THE MAX-MVP METHOD – PART 2

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

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2-part webinar series

Webinar	Topics
June 13 – part 1	*What is MAX?*
	MVP Core Concepts
June 27 – part 2	MAX-MVP Care Pathway
	Operational Dashboard

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

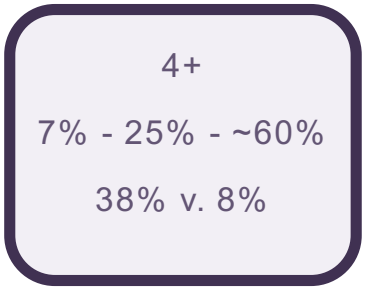
- Recap: 5 Innovative MAX-MVP Core Concepts
- MAX-MVP Care Pathway
- Operational Dashboard
- Examples

MAX-MVP METHOD

5 innovative core concepts that define the MAX-MVP method

MAX-MVP Innovative Core Concepts - 1

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



Source: 2018 Boutwell in collaboration with CHIA

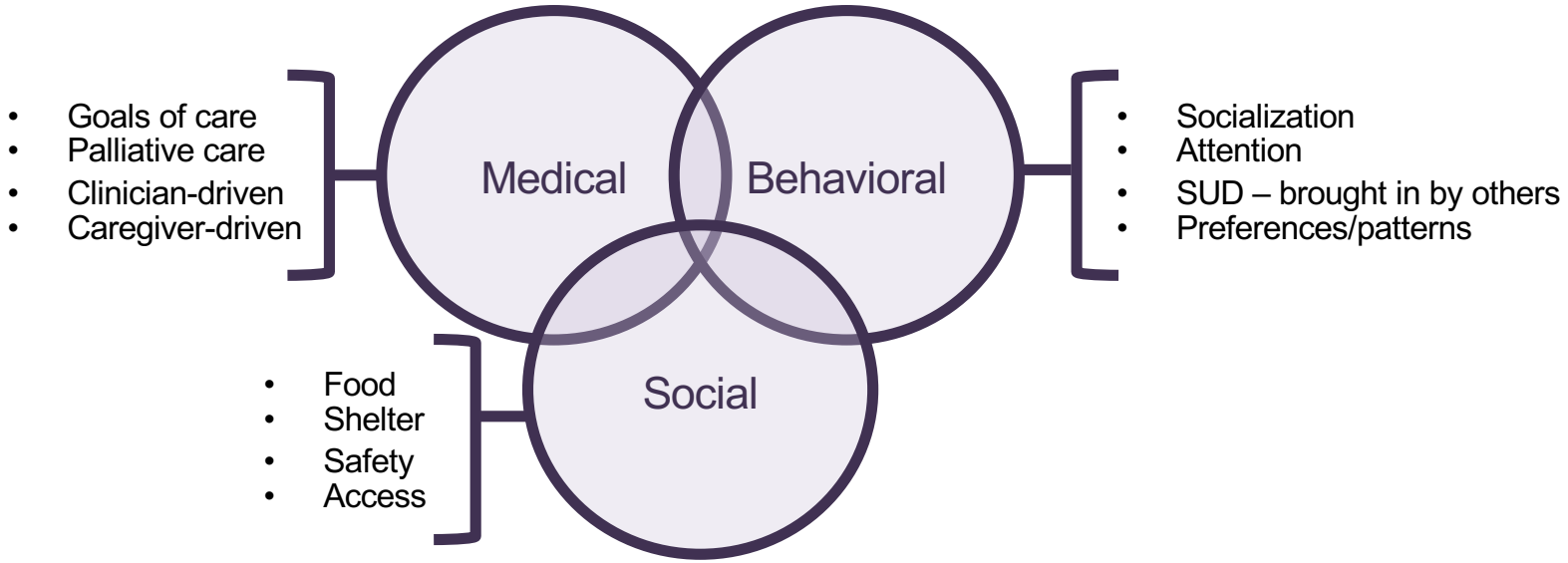
*for inpatient HU at 4+/12 mo, ok to exclude planned chemo, radiation

** smallest hospitals might use 3+ IN or OBS in past 12 months
**largest EDs might use 15+ visits in past 12 months

MAX-MVP Innovative Core Concepts - 2

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



MAX-MVP Innovative Core Concepts - 3

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 of 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?"*

58M
CAD
DM
HTN
AF
CKD
PVD

Not an MVP

MVP

58M
CAD
DM
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What's the driver of utilization? "Why?"

MAX-MVP Innovative Core Concepts - 4

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

Driver of Utilization	Response
• Anxious, Alone	• Frequent contact, reassurance
• Seeking basic needs: shelter, safety, warmth, food	• Address basic need
• Seeking other needs: socialization, empathy	• Intensify social, supportive contact
• Chronically unstable baseline	• "ED Care Alert"
• "Someone else" sends/brings the patient in	• Work with the person/entity sending patient
• Inadequately managed symptoms / End of life	• Palliative care, hospice, goals of care

Illustrative; not exhaustive

MAX-MVP Innovative Core Concepts - 5

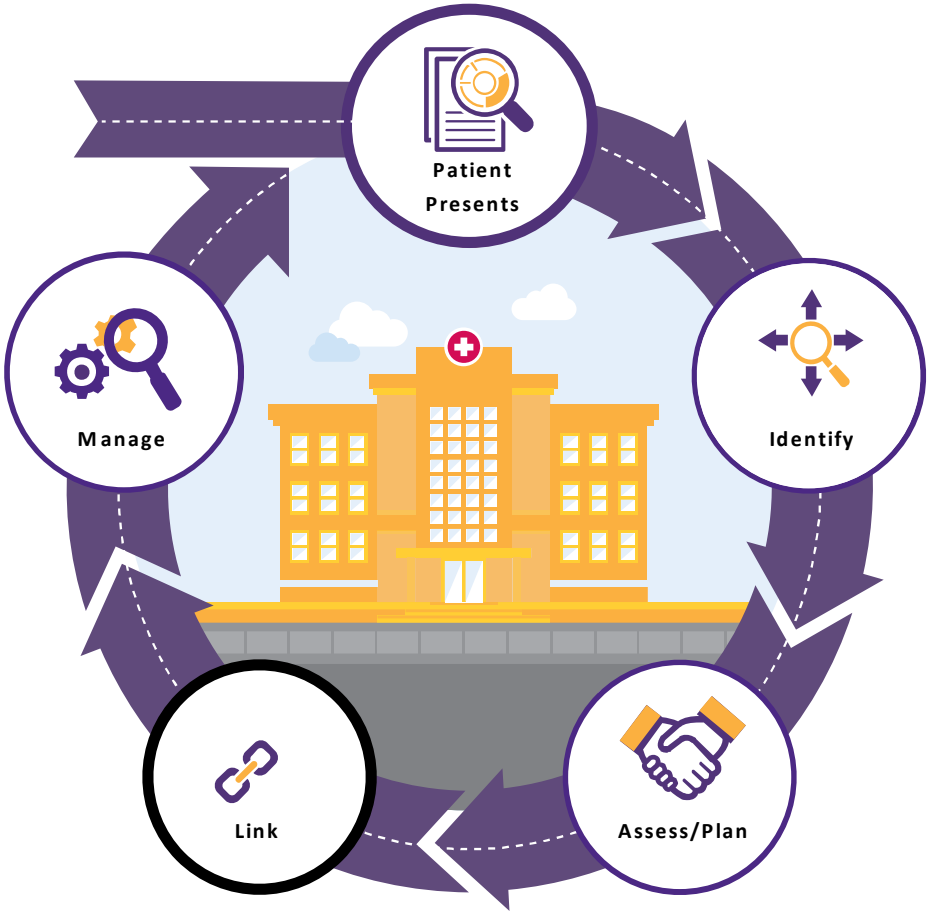
5. Engage On-Site and Manage Over Time and Across Settings

- 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



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

Identify / Notify

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.

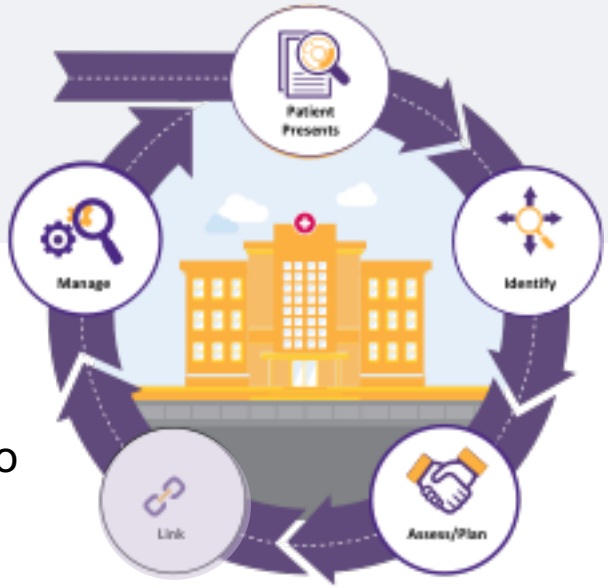
Assess / Plan

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?

Link



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**

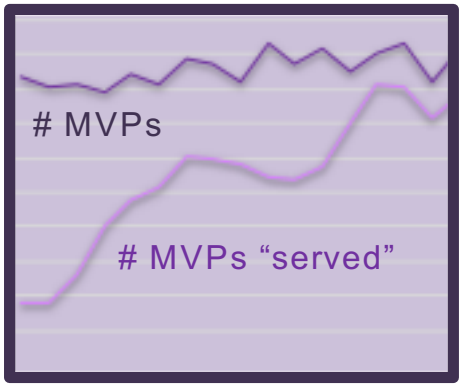
OPERATIONAL DASHBOARD

Weekly tracking; close gaps

MAX MVP Operational Dashboard

Implementation Dashboard	Week 1	Week 2	Week 3	Week 4
A. Number of MVPs	10	8	11	9
B. Number of MVPs "served" while in-house	3 (30%)	6 (75%)	6 (55%)	7 (78%)
C. Number of MVPs "served" after discharge	1 (10%)	3 (38%)	4 (36%)	5 (55%)

- 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



MAX MVP Outcomes Measurement

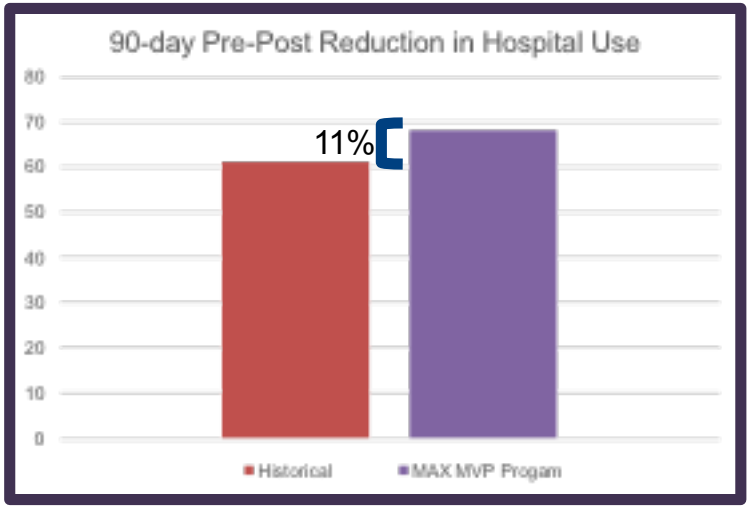
- 30-day readmissions or 30-day ED revisits
  - Phase 1: focus on same-hospital
  - Phase 2: work on any-hospital
  - *Often improving care for MVPs involves addressing care seeking patterns and establishing a consistent response – we first achieve that within our own domain*

- 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*

MAX-MVP Outcome Measurement

Best of the inpatient MAX MVP first year results



- 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

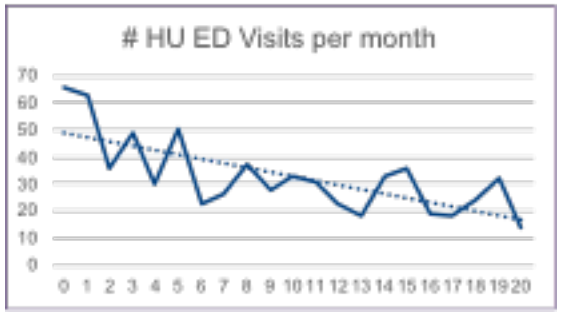
Target population: Patients with 5+ ED visits for pain

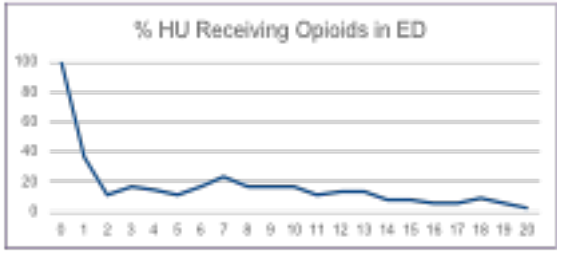
Identify chronic pain-MVPs at ED registration
Notify Action Team, MVP Navigator

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





Jamaica Hospital, Queens, NY

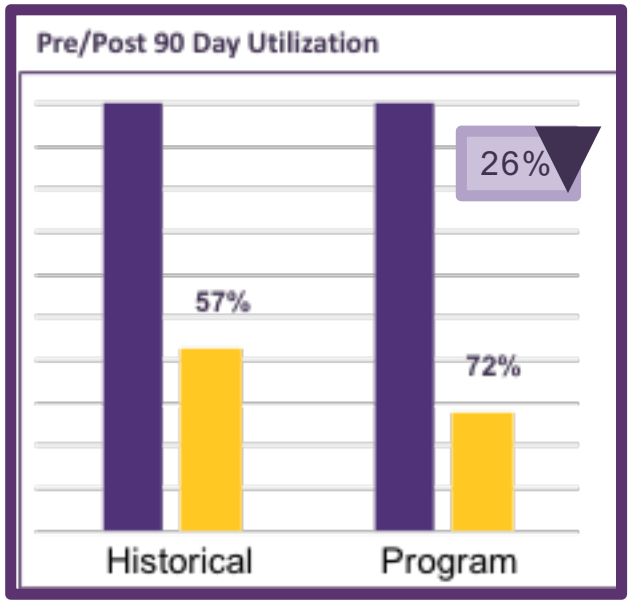
Target population: 4+ admissions in past 12 months

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



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

Universally applicable, locally adaptable method

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

Prioritize service delivery

Implementation Dashboard	Week 1	Week 2	Week 3	Week 4
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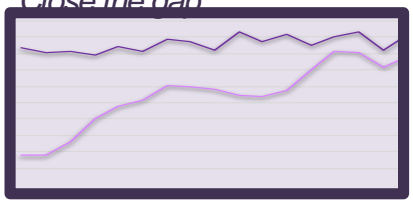
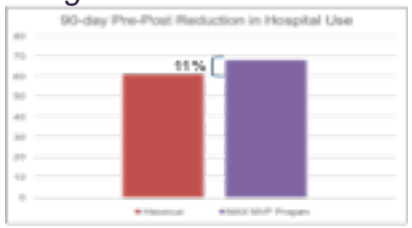
Close the gap



30-day readmission or revisit

Program vs. Historical Period



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)

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