a UnitedHealth Group company.

> *"KSC designed and implemented a CCTA-first strategy for ischemia evaluation using an "Ischemia E-consult."*

Using Noninvasive Coronary Computed Tomography Angiography First Clinic Reduces Unnecessary Invasive Coronary Angiograms

Introduction

Invasive coronary angiogram for the diagnosis and treatment of coronary artery disease (CAD) is a necessary procedure in several clinical scenarios, including myocardial infarction and angina refractory to medical therapy. However, it is often performed for the diagnosis of CAD in patients with atypical chest pain and/or an abnormal nuclear single-photon emission computerized tomography (SPECT) stress test. Nationwide, the unnecessary cardiac catheterization rate is between 60-70%.[1]

The Challenge

The American College of Cardiology gave coronary computed tomography angiography (CCTA) a Class 1 recommendation in its 2021 Guidelines for the Evaluation and Diagnosis of Chest Pain.[2] This was the first guideline to elevate a noninvasive anatomic testing modality to a Class 1 endorsement supported by Level A evidence for diagnostic evaluation of patients with acute or stable chest pain and no known CAD.

However, given the entrenched ordering practices of physicians at Kelsey-Seybold Clinic (KSC), a program was needed to simultaneously educate primary care physicians (PCPs) on CCTA referral criteria and encourage them to order the appropriate image-based ischemia testing for their patients.

The Intervention

In November 2024, KSC pioneered a high-quality CCTA-first program with the goal of reducing the number of patients undergoing unnecessary invasive coronary angiograms due to false-positive nuclear SPECT stress tests. This new program, the "Ischemia E-consult," consisted of a "doctor-to-doctor telecommunication consult" created inside KSC's electronic health record (EHR).

The program allowed PCPs to receive a formal recommendation from cardiology regarding the most appropriate modality of ischemia evaluation for their patients *(Figure 1)*. KSC compensated the cardiologist for the time spent reviewing the consult in the EHR and providing patient-specific recommendations. PCPs were compensated for the additional time

associated with learning about and engaging with the Ischemia E-Consult program, including discussing recommended evaluation options with patients as appropriate.

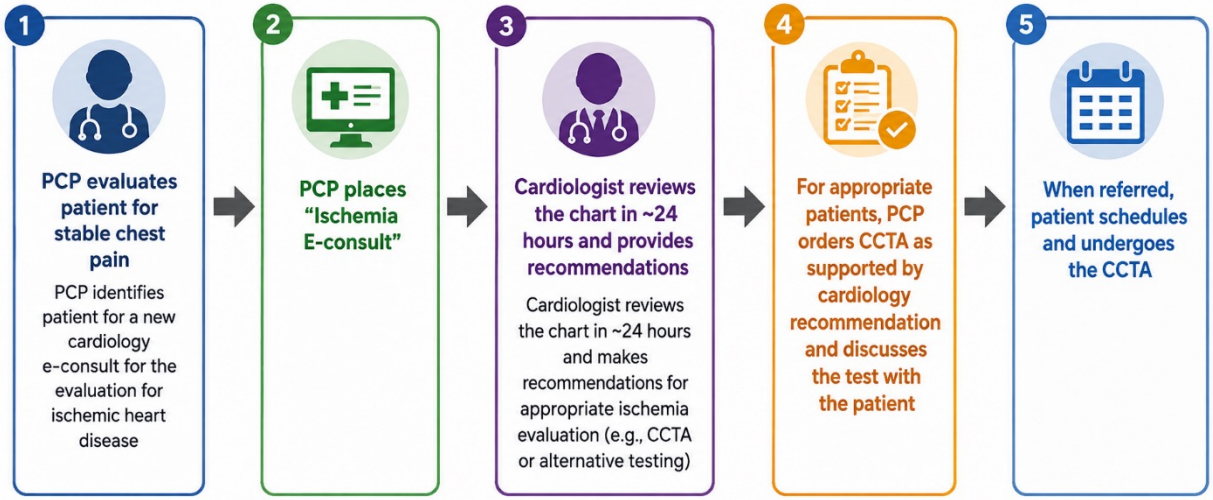
KSC cardiologists monitored requests from this workflow daily to ensure that patients received timely recommendations for appropriate ischemia evaluation.

The Results

Within one year of implementing KSC's electronic consultation process, most image-based stress testing ordered by PCPs switched from nuclear SPECT to CCTA *(Figure 2)*.

Figure 1

"ISCHEMIA E-CONSULT" – A DOCTOR-TO-DOCTOR TELECOMMUNICATION CONSULT TO DETERMINE THE BEST MODALITY OF ISCHEMIA EVALUATION FOR THE PATIENT



All clinicians performing CCTAs at KSC have the option to send images for fractional flow reserve CT (FFRCT) post-hoc analysis to evaluate ischemia across coronary stenoses that are greater than 50%. To evaluate the efficacy of KSC's CCTA-first strategy, between September 1, 2025, and December 31, 2025, all patients who either underwent an outpatient nuclear SPECT stress test or CCTA and then continued to invasive coronary angiography were enrolled in a registry. During this period, 1,270 nuclear SPECT stress tests and 891 CCTAs were performed at KSC. Of these, 134 patients who underwent nuclear SPECT stress tests and 71 patients who underwent CCTA continued to invasive angiography. The cardiac catheterization rate was 11% among patients who received SPECT and 8% among those who received CCTA.



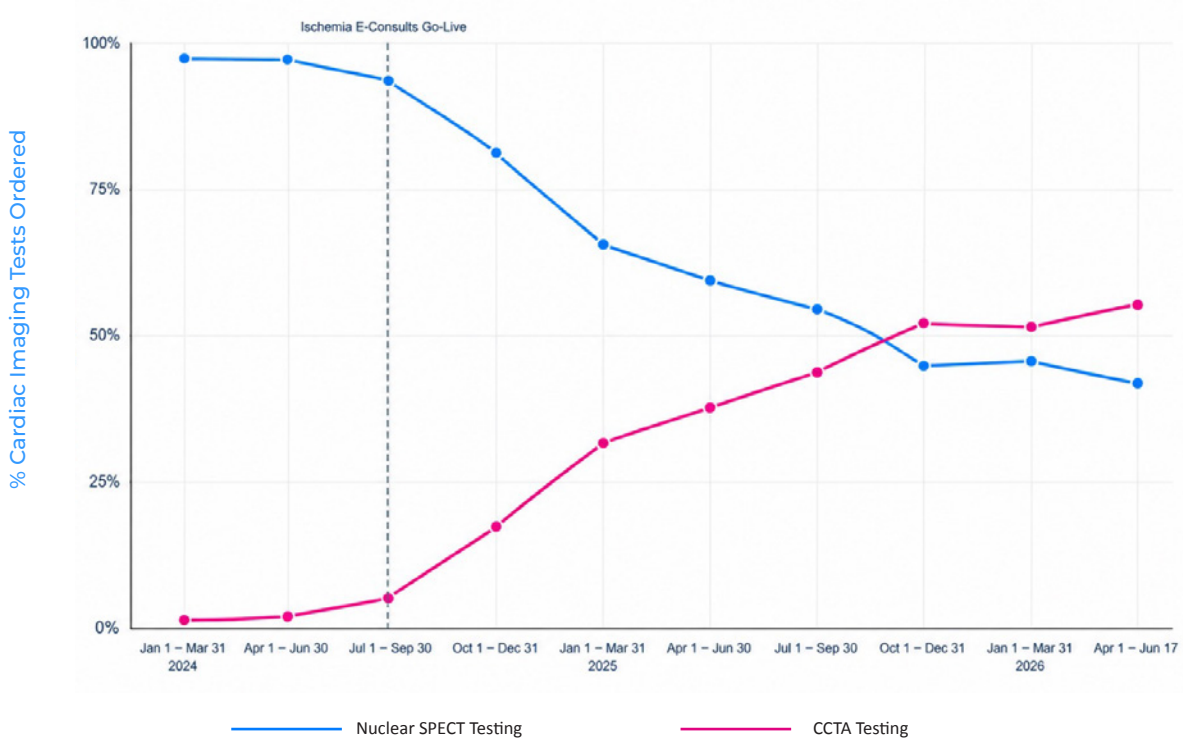
Of the 134 patients who underwent nuclear SPECT stress tests with subsequent invasive angiography, the positive predictive value (PPV) of SPECT to identify a significant CAD lesion was 37%. When patients with prior coronary artery bypass surgery or coronary stenting were excluded from the SPECT group (to mimic the type of patient that is typically a good candidate for CCTA), the PPV went down to 33%. Of the 71 patients who underwent CCTA/FFRCT with subsequent invasive angiography, the PPV for CAD was 67%. In patients eligible for either nuclear SPECT or CCTA, a CCTA-first strategy for ischemia evaluation therefore yielded a 50% reduction in unnecessary invasive coronary angiograms.

The Conclusion

To guide primary care physicians at the point-of-care, KSC designed and implemented a CCTA-first strategy for ischemia evaluation using an “Ischemia E-consult.” This strategy led to a 50% reduction in unnecessary invasive coronary angiograms. With high-quality imaging capabilities and a unified EHR, a CCTA-first strategy can be replicated in other multi-specialty clinics.

Figure 2

CARDIAC IMAGING TESTS ORDERED FOR ISCHEMIA EVALUATION BY PCPs AT KSC, JANUARY, 2024 TO JUNE, 2026



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MedPOINT MANAGEMENT



MedPOINT Management is a management services organization that has supported IPAs and health care networks throughout California for more than 30 years. MPM partners with physician organizations and health plans to support value-based care through integrated utilization and case management, quality improvement, provider network operations, and data-driven population health strategies. Through multidisciplinary clinical teams and technology-enabled care management, MPM works to improve health outcomes, coordinate care across the continuum of care, and promote appropriate utilization of health care resources.

> *"MPM moved care management from a retrospective process to a proactive operational model.*

A Real-Time Operational Framework Using Actionable Health Information Exchange Alerts to Improve Outcomes for Medicaid Members with High Service Needs

Introduction

Many Medicaid members have multiple chronic conditions, behavioral health needs, and unaddressed social drivers of poorer health status, such as unstable housing or lack of access to transportation. These patients often experience fragmented care with frequent emergency department (ED) visits and hospital admissions and are therefore often identified as having high service needs. Although multidisciplinary care management programs are common, most programs rely on retrospective claims data that may identify high-risk members weeks or months after an ED visit or hospitalization. This delay limits the opportunity to effectively intervene, especially when earlier clinical and social supports might have led to better outcomes and reduced the need for additional downstream care.

The Challenge

Traditional care management often intervenes after the acute episode has been resolved, when opportunities to influence discharge planning, address patients' social needs, and prevent recurrent utilization may have already passed. Established ambulatory and complex care programs through hospitals, independent practice associations (IPAs), and health plans are important but may not be sufficient for the most complex patients. MedPOINT Management (MPM) needed a scalable model to identify a subset of California Medicaid (Medi-Cal) patients with the highest service needs in real-time and rapidly coordinate interventions while those needs remained more actionable.

The Intervention

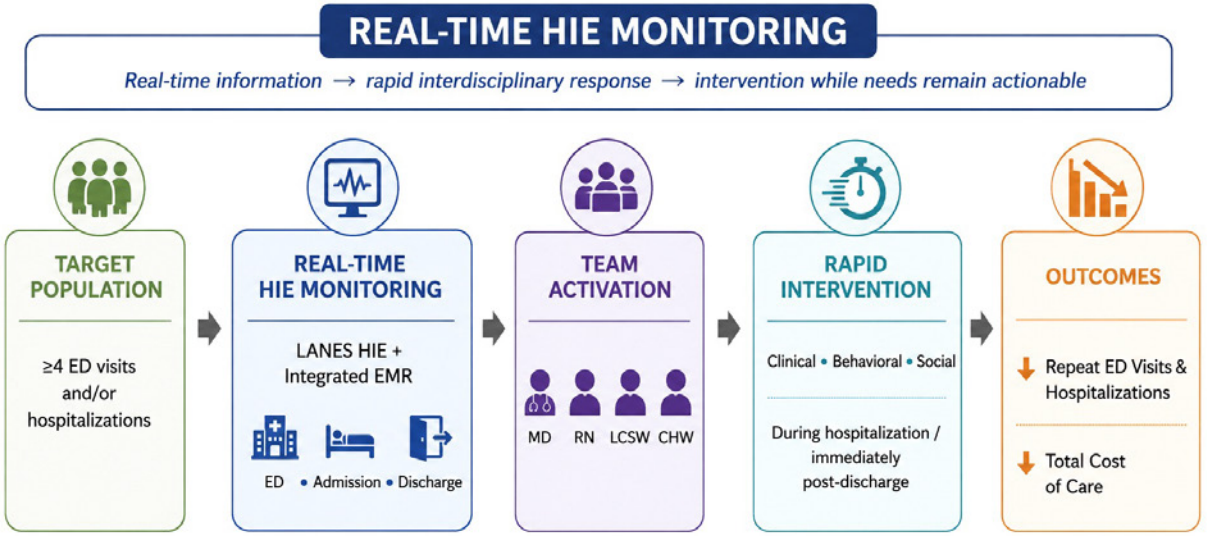
As the Management Services Organization (MSO) supporting networks of physicians and practices within IPAs and Clinically Integrated Networks, MPM implemented the 360-Degree Care Integration Model, a program that proactively identifies the highest-risk Medi-Cal members and provides real-time supportive interventions during critical transitions of care. The key feature of this program was the integration of actionable, real-time health information exchange (HIE) alerts with a dedicated physician-led interdisciplinary team that could intervene during hospitalizations or immediately following discharge, rather than waiting for retrospective claims-based outreach.

With participation in a Medi-Cal managed care dual-risk payment arrangement and as part of an "integrated delivery network (IDN)" with five area hospitals, MPM also had the advantage of aligned financial accountabilities and quality and savings incentives in partnership with

the hospitals. Together, the IDN partners shared responsibility for health care costs for an attributed cohort of Medi-Cal patients – the MPM-support IPA accountable for the professional physician and ancillary service costs, while the partner hospitals bore responsibility for facility-based costs, including for emergency and inpatient services. Through the IDN, MPM had access to an electronic health record (EHR) system that was used across the partner hospitals and their multiple outpatient clinics. Using historical utilization data, MPM prioritized identification of Medi-Cal members with four or more ED visits and/or hospitalizations. These members' health care needs and interactions were then monitored through the Los Angeles Network for Enhanced Services (LANES) HIE. The HIE alerts provided notification of ED visits, hospital admissions and discharges occurring at network and non-network hospitals. These alerts were transmitted via a secure file transfer protocol to a designated MPM coordinator on the team.

Figure 1

KEY ELEMENTS OF THE 360-DEGREE CARE INTEGRATION PROGRAM



The 360-Degree Care Integration program thus included four key components: (1) proactively identifying a targeted high-risk population through utilization analytics; (2) continuously monitoring these members through actionable real-time HIE alerts and access to clinical records in a shared EHR across the IDN; (3) activating a dedicated physician-led interdisciplinary team; and (4) providing rapid, community-based interventions during hospitalization or immediately following discharge *(Figure 1)*.

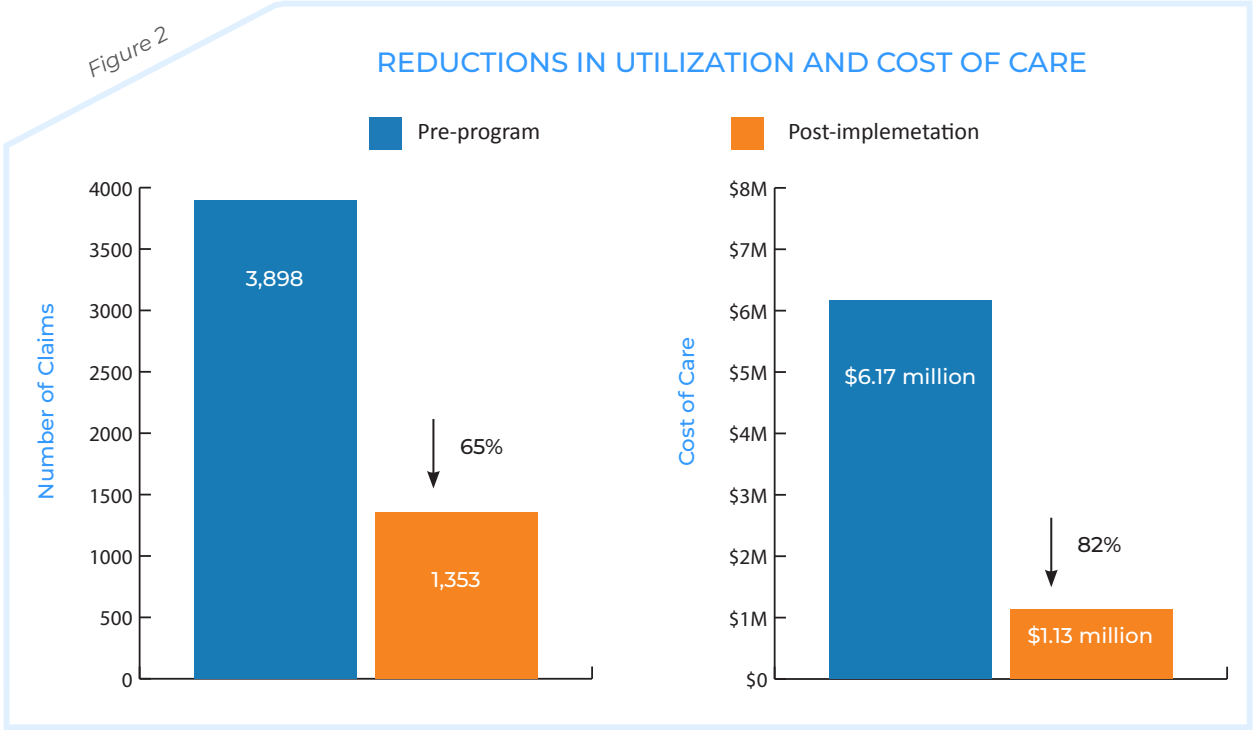
Each alert triggered review by MPM's dedicated interdisciplinary team consisting of a physician medical director, a registered nurse, a licensed clinical social worker, and a community health worker. The team identified clinical, behavioral, and social factors contributing to recurrent instability, exacerbation or decompensation of members and their conditions and developed individualized intervention plans. Interventions began while a given member was hospitalized or immediately following discharge rather than weeks or months later. Depending on the member's needs, the team addressed chronic condition management, medication access, housing, transportation, food insecurity, behavioral health, care coordination, and importantly, timely outpatient follow-up with a primary care medical home within the IDN.

The Results

Between January 1 and October 31, 2025, 374 members with four or more ED visits and/or hospitalizations were identified as being eligible for the 360-Degree Care Integration Program, and 204 enrolled. The program achieved a 65% reduction in total claims from 3,898 to 1,353 and an 82%

reduction in total cost of care from $6.17 million to $1.13 million *(Figure 2)*. These reductions included claims for ED, inpatient hospital, and skilled nursing facilities and services, durable medical equipment, and home health and ambulance services. The greatest cost reductions were associated with improved management of chronic conditions and reductions in recurrent acute-care utilization, particularly hospitalizations and repeat ED visits.

Figure 2



Key operational lessons emerged from MPM's experience to date. Real-time HIE alerts were most effective when paired with clearly defined triage roles, responsibilities, and intervention workflows that allowed the team to act on information quickly. The HIE provided visibility into when and where intervention was needed, while the interdisciplinary team translated that information into timely clinical and community-based actions. Defined interdisciplinary roles supported the diverse range of interventions while members were still hospitalized or immediately following discharge. Community health workers, who had in-person access to the five partner hospitals before patients were discharged, were particularly important in establishing trust, identifying barriers that were not always apparent in the medical records, and maintaining member engagement after discharge. However, not all eligible members enrolled, highlighting the continuing challenge of engaging members with complex clinical and social needs.



The Conclusion

MedPOINT Management's 360-Degree Care Integration model demonstrated that building on a dual-risk payment arrangement to align multiple care delivery partners, combined with population-based analytics, actionable real-time HIE alerts, a dedicated physician-led interdisciplinary team, and rapid community-based interventions, can significantly improve care for Medicaid members with high service needs. By identifying a targeted population, continuously monitoring service needs across health care settings, and intervening during hospitalizations or immediately following discharge, MPM moved care management from a retrospective process to a proactive operational model. This program provides a practical and replicable approach — provided that the appropriate financial accountabilities and incentives are in place — for diverse care delivery stakeholders including MSOs, IPAs, other accountable physician organizations, and hospitals to use real-time HIE information to improve transitions of care, reduce avoidable ED visits and hospitalizations, and lower total cost of care.

MemorialCare
Medical Foundation



MemorialCare Medical Foundation is a medical foundation within MemorialCare Health System, an integrated nonprofit health system serving Southern California. MCMF partners with affiliated physician groups to deliver coordinated, value-based care to Commercial HMO and Medicare Advantage populations across primary, specialty, and home-based settings. MemorialCare Medical Foundation is based in Orange County, California.

> *"High-touch, home-based care can be redesigned to improve outcomes and remain financially viable under shared risk.*

Optimizing the Safety Net: Redesigning Home-Based Care to Improve Value Under Shared Risk

Introduction

Home-based medical care has become a leading value-based strategy for homebound and semi-homebound older adults, but Medicare spending among these high need patients is nearly twice that of their non-homebound peers.[1] If risk-bearing physician organizations move from full to shared risk and retain only a portion of the institutional savings these programs generate, the financial case for these resource-intensive models weakens and many groups scale them back. MemorialCare Medical Foundation (MCMF) took the opposite path. Facing this shift across its Medicare Advantage contracts, it redesigned its WHOLE Life home-based care program to operate more efficiently, preserving and improving value under shared risk rather than retreating from an evidence-based model of care.[2]

The Challenge

Homebound and semi-homebound older adults often cannot access traditional office-based primary care without substantial cost and difficulty. As a result, chronic conditions and goals of care are poorly managed until an acute crisis forces an emergency department (ED) visit or hospitalization that generates avoidable utilization and downstream cost.

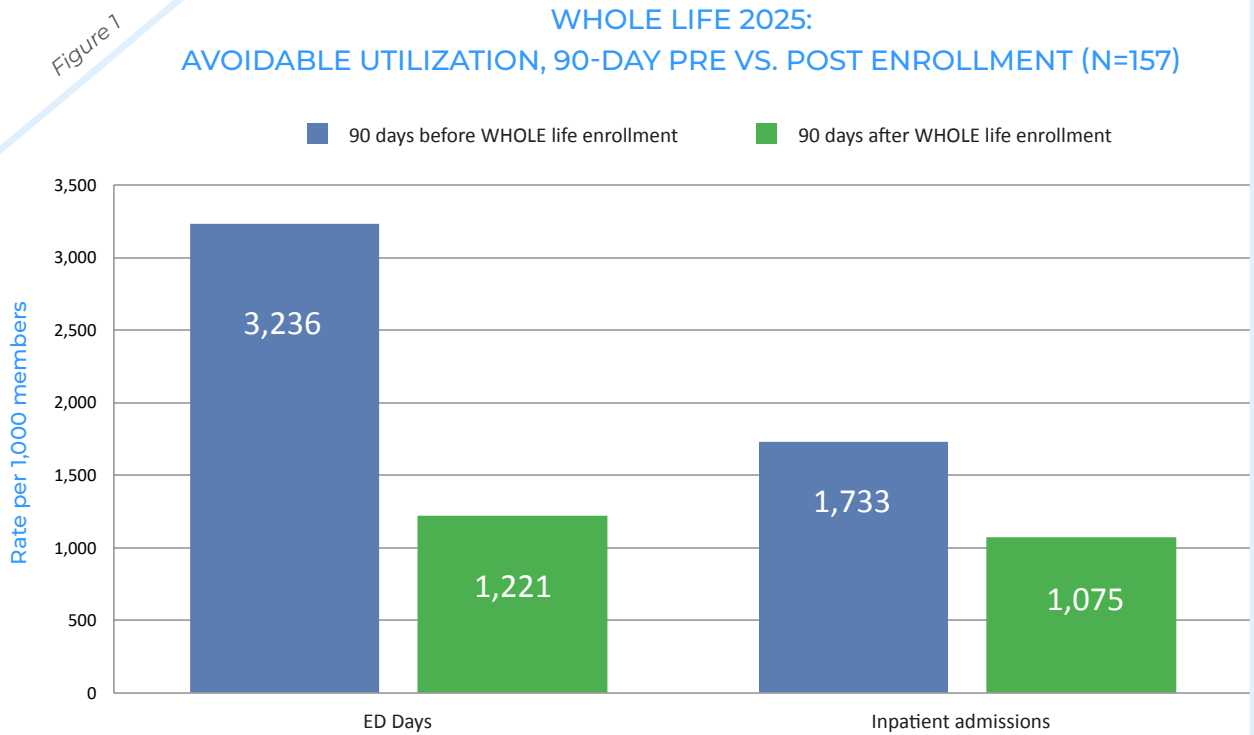
MCMF confronted this clinical reality in parallel with a financial one: Its contracts for the Medicare Advantage population shifted from full (global) risk to shared-risk arrangements with many payers. Under this arrangement, the organization became primarily responsible for only professional physician and ancillary service costs and shares, rather than fully retains, institutional (facility) savings. Because only part of the savings from a prevented hospitalization accrues to the group, conventional return-on-investment logic discourages investment in high-touch, home-based programs, and organizations in this position commonly respond by scaling these programs back. Compounding this financial pressure, MemorialCare's legacy WHOLE Life program carried inefficiencies: an enrollment panel that had drifted to include patients who no longer needed home-based care, operations that relied largely on reactive patient monitoring, and a staffing model that did not fully match clinical needs.

MCMF faced a defining choice: disinvest in home-based care to protect margins under shared-risk or redesign the program to deliver value more efficiently. It chose the redesign option.

The Intervention

WHOLE Life delivers high-quality primary care wherever the patient calls home. It provides regular visits based on medical necessity, along with social work assessment for social determinants and behavioral health needs, in-home labs and imaging, palliative care, wound care, annual wellness visits, and end-of-life planning for homebound and semi-homebound Medicare Advantage and high-risk HMO patients.

Figure 1



The 2025 redesign concentrated on delivering these services more efficiently. A monthly enrollment audit right sized the panel to patients who most needed home-based care, curbing spending on members who no longer benefitted. To shift from reactive to proactive care, the team built two new electronic health record (EHR)-based reports in Epic that identified patients who were (1) recently seen in the ED or discharged from inpatient care and who did not have a next visit scheduled within seven days and (2) all patients in the program without a check-in scheduled. This approach enabled timely outreach without added staff. A centralized Navigation Center absorbed after-hours and weekend phone coverage in place of dedicated staffing.

The redesign also strengthened the clinical model: earlier social worker assessments for every new patient, advanced wound care upskilling of nurse practitioners, faster in-home lab and imaging turnaround times, expanded e-consults, and more aggressive end-of-life care planning and documentation of goals. Notably, these gains were achieved while reducing staffing, including the removal of one per-diem nurse practitioner.

The Results

WHOLE Life compared each patient's utilization and cost in the 90 days before enrollment with the 90 days after, then aggregated the four quarterly 2025 cohorts into a single enrollment-weighted, program-level result. The outcomes cohort consists of 157 unique members who



newly enrolled across 2025's four quarters. Separately, the active census grew from a redesign baseline of 144 patients (January 2025) to 227 (April 2026). Since the census also reflects expected departures, audit disenrollment, insurance changes, and hospice or death in this high-risk population, net growth is smaller than total new enrollment.

The WHOLE Life program was associated with reductions across all three measures: ED days fell 62% (3,236 to 1,221 per 1,000 members), inpatient admissions fell 38% (1,733 to 1,075 per 1,000 members; *Figure 1*), and the PMPM cost of care fell 41%. Although there was some quarter to quarter variation for the enrolled cohort, the favorable trend remained consistent over time. While compelling, these results are derived from an uncontrolled, pre/post comparison that may reflect some regression to the mean.

The Conclusion

WHOLE Life shows that high-touch, home-based care can be redesigned to improve outcomes and remain financially viable under shared risk, countering the industry default to disinvest.

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SHARP



Sharp Rees-Stealy Medical Group is a multispecialty medical group within Sharp HealthCare serving the San Diego region of California. More than 600 clinicians provide coordinated care across primary and specialty services. SRSMG participates in capitation and value-based contracts and uses population health strategies to improve outcomes, access, and affordability.

> *Despite their potential to identify early lung cancer, an estimated 70% of IPNs are never followed up.*

Proactive Lung Cancer Prevention: An AI-Enabled, Population-Health Model for Closing the Incidental Pulmonary Nodule Follow-Up Gap

Introduction

Incidental pulmonary nodules (IPNs) are among the most common and frequently mismanaged findings in modern radiology. In the United States, roughly 30% of chest computed tomography (CT) scans reveal an incidental nodule, resulting in findings of an estimated 1.6 million nodules annually. Of these nodules, 2% to 5% prove to be malignant, a rate comparable to that of lung cancers detected through dedicated low-dose CT lung cancer screening programs.[1]

Despite the potential of IPNs to identify early lung cancer, an estimated 70% of IPNs are never followed up.[2] The U.S. Preventive Services Task Force screening criteria exclude roughly 65% of at-risk individuals,[3] and about one in four lung cancers are asymptomatic at diagnosis.[4] Taken together, these data suggest that unfollowed IPNs represent a major remediable source of missed early-stage lung cancer in community practice.

The Challenge

Sharp Rees-Stealy Medical Group (SRSMG) reviewed approximately 140 incidental nodules each month, with hundreds of open follow-up recommendations at any given time. The existing workflow relied on post-CT scan messages and alerts to primary care physicians (PCPs), but follow-up remained inconsistent. PCPs faced alert fatigue, complicated coordination processes, and fragmented responsibilities for follow-up care across multiple clinical departments, while the organization lacked a centralized mechanism to track due dates for subsequent imaging or repeat screenings. The volume exceeded what unassisted primary care teams could reliably track and act upon.

This care gap carried both clinical and business consequences for a physician group working under capitation and value-based contracts. Missed or delayed follow-up could potentially postpone diagnosis, affect patient outcomes, increase medicolegal risk, and contribute to higher total costs of care when cancer is identified at a later stage. Published estimates place first-year lung cancer care at approximately $184,000 for late-stage disease versus $61,000 for early-stage disease.[5]

The Intervention

SRSMG designed and implemented a systematic IPN follow-up program. Initially launched in 2024 on a registry-based tracking platform, the program paired a dedicated pulmonary physician with advanced practice clinicians who reviewed every flagged nodule, applied evidence-based Fleischner Society criteria for managing IPNs, and routed standardized follow-up and consultation recommendations to PCPs.

Figure 1

SRSMG IPN PROGRAM FLOW, DECEMBER 2025 THROUGH JUNE 2026

Nodules Reviewed	Follow-up Recommendations	Pulmonary Consults	Biopsies	Malignancies	Referrals
732 →	287 →	36 →	12 →	10 →	4 Surgical 6 Oncology

In December 2025, SRSMG deployed an Epic electronic health record system (EHR)-based, AI-enabled nodule-tracking tool that uses natural language processing to extract nodule findings from radiology reports and follow each patient longitudinally across the nodule-to-diagnosis-to-treatment continuum. This EHR-based tool supports monitoring of time to pulmonary consultation, biopsy, and treatment so the dedicated IPN follow-up team can identify coordination bottlenecks.



The Results

Between December 2025 and June 2026, the program reviewed 732 IPNs, generated 287 structured follow-up recommendations and 36 pulmonary consultations, completed 12 biopsies, and identified 10 malignancies. These findings led to four surgical referrals and six oncology referrals. The malignancy-detection rate was 10 of 732 reviewed nodules, or approximately 1.4% *(Figure 1)*.

Four patients were identified with early stage lung cancer and referred for surgical management. Using the published difference of approximately $123,000 between late-stage and early-stage first-year treatment costs, those four early-stage detections suggest potential avoidance of approximately $492,000 in first-year care costs compared to later stage presentations. This is a modeled estimate, not realized savings.

Implementation to date also yielded additional operational insights. Although automated case identification improved visibility, there was still need for clinical review and for establishing clear ownership of who was responsible for following and contacting patients, ordering and scheduling follow-up tests and procedures, and the longitudinal tracking of care and outcomes. EHR workflow design also mattered: Teams identified the need for clear recommendations and communications on discrete follow-up intervals, tracking support for test due

dates, functionalities in the registry dashboard to enable sorting and prioritization of patients, automated bulk outreach communications to patients, and optimized surveillance reminders that do not exacerbate EHR alert fatigue for PCPs or their clinical staff.

As the growing volume of cases exceeded the capacity of the IPN follow-up team and in order to sustain and scale the program, SRSMG invested in the addition of a “nodule navigator” — a registered nurse — to support care coordination, protect timeliness, and extend the model across the full at-risk population. Future efforts will focus on follow-up completion, time to consultation and biopsy, stage at diagnosis, and cost avoidance.

The Conclusion

SRSMG demonstrated that an AI-enabled, clinician-led population health model can convert incidental radiology findings into a structured care pathway for follow-up, diagnosis, and treatment. The program identified 10 malignancies during its first six months—including four patients referred for surgical management—while creating a standardized process for hundreds of additional patients requiring surveillance or consultation.

This care model exemplifies value-based care by addressing quality, safety, access, and total cost of care simultaneously. Its core best-practice elements consist of automated case identification, evidence-based clinical review, explicit accountability, closed-loop follow-up, and measurement across the full nodule-to-treatment continuum.

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Embedding Behavioral Health in Community Oncology: Measurement-Guided Collaborative Care at Scale



Starling Oncology is one of the largest value-based community oncology groups in the United States with clinics in California, Oregon, Arizona, Nevada, and Florida. Starling's clinical network includes board-certified hematologists and oncologists and radiation oncologists serving patients across more than 80 clinic locations.

> *"Whenever I need them, they are available, in my most vulnerable moments, the counselor is there to listen. Thank you."*

Introduction

Depression and anxiety affect 30–50% of patients with cancer,[1,2] yet access to behavioral health (BH) services within oncology practices remains limited. Only 27% of cancer patients with depression receive mental health treatment, and only 5% ever see a mental health professional.[1]

The Challenge

Starling Oncology implemented PHQ-9 (depression) and distress thermometer screening across its clinic network and was identifying large numbers of patients with clinically significant depression and anxiety. However, it was difficult to connect patients who screened positive with timely BH treatment. Starling Oncology explored building an internal BH team but encountered a challenging set of obstacles, as follows:

- Difficulty getting BH resources to the organization's rapidly expanding network across the United States;
- Difficulty establishing in-network insurance contracts for BH billing;
- Prolonged clinician credentialing timelines;
- Ongoing complexity of recruiting, training, and supervising licensed clinicians across multiple clinic sites;
- Staff attrition that disrupted continuity of care for patients already in treatment.

In addition, the anticipated volume of referrals generated by systematic PHQ-9 screening was judged to exceed what an internal team could absorb. Starling Oncology needed a model that could provide consistent BH access without requiring the organization to build and manage an independent clinical BH service line.

The Intervention

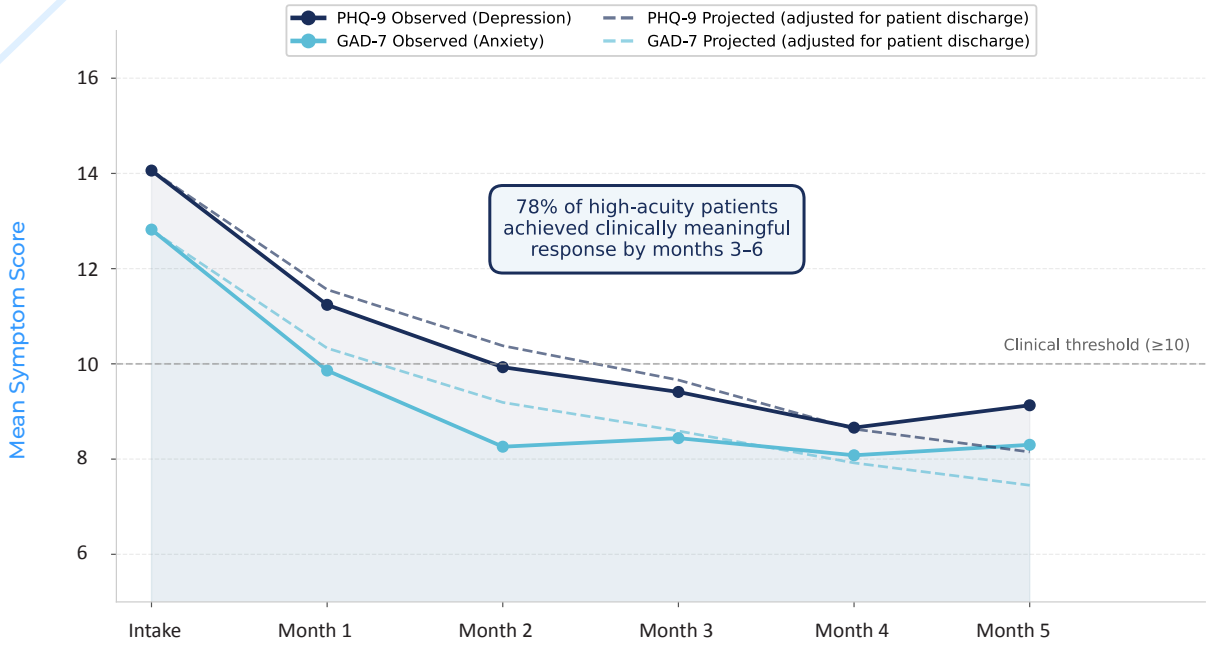
In 2025, Starling Oncology partnered with Protocol Behavioral Health to implement a Collaborative Care Model (CoCM) across its clinic network. The CoCM is a measurement-

guided framework for integrated BH care designated by the National Comprehensive Cancer Network as the standard of care for distress management in oncology.[3] Key program elements included the following:

- Masters-level BH care managers and psychiatric consultants embedded within the Starling Oncology care settings and available via telehealth;
- Clinician recruitment, credentialing, malpractice coverage, training, and quality oversight managed through the BH service partner that reduced administrative burden on Starling Oncology staff;
- An automated patient registry that tracks enrolled patients, with alerts for overdue assessments or worsening scores;
- Billing through established CoCM CPT codes (99492, 99493, 99494);
- Spanish-speaking clinicians to support patients with limited English proficiency.

Figure 1

CHANGE IN MEAN PHQ-9 AND GAD-7 SCORES AMONG PATIENTS WITH CANCER AND HIGH ACUITY DEPRESSION AND ANXIETY SYMPTOMS AT INTAKE, N=516



Solid lines: observed mean scores among patients assessed each month. Dashed lines: mixed-effects model projection adjusting for graduation bias (patients who reach remission discharge from care and no longer contribute scores). Data through August 2026.

Patients who scored ≥8 on the PHQ-9 during in-clinic screening were referred for enrollment in the BH program. Once enrolled, PHQ-9 (depression) and GAD-7 (anxiety) symptom scores were reassessed monthly and shared with the treating oncology team via notes and messaging within the electronic health record.

The Results

Between September 2025 and August 2026, 747 patients were enrolled in the program. Of these, 516 (69%) presented with high acuity scores (PHQ-9 or GAD-7 ≥10) captured by validated symptom severity measurement tools *(Figure 1)*; the remaining 231 scored below the high acuity threshold but also received the same CoCM care with monitoring and step-up treatment as clinically indicated. Because validated response criteria and

published CoCM benchmarks are designed for patients with clinically elevated symptoms, the outcomes reported below focus on the 516 high acuity patients. Of these patients, 218 had reached three to six months of care at the time of this analysis. The p-values are from paired t-tests between baseline and month three, and Cohen's d is a measure of effect size that quantifies the difference between two group means in terms of standard deviation units. CoCM trials outside of oncology settings have reported Cohen's d statistics ranging from 0.3-0.6.[4]

- Mean PHQ-9 score of 14.1 at intake decreased to 9.4 at month three ($p < 0.001$, Cohen's $d = 1.10$).
- Mean GAD-7 score of 12.8 at intake decreased to 8.4 at month three ($p < 0.001$; Cohen's $d = 1.25$).
- 78% of high-acuity patients with follow-up data after three months of care (n=218 of 516) achieved a clinically meaningful response (defined as ≥50% or ≥5-point absolute reduction in PHQ-9 or GAD-7) at an assessment point between months three and six.
- Month-over-month retention in care rate averaged 84% across the program and increased over time, reaching 89% from month three to four and 95% from month four to five.

As this program matures and longitudinal data accumulate, future analyses will examine whether sustained improvements in BH measures translate to better oncology outcomes, including treatment adherence and care continuity. Understanding these longer-term links constitutes an important next step for demonstrating the full value of integrated BH in oncology settings.



The Conclusion

Starling Oncology's experience shows that structured BH integration in community oncology is operationally feasible and produces clinically meaningful improvements in depression and anxiety symptoms within a short time after implementation. The barriers most cited by oncology practices (credentialing, staffing, and BH billing) can be addressed through a purpose-built external partnership model.

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Sutter Health



Founded in 1984 and based in Sacramento, California, Sutter Medical Group is affiliated with Sutter Health. SMG is a diverse group of over a thousand clinicians including both primary and specialty care that enhances the well-being of people in the communities it serves through a not-for-profit commitment to compassion and excellence in health care services.

> *"Timeliness of patient grievance reviews improved substantially following program redesign.*

Ambulatory Peer Review Innovation: Transforming Quality Improvement, Clinician Engagement, Organizational Learning, and Operational Excellence

Introduction

Value-based care requires health care organizations to simultaneously drive quality improvement, clinician engagement, organizational learning, and operational excellence. Ambulatory peer review offers an opportunity to influence all four domains through its role in advancing clinical quality, patient safety, professional accountability, and organizational learning. However, many organizations continue to utilize retrospective review processes that are often viewed as punitive and disconnected from broader quality improvement efforts.

In early 2024, Sutter Medical Group (SMG) sought to redesign ambulatory peer review as a system-wide learning platform supporting organizational improvement and value-based care performance.

Ideally, the redesigned model would emphasize transparency, multidisciplinary collaboration, operational process accountability and individual accountability. By integrating peer review findings into leadership governance structures and educational initiatives, the organization sought to improve timeliness, clinician experience, and system performance while generating actionable learning that could benefit patients and care teams across the medical group.

The Challenge

Prior to the redesign, many clinicians (including MDs, DOs, NPs, PAs and podiatrists) perceived ambulatory peer review as an adversarial process rather than a constructive mechanism for professional growth and quality improvement. This perception limited participation and reduced the potential value of peer review as a tool for learning and system enhancement.

Operational performance also required improvement, with resolution of patient grievances frequently exceeding desired timelines. In 2024, while the organizational target was for 90% of cases to be resolved within 30 days, only 50% of patient grievance cases achieved resolution within the goal timeframe.

In addition, lessons identified through peer review activities were not cohesively and consistently translated into broader organizational improvements. Opportunities to inform clinician education, redesign workflows, and strengthen patient safety processes often remained isolated within individual case reviews. Yet organizational leaders recognized

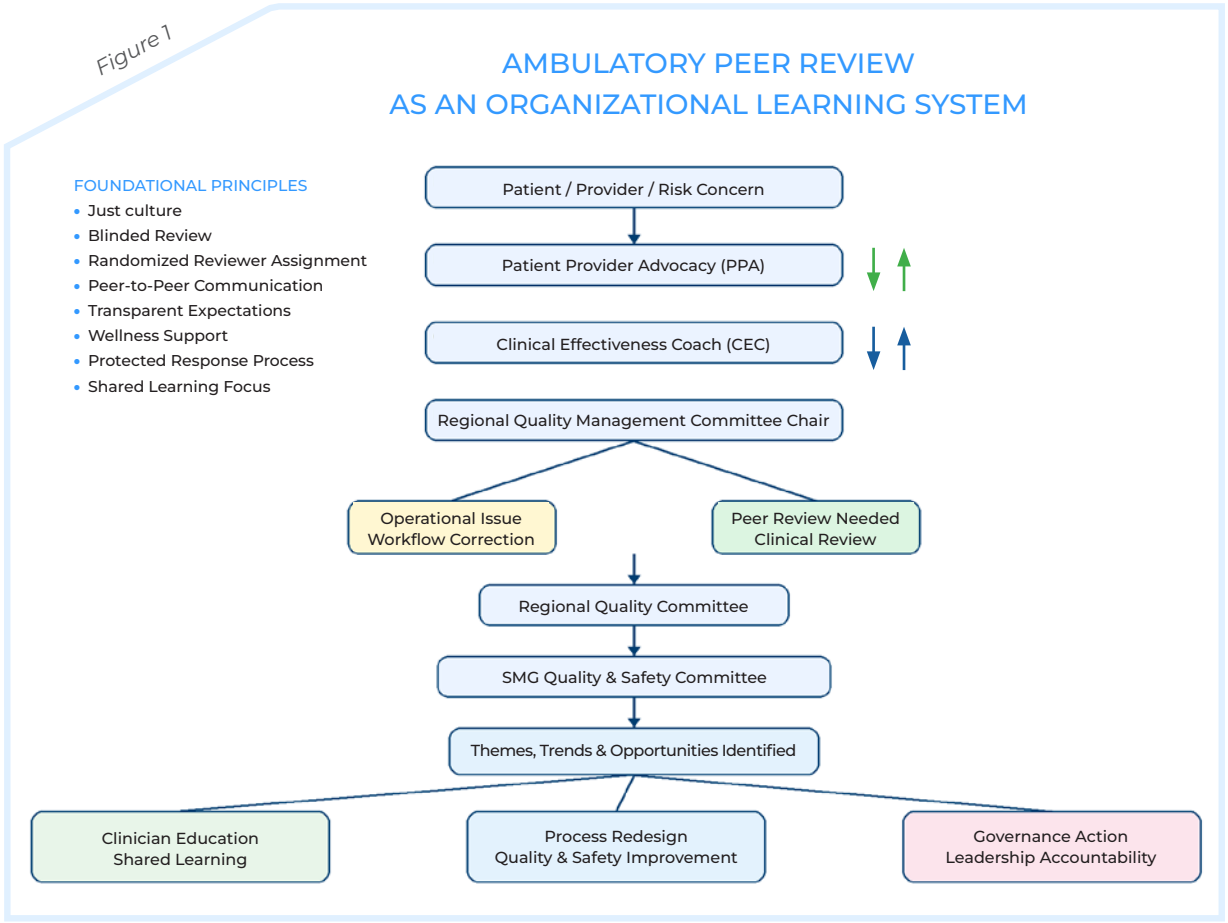
that improving peer review and undertaking related operational changes could support risk reduction efforts as well as quality and process improvements.

The Intervention

Supported by clinician and quality leaders, operational partners, and clinician wellbeing experts, SMG implemented a comprehensive redesign of ambulatory peer review *(Figure 1)*.

Peer review findings were intentionally linked to governance structures, educational initiatives, operational redesign efforts, leadership accountability mechanisms, and organizational learning activities, thereby enabling system-level impact beyond individual case reviews. Integrating peer review into quality governance transformed isolated case reviews into opportunities for quality improvement, clinician engagement, shared learning, and process improvement across the organization.

Figure 1



The initiative began with development of a continuing medical education program, dubbed Ambulatory Peer Review Boot Camp, to improve understanding of peer review principles among clinician leaders. "Just culture" principles of shared accountability for errors emphasized learning, accountability, and system improvement rather than blame. Peer review then focused on human errors, at-risk behaviors, and reckless behaviors — those behavioral choices that disregarded substantial and unjustifiable risks. The emphasis shifted from "who caused the problem?" to "what went wrong?" with the aim of balancing individual accountability for at-risk and reckless behaviors with shared organizational responsibility for systems process redesign.



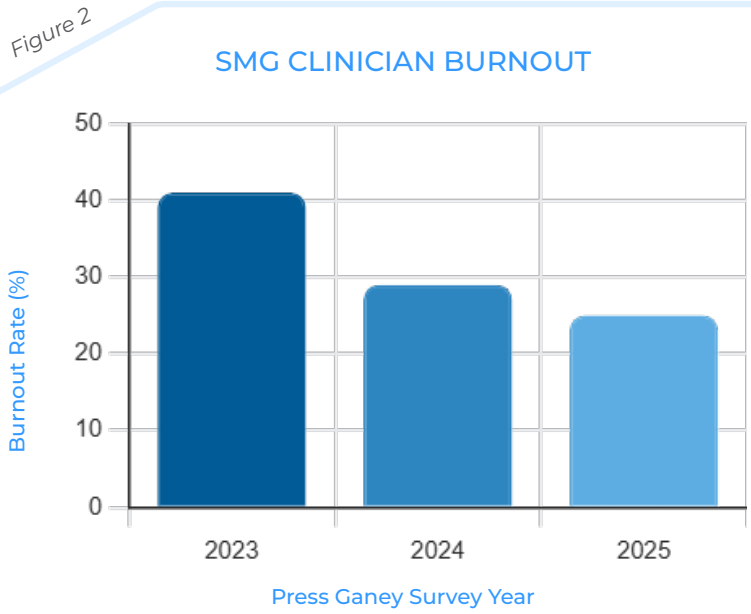
The program strengthened collaboration between Patient-Provider Advocacy teams (where patient complaints originate) and staff who support peer review throughout SMG. This enhanced partnership improved intake processes and established clearer operational workflows.

To promote impartiality and build clinician trust, the organization adopted randomized, blinded, and geographically based peer reviews rather than traditional specialty-based review approaches. Program leaders redesigned communication letters in collaboration with clinician

wellbeing experts to create a more supportive and less punitive experience. Regional Quality Management Committee chairs reviewed cases and elevated themes with broader organizational significance to the SMG Quality and Safety Committee.

These changes transformed peer review from an isolated activity into a structured organizational learning system that identifies improvement opportunities across quality, clinician engagement, organizational learning, and operational domains.

Figure 2



The Results

Operational Outcomes

Timeliness of patient grievance reviews improved substantially following program redesign. The proportion of grievances resolved within 30 days increased from 50% in 2024 to 92% in 2025.

Physician Wellbeing

Physician wellbeing demonstrated notable improvement during implementation. Burnout, assessed annually by anonymous Press Ganey surveys, decreased from 41% in 2023 to 25% in 2025 *(Figure 2)*, reflecting the organization's broader commitment to a learning-oriented and supportive peer review culture.

Organizational Learning

Ten process redesign initiatives and five organization-wide clinician educational programs were developed from themes identified through peer review activity.

Lessons Learned from Ambulatory Peer Review Transformation

- Physician trust is foundational to effective peer review.
- Blinded review reduces perceived bias and strengthens credibility.
- "Just culture" principles promote learning rather than punishment.
- Governance pathways are essential to convert findings into action.
- Organizational learning amplifies the value of individual case reviews.
- Financial stewardship may emerge as an additional benefit when peer review is integrated with quality and safety infrastructure.

The Conclusion

A just culture-based ambulatory peer review framework transformed peer review from a retrospective review process into a strategic asset supporting quality improvement, clinician engagement, organizational learning, and operational excellence. The initiative improved patient grievance turnaround times, reduced physician burnout, generated system-wide educational and process redesign initiatives, and strengthened governance accountability.

UCLA Health



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 280 clinics throughout Southern California and at five world-class medical centers: Ronald Reagan UCLA Medical Center, UCLA Mattel Children's Hospital, UCLA Resnick Neuropsychiatric Hospital, UCLA Santa Monica Medical Center, and UCLA West Valley Medical Center.

> *"MAP's migration in October 2025 introduced new, real-time data tracking capabilities.*

Following the "MAP": Guiding Patients from Outreach to Action Using "My Action Plan," A High-Impact Centralized Patient Outreach Strategy

Introduction

Health care organizations continue to seek more effective ways to manage chronic health conditions and encourage patients to complete preventive care screenings while they simultaneously meet quality and value-based performance expectations. However, patient outreach efforts are frequently siloed by condition, department, or campaign. This situation results in fragmented communication that can overwhelm patients and minimize the effectiveness of engagement initiatives. The challenge is particularly great for large health systems that must balance the need to tailor interventions and scale them while maintaining operational efficiency.

The Challenge

In 2022, UCLA Health identified a critical improvement need related to preventive health and chronic care management due to lagging performance with HEDIS standards and managed care contract benchmarks. A key factor contributing to poor performance was messaging fatigue. Health messaging and consumer psychology research indicate that repeated messaging often drives a transition from positive task perception to avoidance and disengagement.[1] UCLA patients reported receiving individual messages for different care gaps, often originating from multiple departments. These repeated messages from numerous providers frequently resulted in confusion and inaction.

The Intervention

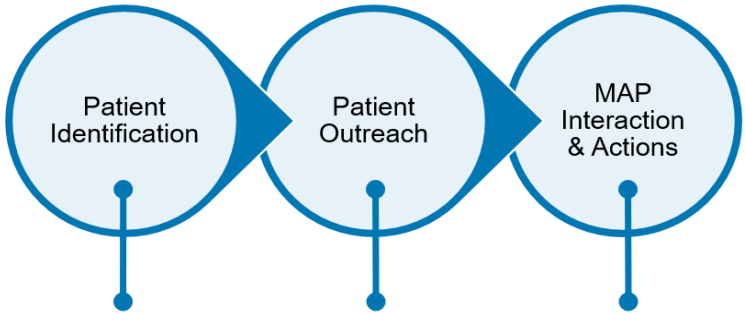
To address this issue, UCLA Health developed My Action Plan ("MAP"), a primary care network-wide outreach initiative designed to centralize and streamline patient communication for overdue preventive health screenings and chronic care management related to diabetes, hypertension, and breast, cervical, and colorectal cancer screenings.

Launched in 2023, MAP consists of two main outreach methods: (1) an electronic health record (EHR) patient portal message that includes education and actionable next steps pertaining to overdue services and (2) a text message notification informing patients of

important messages posted to their EHR accounts. If a patient does not engage with either the EHR patient portal message or text message within two weeks, another reminder text message prompts the patient to access the message in the patient portal *(Figure 1)*. This initial version of MAP consisted of three independent, manual processes in which separate teams were responsible for submitting bulk orders, EHR patient portal messages, and text messages.

Figure 1

MY ACTION PLAN (MAP) COMPONENTS



Patients Due for Identified Care Gaps:
1. Annual Primary Care Visit
2. Breast Cancer Screening
3. Colorectal Cancer Screening
4. Cervical Cancer Screening
5. Controlling High Blood Pressure
6. Diabetic HbA1c Blood Sugar
7. Diabetes Poor Control: A1c>9
8. Diabetes A1c>9: Diabetes Educators
9. Diabetes Eye Exam
10. Kidney Health Evaluation

Outreach Modality:
- MyChart Message
- Text Message
- Reminder Text Message
- Bulk Outreach Automated in October 2025

Resulting Actions:
- Patient Engagement with "MAP" Message in MyChart
- Bulk Orders
- Direct Scheduling or Scheduling Tickets
- Mailed FIT Kits for Colorectal Cancer Screening
- Bulk Clinical Orders Automated in October 2025

To streamline MAP, stakeholders reconvened in 2025 to migrate the initiative from its original build into Epic Campaigns, an EHR-integrated outreach feature that identifies patients for targeted communication, automates messaging and clinical order workflows, and tracks engagement and care-related outcomes. The program migration consolidated and automated all MAP processes and removed manual components without hampering patient engagement.



The Results

MAP's migration in October 2025 introduced new, real-time data tracking capabilities. Previously, patient engagement rates with MAP text message outreach were not easily accessible or timely for UCLA's program team due to reliance on an outside vendor. After the migration, engagement with the MAP message (defined as opening the message) and text message outreach (defined as clicking the URL included in the text message) are both now trackable. In monthly MAP cycles between October 2025 and July 2026, 32% to 35% of all outreaches resulted in engagement, with an overall average of 33.2% engagement during this period.

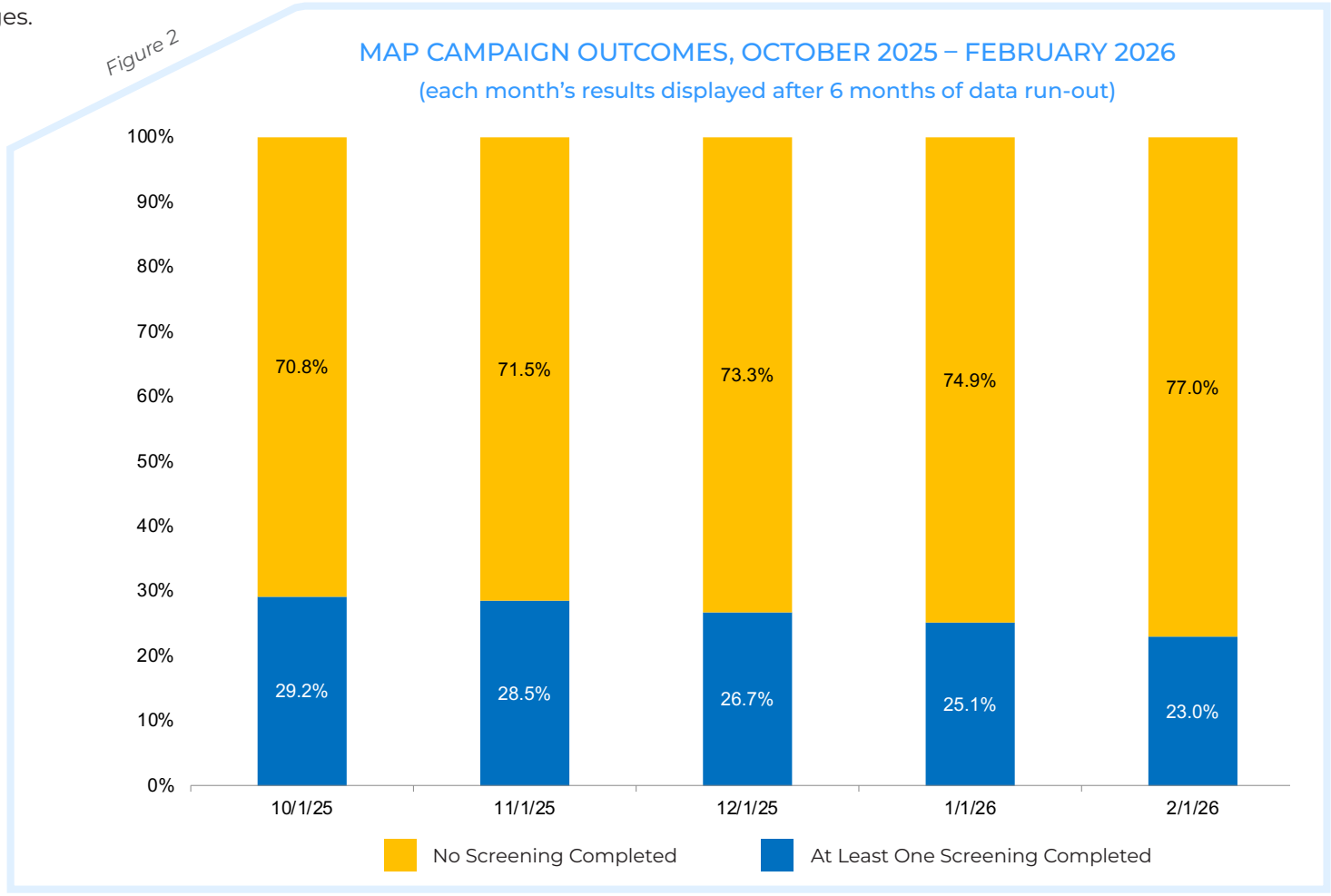
Five of the ten measures captured by MAP are defined by an established EHR-based Health Maintenance Topic: Breast Cancer Screening, Colorectal Cancer Screening, Cervical Cancer Screening, Diabetic Eye Exam, and Kidney Health Evaluation. The topic is considered "satisfied" when the patient completes the associated screening or lab. After the October 2025 migration, 27% of patients completed at least one of the five measures within six

months of receiving MAP messages. As expected, patients often took several months to act on the recommendations that they received from MAP. The results reflect this phenomenon and show a higher share of patients with at least one completed screening in earlier months compared to more recent months when the data on patient actions are captured during lookback periods and refreshed each month *(Figure 2)*.

The Conclusion

My Action Plan serves as a blueprint that demonstrates how physician organizations can pursue centralized, automated communication that drives recommended screenings and chronic care management while maintaining personalized connections with patients.

Figure 2



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[1] Schmidt, R. J., & Eisend, M. (2015). Advertising repetition: A meta-analysis on effective frequency in advertising. Journal of Advertising, 44(4), 415–428.

AMERICA'S PHYSICIAN GROUPS

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