

Ambulatory Complex Care Management

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Background

- The Care Support Program leverages key aspects of complex care models to support and care for the most vulnerable patients with medically and psychosocially complex issues, who tend to be high utilizers of costly health system services.
- Patients eligible for complex care services include:
 - Age 18 years or older with ≥4 chronic conditions (Diabetes or Heart Failure, asthma, COPD, depression, diabetes, heart failure, hypertension or cardiovascular disease)
 - High utilization patterns as defined by ≥2 inpatient stays or ≥3 ED/observation visits within the past 6 months
 - Patients who are represented in an ACO partnership
- Sentinel events such as hospitalizations and ED visits offer opportunities for team/systems improvement.
- Weekly Interdisciplinary Case Conference offers regular opportunities for case reviews and attention to specific opportunities for quality improvement.

Project Goals

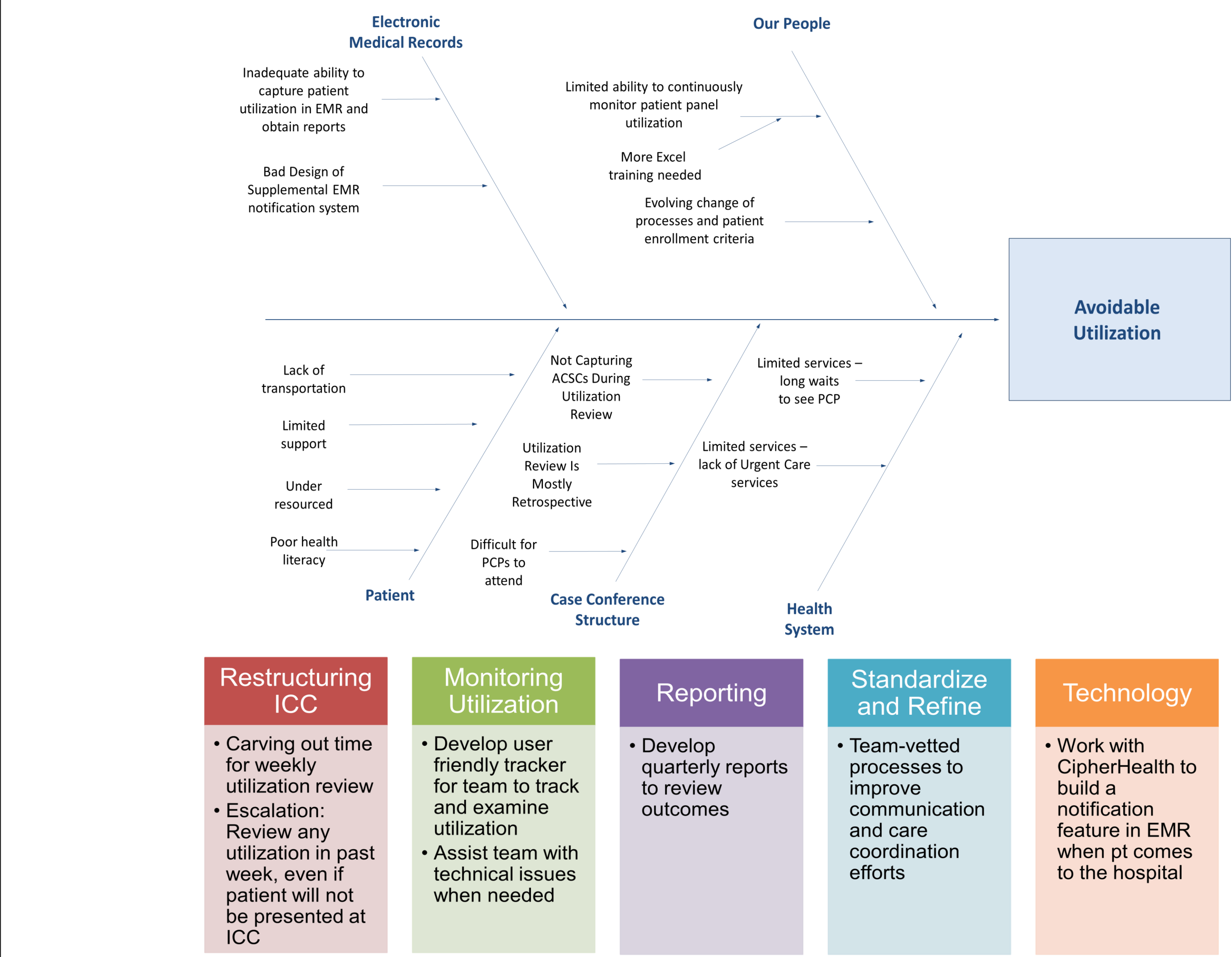
Problem: High risk populations, even after enrollment into complex care programs, disproportionately use higher levels of care.

Goal: To incorporate utilization review processes into ICC with objectives of conducting root cause analysis, capturing ACSCs, determining avoidability (at a care team or system level), and recommending interventions to the care team, the Primary Care Provider, and/or Health System.

Prior to 2017	Jan 2017 to today
1) Each New Patient is presented with utilization in the last 6 months (ED/IP)	1) Each New Patient is presented with utilization in the last 6 months (ED/IP)
2) Utilization is presented only on a quarterly basis, along with usual 3 month interval presentations	2) Patients evaluated in ED or hospitalized in the prior week of ICC date, weekly utilization review is conducted.

Care Support: Improving Interdisciplinary Case Conferences to Monitor Utilization Due to Ambulatory Care Sensitive Conditions (ACSCs)

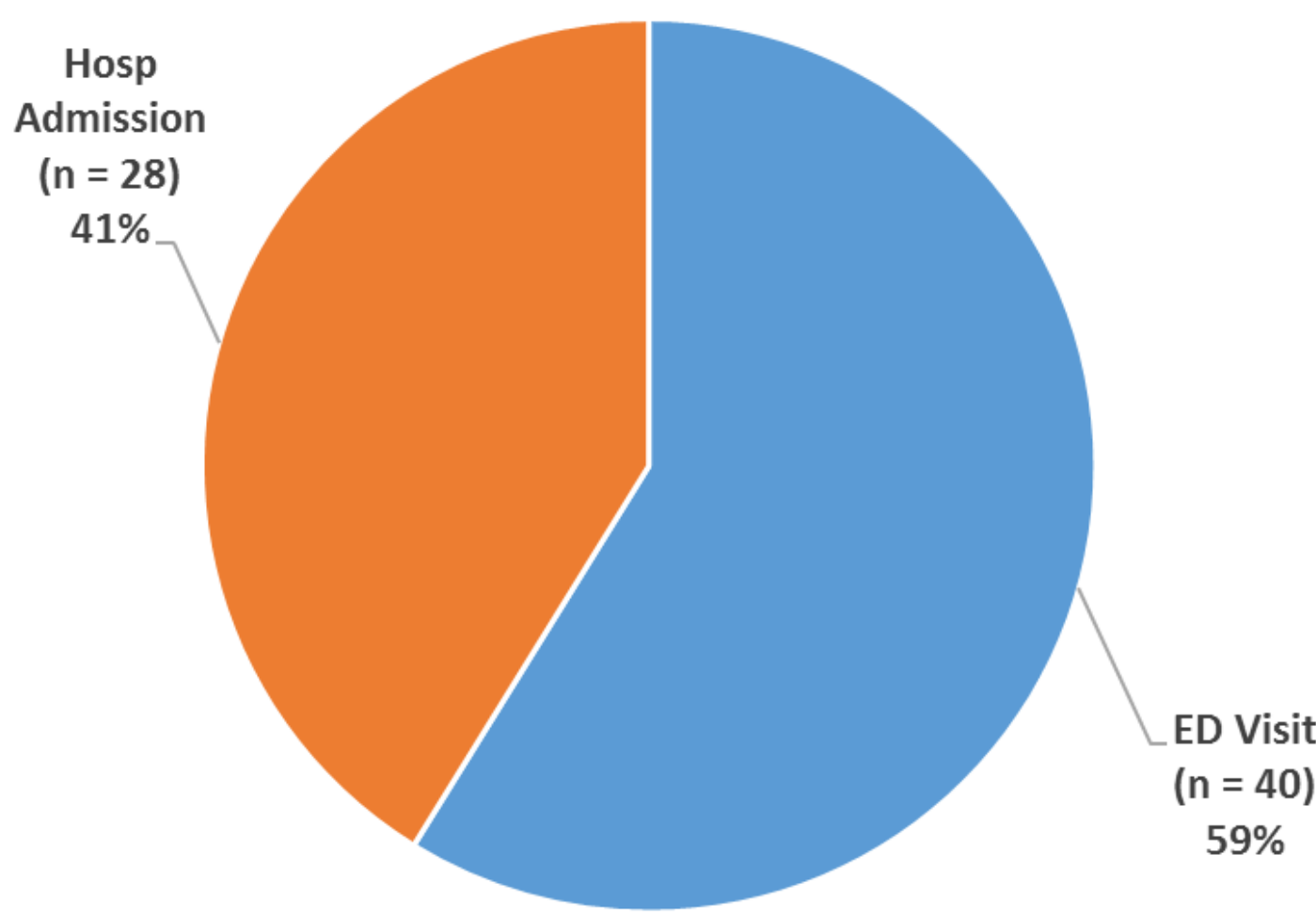
Project Plan and Intervention(s)



Project Evaluation & Impact

Category of Clinical Impression	# of Encounters	% of Encounters
non-ACSC	27	40%
Pain related non-ACSC	24	35%
Pneumonia	5	7%
Diabetes	4	6%
UTI	3	4%
Dehydration	2	3%
CHF	2	3%
Hypertension	1	1%
Grand Total	68	100%

Utilization Breakdown by Type (Q3 FY1718, n = 68)



Could Care Support have avoided this utilization?		
Assessment	# of Encounters	% of Encounters
Avoidable	7	10%
Not Avoidable	61	90%
Grand Total	68	100%

Could Health System have avoided this utilization?		
Assessment	# of Encounters	% of Encounters
Avoidable	11	16%
Not Avoidable	57	84%
Grand Total	68	100%

Examples: -Provide structured education regarding seeking appropriate levels of care
-Reinforce early sx recognition

Examples: -Improve phone tree access in primary care for non-English speaking patients
-Optimize medication review for patients discharged from SNF to home

*calculated based on the number of unique pts (n =35) that reported utilization in last quarter

Next Steps, Dissemination & Lessons Learned

- Next Steps:**
- Develop standardized data management processes to ease ability to gather and analyze pertinent data
 - Explore interventions to improve early symptom recognition and self-management of chronic conditions
 - Explore and test processes to improve patient access to appropriate level of care
- Dissemination:**
- Continue to refine ICC format as patient populations and program structure continue to change to accommodate the system’s growing needs
- Lessons Learned:**
- Top reasons for utilization are not ACSCs but rather pain related (abdominal, chest, etc.)
 - Clinical observations: difficulty documenting utilization outside of UCSF in medical record
 - Systems changes may assist to address low health literacy- poor understanding of disease state and expected symptoms