THE NEW YORKER

MEDICAL REPORT

THE HOTSPOTTERS

Can we lower medical costs by giving the neediest patients better care?

BRIDGES TO CARE

ASSESS · INTERVENE
EMPOWER · CONNECT

MCPN

What are we trying to accomplish here?

- Identify ***WHY*** patients over-utilize the hospital: Build a model around the WHY
- Stabilize, Coordinate, Improve Care, Reduce Cost
- Reduce ER visits and Inpatient stays through a ***community*** intervention

The Bridges to Care Vision

Helping people one at a time to empower themselves with tools, knowledge, and confidence to take responsibility for their own physical and psychological health.

Bridges to Care Model

- Hybrid of the Hospital Discharge, ED, Home, and Community Based Models
- Intervention begins at bedside
- 30, 60, 90, 120 day intervention: Tailored to patient's needs
- 8 visits minimum
- Collect information at each step to evaluate/improve program
- Safe transition from hospital to community, community to medical home

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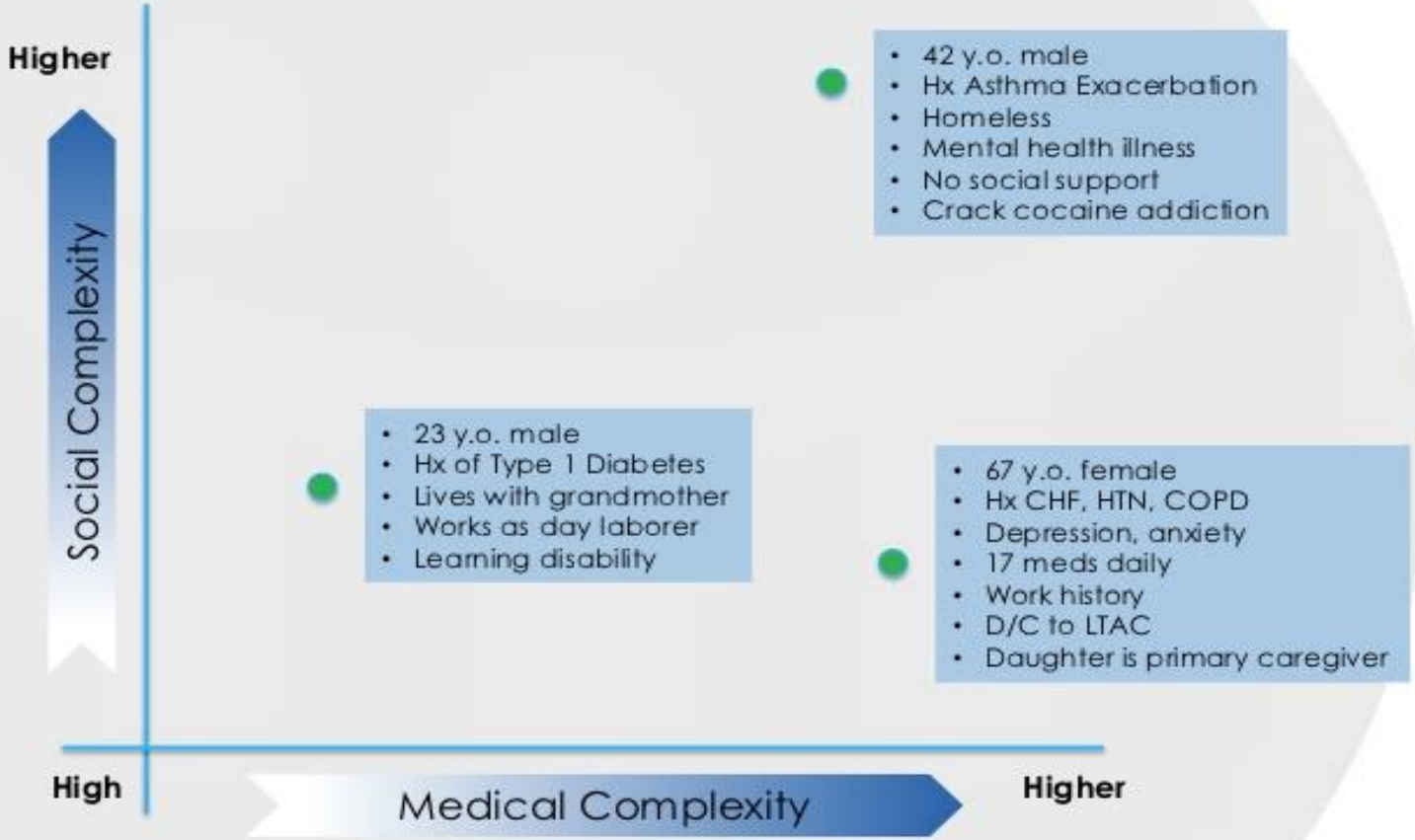
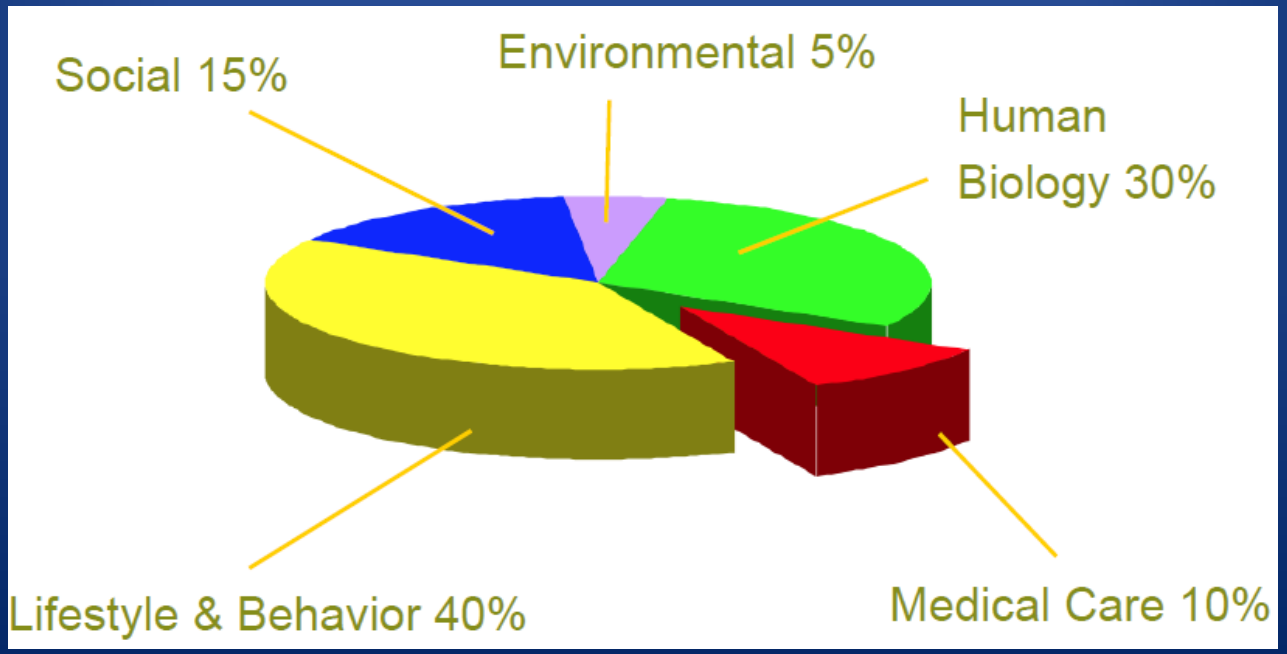
Variations of Patient Complexity



Social Determinants of Health: An Essential Component

- SDAC data revealed nearly 80% of Medicaid patients in this data set had a behavioral health component to condition

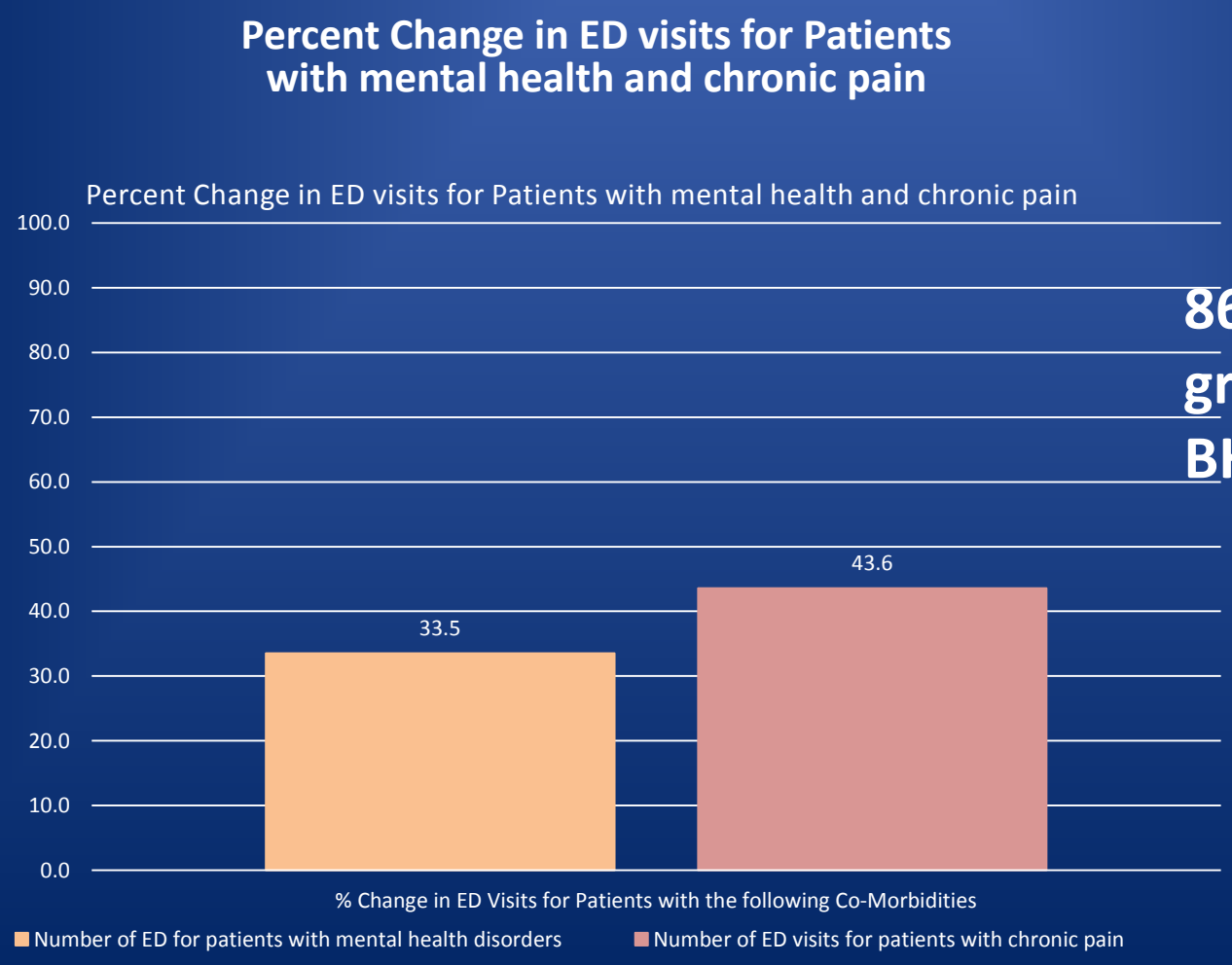


Community Issue= Community driven solution

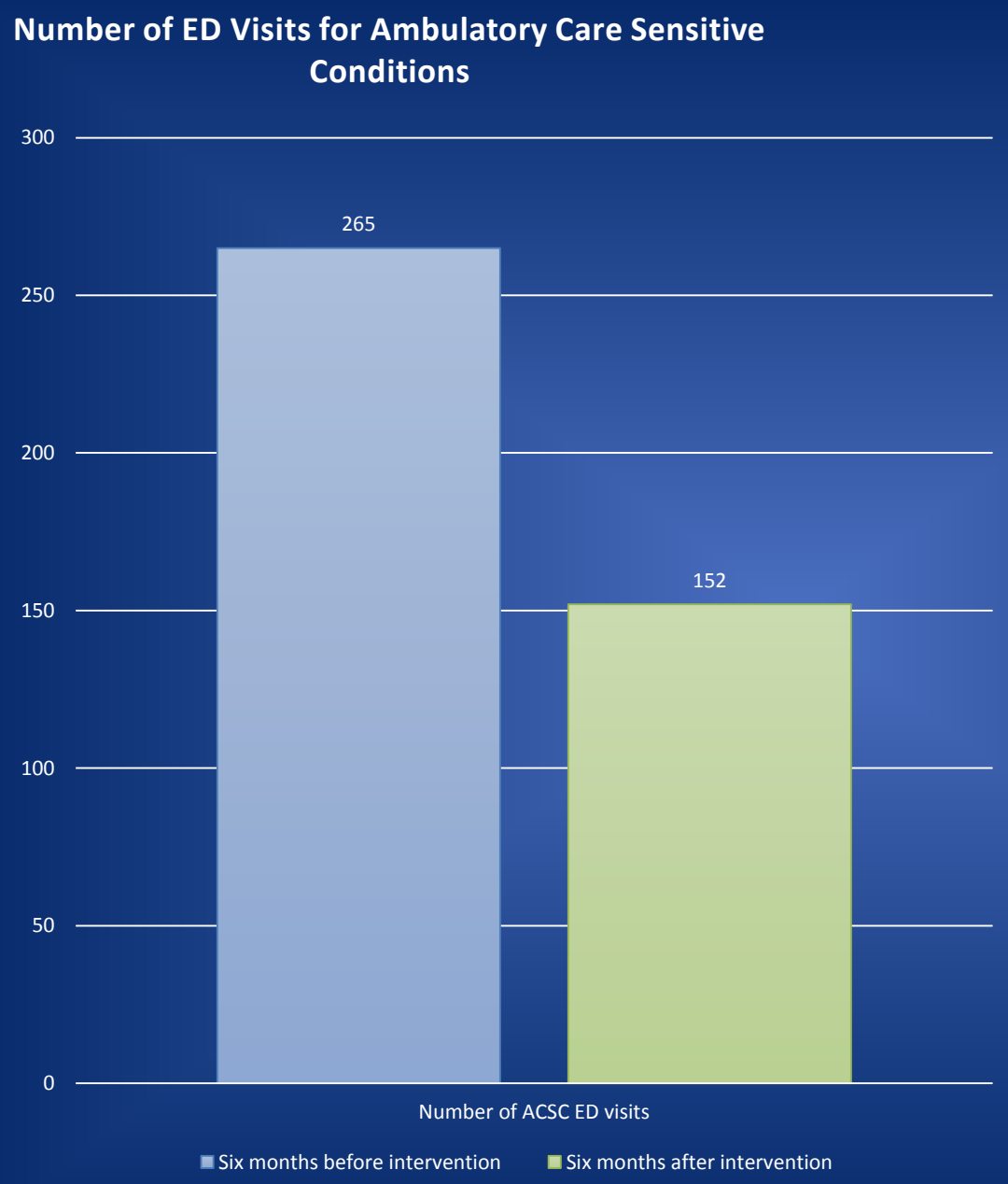
- Increase in quality outcomes and appropriate utilization of services.
- Patients successfully linked into primary care and behavioral health services.
- Strong community partners: Increased collaboration

- Per person Savings: $22,930
- 70% Graduation Rate
- 100% of graduates established a medial home and PCP

Importance of Behavioral Health

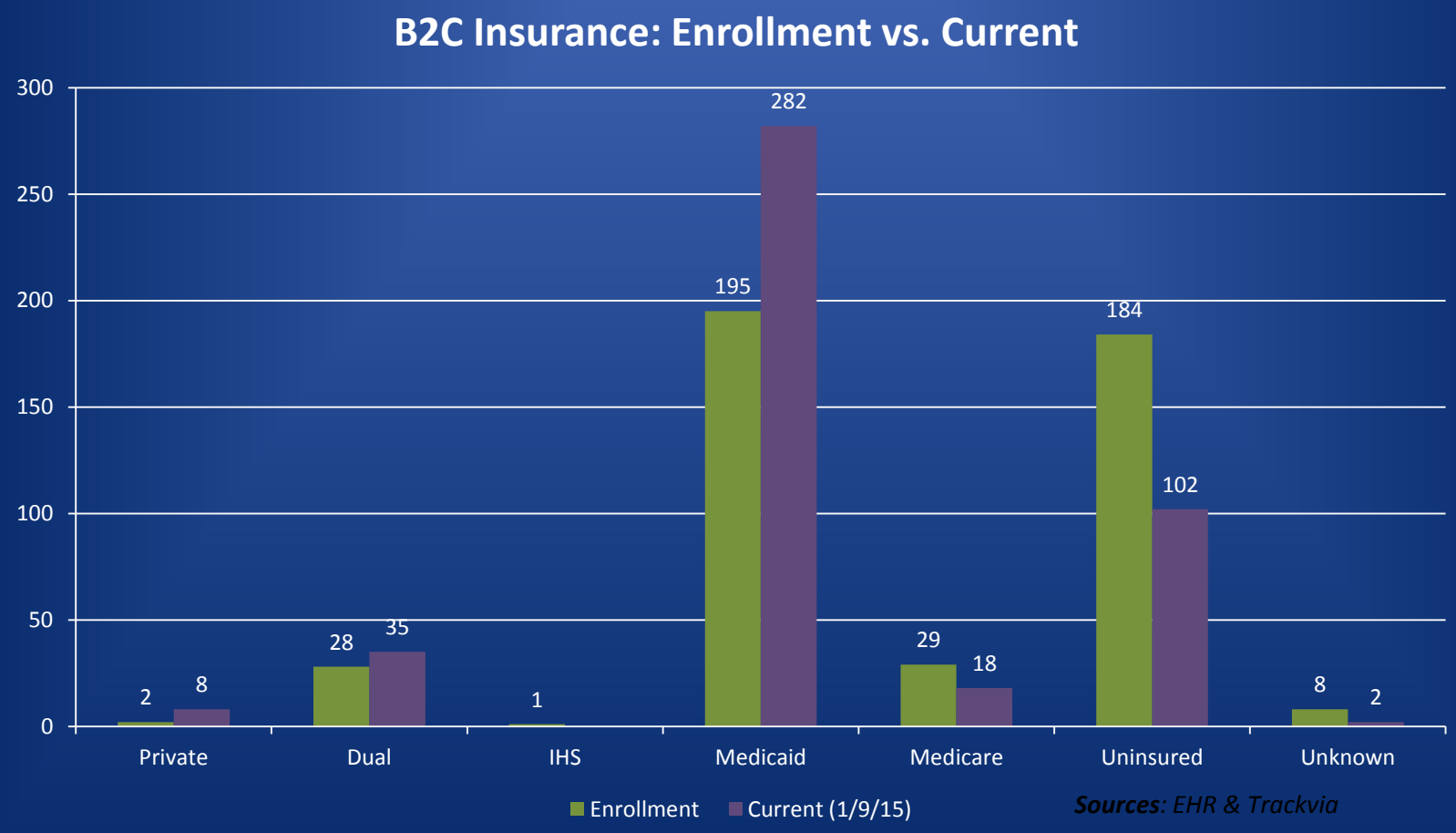


86% of B2C graduates have a BH Diagnosis

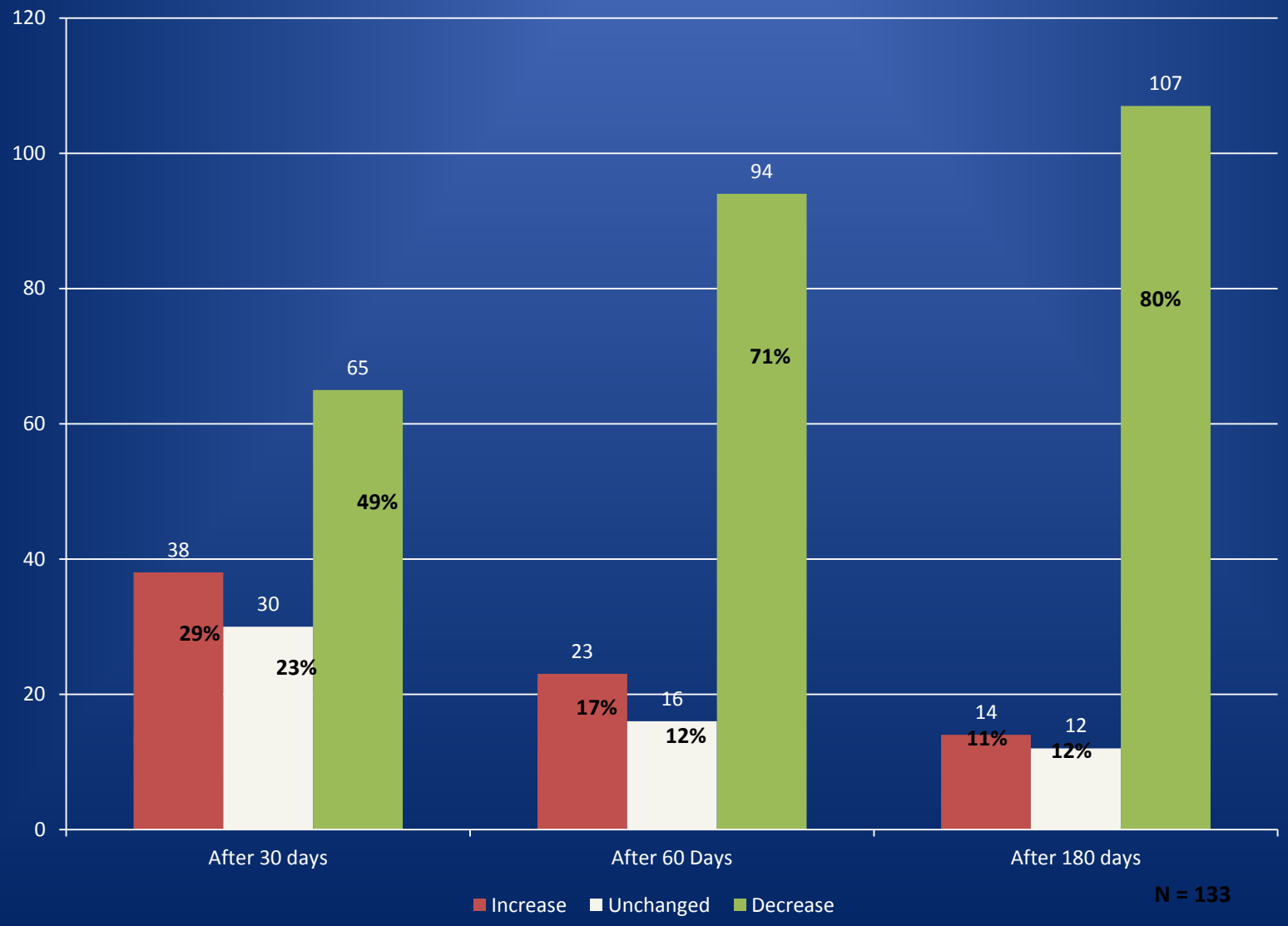


42.6% reduction in visits that could have been treated in a primary care setting

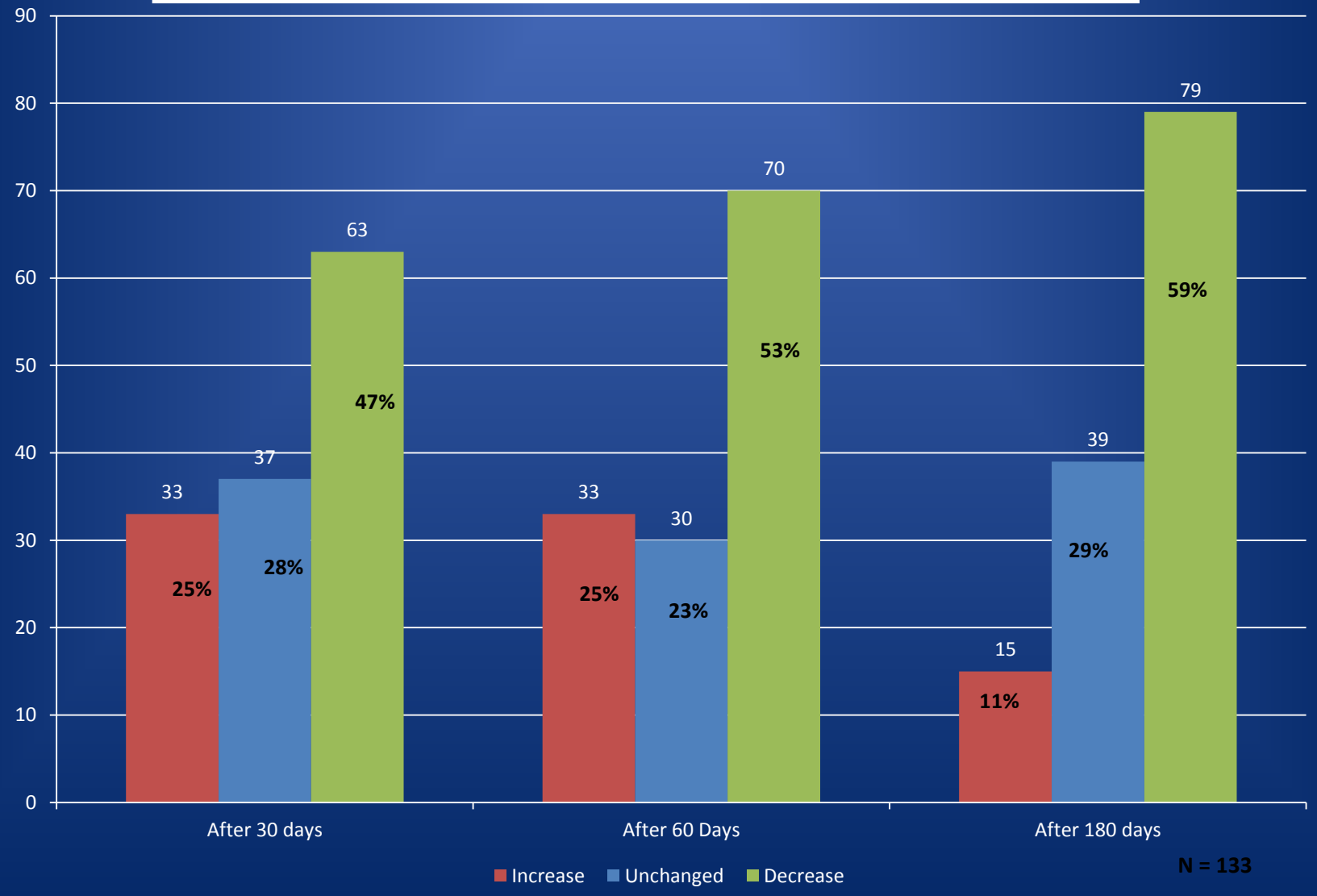
45% increase in Medicaid



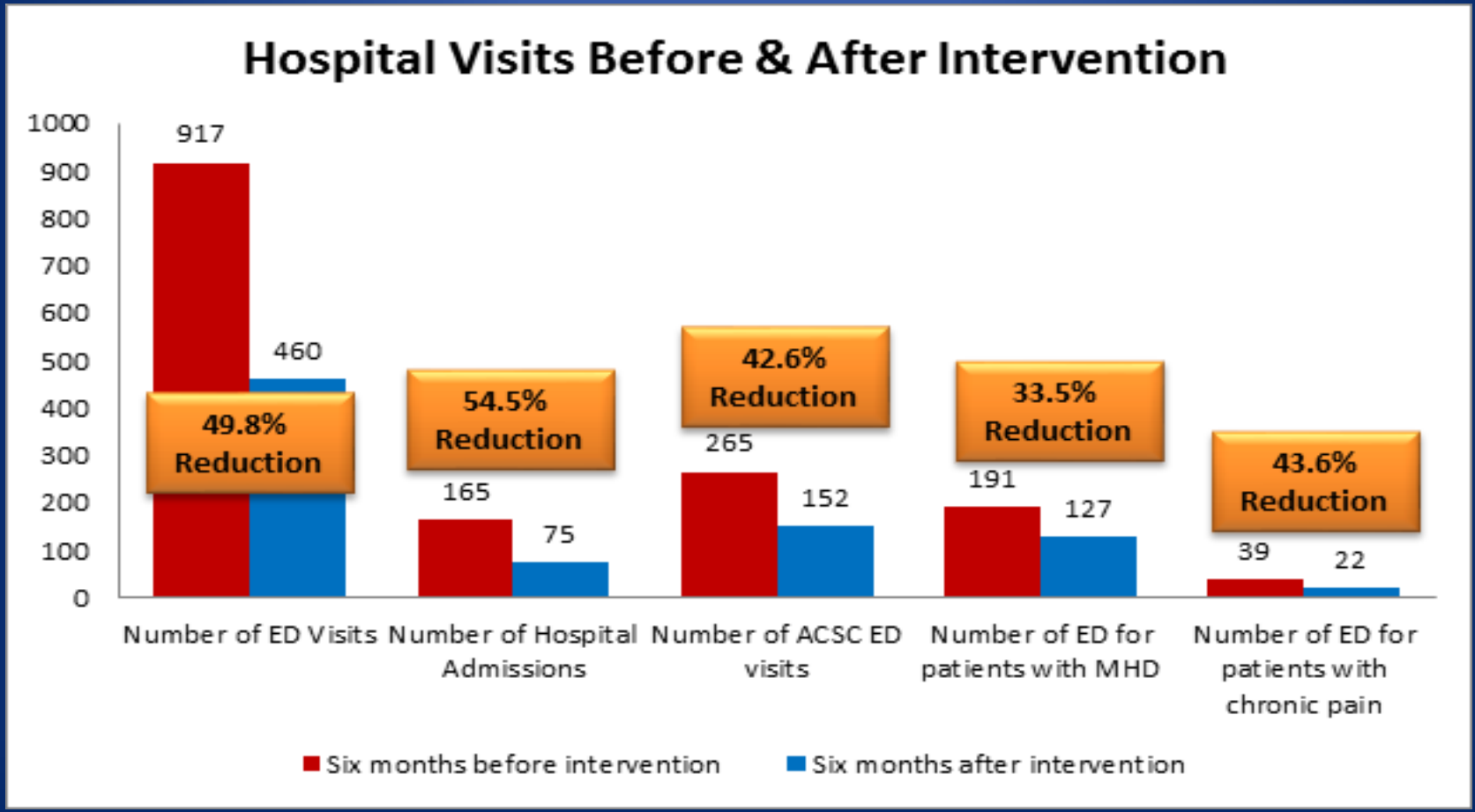
Physically Unhealthy Days



Mentally Unhealthy Days

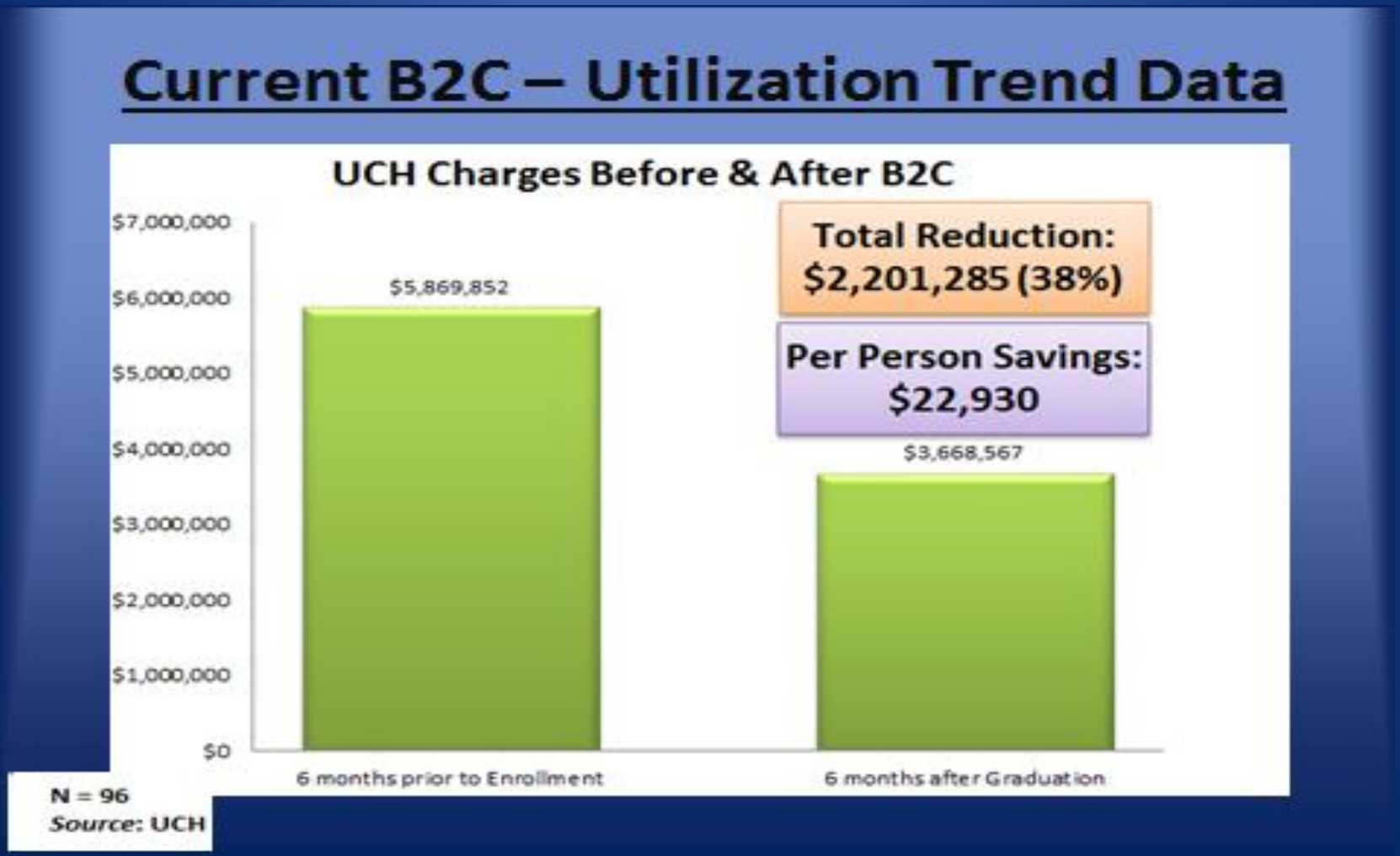


Utilization Trends: 49.8% reduction in ED visits



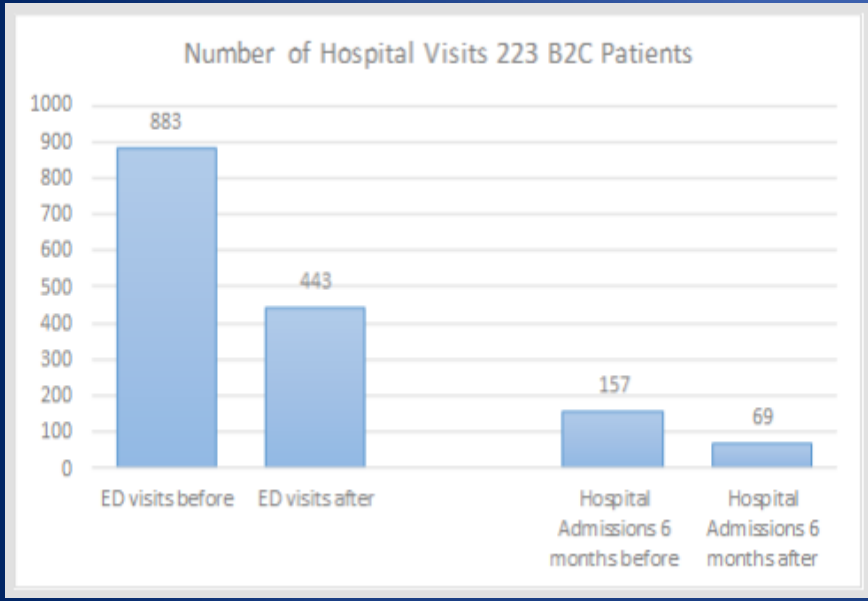
Cost Savings

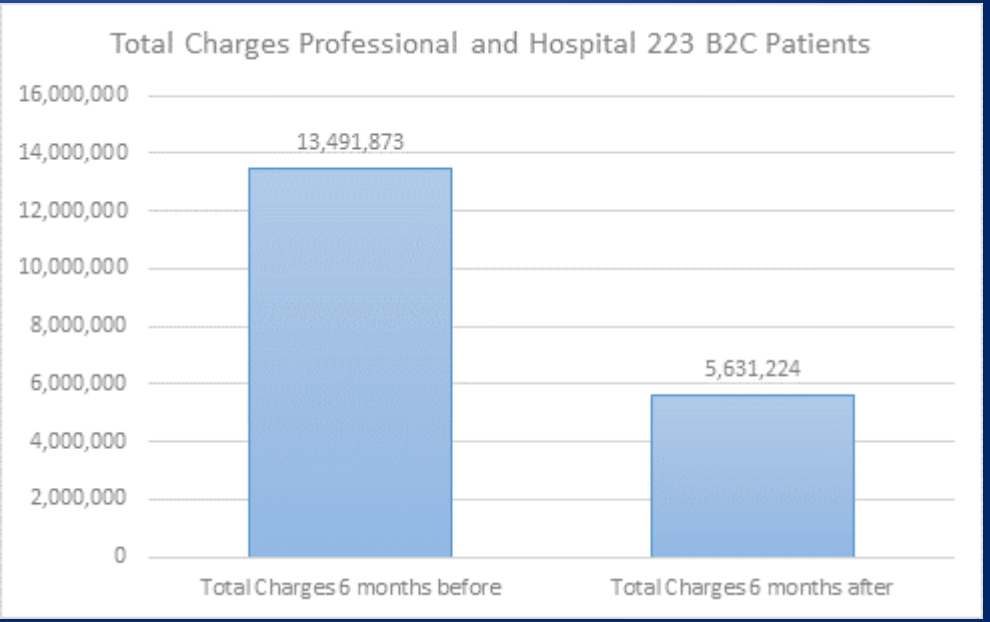
First 96 graduates



Cost Savings: Based on 223 patients

$7,860,649





Lessons Learned

- Support with SDH: All-inclusive Approach to Care
- Partnership with patients: Joint decision making
- Not all patients fit into a 60 day model: Tiered system evolved
- Role of trauma in hospital utilization
- Be realistic about what change means!
- Continuity is key: Patient messaging, relationship building
- Payment reform is necessary to do this type of work

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What's Next?

- We know Bridges to Care is effective; its been proven!
- Opportunity to Replicate: Expansion
  - Technical Assistance
  - Ongoing Grant Support
- Health Care Reform: Reimbursable Model
  - Transition: RCCO's to RAE's
  - ACC 2.0: Enhanced PMPM
  - Hospital Support

Bridges to Care

"I felt so lost and sad all of the time. I didn't now where else to turn besides the emergency room. Now I know how to take control of my health, I know what to do."

"They changed my life and gave me hope."

"I feel like I have people who care about me as a whole person, not just my health."

"I now have access to medical care, resources for my family and financial assistance".

Thank you!

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