



Sixth Annual National ACO Summit

June 17-19, 2015

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THE SIXTH
NATIONAL

Accountable Care Organization Summit

Track Six: Strategies for Managing Vulnerable Populations

Keynote

Larry Atkins, PhD

Executive Director

Long-Term Quality Alliance (LTQA)

(Keynote, Moderator)

Strategies for Managing Vulnerable Populations

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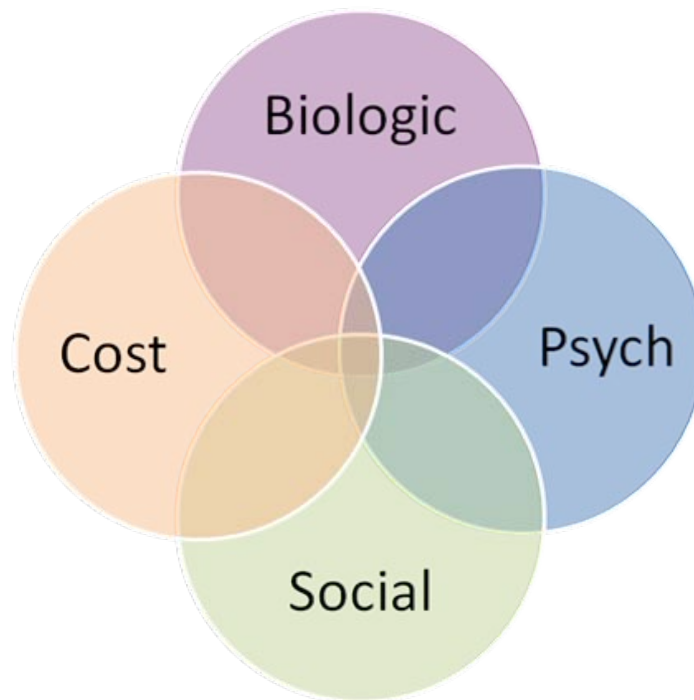
Christine S Ritchie MD, MSPH

Harris Fishbon Distinguished Professor and

Medical Director of Clinical Programs, UCSF Office of Population Health Department of Medicine

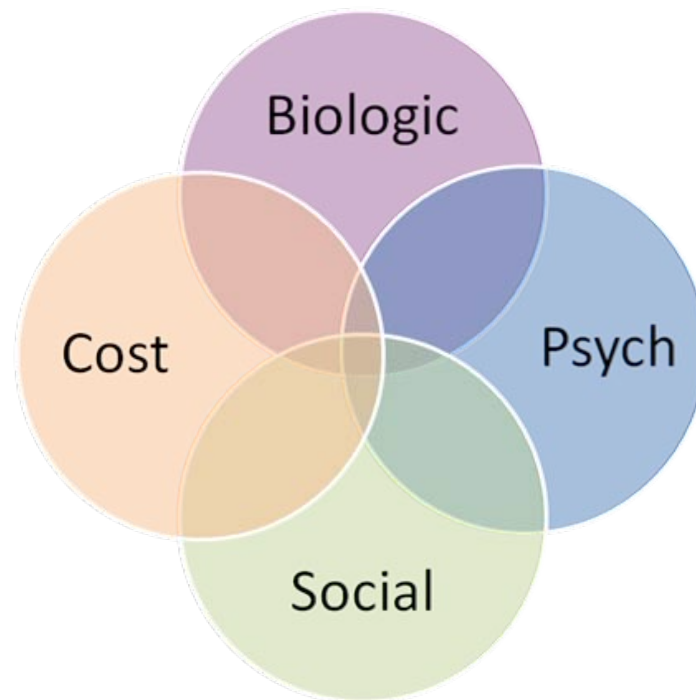
Who is “High Risk?”

- Hundreds of “analytics” out there to identify “high need”
- Usually take into account biological, social, psychological factors along with cost
- Many “red flags” provide sufficient indicators of need
- **More important is the intervention...**



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A spectrum of differing needs...



Strategies That Work and Investments Required

Strategies

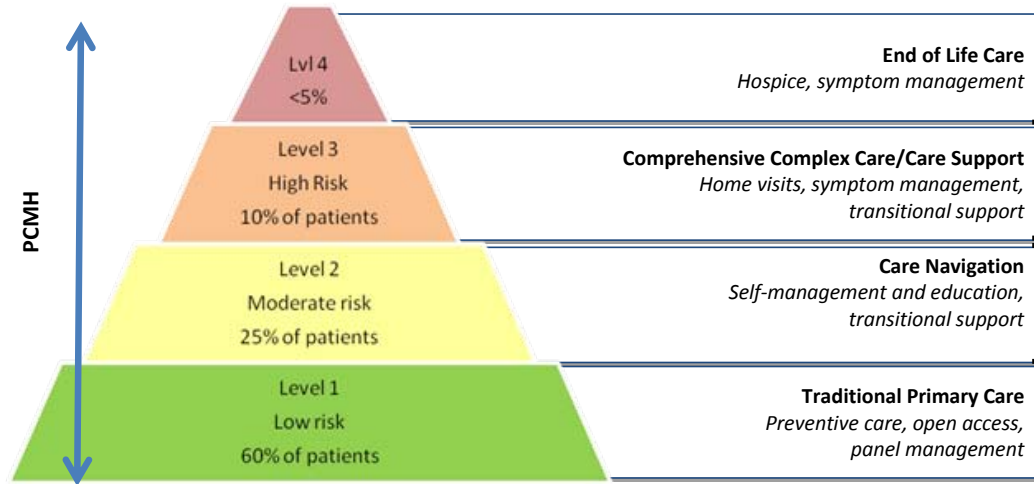
- Coordination across settings
- Comprehensive structured assessments
- Interprofessional care planning
- Co-management

Investments

- Communication tools/work flow maps/“care everywhere” records
- Assessment that takes into account “complexity environment”
- Investment in “non-revenue generating” team members
- Clarity around roles and responsibilities

UCSF Office of Population Health Care Support Team

for Patients with Moderate and High Risk Needs



Health Navigation Program Leadership Team:

- Complexivist Medical Director:** Clinical consultation, oversight and support for CPI
- RN Manager :** Provides program leadership, training, supervision and supports analytics/reporting and CPI

Care Support Tier 2:

- 2 NPs and 2 SWs:** Actively manage highly complex patients, act as consultants to HCN's for complex patient problems
- Psychiatric Nurse Practitioner:** Mental and behavioral health consultations
- Clinical Pharmacist:** Medication Management
- Consultation Psychiatrist

Care Support Tier 1:

- 5 Health Care Navigators:** Assist in the delivery of patient-centered care to patients empaneled within the UCSF Primary Care Practices.
- Work collaboratively with patients to help them self-manage their chronic conditions.**

Summative Evaluation: Healthcare Utilization

	Before CS	After CS	P-value
Observation days	182 (n/a)	180 (26 – 397)	.54
ED visits/1000 days	5.5 (0 – 54.9)	0 (0 – 87.0)	.015
% No ED visits	56 (40%)	75 (54%)	.015
IP visits/1000 days	5.5 (0 – 33.0)	0 (0 – 43.0)	<.001
% No IP visits	46 (33%)	84 (60%)	<.001
LOS days (hospitalized)	6 (1 – 57)	5 (1 – 72)	.25

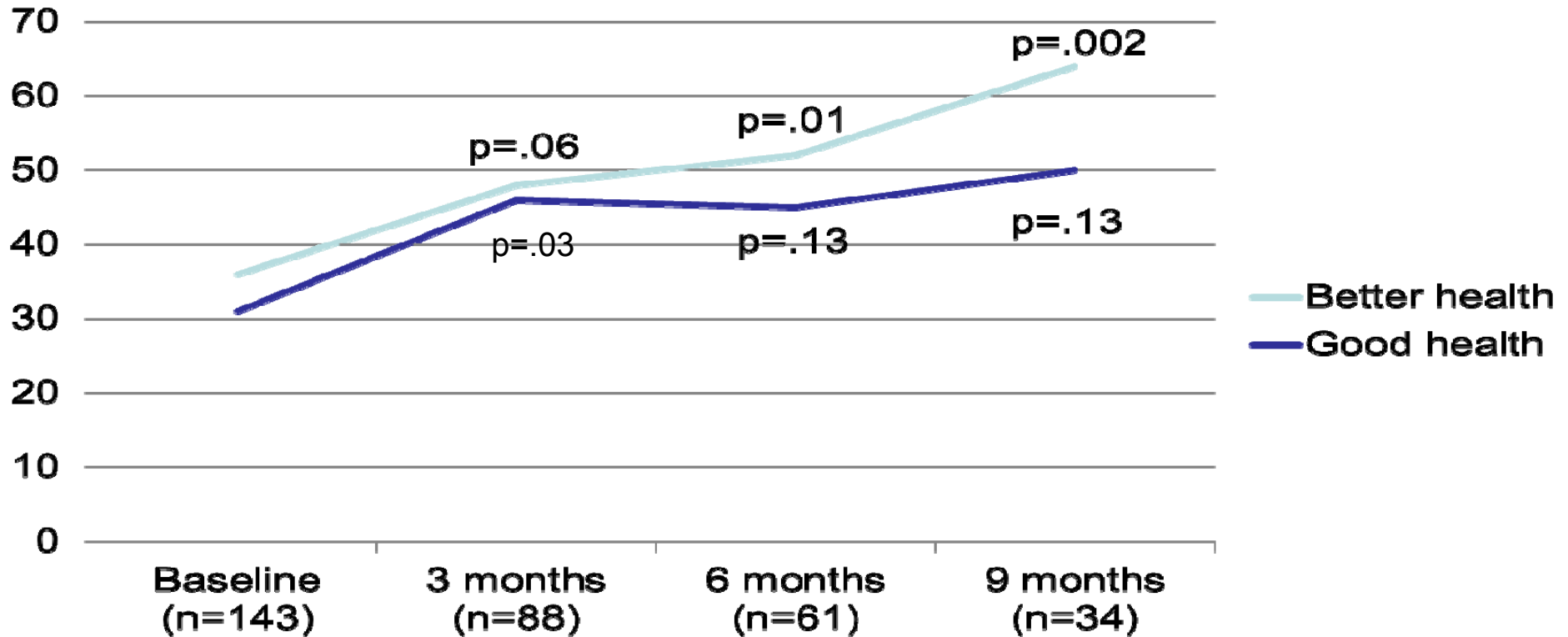
Values are median (range) or number (%).

P-values based on Wilcoxon signed-rank test or McNemar test of symmetry.

Restricted to 139 patients with >25 days of follow-up.

LOS restricted to those with ≥1 IP visit.

Significantly Better Self-Rated Health After Care Support



Good health = good, very good or excellent current self-rated health

Better health = somewhat or much better health over past 3 months

P-values based on McNemar's test for paired proportions versus baseline

Track Six: Strategies for Managing Vulnerable Populations

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