Greetings from the Office of Population Health and Accountable Care!

UCSF Health’s 5-Year Strategic Plan highlighted population health and accountable care as pillars of UCSF’s long-term success. We are writing today to keep you updated on our work in these areas.

An Overview: Accountable Care and Population Health

- An **Accountable Care Organization (ACO)** is a partnership among providers (e.g., hospitals and medical groups), payers, and sometimes employers to increase the value of care that is delivered to a population throughout the continuum of care. In these new relationships, provider organizations often take on some degree of financial risk for the overall cost and quality of care for a population of patients.

- **Population Health** is the effort to improve health outcomes of a group of individuals (a population).

Why are these strategic priorities?

As a result of the Affordable Care Act and the market changes in Northern California, patients and purchasers of health care are looking for more coordinated care for patients and better value at the population level. Patients and Employers are looking for systems of care that can provide improved outcomes, quality and experience at lower overall cost.

Is UCSF Health already part of an “ACO”?

Yes! The overall goal for all of our ACOs is to decrease total costs, while improving coordination of services and quality of care. Our three ACOs include:

1. Blue Shield HMO patients with a Hill/UCSF PCP in San Francisco (12,000 patients)
2. Health Net Blue & Gold HMO patients with a Hill/UCSF PCP in San Francisco (12,000 patients)
3. Anthem Blue Cross PPO patients (13,000 patients)

ACO Utilization Goals

<table>
<thead>
<tr>
<th>Metric</th>
<th>FY2013</th>
<th>FY2014</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Admissions</td>
<td>↓</td>
<td>↑</td>
<td></td>
</tr>
<tr>
<td>Inpatient Length of Stay</td>
<td>↓</td>
<td>↑</td>
<td></td>
</tr>
<tr>
<td>Inpatient Readmissions</td>
<td>↓</td>
<td>↑</td>
<td></td>
</tr>
<tr>
<td>Preventable ED visits</td>
<td>↓</td>
<td>↑</td>
<td></td>
</tr>
</tbody>
</table>

ACO Quality and Experience Goals

- Access to primary care and urgent care
- Health coaching for chronically ill patients
- Compliance rates for selected quality metrics (e.g.: colorectal cancer screening, HbA1c control among diabetics)

One ACO’s Performance Highlights from 2014

**BlueShield ACO:** Although the risk score (as measured by DxCG) of this population has increased over the last 2 years, the ACO has continually improved days/1,000, average length of stay, and generic prescribing.

<table>
<thead>
<tr>
<th>Metric</th>
<th>FY2013</th>
<th>FY2014</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk Score (DxCG, concurrent)</td>
<td>1.79</td>
<td>1.96</td>
<td>+9.5% ↑</td>
</tr>
<tr>
<td>Average Length of Stay</td>
<td>5.63</td>
<td>4.66</td>
<td>-17.2% ↓</td>
</tr>
<tr>
<td>Days per 1,000</td>
<td>325.2</td>
<td>281.8</td>
<td>-13.3% ↓</td>
</tr>
<tr>
<td>Generic Prescribing</td>
<td>80.7%</td>
<td>82.7%</td>
<td>+2.5% ↑</td>
</tr>
</tbody>
</table>

---

1. DxCG scores are calculated based on age, gender, and diagnosis codes submitted through claims. On a population level, these risk scores can be predictive of total cost of care. A patient with a DxCG score of 2.0 is predicted to spend 2 times more in annual resources compared to the average person in the benchmark sample.
How can we improve care coordination?

Meet our new Health Navigation Team!

Our Health Navigation Team works closely with UCSF primary care and specialty providers to deliver high-touch, coordinated care to our at-risk patients with the most common and costly chronic conditions. The team uses validated approaches such as motivational interviewing, health coaching, comprehensive home-based assessments, and psychosocial tools to help patients overcome barriers to becoming and remaining as healthy as possible. In December 2014, UCSF won the prestigious 2014 CAPH/SNI Quality Leaders Award for its successes in complex care management. This award recognizes innovations to improve the quality of care in California’s public hospitals and health systems.

Health Navigation Patient Profile

- Multiple chronic conditions
- Frequent hospital admissions
- Frequent ED visits
- Complex family or psychosocial environment
- Within the top 1% to 10% of highest cost health plan members
- High risk per health plan predictive modeling
- Challenging and time intensive for providers

Patient Stories – Health Navigation and Care Transitions

“Ms. X” is a young patient who has required a number of abdominal surgeries resulting in chronic abdominal pain. She also struggled with depression and substance abuse. In the month before arriving at UCSF, she had over 15 ED visits. Our Health Navigation Team arranged for in-home infusion appointments, ParaTransit services, and expedited appointments for mental health and pain management. The patient’s quality of life has dramatically improved: after 3.5 months of enrollment, there have been no inpatient admissions and a dramatic reduction in ED visits. The PCP is thrilled with the partnership and expertise of the Health Navigation Team.

“The Care Transitions Manager contacted us at the hospital and followed up for almost five weeks after my family member’s discharge from the hospital. He sorted out the confusion regarding her post-operative medicine regime and assisted in coordinating with the Orthopedics Department, Blue Shield/Hill Physicians and CVS Pharmacy. His caring and sympathetic attitude was very helpful at a difficult transition time.” – ACO Patient

For questions about our ACOs, please contact Ami.Parekh@ucsf.edu or Sara.Coleman@ucsf.edu
For questions about our Health Navigation team, please contact Ellen.Kynoch@ucsf.edu