Adirondack Health Institute
Champlain Valley Physicians Hospital

Baseline

(Data reflects Jan. '15 – Dec. '15)

Initial cohort criteria was defined as patients with 10+ ED visits in a 12 month period

91 Patients = 1,245 ED Visits — 243 IP Admissions

Patient Success Story

Patient is a 39 year old male who suffers from anxiety and had 9 visits in the 3 months (Apr. 11 – Jun. 11) prior to his index visit on Jun. 11 and has had 3 visits in the 3 months since his index visit (Jun. 12 – Aug. 12).

ACTIONS

- Patient was flagged in the ED and alerts were received by the care team
- Typically patient was provided anxiety meds and discharged, but care team performed a needs assessment instead and discovered social and behavioral health needs were unmet
- Patient was prescribed new meds, had a psychiatrist appointment made, and connected with BHSN for behavioral health services
- The care manager is working to enroll patient in Medicaid and connecting him to money management services, transportation services, and a food pantry

LESSON LEARNED/BRIGHT IDEA

1. It can be difficult and time consuming to address the needs of Super Utilizers
2. Community resources are a critical element of successfully assisting these patients and the team was able to effectively leverage resources within the community
3. Collaboration is necessary to be successful in assisting these patients

Impact

(Mar. '16 – Sep. '16)

Patient Engagement

88 patients presented

32 patients engaged

8 patients connected to services

Including: BHSN, NAMI, Meals on Wheels, Medicaid, HCR

Hospital Utilization

Note: Only includes patients with an Index visit and at least 90 days of post-index visit data (n = 9)

	Before 3 mo. Pre-Index Visit	After 3 mo. Post-Index Visit	%Δ
ED Visits	53	12	-77%
IP Admissions	3	1	-67%
Total	56	13	-77%

*Calculations are based on self-reported data from Action Team