ActivateCare

Queen of the Valley
CARE Network

C - Case Management
A - Advocacy
R - Resources
E - Education

St.JosephHealth
Queen of the Valley

Providence St. Joseph Health Case Study

Every day 119,000 compassionate caregivers serve patients and communities through Providence St. Joseph Health, a national, Catholic, not-for-profit health system, comprising a diverse family of organizations and driven by a belief that health care is a human right.

Many patients who are discharged from the hospital face obstacles to maintain their health. For some patients, these challenges are health care related—not understanding their medication regimen or the recommended diet. For others, the obstacles may be societal—transportation and financial issues, or substandard living conditions. But for the most vulnerable of patients, it's a combination of the two.

St. Joseph Health, Queen of the Valley Medical Center, a 208-bed hospital in Napa, California, is improving the health and quality of life for Napa County's most vulnerable populations. The hospital's CARE Network—case management, advocacy, resources and education—delivers timely health care services to chronically ill patients who are low-income and uninsured or underinsured. Through the work of the CARE Network:

- Hospitalizations and emergency room utilization each decreased by about 64 percent for these patients.
- CARE Network patients have a 21 percent lower 30-day readmission rate than the hospital's other patients – 8.3 percent versus 10.5 percent.

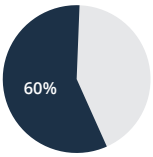
The CARE Network provides a seamless continuum of care from hospital discharge back into the community setting. First and foremost, a team made up of a social worker and nurse visit the patient's house to make sure that their most basic needs are met. Often this includes arranging adequate hous-

Community health outcomes that last:

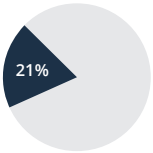
ing and food, and arranging transportation to the patient's follow-up primary care provider and pharmacist for the necessary medications. In many cases, the social worker is tasked with arranging needed social services like California's Medicaid and welfare programs.

Once the patient's basic needs are met, the nurse makes return trips to the patient's house to make sure they understand their post-discharge care plan. Together, they go over the dosages and timing of the patient's medications, the recommended diet and exercise plan, as well as future primary care appointments. The home visits continue until the patient is empowered to manage their care effectively.

Activate Care is proud to support this cornerstone community health investment for Northern California. The Activate CareHub™ platform helps to power this interdisciplinary, whole-person approach to intensive outpatient care management for socioeconomic and medically complex populations.



60%+ Reduction
in Hospitalizations & Emergency Department utilization



21% Lower
30-Day readmission rate compared to overall Hospital Population

Queen of the Valley's care teams use their CareHub to:

- Develop and execute individualized, holistic care plans reflecting patient's goals and priorities
- Manage and track activities associated with a patient's care
- Communicate and collaborate amongst team members securely and efficiently
- Develop and share individualized care plans
- Provide access and a meaningful experience for patients, families, and caregivers
- Track new and unique data to inform and drive process improvement

All-in-one platform for SDOH care

Imagine if our healthcare system seamlessly coordinated care around all of our physical, behavioral, and social needs. With Activate Care this is the new standard of care.

The Activate CareHub™ offers everything communities need to manage high-quality care coordination and community resource referral networks in your community. Hundreds of organizations across the country rely on Activate Care to improve community health outcomes and address the social determinants of health. **Join us.**