

## Abstract

<b>Project Title</b>	Santa Cruz Beacon (SCB) Consortium — Integrating Health Information Technology and Exchange into Care Delivery to Link Medical Homes and Improve Transitions in Care
<b>Service Area</b>	Santa Cruz County, California; Hospital Referral Region (HRR) #87 Zip codes 95001, 95003, 95005-07, 95010, 95017-19, 95033, 95041, 95060-67, 95073, 95076-77.
<b>Applicant Name</b>	Santa Cruz County Health Services Agency (HSA)
<b>Address</b>	1080 Emeline, Santa Cruz, CA 95060
<b>Contact Name</b>	Rama Khalsa, PhD, Director
<b>Contact Phone</b>	Voice: 831-454-4474; Fax: 831-454-4770
<b>e-mail</b>	rama.khalsa@health.co.santa-cruz.ca.us
<b>Web site</b>	<a href="http://www.santacruzhealth.org/">http://www.santacruzhealth.org/</a>

**Project Goals and Objectives:** Building on one of the most advanced health information exchange (HIE) environments in the nation and a high rate of electronic health record (EHR) adoption (68%) and meaningful use in a diverse demographic region, the Santa Cruz Beacon (SCB) consortium plans to integrate health information technology (HIT) and HIE into care delivery across a diverse health delivery system. Specific goals include:

- **ending medical homelessness** in Santa Cruz County to give all residents access to patient-centered, coordinated, integrated care, starting with a focus on assigning uninsured and Medicare fee-for-service patients to medical homes and follow-up care from teams of Health Navigators;
- improving **transitions in care** (especially from the ED and hospital to outpatient settings) to build a more effective, safe and coordinated health care system for all patients, and
- **enhancing chronic disease care coordination** to improve population health and patients' experiences (particularly for CHF patients), while reducing costs.

**Approach:** Our approach is to build on a strong existing HIT/HIE infrastructure to identify patients who do not have medical homes (particularly the uninsured and Medicare fee-for-service patients) and link them to one. In addition, a Quality Improvement Council will convene partners to develop consensus and protocols for the medical home directory and linkages as well as a new Transitional Care Record that would be available at the point of care. Teams of Health Navigators dedicated to each target population (the uninsured, fee-for-service Medicare, and CHF patients) will work to coordinate care using HIE/EMR tools and system approaches to care delivery.

**Anticipated Outcomes:** We expect to significantly reduce the proportion of uninsured and Medicare fee-for-service patients lacking a medical home, as measured by inpatient and/or ED discharge data and a County survey of where residents report receiving routine care. Outcomes for improved transitions in care include improved medication reconciliation at discharge, reduced 30-day hospital readmission rates, reduced hospital admissions for ambulatory care-sensitive conditions, a decrease in avoidable ED visits, and improved continuity of care following inpatient and ED visits (through the Health Navigator teams). We also expect to document improved CHF quality and payment measures as well as reductions in 30-day hospital readmission rates and ED visits for CHF patients.

**Products:** In addition to documenting progress in meeting specific cost, quality, and population health goals through research and evaluation studies, we will develop a model for HIT/HIE “shared services” that can be replicated elsewhere, as well as an example of a community-wide practice redesign/quality improvement program. We also expect to engage payers in both participating in and sustaining this work as well as others in scaling up models to benefit other communities.

**Duration:** The project will span 30 months, from October 2010 – March 2013, but will be sustained beyond that period.