THE MAX-MVP METHOD

A feasible, adaptable, effective method for improving care for high utilizers

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Maryland Hospital Association
June 13 2018
The MAX-MVP Method

- The MAX Program
- MVP Core Concepts
- MAX-MVP Care Pathway
- Implementation and Operational Dashboard
- Examples
2-part webinar series

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Objective 2-part webinar series
• Inform, inspire, catalyze

National vision:
• Every hospital has an MVP team as part of high-value portfolio of strategies
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National vision:
- *Every hospital has an MVP team as part of high-value portfolio of strategies*
J.B.
“I need housing, not a shelter. I need someone to help make sure I take my medicines. In a shelter, they don’t do that and they kick you out every morning. I need a stable residence and no one is able to help with that.”

- J.B.
“I’m thinking of throwing a brick through a window to get sent back to prison. At least they’ll take care of me there.”

- J.B.
Too sick
Too complex
Too disengaged from care
“un-impactable”
It is possible
Universal method implemented across a wide variety of settings & populations
MAX Method

Person-centered
Clinically credible
Operationally feasible
Locally adaptable
Effective
WHAT IS MAX?

Improving care for multi-visit patients
The MAX Program

• New York State Medicaid DSRIP Program
  • DSRIP = Delivery System Reform Incentive Payment program
  • 2014-present (5 years)

• Aims
  • Reduce avoidable hospital and ED used by 25% over 5 years
  • Move into Value-Base Payment models for Medicaid program
The MAX Program

• New York State Medicaid DSRIP Program
  • Cross-continuum, population health infrastructure development
  • Implementation of projects from a “Toolkit”
  • CMS requirement to use rapid-cycle continuous improvement

• Genesis of MAX
  • Filled a gap, filled a need, ready environment
  • Gap: no known method in “Toolkit” to improve care for high utilizers
  • Need: use rapid-cycle continuous improvement
  • Launched one project in 2015 with 6 teams – success!
  • Launched another in 2016 with 7 teams – success!
  • Serial rollouts → large scale spread → sustained approach
MAX: Solid Foundation of 10 years of Work

- Know your data
- Understand root causes
- Cross-continuum team
- Behavioral, social services
- Effective engagement
- Whole-person needs
- Find MVPs on-site
- Have a care pathway
- Reliably implement
- Plan for the return
- Alert next provider
MAX: Rollout → Diffusion of Innovation

2015

6 teams
+7 teams
+10 teams

2016

6 teams
7 teams
10 teams
+22 teams
+~25 TTTs

2017

6 teams
7 teams
10 teams
22 teams
40 TTTs
+19 teams
+ 23 teams
+ ~25 TTTs

2018

6 teams
7 teams
10 teams
22 teams
40 TTTs
+19 teams
+ 23 teams
+ ~25 TTTs

Beyond

PPS/Systems:
MAX sustained
MVP sustained
MAX: Rollout → Diffusion of Innovation

- 87 MAX teams
- 100 projected by end of 2018
- ~1,000 professionals participated in MAX workshops
- Rural, suburban, urban
- Community, teaching, academic medical centers
- ED HU, IN HU, special populations: BH, HIV, sickle, homeless
The MAX Program

- Designed for scale
  - Universal method, not a prescriptive model
  - The *method* is what can be used by any team for any HU population

- Clinically credible, operationally feasible, locally adaptable
  - >90% of teams implemented >90% of processes
  - >97% of professionals in MAX program recommend to colleague

- Effective
  - Year 1: team-specific successes
  - Year 2: cohort analysis
    - 18% *reduction in readmissions*
    - 8% *reduction in hospitalizations*
Success of the MAX Program

MAX Program

- Structured 9 month program
- Participation requirements
  - Executive support
  - Action team
  - Full participation in program, reporting
- Program
  - Pre-launch preparation
  - Workshop 1, 30-day action period
  - Workshop 2, 60-day action period
  - Workshop 3, 60-day action prior
  - Weekly check in calls
  - Periodic webinars
  - On-site working session
  - Analytic support (year 2, 3)

MVP Method

- Core Concepts
- MVP Care Pathway
- Implementation Dashboard
- Outcomes Measurement
MVP CORE CONCEPTS
Who are High Utilizers*?

• High
  ✓ A lot
  ✓ More than necessary

• Utilization
  ✓ Of the acute care setting

*nomenclature modified to “multi-visit patient” (MVPs) to reduce negative connotation, maintain accurate numeric description of the patient subgroup
Key Stats

4+

7% – 25% – 60%

85%

38% v. 8%

Inpatient high utilizers, defined as 4+ inpatient admissions/12 mo period
CHIA Hospital-wide All Payer Readmissions in Massachusetts June 2016
AHRQ HCUP Statistical Brief #184 November 2014
AHRQ HCUP Statistical Brief #190 May 2015
Top Diagnoses

- Acute medical: sepsis, UTI, pneumonia, cellulitis
- Chronic medical: CHF, COPD, diabetes, sickle cell
- Behavioral health: mood disorders, schizophrenia, ETOH

➢ Combination of medical, behavioral health and social needs

AHRQ Statistical Brief #190; inpatient HU
ED HU and IN HU

- Less overlap than you might expect
- Some “drivers of utilization” are more prevalent in one group than another
Data → Root Causes

- Ask “why”
- Be curious
- Listen and ask, ”tell me more”
- Put a pathophysiological ddx aside as much as possible
- Look for the care seeking patterns, the practice patterns, the logistics, the elements of urgency, convenience, or uncertainty
- Observe: anxious/concerned? normalized/routine? 3rd party?

➢ *Opportunities for improvement can only be identified if you are looking for them and if you believe improvement should be possible*
Understand the story behind the chief complaint

61M with 8 hospitalizations for shortness of breath.

“Oh honey, I’m in here every couple of weeks and it always takes about 5 days to tune me up.”
When we don’t……

43M hospitalized 5 days on psychiatry service; medicine called at 12am for acute severe thigh pain. Ultrasound found clot; medical history significant for clotting disorder.

- Medicine attending accepted transfer
- Patient arrived on floor, RN pages MD as patient in pain
- MD orders IV opiate
- MD then sits down to review the chart…..
View High Utilization as a Symptom

• Symptom of a problem – an inadequately addressed issue

• We must address the issue if we are going to “treat” high utilization

• As with any symptom in medicine, there are a range of possible reasons for that symptom; we need to accurately diagnose what is causing the symptom before we can effectively treat

• “Why is this person, with these needs and comorbidities, coming to the hospital so frequently, when someone else like them is not?”
Identify the “Driver of Utilization”

Innovative Concept: Identify the root cause of frequent admissions

- Different from a clinical assessment
- Different from a social needs assessment
- Amidst all the clinical and social needs, why does this person come? Why are is this person repeatedly admitted?
- What needs are met in the hospital environment?

“Why is this person, with these needs and comorbidities, coming to the hospital so frequently, when someone else like them is not?”
Identify the “Driver of Utilization”

- Ask “why”
- Identify the drivers of utilization
- Listen for all the factors that lead to acute care utilization
- Information + observation = assessment
- Assess for clinical – behavioral – social needs
- Don’t over-medicalize recurrent utilization
Address the “Driver of Utilization”

Innovative Concept: Until we **effectively address** the DOU, we should not expect utilization (outcomes) to change

- Changes orientation from what we put in place last time
- Changes orientation from what the person did or did not do on their own
- Focuses us on “doing something different”

“It doesn’t matter what SU population you identify – the needs are determined by the psychosocial and behavioral health issues”
### Innovative Concept: Diagnose and Treat the Driver of Utilization

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<td>• Anxious, Alone</td>
<td>• Frequent contact, reassurance</td>
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<td>• Seeking basic needs: shelter, safety, warmth, food</td>
<td>• Address basic need</td>
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<tr>
<td>• Seeking other needs: socialization, empathy</td>
<td>• Intensify social, supportive contact</td>
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<td>• Chronically unstable baseline</td>
<td>• “ED Care Alert”</td>
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<td>• &quot;Someone else” sends/brings the patient in</td>
<td>• Work with the person/entity sending patient</td>
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<td>• Inadequately managed symptoms / End of life</td>
<td>• Palliative care, hospice, goals of care</td>
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*Illustrative; not exhaustive*
Plan for the Return: ED Care Alert

- High-value, need-to-know information about a patient to support better decision-making at the point of care
  - Instantly accessible
  - Brief
  - Guidance from a clinician who knows the patient
  - Convey baseline
  - Identify clinician, care team with contact info
  - Intended to inform the decision to admit

- Thank you Maryland!
WHAT DOES SUCCESS LOOK LIKE?

Stories from the field
Ellenville Regional Hospital and The Institute for Family Health
Target population: Patients with 5+ ED visits for pain

Identify
- Flag HU at registration
- Alert action team

Assess
- Identify the DOU
- Identify needs

Link
- Ensure link with primary care
- Warm handoff/referrals

Manage
- Implement a chronic pain policy
- Dedicated Navigator provides in-person, in-home support
- Education, outreach to PCPs to use pain contracts
Ellenville Regional Hospital and The Institute for Family Health
Target population: Patients with 5+ ED visits for pain

# HU ED Visits per month

# Referrals to Navigator per month

% HU Receiving Opioids in ED
Summary for Part 1

- Focus on high utilizers (aka multi-visit patients)
  - Clearly defined by frequent use of acute care setting
  - Population classically called “difficult,” “un-impactable”
  - And they are! With our current systems and processes…..

- Core concepts
  - High utilization is a symptom, not the problem
  - Symptom of an unmet, inadequately addressed need
  - We need to identify (diagnose) the “driver of utilization”
  - Prioritize addressing the ”driver of utilization” above all other efforts
  - Must manage care across settings and over time to “achieve stability”
Resources - More to Come!

DSRIP – Medicaid Accelerated eXchange (MAX) Series Program

Final Report
Improving Care for Super Utilizers

New York State Department of Health in collaboration with Dr. Amy Boutwell, Emmeline Kunst, Josh Sorin, Adin Shniffer, Jessica Logozzo, Dr. Douglas Woodhouse

Thank you for your commitment to improving care for multi-visit patients (MVPs)

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President, Collaborative Healthcare Strategies
Strategic and Technical Advisor, New York State ”MAX” Program
2-part webinar series

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