UCSF Health
Office of Population Health

Overview of Office of Population Health (OPH) Programs and Populations

Intended Audience: UCSF Providers (ie PCPs)
Updated 05/28/2024

The purpose of this document is provide an overview of the Office of Population Health's programs, patient populations, and how patients are identified for enrollment for each program.

	Program	Description	Eligible population	Enrollment (provider referral vs. report-driven)	Outreach (one time vs. ongoing)	Duration of Program	Contact
Patient Outreach and Prevention	**Care Gap Outreach and Health Coaching**	*Automated calls to primary care empaneled patients to close care gaps and provide health coaching for cancer screenings (Cervical, Breast, Colorectal), depression screening, panel clean-up diabetes, hypertension, pediatric/adolescent well child visits, Advanced Care Planning by health care navigators*	All empaneled UCSF primary care patients (Cancer Screening) & Others (ACO and special populations)	Auto-enrollment - Healthy Planet Registries from Health Maintanance Banner	Continuous based on Health Maintenance Banner due dates	N/A	Tasha Toliver
	Medicare Advantage Outreach	*Outreach to patients with Hill Physicians HMO-Assigned Medicare Advantage plan (includes Canopy). Objectives are: 1. Schedule a follow-up with PCP if not seen by PCP in past 6 months 2. Schedule an Annual Wellness Visit (AWV) if no AWV in past 1 year*	Canopy and Hill MA patients	Auto-enrollment	Ongoing	N/A	Avi Tutman
	Medicare AWV Operations Support	*1. Outreach to Medicare patients with an upcoming Annual Wellness Visit and incomplete HRA Questionnaire; includes patient education on AWV expectations 2. Outreach to Medicare patients with ambiguous scheduling note to clarify visit objective*	Canopy MA, Hill MA, and Medicare FFS primary care patients	Auto-enrollment	Ongoing	N/A	Avi Tutman
	Relay Center	*Ensure that providers (internal and external) are notified of subcritical test results collected at UCSF ED, inpatient, and ambulatory care sites*	All UCSF patients with a subcritical (not life threatening but significant risk if not addressed) lab, radiology, micro result	Auto-enrollment - Radiology and Laboratory Report	One time	N/A	Margaret (Meg) Wheeler
Care Management and Disease Management	**Asthma health coaching**	*Provides short-term health coaching to patients (ie review asthma action plans, how to use inhalers, teaching around asthma triggers) assisted by a Health Care Navigator and Pharmacist*	San Francisco Health Plan - Pediatric and adult primary care empaneled patients	Auto-enrollment - Healthy Planet Registry	Ongoing	Average 60 Days	Tasha Toliver
	Behavioral Health/Collaborative Care	*Collaborative Care provided virtually to primary care patients with depression and anxiety via social workers and psychiatric consultants*	Empaneled patients from DGIM, Lakeshore, Laurel Village, and Care at Home	**Referral** (if patient is referred to BH Navigation team first and deemed appropriate for collaborative care)	Ongoing	Until patient remission or response (usually 3-6 months)	Carolyn Stead
	Behavioral Health Navigation	*Connects patients to UCSF psychiatry services, embedded behavioral health, and community resources*	Primary care patients who need BH resources	**Referral** (REF362-Ambulatory Referral to Primary Care Behavioral Health)	Ongoing	1-3 Encounters	Carolyn Stead
	Care at Home	*Provide home-based primary care*	Homebound patients living in San Francisco, generally age 65 and up with some exceptions	**Referral** (REF318-Ambulatory referral to Care at Home)	Ongoing	N/A	Irina Kaplan
	Adult Complex Care Management	Limited longitudinal care management - *High-tough care management with high health complexity aimed at decreasing the overall cost of care and reducing unnecessary health system utilization while improving health outcome metrics and patient well-being*	ACO patients, 18 or older, 2 or more unplanned ED/OBS/INP in prior 12 months, AND one or more indicators of health complexity (Medical + Social)	Auto-enrollment - Healthy Planet Registry and other reports	Ongoing	90 days	Robin Andersen
		Short Term Emergency Department Discharge Intervention - *High-touch care management by LCSWs and ANSs for high complexity patients discharged to home from the Parnassus ED aimed at avoiding unnecessary hospital admissions and decreasing return to ED*	High health complexity patients discharged to home from Parnassus ED who have high risk of return to the ED within 2 weeks based on clinical and psychosocial criteria	**Referral** by ED only (REF3220- DISCHARGE REFERRAL TO STEDDI (OPH)) and also enrollment by STEDDI team (report driven)	Ongoing	14 days after ED visit	Robin Andersen
	Pediatric Complex Care Management	*Following the Novel Interventions in Children's Healthcare (NICH) model of care delivery, provides intensive care management to support families of kids with complex medical conditions who also face barriers with social drivers of health (SDOH)*	17 or younger, resident of counties served, certain chronic health condition (focus on DM 1 or 2) AND evidence of avoidable health system utilization within the last 6 months	Primarily reports from payors; also **Referral** from PCPs and specialists via Qualtrics (http://tiny.ucsf.edu/NICHreferral)	Ongoing	12 months	Robin Andersen
	Hepatitis C Cure Program	*Assists patients with education and treatment to cure Hepatitis C*	ACO patients, 18 or older	Auto-enrollment - Report driven	Ongoing	3-4 months	Tasha Toliver
	Diabetes Collaborative Care	*A collaborative care model, led by a nurse and health care navigator, that a ssist s patients in managing their Type 2 Diabetes through health coaching , medication management , consultations with an endocrinologist, and partnering with the patient's PCP*	San Francisco Health Plan primary care empaneled patients	Auto-enrollment - Report driven, based on A1C values)	Ongoing	6 - 12 months	Tasha Toliver and Henrietta Tran
	Hypertension Care Management	*Assists patients with hypertension management with different intervention arms of 1) nurse and navigator coaching focused on lifestyle management and treatment adherence or 2) Pharmacist and navigator sessions focused on medication adjustment and health coaching*	San Francisco Health Plan primary care empaneled patients	Auto-enrollment - Report driven based on BP values	Ongoing	2-3 months	Tasha Toliver and Henrietta Tran
	Peripartum Remote Blood Pressure Management	*Remote blood pressuring monitoring for antepartum and postpartum patients with hypertension*	Commercial ACO (HN, Cigna, Anthem) and BlueShield, Black/AfAm, LatinX, and other non-white patients with diagnosis of hypertension during antepartum <20 weeks or any point intra- and postpartum	Auto-enrollment - Report driven, ie Health Planet Registry, DAPP Lists, and COM DEP schedules	Ongoing	Enrolled at antepartum or postpartum up to 6-weeks postpartum	Henrietta Tran

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Utilization Management and Transitional Care	**ACO Care Transitions**	*30 day longitudinal phone calls post discharge, repatriation, post-discharge PCP assignment/follow up appointment, pharmacy services such as med rec or adherence counseling, care gap closure*	Commercial ACO (HN, Cigna, Anthem), Canopy MA, and SFHP patients who were admitted to UCSF inpatient or had an observation stay	Auto-enrollment - Health Planet Registry based on admission to UCSF	Ongoing	30-days after discharge	Henrietta Tran
	Care Transition Outreach Program (CTOP)	*Automated calls/texts to patients within 3 days of discharge home from UCSF hospitals to complete the discharge process, support during transition, avoid unnecessary utilization or expedite care when needed*	Any UCSF patient discharged home from UCSF West Bay hospitals (Parnassus, Mission Bay, Mt. Zion)	Auto-enrollment - Report driven	One time	N/A	Margaret (Meg) Wheeler
	UCSF Service at Jewish Home SNF	*Primary management of patients discharged from UCSF to Jewish Home SNF for short-term rehabilitation in collaboration with UCSF Division of Geriatrics. Includes automated 30 day follow-up calls post-Jewish Home discharge*	Any UCSF patient discharged to Jewish Home SNF for short term rehabilitation from UCSF West Bay hospitals (Parnassus, Mission Bay, Mt. Zion). Maximum of 30 patients daily census	Admission is determined by the San Francisco Center for Jewish Home Intake Coordination Team	Ongoing	Duration of SNF stay and 30-days post SNF discharge	Irina Kaplan
	Comprehensive Perinatal Services Program (CPSP)	*Provides a wide range of culturally competent services to pregnant individuals from conception through 60 days postpartum. In addition to standard obstetric services, patients receive enhanced services in the areas of psychosocial, health education, and nutrition*	All Medi-Cal patients	Auto-enrollment - Based on insurance type through Health Planet Registry	Ongoing	Conception (or start of OB care at UCSF) up to 60-days postpartum	Tasha Toliver