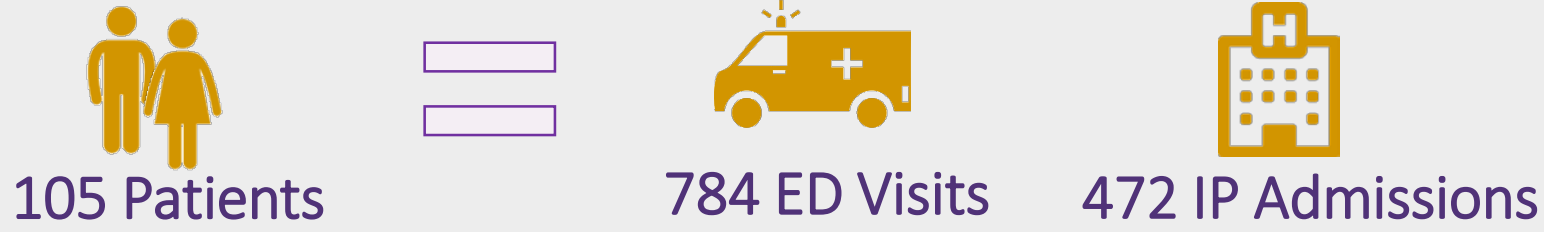


# Richmond University Medical Center Staten Island PPS

## Our Cohort

(Data reflects Jul. '15 – Jun. '16)

Initial cohort defined as patients with 6+ ED Visits or 3+ IP Admissions in a 2-year period with comorbidities of diabetes and behavioral health



## Our Actions



### Patient Identification

- Created a **Super Utilizer EMR flag** upon registration and an email notification **alert process**



### Planning

- Created an ED **Social Worker script** to engage the patient and initiate the **care plan**




### Management

- Connected patients to **CHASI (Health Home)**
- Evaluation and referral staff assisted service **connection, follow up, and off-hour communication**




### Follow- Up

- Transitioned patients to appropriate **community-based resources**



### Lessons Learned

- Data Analyst was essential** for collecting and analyzing the data necessary to refine the Action Team's approach throughout the program
- Meetings between interdisciplinary providers and community organizations are important** for aligning goals/action and often times leads to unexpected insights

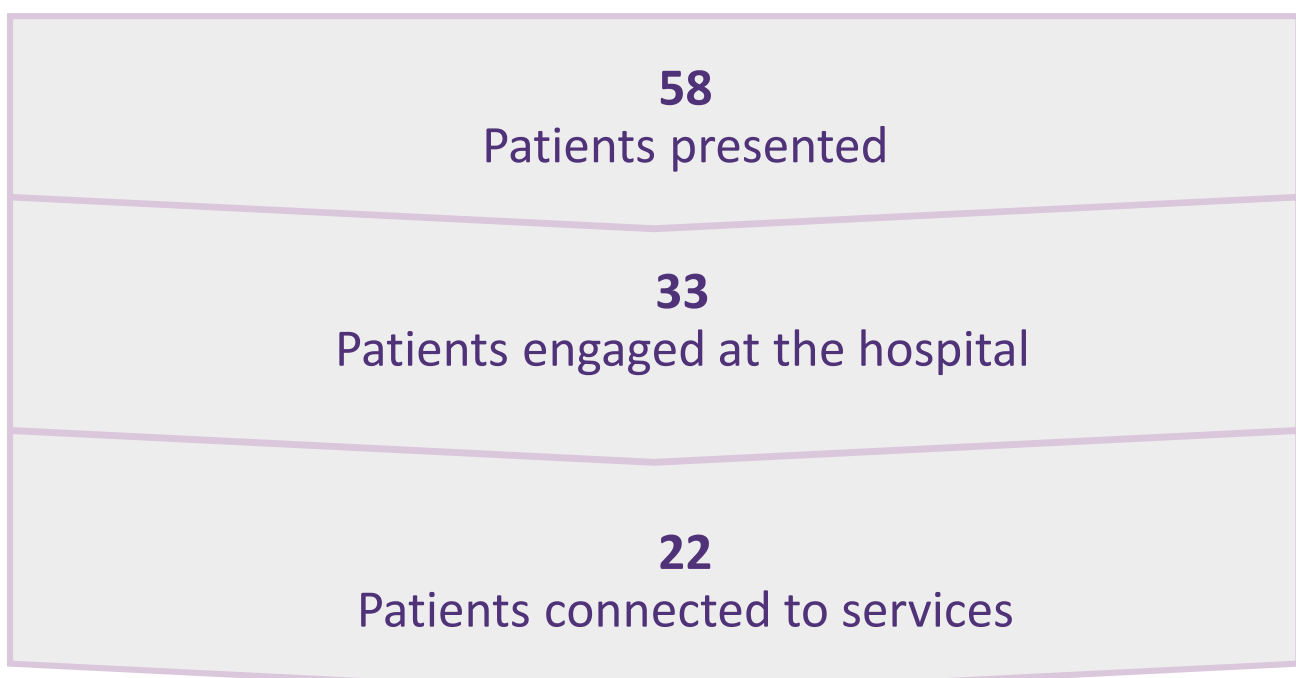


### Patient Story



- 55 year old female with mental health issues
- During 6 months prior to intervention, she had 21 ED visits, 5 months post MAX intervention, she has had 3 ED visits
- Patient was engaged by the ED Social Worker who determined drivers of utilization and helped connect the patient with a visiting nurse and CHASI Strong Steps Domestic Violence Program

## Our Impact

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



### Hospital Utilization

	Before (May. '15- Oct. '15)	After (Nov. '16-Jul. '16)	%Δ Rate (/month)
 ED Visits	32.3 /month	27.7 /month	-14.2%
 IP Admissions	19.8 /month	11.1 /month	-44.0%

self reported data up to July 31, 2016