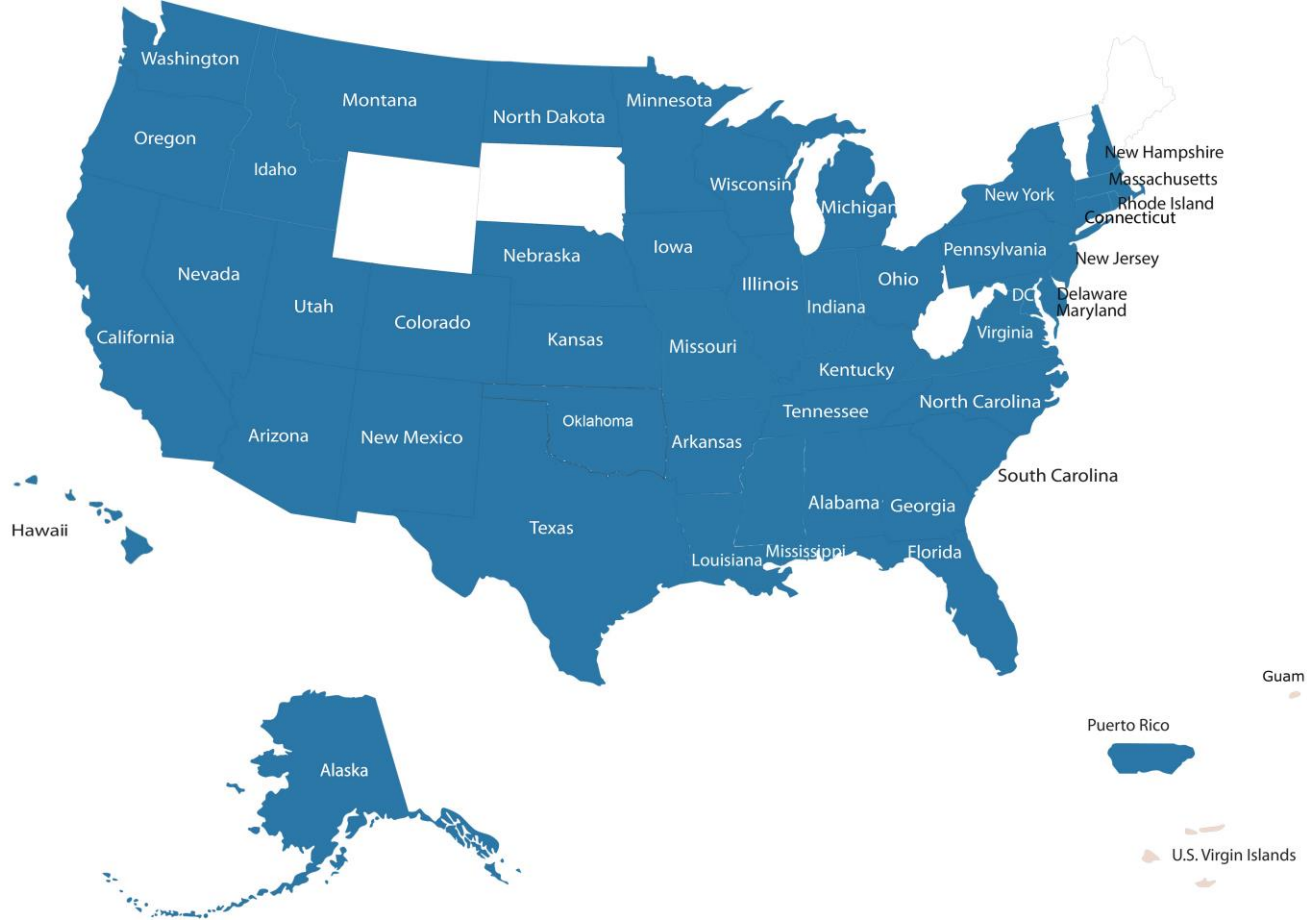


SUPPORTING THE CLINICAL COMMUNITY'S PARTICIPATION IN APMS

AMY NGUYEN HOWELL, MD, MBA, FAAFP
CHIEF MEDICAL OFFICER

AMERICA'S PHYSICIAN GROUPS



PILLARS OF EXCELLENCE

Education

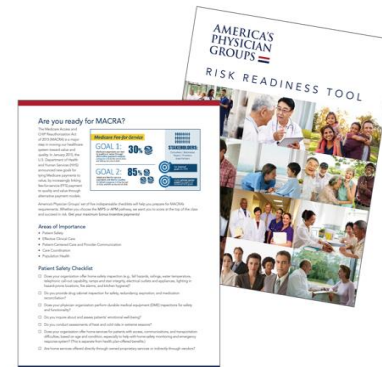
- National conferences
- Committee and regional meetings
- Webinars, summits, presentations
- Publications, resources, tools

Advocacy

- Updates on government policies & regs
- Comment letters & position papers
- Meet with the Administration, CMS, the Hill

Leadership

- Leading professional association in risk-based, coordinated care
- National network of executive leaders
- Powerful source of truth with policymakers



April 19-21, 2018
Manchester Grand Hyatt, San Diego, CA



October 10-12, 2018 | Hyatt Regency Washington on Capitol Hill • Washington, DC



APM MUST HAVES

- Communication
- Consumer
 - Choice
 - Convenience
 - Comfort
 - Control
 - Collaboration

UNDERSTANDING APM ELEMENTS

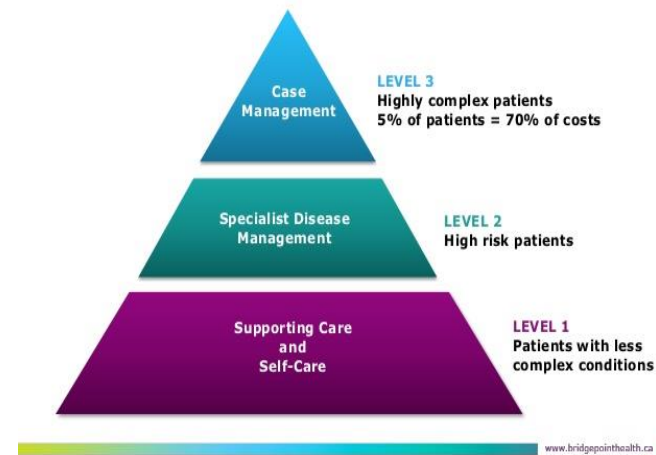
1. Care Management Processes
2. Health Information Technology
3. Accountability and Transparency
4. Patient Centered Care
5. Advanced Primary Care



HIGH COMPLEX CARE

- Staffing (RN, LCSW, BH, Rx, Nutritionist, Dietician)
- Sources of identification
- Predictive modeling to assess transitions or disease states:
 - Frail elderly
 - Vulnerability to fall
 - Recent cancer diagnosis
 - CHF
 - HA1C>9
 - COPD
- Full delegation

Kaiser Permanente Model



BEHAVIORAL HEALTH

- Manage behavioral health pop
- Access to in-network behavioral specialists for consultation (MD, psychologist, LCSW, MFT)
- Tele-health for BH services
- Real-time access BH specialists co-located with PCPs
- BH integration process working with interoperability of data sharing between health plan and provider organization

HOSPITALIST / SNFIST / INTENSIVIST / NOCTURNIST

- Physicians working exclusively in hospitals to deliver medical/surgical and/or NICU inpatient care
- Percentage of hospitalists used
- Employment relationship
- Contractual performance measurement and aligned incentives



- Formal SNF oversight program, linked to care coordination personnel
- SNF oversight for those SNF residents housed outside of area (>30 miles from office location)

POST-DISCHARGE & CARE COORDINATION

Concurrent Review

- Organizations' employment of on-site-in-person concurrent review nurses at affiliated hospital for utilization management, M-F

Post-Hospital Discharge Continuity and Care Coordination

- Concurrent review, pre-discharge planning, care team
- Hospital CM, Hospitalist, PCP, Rx, BH, SW, HH, SNF
- Track unplanned readmissions, peer committee clinicians for review, post discharge continuity clinic
- Plan to reduce avoidable ED use, physician incentivization, after-hours/urgent care clinic

ADVANCED ILLNESS AND PALLIATIVE CARE

- Formal ambulatory/home-based AIM program
- Contracted AIM specialists for referrals
- Level of palliative care specialty consultation
- PCPs, contracted organization, palliative care physicians
- Provide education, family support, community resources, and clinical navigation

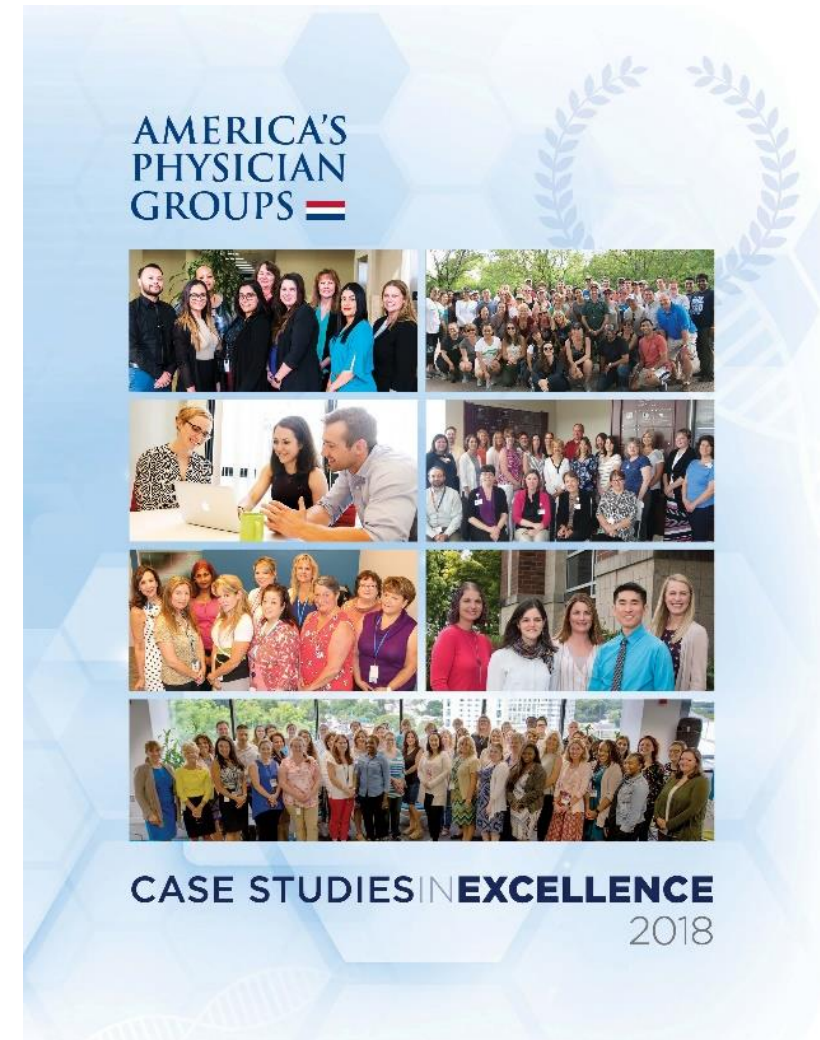


SOCIAL DETERMINANTS OF HEALTH

	Do you coordinate this service?	
Housing (e.g., addressing needs like adequate housing conditions, fear of eviction, overcrowding, and homelessness)	<input type="radio"/> Yes	<input type="radio"/> No
Personal Assistance (e.g., helping with everyday activities like bathing and dressing, meal preparation, and household tasks to enable independence and safety)	<input type="radio"/> Yes	<input type="radio"/> No
Health Self-Management Workshops (e.g., addressing the physical, mental, emotional and social challenges for people living with chronic conditions; offering low impact exercises and gentle activities to increase joint flexibility, range of motion and muscle strength for patients with arthritis)	<input type="radio"/> Yes	<input type="radio"/> No
Nutrition Services (e.g., addressing food insecurity; providing access to nutritious foods; providing mobile food delivery)	<input type="radio"/> Yes	<input type="radio"/> No
Social Work Assistance (e.g., helping with job security and unemployment; aiding with federal assistance programs; connecting patients with social supports and safety network)	<input type="radio"/> Yes	<input type="radio"/> No
Transportation (e.g., providing a mobile van to transport patients to their PCP's office; addressing transportation costs and lengthy times to reach needed healthcare services)	<input type="radio"/> Yes	<input type="radio"/> No
Behavioral Health (e.g., addressing issues like mental health conditions, post-partum depression, substance abuse, opioid addiction, smoking cessation)	<input type="radio"/> Yes	<input type="radio"/> No

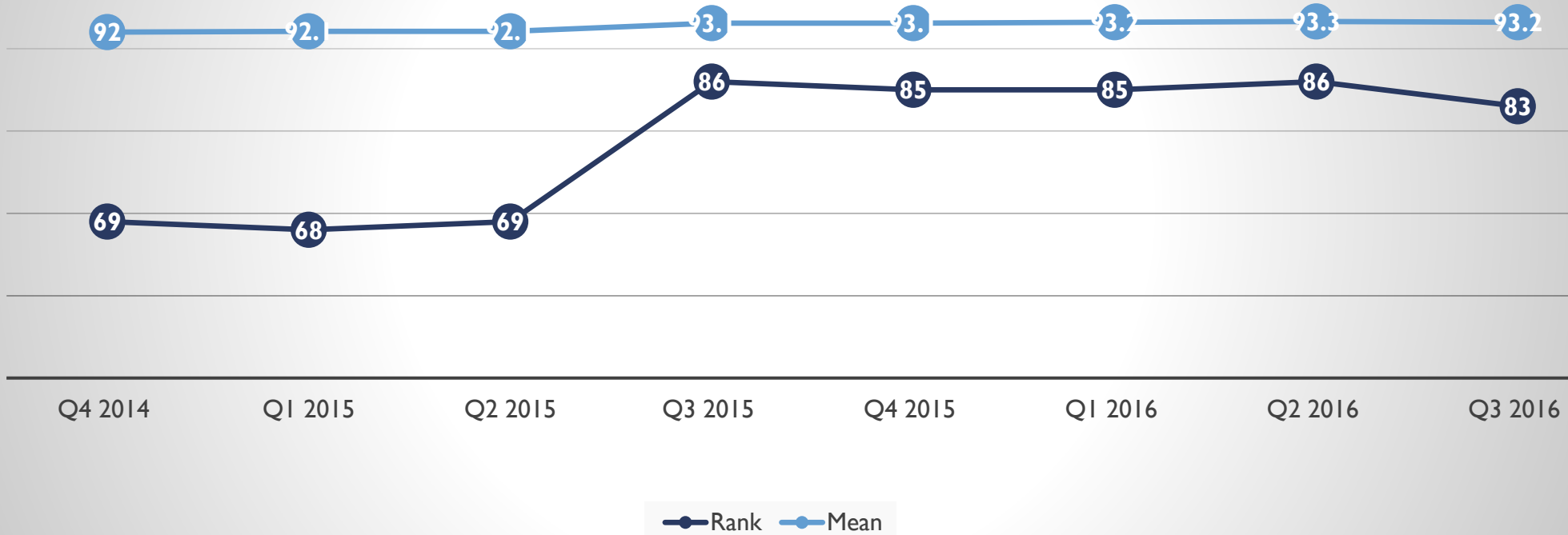
CASE STUDIES IN EXCELLENCE

- Engaged Leadership
- Practice Transformation
- High-Touch High-Risk



Log into our Resource Library for more info:
www.apg.org/resources

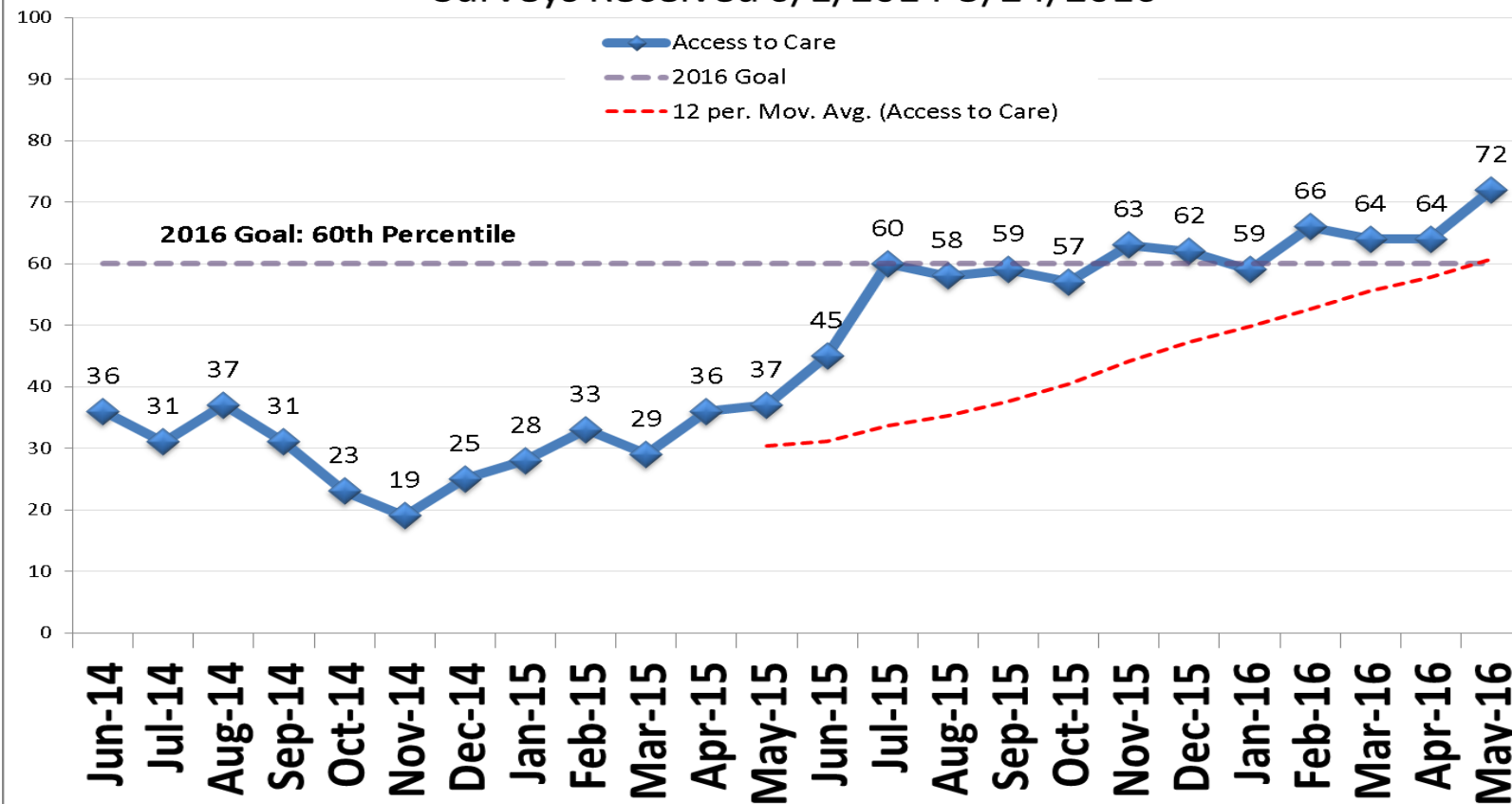
PATIENT SATISFACTION - NATIONAL



RESULTS FOR ACCESS TO CARE

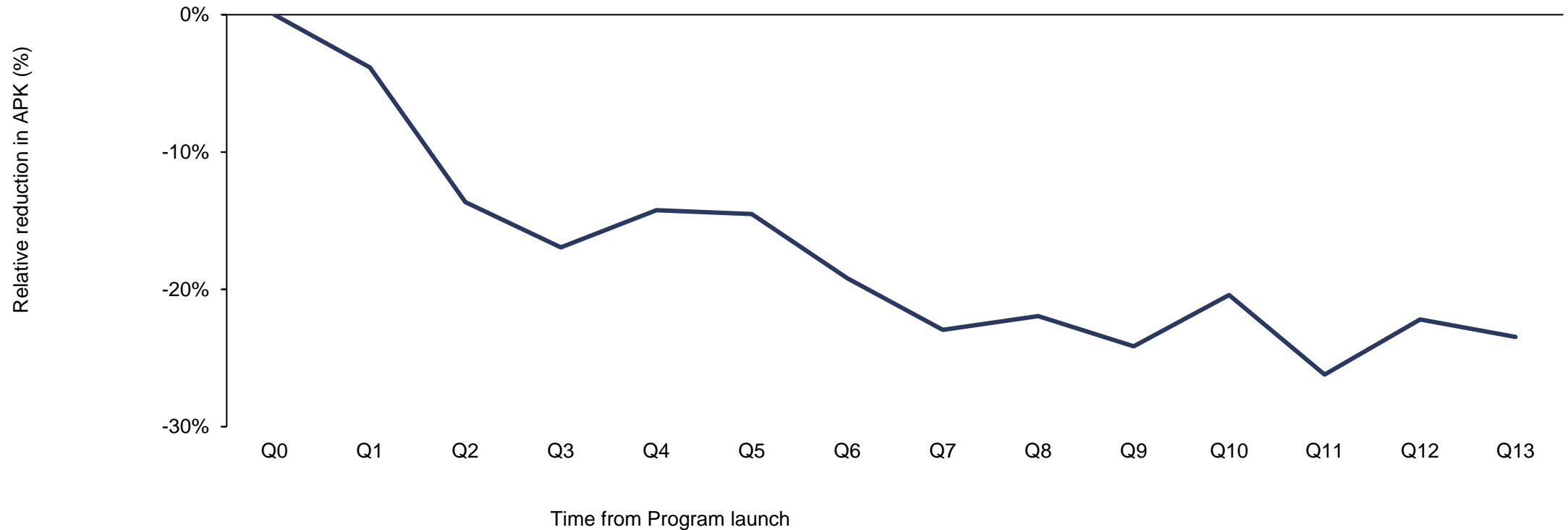
Press-Ganey Access to Care Percentile Ranking

Surveys Received 6/1/2014-5/24/2016

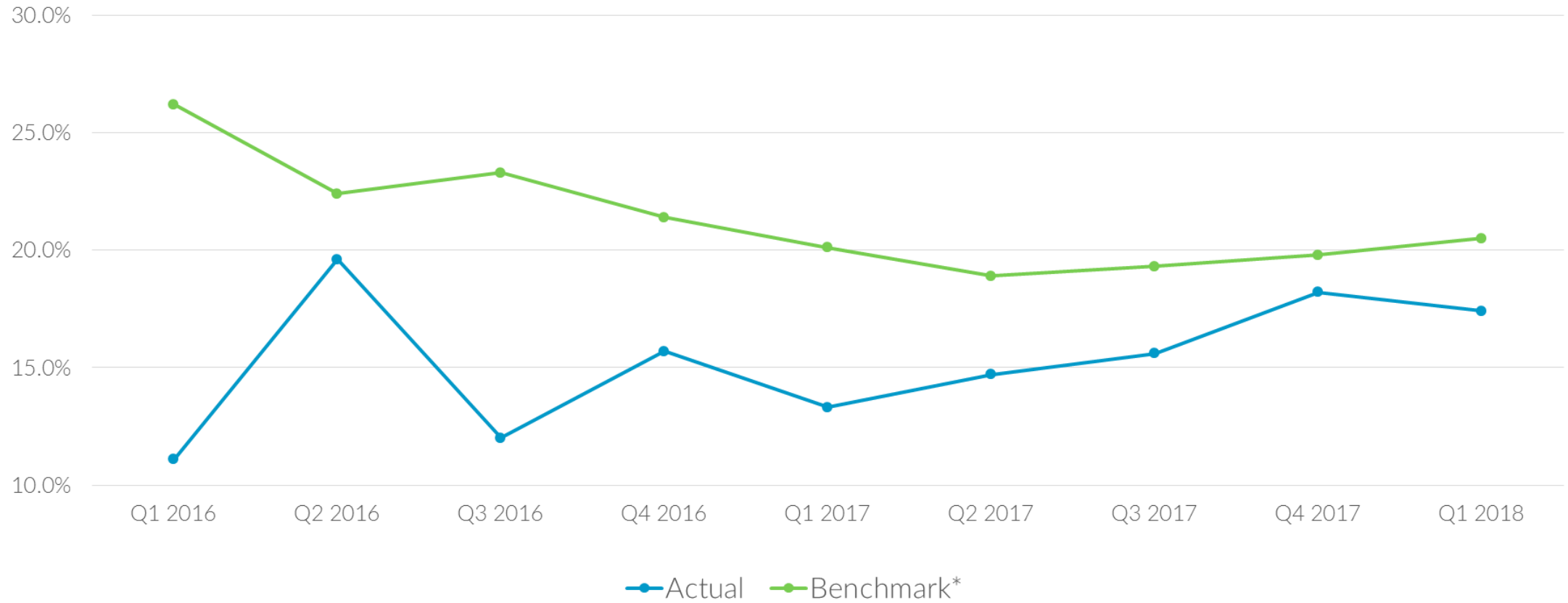


REDUCTION IN-PATIENT UTILIZATION

Impact on Total Cohort In-Patient Utilization in Medicare Advantage

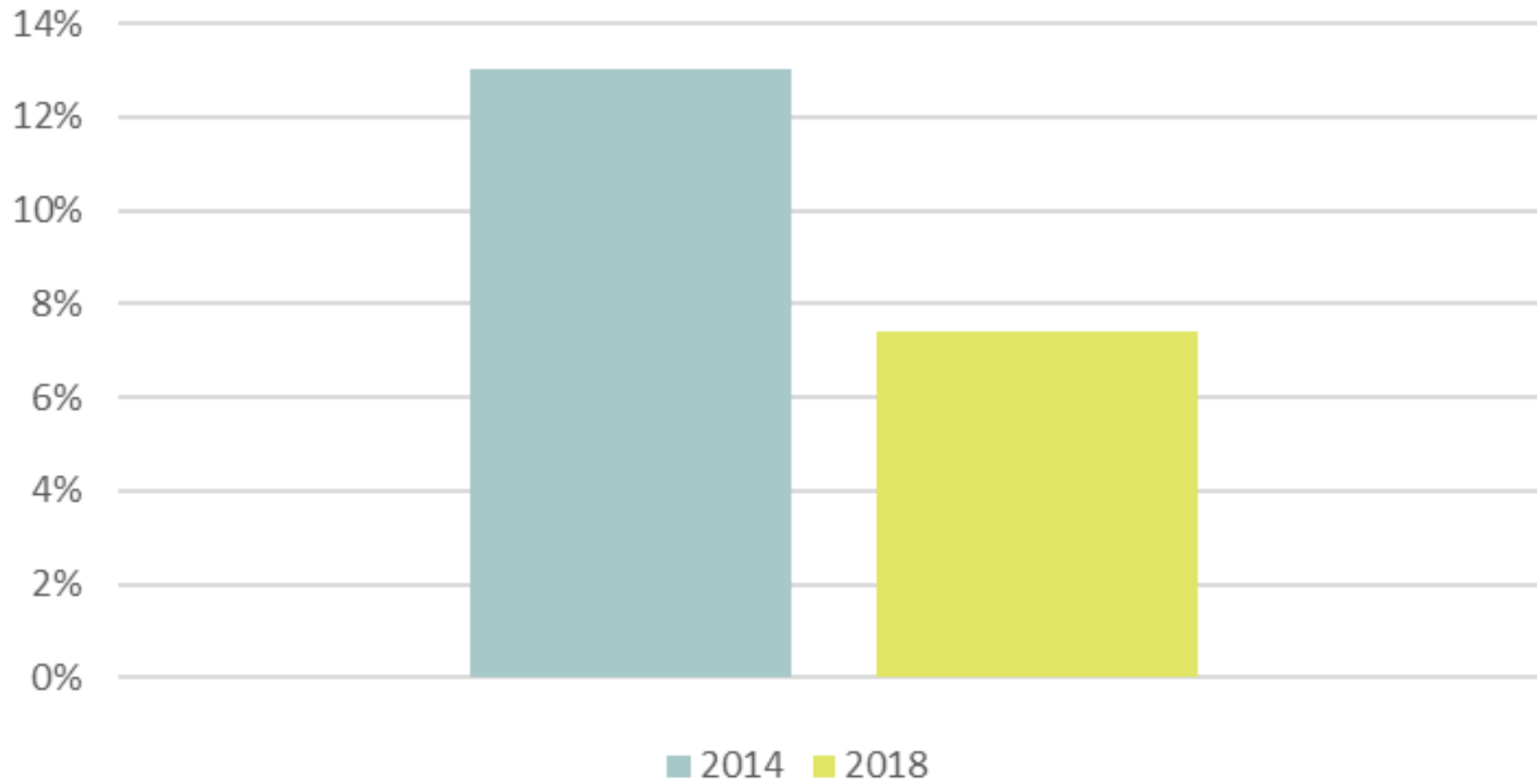


Medicare High Risk Programs: 30 Day Readmission Rate



* BENCHMARK READMIT RATE USING LACE SCORE FROM JOHN MUIR HEALTH REPORT DATED 09/24/2013

Hospital Readmission Rates



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Quality and Efficiency:
How to Succeed in
Risk-Based Models

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Amy Nguyen Howell, MD, MBA, FAAFP
Chief Medical Officer
America's Physician Groups
anguyen@apg.org

