Sixth Annual National ACO Summit

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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

Sixth National ACO Summit

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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...**
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...
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
UWF 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

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