WakeMed High Utilization Patient Collaborative

Goal: Connect patients with appropriate medical home to provide comprehensive care and limit hospitalizations and ED visits, while improving patients overall health

- Determined highest utilizing patients over 6 months
  - >9 ED visits, or >4 admissions or >2 30 day readmits
- Engaged community partners and WakeMed departments/Leaders
  - CCWJC - EMS - WakeMed ED
  - Southlight - WKCC/Evolent - WakeMed Case Mgmt and Community Care Mgmt
  - Paired Health - Transitions Life Care - WakeMed Hospitalists
- Meeting monthly to review patient cases and discuss collaborative strategies
- Most recently noted 80 patients on the original list of over 200 that had decreased their average utilization per month. Some noted as likely episodic, others clearly due to interventions and collaboration.
- Creating documentation in Epic for common items to allow for improved coordination – PCP, Access Plan for quick follow up, Community Care Mgr, Behavioral Health Dx and plan, ACT Team, list of community services with which patient is engaged
- Ongoing challenges – patient compliance/engagement, medication management, sickle cell management
- Will continue to collect data and report results, financial impacts forthcoming