



# Define - Measure - Analyze - Improve -

## Control

Project or Program: <b>Pinellas County Health Program</b>					
Goal: Improved health outcomes for client population; reduction of health disparities					
INPUTS	ACTIVITIES		OUTCOMES		
What we invest	What we do	Who we reach	Short-term results	Intermediate results	Long-term results
\$ 11,540,788.00  <b>Provider Partners:</b>  FL Department of Health	<ul style="list-style-type: none"> <li>• Primary and preventive care</li> <li>• Referral to laboratory services</li> <li>• Expanded dental Services</li> <li>• Relief of pain dental services</li> <li>• Preventive dental services</li> <li>• Specialty care referrals and services</li> <li>• Referral to home health services and durable medical equipment</li> <li>• Behavioral health</li> <li>• Provision of Community-based care</li> <li>• Care coordination</li> <li>• Rx through contracted pharmacy and Rx assistance program</li> <li>• Compassionate prescription program</li> </ul>	<ul style="list-style-type: none"> <li>• Adults 18-64</li> <li>• &lt;=100% FPL</li> <li>• Uninsured, do not qualify for any other insurance</li> <li>• Homeless (MMU)</li> <li>• Pinellas County Residents</li> </ul>	<p>90% of newly enrolled clients will access medical home within 4 weeks of enrollment.</p> <p># medical encounters # dental encounters # unique medical patients seen # unique dental patients seen (Increased access to medical and behavioral healthcare)</p> <p>80% of Clients receive maintenance Rx with 90 day refills where appropriate</p> <p>95% of available brand Rx accessed through Mednet</p> <p>% clients with &gt;5 missed appointments in FY</p> <p># of clients connected to care coordination upon hospital discharge.</p> <p># of high-use ER clients connected to care coordination.</p>	<p>95% of Clients receive appropriate screenings by race/ethnicity and age (breast, cervical, colorectal cancer)</p> <p>70% of Clients receive flu shots by race/ethnicity and age</p> <p>60% of Chronic conditions controlled by race/ethnicity and age</p> <ul style="list-style-type: none"> <li>○ Hypertension</li> <li>○ Diabetes</li> </ul> <p>95% of Appropriate assessments performed (BH, tobacco use)</p> <p>95% of BH referrals provided where indicated by BH screening</p> <p>70% complete specialty care referral</p>	<ul style="list-style-type: none"> <li>• Improved health outcomes               <ul style="list-style-type: none"> <li>○ Asthma controlled (%)</li> <li>○ Less uncontrolled hypertension (%)</li> <li>○ Less uncontrolled diabetes (%)</li> <li>○ Fewer smokers (%)</li> </ul> </li> <li>• Reduction of health disparities (%)</li> </ul>

Monthly Primary care Data  
 HEDIS Measures  
 Pharmacy data  
 Specialty Care Data



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Last Updated 8/10/2016

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