Bassett Medical Center PPS
Little Falls Hospital

Baseline

(Data reflects Jan. '15- Dec. '15)

Initial cohort criteria was defined as patients with 6+ ED visits in a 12 month period

68 Patients = 578 ED Visits | 48 IP Admissions

Patient Success Story

Patient is a 24 year old female with multiple medical and behavioral health conditions. In 2015 she had 33 visits. Although the patient continues to visit the hospital frequently the Team has developed a strong relationship with the patient who has taken steps to improve her situation.

ACTIONS

- Patient was flagged upon presenting to the ED
- Social Worker and Case Manager met with patient uncovering multiple potential drivers of utilization including depression and anxiety
- Care Manager and the hospital developed a care plan
- Social Worker and Care Manager worked to get patient surgery for medical condition, referred her to BH counselor and psychiatrist, arranged home medications, developed daily living routine contract, referred patient to a diabetes educator, and frequently keep in contact with the patient

LESSON LEARNED/BRIGHT IDEA

- Leverage the broader care network, including internal resources, community organizations, and the PPS
- Seek to understand patients from a different perspective with more of an emphasis on their psychosocial issues
- Super Utilizers require a greater level of attention, advocacy and management in order to connect them to critical social services and support

Impact

(Mar. ' 16 – Sep. '16)

Patient Engagement

45 patients presented

30 patients engaged

20 patients connected to services
Including: Primary care, specialist, education, mental health services, social services

Hospital Utilization

Note: Only includes patients with an Index visit and at least 90 days of post-index visit data (n = 15)

	Before 3 mo. Pre-Index Visit	After 3 mo. Post-Index Visit	%Δ
ED Visits	33	20	-39%
IP Admissions	10	7	-30%
Total	43	27	-37%

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