
HOW COUNTIES CAN STRENGTHEN

Street Team Medicine

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One person can cross five systems in seven days



The failure is rarely a lack of effort

Teams lack timely context, a clear owner for the next action, and proof that the handoff closed.

Street medicine succeeds when the handoff produces a measurable result

REACH

Roster match rate

Patients visible across systems

SPEED

Time from alert to review

Time to outreach or warm handoff

CONTINUITY

7- and 30-day follow-up

Closed-loop clinical referrals

UTILIZATION

Repeat ED visits

Psychiatric admissions and readmissions

North-star outcome

More people remain connected to planned care after an acute event

Large-scale programs show the value of data plus accountable workflows

CALIFORNIA WHOLE PERSON CARE

25 Whole Person Care pilots

Across 26 California counties, UCLA's Center for Health Policy Research conducted the statewide evaluation. Pilots combined real-time data sharing with coordinated health, behavioral health, and social services.

130

fewer ED visits

per 1,000 beneficiaries per year

45

fewer hospitalizations

per 1,000 beneficiaries per year

\$383

lower Medi-Cal spending

per beneficiary per year

Separate national HIE review

Menachemi et al., Journal of the American Medical Informatics Association (2018): 24 HIE studies and 63 analyses. All 7 stronger causal studies reported a benefit. Reported benefits included lower costs, less duplicate testing and imaging, and improved patient safety. Community HIEs were more likely to demonstrate benefits than enterprise or vendor-based exchanges.

LANES connects the patient journey without replacing county workflows

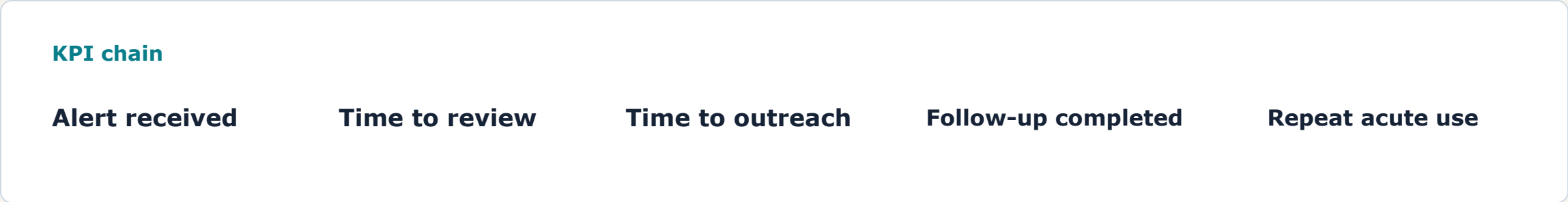
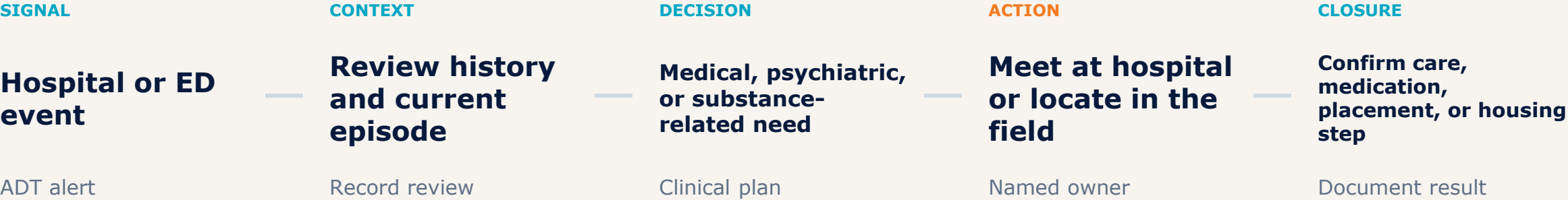
- 1 Longitudinal record** Recent encounters, medications, labs, diagnoses, and care relationships

- 2 Event signal** Near-real-time notice of an ED visit, admission, or discharge

- 3 Cohort view** A roster that lets the accountable team track a defined population

The county still defines who acts, by when, and how success is measured.

HOME Team turns a hospital event into field-based follow-up



LANES - county pilot paired a defined cohort with a recurring operating rhythm

733

adults with frequent
psychiatric admissions

Eligibility

4+ admissions in the prior 13
months, including one at
either participating hospital

1

ROSTER

DMH identified the cohort

2

TRAINING

Hospital teams learned the workflow

3

WEEKLY REVIEW

County and LANES examined outliers and new
information

4

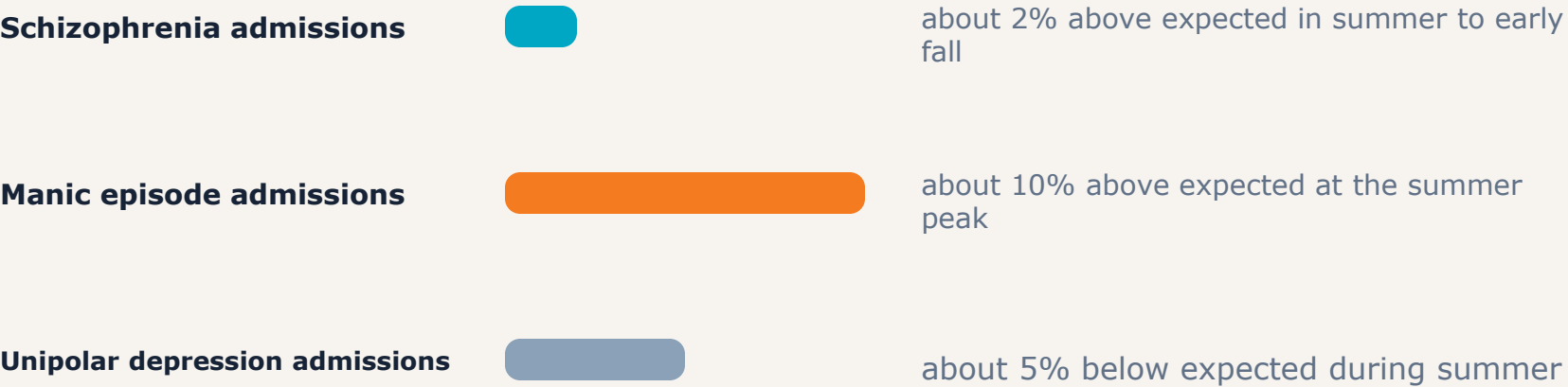
CARE ACTION

County routed findings to the responsible team

Comparison: January–June 2022 vs. July–December 2022

Published seasonal patterns are too small to explain a 40% decline by themselves

PUBLISHED SEASONAL RANGE



Why seasonality is unlikely to be the sole explanation

The pilot's largest diagnostic group was schizophrenia. Published data show a small summer and early-fall increase, while the pilot recorded a large decline after July.

Important limitation

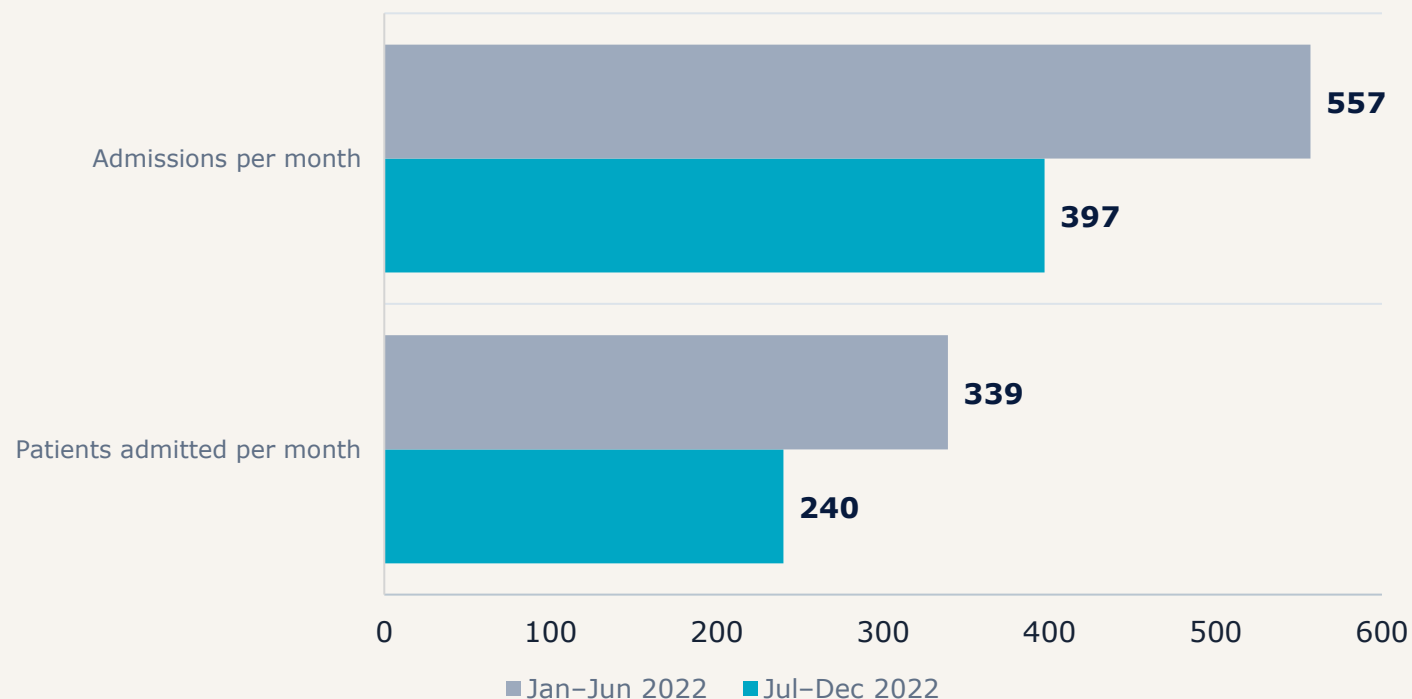
The study did not perform a same-month prior-year comparison or a formal seasonal adjustment.

DMH PILOT CHANGE

40.3% decline in average monthly inpatient psychiatric admissions

Interpretation: seasonality does not plausibly explain the full effect, but the study cannot formally rule it out

Inpatient psychiatric use declined during the adoption period



40.3%

decline in average monthly
inpatient psychiatric
admissions

Association only: the pre/post review did not establish causation

The strongest results came from pairing alerts with a team that could act

DMH HOME TEAM

70%

reduction in avoidable ED visits

174-patient high-utilizer cohort

Operational lever

Hospital notifications supported field response and discharge coordination

VISTA DEL MAR MCOT

60%

reduction in avoidable ED visits

260-patient mobile crisis roster

Operational lever

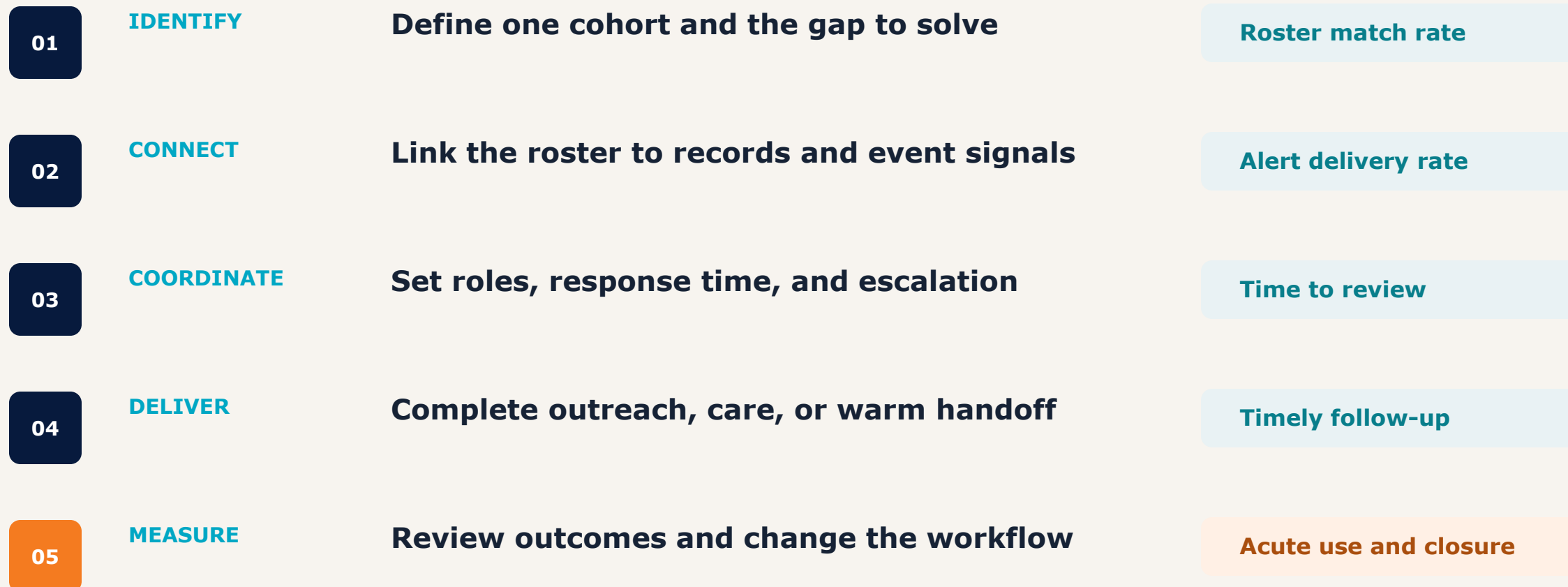
Shared clinical context supported transport and residential placement decisions

A county scorecard should connect workflow performance to patient outcomes

DOMAIN	KPI	DEFINITION	CADENCE	OWNER
Reach	Roster match rate	% of target cohort matched to shared records	Monthly	Program lead
Speed	Time to review	Median time from event alert to record review	Weekly	Care manager
Action	Timely outreach	% with outreach within the locally defined interval	Weekly	Street team
Continuity	Follow-up completed	% with clinical follow-up within 7 and 30 days	Monthly	BH or PCP lead
Closure	Closed-loop referral	% of referrals with a documented disposition	Monthly	Referral owner
Utilization	Repeat acute use	ED revisits, admissions, and readmissions by cohort	Monthly	County analyst

Every KPI needs a numerator, denominator, data source, baseline, target, and named owner

Five decisions create an accountable care pathway



A 90-day pilot can establish the workflow before testing utilization change

DAYS 1–15

DESIGN

Cohort, partners, event, owner

KPI

Baseline and measure definitions

DAYS 16–30

ACTIVATE

Roster, access, alerts, training

KPI

Match and alert delivery rates

DAYS 31–60

OPERATE

Weekly case review and escalation

KPI

Time to review and outreach

DAYS 61–90

IMPROVE

Fix failure points and report

KPI

Follow-up, closure, early utilization

Workshop output

For [cohort], when [event] occurs, [owner] will [action] within [time], measured by [KPIs].

Which patient journey should your county fix first?

- 1 What event should trigger action?**
- 2 Who owns the response and loop closure?**
- 3 Which two KPIs will show that the workflow works?**

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