Millennium Care Collaborative
Erie County Medical Center

Baseline

(Data reflects Jan. '15 – Dec. '15)

Initial cohort was defined as patients with 6+ ED visits and 1+ primary care visit in a 12-month period.

114 Patients = 1,368 ED Visits 680 IP Admissions

Patient Success Story

Patient is a 60 year old female with multiple co-morbidities (CHF, COPD, Diabetes, etc.) The patient lacked an understanding of how to manage her illnesses. The patient has had only 1 ED visit in the 1 month since her index visit on Jun. 27.

ACTIONS

- Patient was flagged upon presenting to the ED, which triggered a visit from the ED Care Manager
- ED Care Manager linked the patient with the Catholic Health Home, set up appointment with Pain Management Doctor (PMD) and instructed the patient to call PMD before visiting the ED
- Patient attended two follow up visits with the PMD; at the PMD appointment a Social Worker set her up with Meals on Wheels and linked the patient the "Going Place" van to take her to the grocery store

LESSON LEARNED/BRIGHT IDEA

1. Teams should take a broad look across services when building their team
2. Do not underestimate the related work flows needed to integrate Health service providers into the ED and PCP practices
3. Teams have to continually make efforts to keep the MAX Series Team members energized and engaged

Impact

(Mar. '16 – Sep. '16)

Patient Engagement

99 patients presented

26 patients engaged

24 patients connected to services
Including: Care Management, Health Home (Evergreen), financial counseling, physician follow up, drug rehab

Hospital Utilization

Note: Only includes patients with an Index visit and at least 90 days of post-index visit data (n = 6)

	Before 3 mo. Pre-Index Visit	After 3 mo. Post-Index Visit	%Δ
ED Visits	23	18	-22%
IP Admissions	8	2	-75%
Total	31	20	-35%

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