

Brookhaven Memorial Hospital Medical Center

Suffolk Care Collaborative

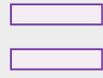
Our Cohort

(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

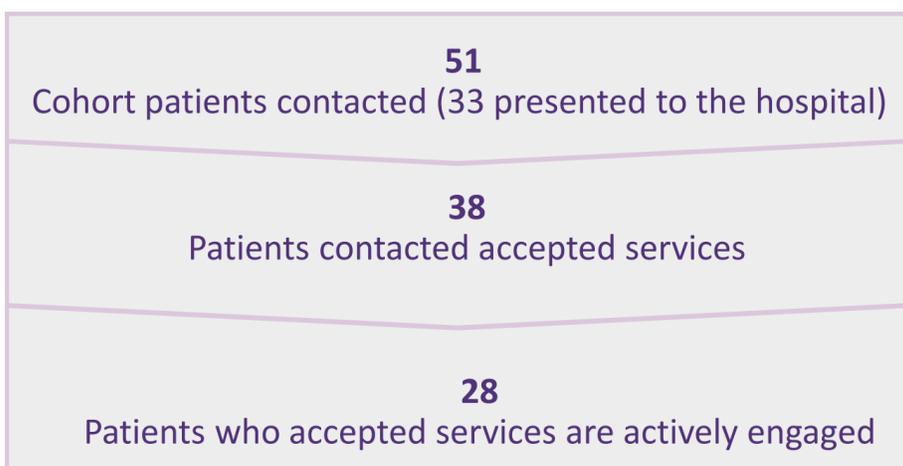
- **Frequent, high touch contact by a consistent resource helps build patient relationships**, and is critical for supporting the 'never give up, and keep trying!' culture
- **Mitigating capacity overload through patient "graduation" protocol was critical** in matching patients to appropriate levels 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)



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