UCSF Health has entered into contractual agreements with multiple payors obligating us to provide care management to their complex patient populations and achieve health quality goals, while decreasing the overall cost of care.

- **Customer Benefit:** Improve health outcomes, patient well-being and confidence in self-management of chronic conditions.
- **Expected Financial Impact:** Continued accountable care partnerships allow for improved processes and decreased health system cost.
- **Other Business Benefit:** Promoting right level of care at the right time reduces negative impacts of unnecessary ED visits and/or hospitalizations and subsequent strain on the health system.

**Background**

**Project Goals**

- **Outcome Measures:** Total volume of ED/OBS/IP encounters in PC empaneled ACO patients; Rate of ED/OBS/IP utilization in PC empaneled ACO patients; % patients admitted to MAACC; duration of admission with MAACC.
- **Process Measures:** Operationalizing our RWB to identify complex patients; % of patients who achieve their Discharge Goals within 90 days; documentation of addressing SDOH.
- **Balancing Measures:** Increased rate of primary care visits.

**Problem Statement:** In assuming the complex care management of the ACO and Medicare Advantage populations, Care Support’s mission is to decrease overall cost of care by reducing unnecessary health system utilization while improving health outcome metrics and patient well-being.

**Project Plan and Intervention(s)**

- **Hypothesis:** Patients who receive interventions focused on the Care Support Domains during a 60 – 90 day longitudinal episode will be better prepared to manage their own health, resulting in reduced strain on the health care system and decreased overall cost of care.

- **Patient Identification:**
  - Patients seen in Parnassus ED in previous 7 days (“ED Trigger Report”)
  - Patients with medical complexity and utilization in last 12 months (reporting workbench in Apex)

- **Key Interventions:**
  - ED Transition of Care call
  - Patient education on discharge plan and medication changes
  - Scheduling of PCP/specialty follow up care
  - Coordination of services (e.g., home health, transportation, in home support)
  - Assess Care Support domains and develop targeted, time-bound plan of care

**Project Results & Impact**

- **WE DECREASED EMERGENCY DEPARTMENT UTILIZATION BY > 70% IN COHORT OF PATIENTS ENGAGED IN MAACC, IN THE 6 MONTHS FOLLOWING VERSUS THE 6 MONTHS PRIOR TO ENGAGEMENT.**

**Conclusions & Next Steps, & Lessons Learned**

**Conclusions & Lessons Learned:**

- Many patients were unaware of ability to access primary care provider after hours for medical advice.
- Patients’ self-reported health measures (SF-2 PROM) showed improvement after our intervention.
- Patients expressed appreciation for and reported benefiting from our team’s outreach, even those who required minimal intervention.
- Achieving these results required a high touch approach from an expert clinical team.
- In first 3 quarters of FY22: 488 unique patients received 3,496 interactions.

**Next Steps:**

- Partner with data/Apex experts to refine patient identification efforts.
- Consider expanding with Health Care Navigator support to continue the work of the ED Trigger Report.

Thank you for reaching out to me. I really appreciate your support. That’s why I keep my care at UCSF... the care you give is awesome!