# Brookhaven Memorial Hospital Medical Center
## *Suffolk Care Collaborative*

## *Our Cohort*

*(Data reflects May. '15 – Oct. '15)*

**Initial cohort defined as patients with ≥3 ED Visits and/or >1 inpatient admission in a 6-month period with a primary *or* secondary diagnosis of COPD**

61 Patients = 394 ED Visits, 93 IP Admissions

## *Our Actions*

### Early Initiatives

- Patient identification via **Super Utilizer EMR flag** and email notification process
- Staff Education
- Opened a COPD unit
- Started Pulmonary Rehab
- Better Breathers Club

### Planning

- Created a **Social Worker checklist needs assessment** to uncover 'Drivers of Utilization'
- Developed a **resource toolkit** to assist providers with risk mitigation activities

### Management

- Social Worker performed **home assessments, telephonic outreach, and coordinated community resources**
- Established **interdisciplinary meetings** between care team and patient
- Health Home Enrollment

### Follow up/ Ongoing Initiatives

- Developed **graduation criteria** for patients no longer needing high touch care
- **Transitioned care management services** from Social Worker to Health Home

### Lessons Learned

- **Frequent, high touch contact by a consistent resource helps build patient relationships**, and is critical for supporting the 'never give up, and keep trying!' culture
- **Mitigating capacity overload through patient "graduation" protocol was critical** in matching patients to appropriate levels of care and alleviating the patient caseload among the team
- Process maintenance is as critical as process generation
- **Super Utilizers often have unmet behavioral health needs that require a personalized approach**

### Patient Story

- Middle aged female with multiple chronic conditions including depression
- During the 6 months prior to program start, she had 14 ED visits and 5 IP admissions, 6 months after program start, she has had 8 ED visits and 4IP admissions
- Patient was administered a needs assessment and care team identified a need for education and support for follow-up appointments
- Patient was connected to care coordination services, primary care, and Medicaid transportation

## *Our Impact*

### Patient Engagement
*(Nov. '15 – Apr. '16)*

**51**
Cohort patients contacted (33 presented to the hospital)

**38**
Patients contacted accepted services

**28**
Patients who accepted services are actively engaged

### Hospital Utilization

| | Before *(May. '15- Oct. '15)* | After *(Nov. '16-Jul. '16)* | %Δ Rate (/month) |
|---|---|---|---|
| ED Visits | 65.7 /month | 32.3 /month | -50.8% |
| IP Admissions | 15.5 /month | 11.0 /month | -29.0% |

**self reported data up to July 31, 2016**