Montefiore Hudson Valley Collaborative

Saint Joseph's Medical Center

Baseline

(Data reflects Jan. '15 – Dec. '15)

Initial cohort criteria was defined as patients with 4+ Inpatient Admissions in 2015

125 Patients = 909 ED Visits 637 IP Admissions

Patient Success Story

Patient is a homeless male who suffers from end stage liver disease who had 7 inpatient visits in the year prior to his index visit on Apr. 12 and has had 5 visits in the 3 months since his index visit (Apr. 13 – Jul. 13). Although the visit volume did not significantly change, the key driver of the visit changed from social to medical in nature.

ACTIONS

- Health Home and multiple hospital departments worked together to locate patient and enroll patient in critical services
- Patient contacted Care Manager before going to the ED; Care Manager contacted ED physician
- Patient was treated at the hospital and then connected to Montefiore for additional treatment
- Patient placed in permanent housing and reported feeling "really good about himself"

<u>LESSON LEARNED/BRIGHT IDEA</u>

Involving organizations and physicians that care for patients in the community to collaborate with intensive care strategies based upon the patients' unique needs strengthens and impacts the entire community we serve.

Impact

(Mar. '16 – Sep. ' 16)

<u>Patient Engagement</u>

87 patients presented

28 patients engaged

19 patients connected to services

Including: Care Coordination, Housing, Drug Rehab, Immigration, Assisted Living

<u>Hospital Utilization</u>

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	Median
ED Visits	129	103	-20%	-50%
IP Admissions	33	4	-88%	-100%
Total	162	107	-34%	-64%

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