Below is the content that will appear in the VITAL2015 poster compendium and on your VITAL2015 poster. Please review and **use track changes** to make any edits or comments, as well as to address any questions or comments from America’s Essential Hospitals staff.   
  
America’s Essential Hospitals staff will create and print your poster for you. You will receive a pdf of your poster by April 1 for final approval.

**Return your review and any accompanying materials to** [**Kristin Sinko**](mailto:ksinko@essentialhospitals.org) **no later than 5 pm ET, Friday, March 20.**Compendium abstract:  
**Santa Clara Valley Medical Center**

**Outpatient Case Management/Care Coordination**

Patients at high risk, those with complex medical issues, and the chronically ill elderly are major drivers of health care costs. In response, Santa Clara Valley Medical Center (SCVMC) introduced evidence-based interventions focused on prevention, health maintenance, and safe transitions across the care continuum.

The hospital instituted a transitional program for inpatients with positive outcomes. And, with the help of a multidisciplinary team of physicians, nurses, specialists, and a health educator, SCVMC created a quality improvement pilot in an outpatient family practice clinic to evaluate the feasibility of evidence-based interventions to meet the needs of vulnerable patients. In the pilot, clinic providers referred 18 participants to a case manager/case coordinator. As a result of the new transitional care model, the hospital saw a cost savings of $160,000 and fewer emergency department visits. The hospital expects the addition of the case manager/care coordinator plan will improve care quality, patient outcomes, and financial performance.

Poster content:  
**Santa Clara Valley Medical Center**

**Outpatient Case Management / Care Coordination**

**Overview**

Santa Clara Valley Medical Center (SCVMC) introduced evidence-based interventions focused on prevention, health maintenance, and safe transitions across the care continuum. The hospital expects these interventions will improve care quality, patient outcomes, and financial performance.

**Premise/Problem**

Patients at high risk, those with complex medical issues, and the chronically ill elderly are major drivers of health care costs. These complex issues impact health and quality of life, are major drivers of health care costs, and threaten health care affordability.

**Methodology**

The hospital tracked patient-centered outcomes, quality of care, and resource utilization.

**Intervention/ Innovation**

SCVMC instituted a transitional program for inpatients and, with the help of a multidisciplinary team of physicians, nurses, specialists, and a health educator, created a quality improvement pilot in an outpatient family practice clinic. The pilot evaluated the feasibility of evidence-based interventions to meet the needs of vulnerable patients. In the pilot, clinic providers referred 18 participants to a case manager/case coordinator.

**Success/Outcomes**

As a result of the new transitional care model, the hospital saved $160,000 and reduced emergency department visits. The hospital expects the addition of the case manager/care coordinator plan will improve care quality, patient outcomes, and financial performance.