Richmond University Medical Center

Staten Island PPS

Our Cohort

(Data reflects Jul. '15 – Jun. '15)

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

105 Patients = 784 ED Visits, 472 IP Admissions

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)

58
Patients presented

33
Patients engaged at the hospital

22
Patients connected to services

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