Bronx Health Access

Bronx Lebanon Hospital Center

Baseline

(Data reflects Jan '15 – Dec '15)

Initial cohort was defined as patients with 4+ inpatient admissions and/or 16+ ED visits in a 12-month period.

109 Patients = 1,049 ED Visits 552 IP Admissions

Patient Success Story

Patient is a 57 year old female with multiple comorbidities whose personal fear of death was driving her hospital utilization. The patient had 8 ED Visits and 2 IP Admissions in the 6 months before her index visit (Jan. 1 – Jun. 12) and has had 3 ED visits in the 3 months since her index visit (Jun. 13 – Aug. 9).

ACTIONS

- Care Transitions identified the patient through an EMR alert
- Patient was screened for Care Coordination by the BLHC Clearinghouse
- Care Coordinator completed a multidisciplinary visit at bedside, revealing the patient was confused about which seizure medications to take and had a personal fear of death
- Medications were modified, patient was educated, and referred to Doctors on Call
- Care Coordinator escorted the patient to pulmonary, PCP, psychiatrist and neurologist appointments, advocated for extended home care hours and conferenced with patient's daughter who is now more involved in the patient's care
- Care Coordinator was also present at all subsequent ED visits

LESSON LEARNED/BRIGHT IDEA

- Patients need more than hospital interventions in order to solve for the patients' key drivers of utilization
- Intensive and extensive Care Coordination upon discharge is critical

Impact

(Mar. '16 – Sep. '16)

Patient Engagement

30 patients presented

13 patients engaged

13 patients connected to services

Including: Doctors on Call, specialist appointments, Health Home, food services, wellness education

Process Improvements

- **Implementation of EMR alerts system**
- **Development and implementation of ED Care Transitions Team**
- **Integration of HealthFirst Care Manager**
- **Enhanced communication among hospital teams and community partners**