Staten Island University Hospital

Staten Island PPS

Our Cohort

(Data reflects Apr. '15 – Mar. '16)

Initial cohort defined as patients with HIV/AIDS and 2+ Hospital Admissions in a 6 month period

99 Patients = 273 ED Visits 131 IP Admissions

Our Actions

Patient Identification

- Generated a **daily Super Utilizer report** and updated the patient registry with the patients who presented

Planning

- HIV Clinic performed ED **patient outreach**
- Developed **Social Worker Checklist** to uncover drivers of utilization
- Created a **Vision Board** to educate patients on approporate use of the ED

Management

- Hospital Social Workers connected patients to **community services**
- Provided **personalized care management** through the HIV Clinic and CHASI (health home)

Follow- Up

- Patients continue to be managed by Care Managers at the HIV clinic, or community agency
- SW is working with subspecialty clinics to **decrease barriers to appointments**

Lessons Learned

- **Data analysis is important in highlighting gaps in care** and can be used to inform resource decisions
- **Understanding the patients' drivers of utilization** is critical in developing programs and initiatives that meet patient needs
- **There is high value in infrastructure development**, ex. the Action Team established channels that facilitated communication between the hospital and outpatient settings to increase program impact
- **Super Utilizers experience barriers to specialty care,** through the support of leadership, the Action Team developed an action plan to create awareness and collaborate on expedited appointment policies with subspecialty clinics

Patient Story

- 41 year old male with history of non-compliance
- During the 5 months prior to intervention, he had 9 ED visits and 1 IP admission, intervention occurred 4/14/16, and he has had 8 clinically related ED visits and 3 IP admissions in the 5 months post-intervention
- Patient was engaged by the ED Social Worker who educated the patient on a community care coordination agency
- A warm-handoff was made to the Health Home and patient is compliant at home
- Team continues to decrease barriers to timely specialty appointments through the next Action Plan "Breaking Down Barriers to Specialty Care"

Our Impact

Patient Engagement

(Jan. '16 – Apr. '16)

22
Patients presented

6
Patients admitted to the hospital

6
Patients connected to services (ex. HIV clinic)

Hospital Utilization

	Before *(Oct. '15- Mar. '15)*	After *(Jan. '16-Jul. '16)*	%Δ Rate (/month)
ED Visits	45.5 /month	13.3 /month	-70.8%
IP Admissions	21.8 /month	4 /month	-86.7%

self reported data up to July 31, 2016