The MAX Program

Improving care for multi-visit patients (MVPs)

Informational Webinar

February 14, 2020

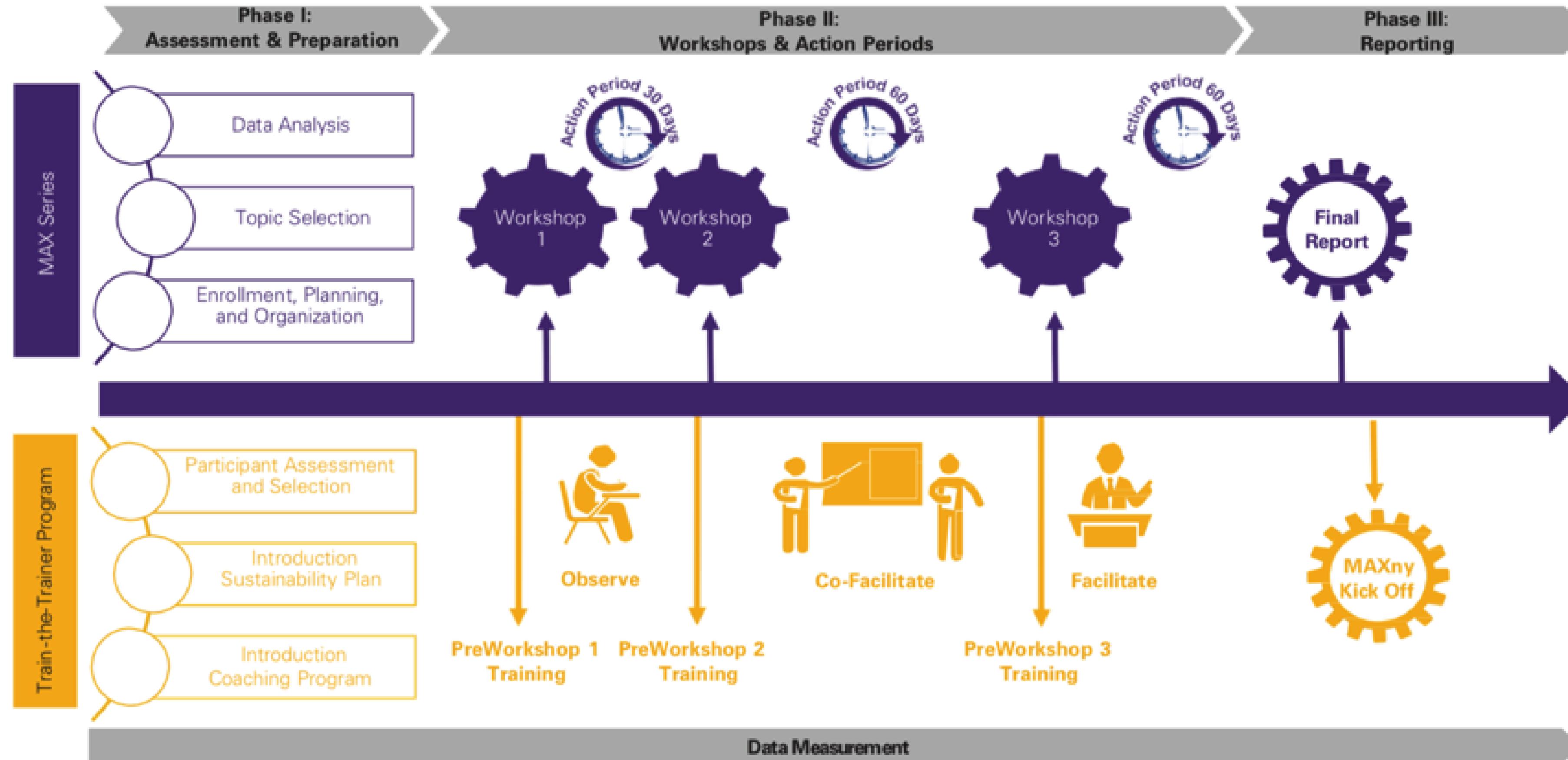
Agenda

Item	Presenter
• Welcome and Introductory Remarks	Peggy Chan
• Who are “MVPs” and what is the MAX Program?	Amy Boutwell
• MAX 2020 Recruitment & Next Steps	Sara Butterfield
• Questions	MAX Program Team

Welcome to MAX 2020

Peggy Chan, MPH
DSRIP Program Director
New York State Department of Health

MAX: *"Medicaid Accelerated eXchange"*



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The MAX Program

6 teams → serial cohorts of MAX teams & serial cohorts of MAXny train the trainers → 87 teams

Spreading innovation across almost **100 sites**

> 900 professionals

>15,000 patients

Services News Government Local Location Translate

Department of Health Individuals/Families Providers/Professionals Health Facilities Search

You are Here: Home Page > 2018 Press Releases > New York State Department of Health Announces Results of Medicaid Redesign Efforts to Improve Patient Care Statewide, Yielding Measurable Reductions in Avoidable Hospital Use

New York State Department of Health Announces Results of Medicaid Redesign Efforts to Improve Patient Care Statewide, Yielding Measurable Reductions in Avoidable Hospital Use

ALBANY, N.Y. (June 19, 2018) - The New York State Department of Health today announced that through the Medicaid Accelerated eXchange or ("MAX") Series, avoidable hospital use for the state's most vulnerable patients has been significantly reduced. Since its launch in 2015, the MAX Series has been an integral part of the Department's strategy toward successfully achieving Delivery System Reform Incentive Payment (DSRIP) goals.

The objective of the MAX Series is to empower hospital and community partners in their care redesign efforts, increase patient and workforce satisfaction and reduce avoidable hospitalizations. More than 900 professionals from 68 hospitals and 11 community-based practices from around the State have participated in the MAX series to date, and early results among teams are showing an 18 percent reduction in hospital readmissions and an 8 percent reduction in hospitalizations overall.

"Under the leadership of Governor Cuomo, our Medicaid redesign efforts are constantly increasing the efficiency of the healthcare system, resulting in improved outcomes and cost savings for New Yorkers," said New York State Health Department Commissioner Dr. Howard A. Zucker. "The Max Series is yet another example of our use of innovative techniques to use data and multi-disciplinary cooperation to transform healthcare delivery in New York State."

The MAX Series places front-line healthcare and community based professionals from throughout the state at the helm of change and provides them with the tools to restructure processes in a manner that is sensitive to local needs. Collectively, Action Teams, which consist of clinicians, administrators, healthcare workers and community-based professionals, have worked to identify the highest need patients, develop innovative solutions to provide better care, and to rapidly implement, test, and measure improvements for positive change.

"For years, we have known that a relatively small number of patients frequently visit hospital emergency rooms or are admitted to the hospital—sometimes many times a week or month – at a significant cost to the Medicaid program," said New York State Medicaid Director Donna Frescatore. "The MAX Series empowers local Action Teams to ask the patient why. Many times, the answer may be that the patient needs help with housing, making or getting to doctor's appointments, or help taking their medications. By focusing on the patient and thinking in a different way, the MAX Series has not only reduced hospital admissions and readmissions, it's made a difference in the lives of these patients."

https://www.health.ny.gov/press/releases/2018/2018-06-19_mrt.htm

EXECUTIVE PANEL

BUILD a TEAM that WORKS TOGETHER!

MAX SERIES HELPED US BRING CARE that is COORDINATED.

CONNECTIONS to RESOURCES

ENGAGE PATIENTS 1 AT A TIME

MEET PATIENTS WHERE THEY ARE!

EXECUTE & ALIGN

ALIGNS with OUR GOALS IMPROVING COMMUNITY HEALTH

BREAK DOWN SILOS

RELATIONSHIPS

* MAKE the WORK EASIER
* MAKE EXPANDED CONNECTIONS
* SHARED KNOWLEDGE

THINK ABOUT SYSTEMIC CONDITIONS in OUR COMMUNITIES

LOOK at the SYSTEM from a DIFFERENT PERSPECTIVE

FUN! TEAMS STAYED BUSY, but HAD FUN!

CO-DESIGN BROUGHT JOY to the WORK

CITY HEALTH DASHBOARD

EVERYONE HAVE a MAX TEAM — DEVELOP PROTOCOLS

SCALE for SUCCESS

IDENTIFY PATIENTS with a PROBLEM

GIVE THEM VOICE & LISTEN

BREAK IT UP into SMALL CHUNKS

LEVERAGE COMMUNITY PARTNERS

COMMUNICATION at ALL the PATIENTS TOUCH POINTS

CEO PARTNERS
— UNDERSTAND the WHY LEADS to SUSTAINABILITY

KEY LEARNINGS

THE NUMBER of RESOURCES — HOW to CONNECT

POST-IT NOTES ARE GREAT TOOLS for COLLABORATION

THE ANSWERS ARE in OUR OWN COMMUNITIES

FOCUS on WHAT CAN BE DONE — NOT WHAT CAN'T

BREAK DOWN BARRIERS

FINANCIAL

ACCESS

INFORMATION

HEALTHY MEALS

WHATS NEXT?

- DECENT HOUSING
- RECONNECT PCP
- CREATE "GRAY SPACE" — TRUST the HEALTHCARE COMMUNITY
- COMMUNITIES of CARE
- ADDRESS BURN OUT of PROVIDERS
- IDENTIFY WHERE WE NEED ADDITIONAL RESOURCES
- GET AVAILABLE FOOD to THOSE in NEED
- CBOs WORK with HEALTHCARE PROVIDERS
- ASK BETTER QUESTIONS
- REDUCE READMI

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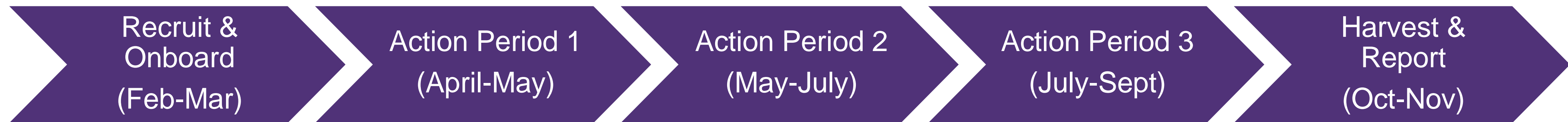
NYS DOH Pleased to Offer MAX 2020

- MAX 2020 Program will run March – October 2020



- We can accommodate up to 24 teams
- We seek to engage 5 “Train the Trainers” to learn the MAX Method & spread
- This is the first of 2 informational webinars in February
- We welcome hearing from teams who are interested in participating!

Who are MVPs? What is MAX?

Amy Boutwell, MD MPP
Developer, MVP Method
MAX Program Subject Matter Expert

Multi-Visit Patients (MVPs)

MVPs: Multi Visit Patients

- High (Multi) = a lot
- Utilizer (Visit) = of the acute care setting
- A numeric definition
- Avoid overlapping terms
- Brings clarity of focus
- Specifies definition of success
- Key for identification & measurement

High Cost

High Risk

MVPs: Defined by Setting

- There are ED MVPs
- There are IN MVPs
- Utilization definitions differ
- Patients differ
- Less overlap than most expect
- Some of the “drivers” differ
- MVP method applicable to both

ED MVPs	IN MVPs
(10+/12mo)	(4+/12mo)

IN MVPs: Key Stats

Inpatient MVP: four or more admissions in the past 12 months

4+

7% - 25% - 58%

38% v. 8%

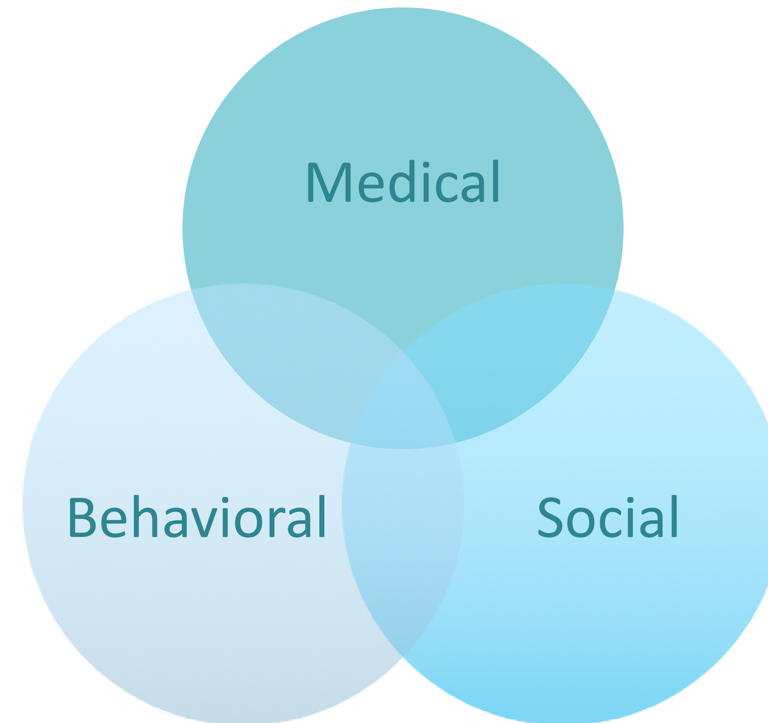
85%

AHRQ HCUP Statistical Brief #190 May 2015
CHIA Hospital-wide All Payer Readmissions in Massachusetts June 2016

MVPs: Top Discharge Diagnoses

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

➢ *Combination of medial, behavioral and social issues*



AHRQ Statistical Brief #190

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."

“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."

Too sick

Too complex

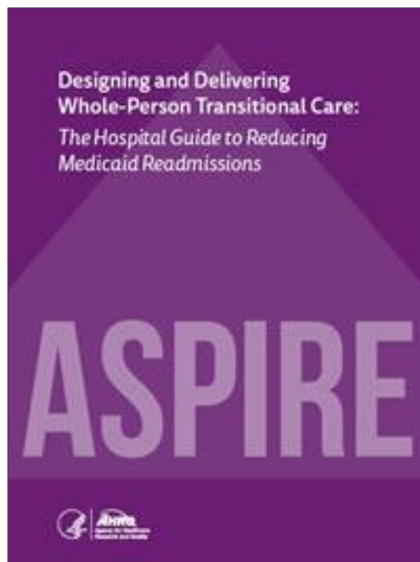
Too disengaged from care

“un-impactable”

It is possible

The MVP Method and the MAX Program

MVP Method Rooted in 10 Years of Readmission Reduction Experience



- 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
- ED care alerts

MVP Method: Core Concepts

View high utilization as a ***symptom***

Our work is to identify the ***root cause*** of the symptom

That root cause is called the ***driver of utilization ("DOU")***

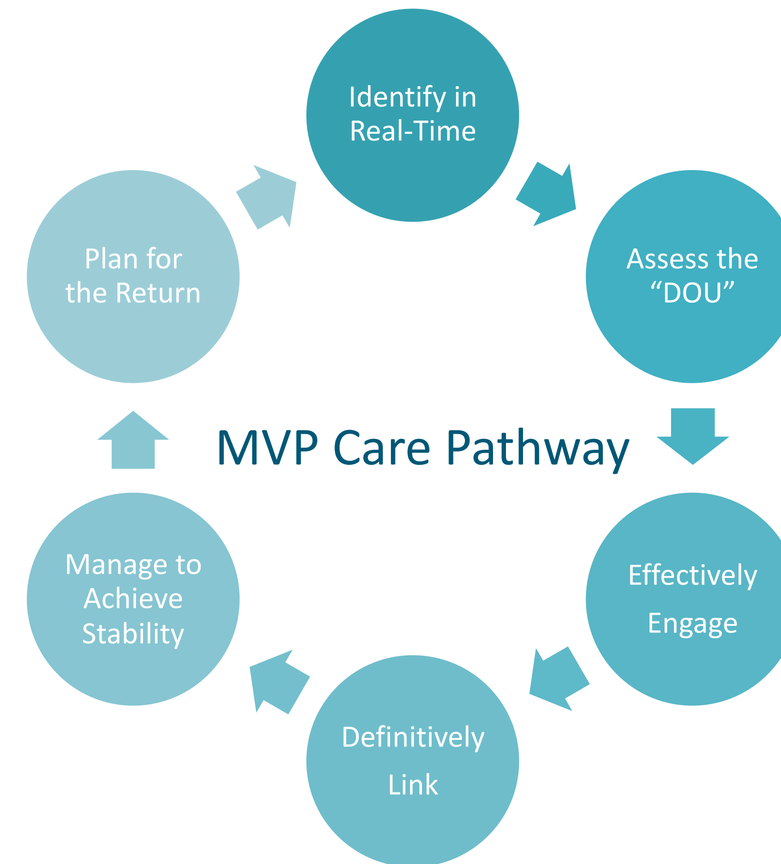
We will slow the cycle of utilization when we ***effectively address*** the DOU

Case find and engage in the ***acute care setting*** because that is where MVPs are

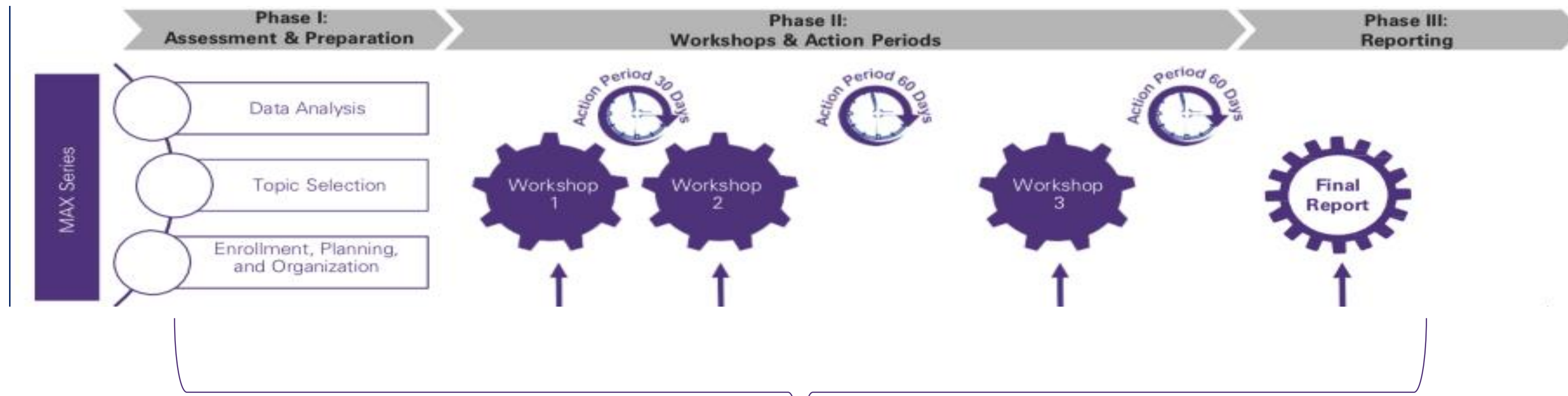
Work across settings, agencies, iteratively, over time, to ***achieve stability***

MVP Method: MVP Care Pathway

1. Identify based on utilization
2. Assess the “driver of utilization”
3. Effectively engage
4. Ensure “definitive timely linkage”
5. Actively “manage to achieve stability”
6. Plan for the return to the ED



MAX: Locally-Adaptable, Operationally Feasible, Effective MVP Care Pathway



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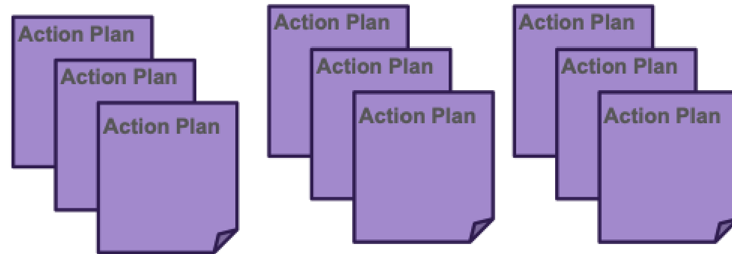

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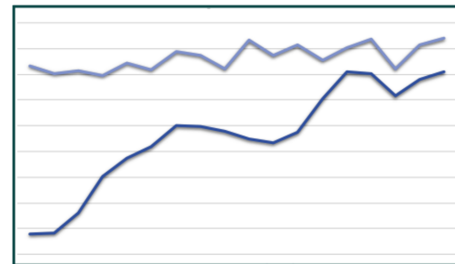

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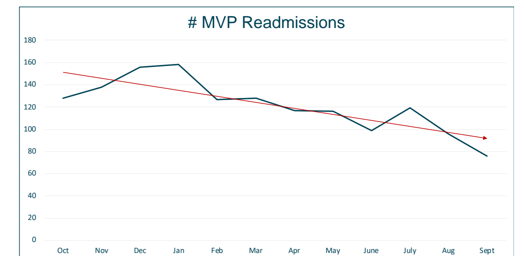
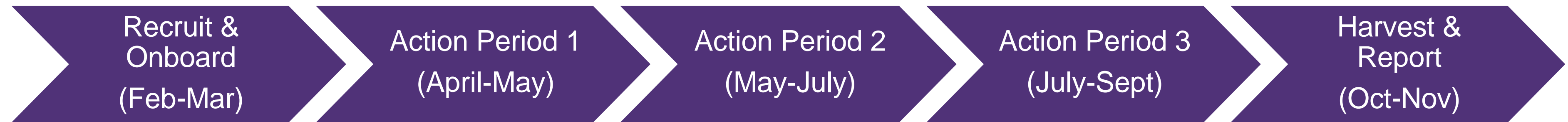


MAX 2020 Recruitment

Sara Butterfield, RN, BSN, CPHQ, CCM
Senior Director, Healthcare Quality Improvement , IPRO
MAX Program Lead

MAX 2020 Program Schedule



	Recruit & Onboard (Feb-Mar)	Action Period 1 (April-May)	Action Period 2 (May-July)	Action Period 3 (July-Sept)	Harvest & Report (Oct-Nov)
Informational Webinars	Feb 14, 28				
Expression of Interest	Feb 14 – March 13				
Selection	Feb 14 – March 13				
Onboarding	Feb 24 – Mar 27				
Workshop 1#		April 7, 14			
Coaching calls		Weekly x 6			
Workshop 2#			May 27,28, June 2,3		
Coaching / on-site visit*			Weekly x 6		
Workshop 3#				July 15, 16, 22, 23	
Coaching / on-site visit*				Weekly x 6	
Final Webinar					Oct 2

All dates are subject to final confirmation; we will notify participants of confirmed dates and locations during onboarding process
#for TTT participants, there will be pre-workshop training sessions, dates TBD
** each team will have one 2 hour on-site working session sometime during Action Periods 2 or 3*

MAX Program: Participation Requirements

- This is a no-cost offering sponsored by the NYS DOH
  - Participation is voluntary
  - Enrollment in the MAX Program requires a commitment to fully participate in the program

- Participation Requirements:
  - ❑ **Commitment** to improving care for MVPs!
  - ❑ **Secure** executive sponsorship
  - ❑ **Convene** an inter-departmental and cross-setting MAX Action Team, according to guidance
  - ❑ **Define** multi-visit patients (MVPs) using utilization-based criteria, according to guidance
  - ❑ **Participate** in all workshops, coaching calls and a one-time on-site working session
  - ❑ **Learn** about and put into action rapid-cycle continuous improvement methods taught in the MAX Program
  - ❑ **Test,** modify as needed, and make changes to care processes to build an MVP Care Pathway
  - ❑ **Track** implementation by maintaining a weekly "Implementation Dashboard," according to guidance
  - ❑ **Measure** outcomes on a monthly basis, according to guidance
  - ❑ **Provide** feedback to MAX Program staff to ensure a great learning experience!

MAX "Train the Trainer" Program

• Seeking:	5 people who are excited to lead delivery system transformation efforts
• Opportunity:	Professional development opportunity; learn to facilitate MAXny Programs
• Ideal Candidates:	In a position related to facilitating delivery system transformation efforts
• Curriculum:	Learn the MAX Method as a participant and as a facilitator
	Participate in pre-workshop preparatory trainings
	Participate in coaching calls with MAX Action Teams
	Progressive experience: Shadow and Learn; Co-Facilitate; Facilitate
	Recruit and launch a MAXny Program
• Time Commitment:	3 days pre-workshop trainings with MAX Program Staff
	3 days MAX workshop participation
	2-4 monthly MAX team coaching calls & debriefs with MAX Program Staff
	Participation in 1 or more on-site working sessions
• Commitment:	Facilitate a MAXny Program upon completing the MAX TTT Program

Let us know if you are interested in MAX 2020!

- **Fill out** an application to participate
  - Application asks 10 questions; to agree to the MAX 2020 Program participation requirements
  - Copy link into your browser: https://app.smartsheet.com/b/form/39ecee357bf94ab2825b69486618c0de
- **Invite** colleagues to the February 28 MAX 2020 Informational webinar
  - February 28 will be a repeat of today's webinar
  - Opportunity to hear about the program with colleagues, review participation requirements and program structure, and consider applying
- **Email** the MAX Program Team with questions!
  - Carolyn Kazdan ckazdan@ipro.org

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Questions

MAX Program Team

Thank you for your interest in improving care for multi-visit patients!

The MAX 2020 Program Leads

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