

# RICHMOND UNIVERSITY MEDICAL CENTER MAX SERIES PROGRAM

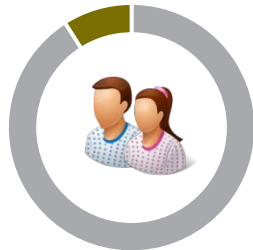
## All-PPS Meeting 12/11/2015

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Senior VP Care Transformation, Quality, and IT

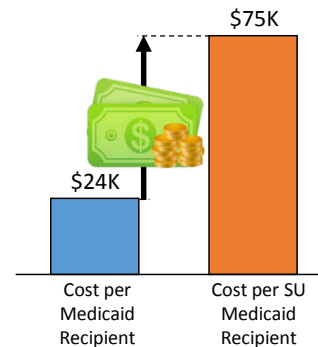
# Staten Island PPSs Super Utilizer population has a high rate of ED visits and accounts for a disproportionate amount of healthcare utilization

## THE IMPACT OF SUPER UTILIZERS ON STATEN ISLAND PPS

**9%** of Staten Island PPS Medicaid Enrollees are defined as Super Utilizers



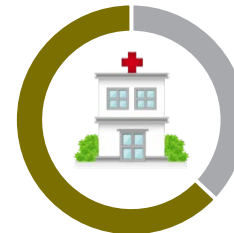
Average spending per Super Utilizer recipient is **3.1X** greater



That population drives **45%** of ED Visits by Medicaid enrollees...

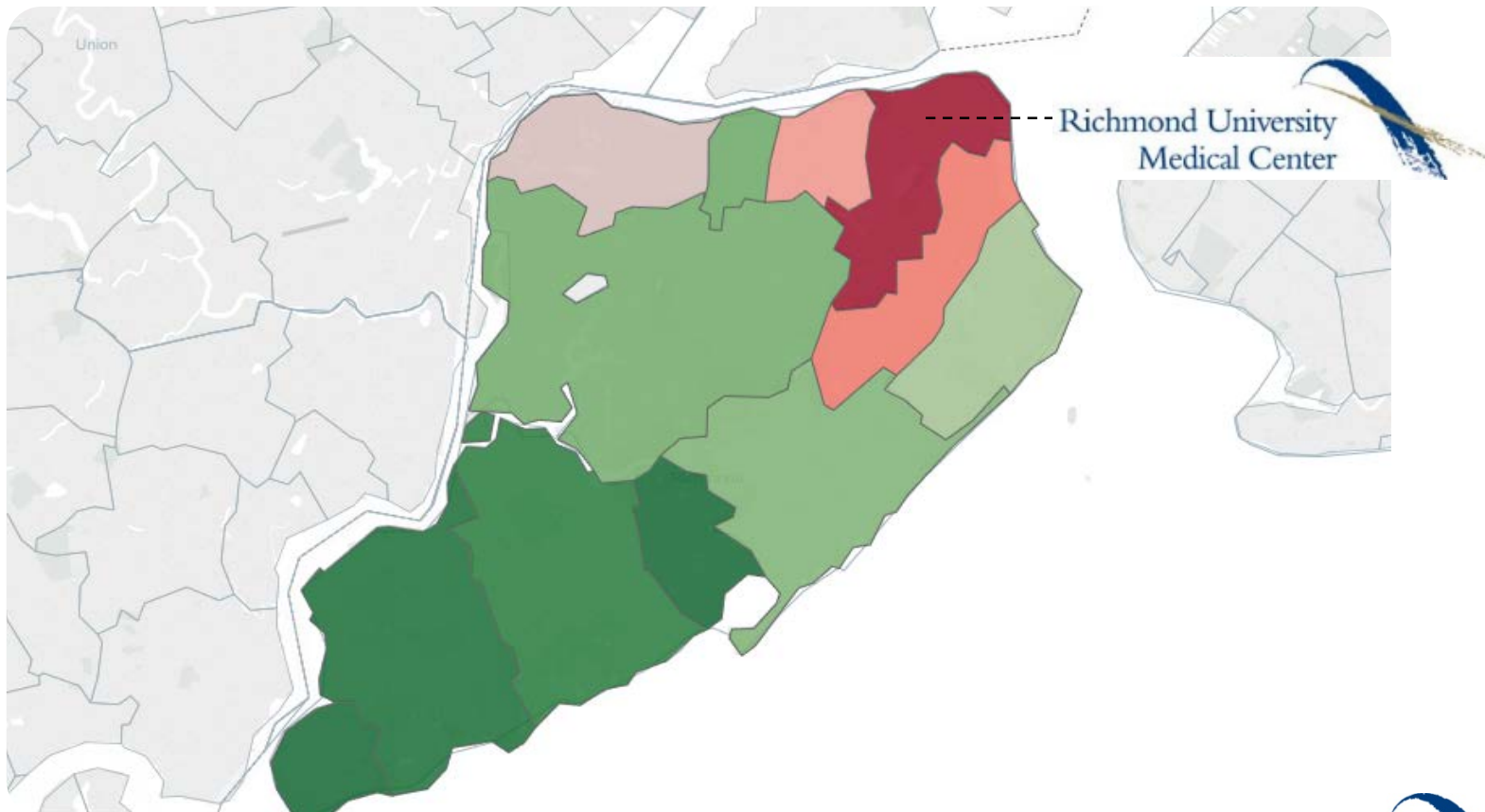


... and **63%** of inpatient admissions



# The Super Utilizer population in Staten Island PPS that drives ED Visits clearly clusters in the NE and presents frequently at Richmond University Medical Center (RUMC)

**Where Staten Island PPS's Super Utilizers Live:**  
Heat Map of Zip Codes Associated with Super Utilizer ED Visits

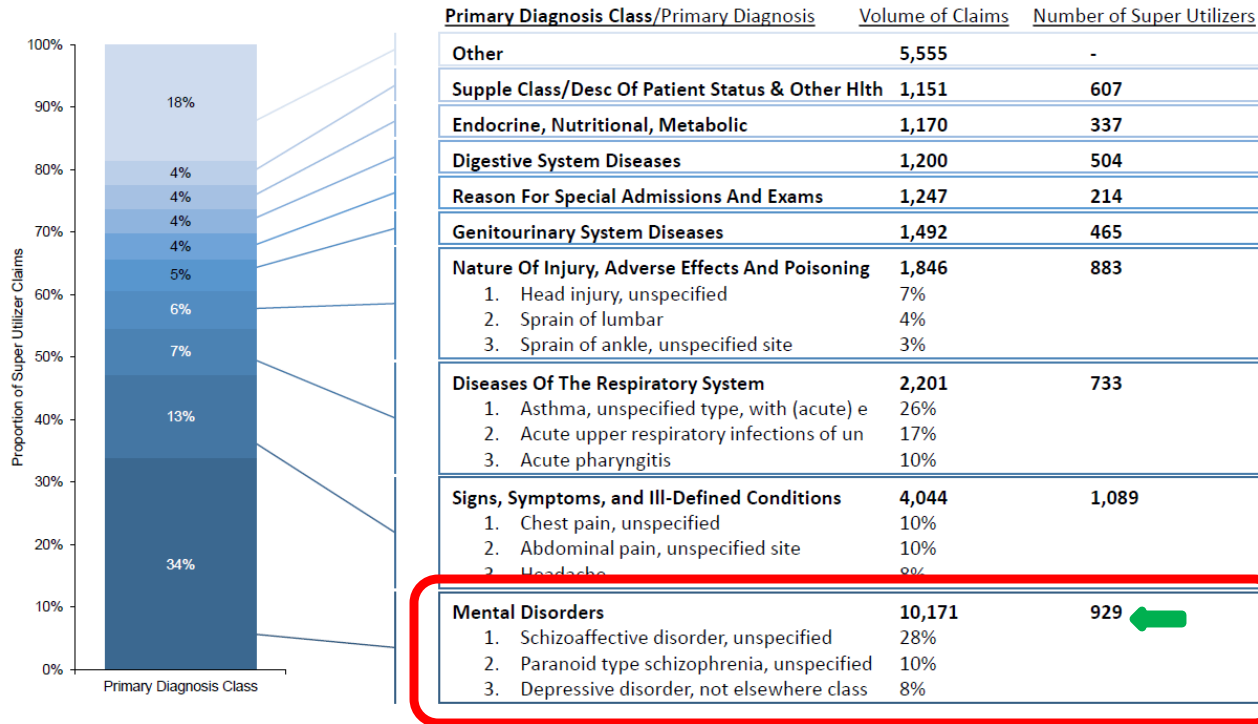


*Note: Zip codes with <30 Super Utilizers not shown*

# The RUMC MAX Action Team is focusing on a sub patient population of the identified Super Utilizers

Among claims by Super Utilizers at RUMC attributed to Staten Island PPS, primary diagnoses related to mental disorders, respiratory illnesses and injuries are prevalent

Primary Diagnosis Class and Top 3 Primary Diagnoses of Super Utilizer Claims at Richmond University Medical Center



**Richmond University Medical Center**  
 Unique Super Utilizers: 2,090  
 Super Utilizer Claims: 30,078  
 Note: Represents data over a two-year period (CY13-14)

Note: The top 3 Primary Diagnoses that account for the greatest volume of claims within a class have been included for the top 3 Primary Diagnoses with the greatest volume of claims (excl. Signs, Symptoms, and Ill-Defined Conditions)



## We brought together a multidisciplinary team to improve the care for our Super Utilizers through the MAX series



- Administrative lead
- Clinical lead
- Ambulatory practice
- ED
- Case management
- Mobile crisis unit
- Health home
- Inpatient

## We're excited to report on impressive progress made on the 3 developed Short Term Action Plans

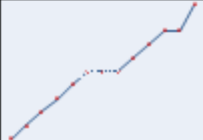
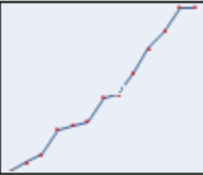


1. Getting access to each others EHR's

2. Flagging patients in EDIMS, ED's EHR

3. Refer SU to CHASI and Mobile Crisis Unit

- **Additional Action plans will be developed in MAX Workshop 2 and 3**

# We're measuring **impact** on the longer term through the following measures:

Select Month	Target	Baseline	Feb-16	Status	Click to View Run Chart
Feb-16					
1. Percentage of the Super Utilizer Cohort enrolled in Health Home	100%	50%	70%	↗	
2. Number of behavioral health outpatients visits by the defined Super Utilizer cohort	1000	0	276	↗	
4. Number of ED Visits by the Super Utilizer Cohort per month	0	150	150	↗	
5. Number of readmissions among the Super Utilizer Cohort	0	50	50	↗	

Example Data

To reach our overall goal:

- To identify our target population and **enroll them in a user friendly system** that addresses their psychosocial needs for over utilization to **decrease ED visits and hospitalizations.**

