uds ACMS

Advanced Care Management Solutions

PURPOSE:

- Contract with various hospitals and insurance providers to connect services for continuity of care
- Support transition from hospital to community using integrated communication system
- Facilitate communication between patients and providers, post discharge
- Coordinate the patient's appropriate level of care to remain safe in the community

BENEFITS FOR HEALTH SYSTEM AND THE COMMUNITY:

- Identify and address Social Determinants of Health needs resulting in less reliance on emergency departments and unplanned hospitalizations
- Estimated cost savings of $10,000 per readmission due to preventative measures (based on National average hospital cost of $2,000 per day with average LOS 5 days)
- Enhance the hospital's star ratings, such as participant experience and 0 day readmissions (e.g. 6,000+ UDSF participants have < 1% readmission rate)
- Home Assessments to identify barriers, safety issues and unmet needs
- Interface between hospital and community providers in real time
- Improve collaboration between patients and their providers to increase outpatient utilization
- Educate patients about their prescribed medication and treatment regimens; therefore, improving adherence, providing resources to manage chronic illnesses and avoiding exacerbations
- Educate consumers in proactively navigating health care systems
- Engage participants in maintaining a healthy lifestyle

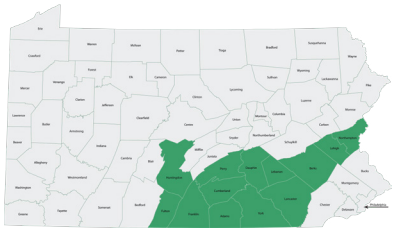
SERVICES WE PROVIDE:

- Annual Medicare Wellness Visits by CRNP
  - On-site clinic or home based evaluations
- Complex Case Management
- Wound Care Program
  - Telehealth and home visits by RN, WCC
- Supportive Discharge Planning
  - Hospital and home visits both pre and post discharge
- Supportive Community Integration
  - Navigate enrollment into community resources
- Home Modifications
- Durable Medical Equipment
- Wellness Calls
- Home Health/Home Care

HOW MANY PEOPLE WE CAN HELP:

- Interactive software allows us to ramp up services as aligned to contractual needs
- Will benefit roughly 500 participants in the service area within the first year

OUR TARGET AREA (green shading):



MEDICAL DIRECTOR:

- Dr. Susanne Scott is the Medical Director and collaborating physician for the ACMS program. She is an experienced board-certified family physician who aligns her talents with the UDS Mission. She provides medical oversight of the clinical quality measures associate with social determinants of health and provides medical leadership for our team in caring for vulnerable individuals.

putting the pieces together

A FOUNDATION OF SUCCESS

-- CASE STUDIES --

PATIENT #1

- Obtained temporary ramp installation to enable discharge home
- Navigated enrollment into CHC waiver services in less than a month
- Facilitated a 'Warm hand off' with permanently assigned service coordinator
- No readmissions 6+ months discharge

PATIENT #2

- Navigated enrollment into CHC waiver services/named authorized representative
- Enrolled into SNAP benefits
- Guided to legal resources for Power of Attorney
- Weekly supportive calls to continue engaging participant in care decisions
- No hospital readmissions 30+ days post discharge

PATIENT #3

- Enrolled in out of state Long Term services and support 'Choices for Care'
- Investigated 60 potential out of state placement options
- Acted as liaison between family members and hospital with weekly check ins and progress calls
- Guided to legal resource for guardianship

For more information about
UDS Advanced Care Management Solutions
visit our website:

udservices/ACMS