THE MAX-MVP METHOD – PART 2

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

Amy E. Boutwell, MD, MPP
Maryland Hospital Association
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## 2-part webinar series

<table>
<thead>
<tr>
<th>Webinar</th>
<th>Topics</th>
</tr>
</thead>
<tbody>
<tr>
<td>June 13 – part 1</td>
<td><strong>What is MAX?</strong></td>
</tr>
<tr>
<td></td>
<td><em>MVP Core Concepts</em></td>
</tr>
<tr>
<td>June 27 – part 2</td>
<td><strong>MAX-MVP Care Pathway</strong></td>
</tr>
<tr>
<td></td>
<td><em>Operational Dashboard</em></td>
</tr>
</tbody>
</table>

### Objective 2-part webinar series
- *Inform, inspire, catalyze*

### National vision:
- *Every hospital has an MVP team as part of high-value portfolio of strategies*
Today’s Agenda

• Recap: 5 Innovative MAX-MVP Core Concepts

• MAX-MVP Care Pathway

• Operational Dashboard

• Examples
MAX-MVP METHOD

5 innovative core concepts that define the MAX-MVP method
1. Define High Utilization
   • High (a lot ... eg >2 standard deviations above average)
   • Utilization (of the acute care setting)
   • No modifiers* (not by diagnosis, age, payer, risk score, risk screen)
   • Inpatient definition**: 4+ admissions in the past 12 months
   • ED definition**: 10+ visits in the past 12 months
   • ED HU and IN HU are not the same; there is less overlap than you might guess

4+
7% - 25% - ~60%
38% v. 8%

Source: 2018 Boutwell in collaboration with CHIA
2. The MVP Syndrome

- Syndrome: a combination of signs and symptoms that commonly go together
- Multi-visit patients have a combination of medical, behavioral, and social needs
- We often know the medical issues or chief complaint; look for the behavioral, social

- Goals of care
  - Palliative care
  - Clinician-driven
  - Caregiver-driven
- Socialization
  - Attention
  - SUD – brought in by others
  - Preferences/patterns

- Food
- Shelter
- Safety
- Access
3. View High Utilization as a Symptom; Identify the Cause

- Like cough or fever or abdominal pain
- We need to diagnose the cause of the symptom so we can effectively treat it
- The method to diagnose the cause of high utilization is “ask-listen-observe”
- We seek to identify the “driver of utilization” (DOU)
- The DOU answers: “Why this person, with these comorbidities, coming to the hospital so frequently whereas a patient just like them is not?”

What’s the driver of utilization? “Why?”
4. Prioritize Effectively Addressing the DOU

- Until we effectively address the driver of utilization, the cycle of utilization will persist
- We must problem-solve; we must “do something different”
- Often to do so, we must develop new partnerships
- Often to do so, we must develop strategies to address the DOUs

<table>
<thead>
<tr>
<th>Driver of Utilization</th>
<th>Response</th>
</tr>
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<tbody>
<tr>
<td>Anxious, Alone</td>
<td>Frequent contact, reassurance</td>
</tr>
<tr>
<td>Seeking basic needs: shelter, safety, warmth, food</td>
<td>Address basic need</td>
</tr>
<tr>
<td>Seeking other needs: socialization, empathy</td>
<td>Intensify social, supportive contact</td>
</tr>
<tr>
<td>Chronically unstable baseline</td>
<td>“ED Care Alert”</td>
</tr>
<tr>
<td>“Someone else” sends/brings the patient in</td>
<td>Work with the person/entity sending patient</td>
</tr>
<tr>
<td>Inadequately managed symptoms / End of life</td>
<td>Palliative care, hospice, goals of care</td>
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Illustrative; not exhaustive
5. Engage On-Site and Manage Over Time and Across Settings

- Our target population is defined by being here (ED, hospital) frequently
- This is the place to identify and engage with them
- We must use effective engagement strategies to drive up our success
- We form helpful, trusting relationships that continue over time, across settings
- We identify and address issues as they arise
- The goal is to “slow the cycle high utilization” and “achieve stability”
MAX-MVP CARE PATHWAY

*Putting the concepts to work in day to day practice*
The MAX-MVP Care Pathway

- Identify
- Assess/Plan
- Link
- Manage
- Patient Presents
Patient Presents

Be ready for the patient to present:

1. Define your target population (ED or IN)
2. Define your criteria (4+/12mo, 10+/12 mo)
3. Estimate daily MVP volume
   • How many patients met MVP criteria last year? (# people)
   • How many discharges (IN) or visits (ED) did they collectively utilize?
   • Total # MVP discharges (or visits) / 365 = estimated daily MVP volume
   • With MAX MVP recommendations, typically about 1 to 5 per day
   • This is evidence based and operationally feasible
4. Convene interdisciplinary, cross-setting action team
   • IT/Data important! We need a real-time flag and good tracking system!
   • Team of 8: one person per role-type, prioritize patient-facing service providers
   • Include at least 2-3 post-hospital, community based service providers
   • Prioritize social services, navigation, peer advocates, recovery coaches
1. **Identify**: Dynamic identification system
   - MVP icon on banner or tracker board
   - Daily list: MRNs with # encounters in past 12 mo
   - Who presenting today meets MVP criteria?
   - Don’t use a list from last year or claims with lag
   - Who here, now, has been here 4 (to 10) or more times in the most recent 12 mo?

2. **Notify**: Who needs to know this patient is an MVP?
   - Have flag generate automated email to Action Team
   - Identify who responds to the MVP once identified
   - This might be someone from the hospital staff, if might be a community-based intensive care manager, etc.
Assess / Plan

1. **Assess the “Driver of Utilization” (DOU)**
   - Ask – Listen – Observe
   - Analyze the pattern of presentation(s)
   - Identify the DOU

2. **Discuss the DOU with interdisciplinary, cross-setting team**
   - How can we address the DOU? *“Do something different”*
   - Cross-setting partners help identify ideas beyond the medical model
   - Have different DOU – Response plans to become more efficient, effective

3. **If the DOU requires us to “do something different,” write care alert**
   - What have you learned about care seeking patterns, baseline, DOU that you should feed-forward to the next provider of care?
1. “Refer” does not apply to MVPs
   - If an MVP needs something then we arrange for it
   - A referral never has worked, nor shall we expect it to

2. MVPs require “definitive, timely linkage”
   - If they need it, then we definitively link them with the service
   - In-person connection
   - Warm handoff
   - Timely contact (<48h)

3. Link...to someone who will directly help
   - Break from the medical paradigm
   - MVPs need a person – navigator, peer, CHW, SW, ToC RN, team – to help
   - Develop strong collaborative partnerships and processes with CBOs
Manage to Achieve Stability

Effectively Engage

- Offer to help
- Address the patient’s pressing priority
- Patient, persistent, proactive
- Harm-reduction
- Motivational interviewing
- Well done by SW, CHW, peers

Intensive Care Management

- Timely, frequent contact
- Face-to-face and via text
- Active “problem solving”
- Navigate, link, advocate
- Community coalition case conferencing
- Plan for the return: ED Care Alert
OPERATIONAL DASHBOARD

Weekly tracking; close gaps
MAX MVP Operational Dashboard

- Number of MVP discharges (or visits)
  - Number “served” while in-house
  - Number “served” after discharge

- “Served” is your definition
  - What did you INTEND to do? For how many did you do it?

- “Served” should evolve over time
  - Action period 1 “served” in-house might mean ”assessed the DOU”
  - By Action period 3, “served” in-house might mean “direct linkage to service”

- Focus on closing the gap between total and “served”
  - Track and review weekly

### Implementation Dashboard

<table>
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<td>10</td>
<td>8</td>
<td>11</td>
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<td>B. Number of MVPs “served” while in-house</td>
<td>3 (30%)</td>
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MAX MVP Outcomes Measurement

- 30-day readmissions or 30-day ED revisits
  - Phase 1: focus on same-hospital
  - Phase 2: work on any-hospital
  - Often improving care for MVPs involves addressing care seeking patterns and establishing a consistent response – we first achieve that within our own domain

- Pre – Post utilization
  - Detailed method* developed specifically for MVP program measurement
  - Uses concept of MAX-MVP program start date
  - All initial qualifying MVP encounters after start date are called “index”
  - Utilization in 90 days prior to and including “index” compared to 90 days post “index”
  - Create an internal historical control based on measuring MVP population utilization the same way 1 year prior to program launch
  - Calculate the relative reduction between MAX-MVP program and historical period

*Boutwell-MVP method
Patients at high utilization often “regress to the mean”
This measurement method* looks at the MVP population
What happened to MVP utilization before MAX-MVP?
What happened to MVP utilization once MAX-MVP launched?
Want to see that we can “beat” historical
In this case we did! MAX-MVP utilization decreased 68%
Historically utilization decreased by 61% doing nothing
Relative improvement (pre-post/pre) = 11%

*Boutwell-MVP method
EXAMPLES

Small, rural hospital - chronic pain multi-visit patients in the ED
Large, urban hospital – inpatient multi-visit patients
Ellenville Regional Hospital & Institute for Family Health

Target population: Patients with 5+ ED visits for pain

- **Identify** chronic pain-MVPs at ED registration
- **Notify** Action Team, MVP Navigator

- **Assess** drivers of utilization (DOUs)
- **Identify** person-centered needs

- **Link** patient proactively to primary care and MVP Navigator

- **Implement** ED opiate use policy, engage community PCPs to adopt chronic pain management contracts
- **Manage** over time to achieve stability via MVP Navigator

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DESIGNING AND DELIVERING WHOLE-PERSON TRANSITIONAL CARE:
THE HOSPITAL GUIDE TO REDUCING MEDICAID READMISSIONS
Target population: 4+ admissions in past 12 months

- **Identify** high utilizers via SuperMAX logo alert on EHR
- **Notify** Action Team, including Chiefs of Service and MAX Facilitator
- **Assess** drivers of utilization (DOUs) – social worker
- **Conduct** case conference daily on all MVPs admitted
- **Link** patient proactively to PCP, health home, or community partners based on DOU and social work assessment
- **Timely follow up** via home / community-based visits and calls
- **Conduct warm hand off** to CHWs for community-based care

**Pre/Post 90 Day Utilization**

- **Historical**: 57%
- **Program**: 72%
- **26%**
The MAX-MVP Method At-A-Glance

Core concepts
1. Identify based on utilization
2. Engage in real-time
3. Assess the “driver of utilization”
4. “Do something different”
5. “Don’t over-medicalize”
6. Ensure “definitive timely linkage”
7. Actively “manage to achieve stability”
8. Plan for the return

Clinical process
- Make it easy to know a MVP is here and what to do
- Analyze the pattern of utilization; assess the “driver of utilization”
- X (cross) – continuum collaboration: warm handoffs, case conferencing
- Manage care over time and across settings, to achieve stability
- Variety of approaches: “do something different”
- Plan for the return: safe, consistent care with Care Alerts

Universally applicable, locally adaptable method

Prioritize service delivery

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Close the gap

30-day readmission or revisit

Designing and delivering whole-person transitional care: The hospital guide to reducing Medicaid readmissions

Collaborative Healthcare Strategies
Consider

- Do we include MVPs in our PAU reduction programs?
- Do we exclude people with BH, SUD, leave AMA, unstable housing?
- Do we consider a group of patients “un-impactable”?
- Are we ready for the next year of PAU performance aims?
- Are we developing care alerts for MVPs to promote consistent care?
- Are we identifying and effectively addressing the “driver of utilization”?
- Are we co-managing and case conferencing with CBOs?

*Implement the MAX-MVP method to improve outcomes and build a more person-centered, effective delivery system*
Thank you for your commitment to improving care for multi-visit patients (MVPs)

Amy E. Boutwell, MD, MPP
President, Collaborative Healthcare Strategies
Strategic and Technical Advisor, New York State ”MAX” Program
Strategic and Technical Advisor, “Transitions: Handle with Care” Initiative and “Care Alert Sprint”