

**Community Objectives**

**End Medical Homelessness in Santa Cruz County**

*to give all residents access to patient-centered, coordinated, integrated care*



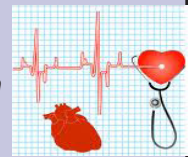
**Improve Transitions in Care**

*to build a more effective, safe, and coordinated health care system for all patients*



**Enhance Chronic Disease Care Coordination**

*to improve population health and patients' experiences, while reducing costs*



**SC Beacon Focus**

- Uninsured patients
- Medicare fee-for-service patients

- ED → Outpatient transitions
- Hospital → Outpatient transitions

- Patients with congestive heart failure (CHF)

**Measured Outcomes**

% all patients by payer with identified medical home (at inpatient and/or ED discharge)

Medication reconciliation at discharge

CHF quality and payment measures

% Medicare fee-for-service patients with identified medical home

30-day hospital readmission rate

30-day hospital readmission rate for all CHF patients

% County residents reporting routine source of care (other than ED)

Admission for ambulatory care-sensitive conditions

Continuity of care measures for CHF

Avoidable ED visits

Continuity of care after inpatient and ED visit

Survey of re-hospitalized patients with CHF

**Outputs**

**Medical home directory** captures medical home linkage, including for newly assigned

**Transitional Care Record** available at point of care

Expansion of SC Beacon Quality Council to include cardiologists, SNFs, hospice, home health

**Health Navigators** follow target patients (uninsured and fee-for-service Medicare) for 30-45 days post-hospital/ED discharge

**ED Power Notes** in use (alerts and content)

CHF care coordination plan developed and piloted

**Community education program** promotes value/benefits of medical home

**Beacon quality metrics** drive best practices, improvements, overlap with physician incentive programs

CHF patients followed by Health Navigators

**Major Activities**

**HIT/HIE infrastructure expanded** ("Shared services" model)

**Transitional Care Record** designed, piloted, implemented

**County-wide, cross-sector coalition reviews CHF data** to identify gaps, opportunities and launch plan

**Agreement on fields, protocols** for medical home assignment

**ED Power Notes** used to transmit ED visit information to medical homes, case managers

**Health Navigator team coordinates** with existing CHF case management

**Health Navigators** for target populations recruited and trained

Physician/case manager **training** offered

**SC Beacon Quality Council** tracks metrics

**Cross-cutting activities** (ongoing; not goal-specific): Steering Committee, Project Administrative/Fiscal Management, Evaluation, Community Outreach, Reporting