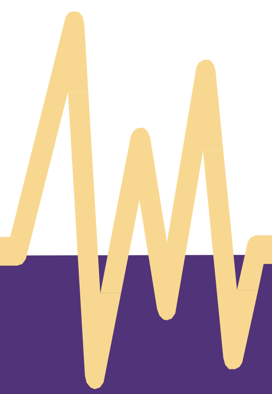
MAX Series: Improving Care for High Utilizers and Sustaining Change

Transforming Care Delivery Locally Utilizing a Standard Methodology

MAX Action Teams January – July 2017
Case Studies



New York State Department of Health, 2018

Contents

1. **Executive Summary** 1
2. **Medicaid Accelerated eXchange (MAX) Series Overview** 2
3. **MAX Action Team Posters (PPS | Site)** 4
    1. Advocate Community Providers | Jamaica Hospital 5
    2. AHI | Adirondack Medical Center at Saranac Lake 6
    3. AHI | Nathan Littauer Hospital 7
    4. Alliance for Better Healthcare | Samaritan Hospital 8
    5. Care Compass Network | Cortland Regional Medical Center 9
    6. CNYCC | SUNY Upstate University Hospital 10
    7. Community Care of Brooklyn | Maimonides Medical Center 11
    8. Finger Lakes Performing Provider System | Arnot Ogden Medical Center 12
    9. Leatherstocking Collaborative Health Partners | A.O. Fox Memorial Hospital 13
    10. Millennium Collaborative Care | Niagara Falls Memorial Medical Center 14
    11. Montefiore Hudson Valley Collaborative | Vassar Brothers Medical Center 15
    12. Mount Sinai | The Brooklyn Hospital Center 16
    13. Nassau Queens | Nassau University Medical Center 17
    14. New York Presbyterian | Weill Cornell Medical Center 18
    15. New York Presbyterian Queens | New York Presbyterian Queens 19
    16. North County Initiative | Samaritan Medical Center 20
    17. NYU Lutheran | NYU Lutheran Medical Center 21
    18. OneCity Health | Bellevue Hospital 22
    19. OneCity Health | Lincoln Hospital 23
    20. Suffolk Care Collaborative | Good Samaritan Medical Center 24
    21. WMCHealth | Bon Secours Community Hospital 25
    22. WMCHealth | HealthAlliance of the Hudson Valley 26

1. Executive Summary

Background

Since its introduction in October 2015, the New York State Department of Health has run the Medicaid Accelerated eXchange (MAX) Series seven times, (with two series currently in progress) engaging over 60 Action Teams with over 600 frontline care and social service providers. The key objective of the MAX Series is to support PPSs in their efforts to redesign the way healthcare is delivered to a specific patient population. To date, the MAX Series has focused on High Utilizers of the Emergency Department (ED) and inpatient (IP) unit, and integrating behavioral health and primary care services.

Starting in early 2017, 22 Action Teams from across New York State participated in the fourth and fifth MAX Series focused on improving care for the inpatient High Utilizer patient population – the small percentage of the patients who account for a disproportionate amount of hospital use and cost. Most Action Teams defined their inpatient High Utilizers as those patients with four or more admissions within a rolling 12-month time frame, excluding patients with planned obstetrical admissions and all pediatric admissions. The primary objective of the MAX Series was to reduce hospital utilization and/or 30-day readmissions by 10% in six months for inpatient High Utilizers.

Process Improvement and Results

With support from their PPSs, Action Teams were able to test and develop meaningful new practices and processes to generate measurable improvements in the way they provided care to High Utilizers in under six months. Through the development of interdisciplinary, cross-setting Action Teams, all teams learned about the inpatient High Utilizer population and how to better understand and meet their needs. The Action Teams rapidly developed key infrastructure (such as identification and notification systems) and concrete Action Plans to develop new care processes and pathways.

MAX Action Teams accomplished all of this work by participating fully in the structure provided by the MAX Series. As a testament to the effectiveness of the MAX Series structure and the commitment of the 22 teams to improve care for High Utilizers, the following outcomes were achieved:

- **22 of 22 Action Teams** defined a specific, measurable **High Utilizer target population;**
- **22 of 22 Action Teams** meaningfully **assembled an interdisciplinary, cross-setting Action Team;**
- **21 of 22 Action Teams implemented systems (manual and/or electronic) to identify High Utilizers** when they **presented to the acute care setting;**
- **22 of 22 Action Teams engaged High Utilizers** in the acute care setting and **assessed the "drivers of utilization"** to understand the non-medical, human reason as to why the High Utilizer was frequently admitted;
- **19 of 22 Action Teams developed High Utilizer-specific care pathways** that integrated care for High Utilizers across care settings by developing effective linkages to key social services and support; and
- **21 of 22 Action Teams implemented interdisciplinary case conferences** to discuss High Utilizer patients and assess on-going care needs.

Prior to their involvement in the MAX Series, the Action Teams had little to no infrastructure or practices in place to specifically manage care for High Utilizers. The significant changes to care processes that the 22 Action Teams were able to implement in just six months are a remarkable achievement, and mark the most progress seen in the three years the MAX Series has been running.

Purpose of this Document

The current document includes 22 Action Team posters from the fourth and fifth cycles of the MAX Series, specifically from January – July of 2017. Posters provide an overview of each Action Team's inpatient High Utilizer interventions and results.

2. Medicaid Accelerated eXchange (MAX) Series Overview

The MAX Series consists of three phases: assessment and preparation (phase I), workshops and Action Periods (phase II), and reporting (phase III), designed around the MAX Series' Rapid-Cycle Continuous Improvement (RCCI) methodology. The following section outlines key considerations for each of the three phases.

Phase I – People: The Importance of Preparation To prepare for the MAX Series, sites are identified and recruited for participation. During this process, on-location site visits are conducted to understand local challenges and current-state processes. Historical data is also collected for prior High Utilizer admissions over a 24-month period. Recruited sites select a key champion (Executive Sponsor) and an Action Team to lead the program.

Phase II – Process: Highly structured and Dynamic Workshop Series to Drive Results

Action Teams are challenged to drive change and accelerate results throughout three workshops and "Action periods," which are made up of Plan-Do-Study-Act (PDSA) cycles.
Action Teams are supported through weekly coaching calls, continuous access to subject matter expertise, performance measurement, and additional touch points to assist in driving change.

Workshops

The MAX Series consists of three intensive, in-person workshops designed to bring the Action Teams together to rapidly generate process improvement ideas and plans to achieve results By the end of the workshop, each Action Team generates three concrete and measurable Action Plans to be implemented within a 30- or 60-day Action Period following the workshop.

Action Periods

While the Action Teams and intensive workshops are designed to build consensus and momentum around a solution, **the Action Periods are where policy truly turns into practice.** Each of the three workshops in Phase II are followed by a PDSA cycle or Action Period. During this time, Action Plans generated during the workshops are implemented by the Action Team, and progress is monitored and measured. Changes to local processes are made, tested, and adjusted over compressed time periods,

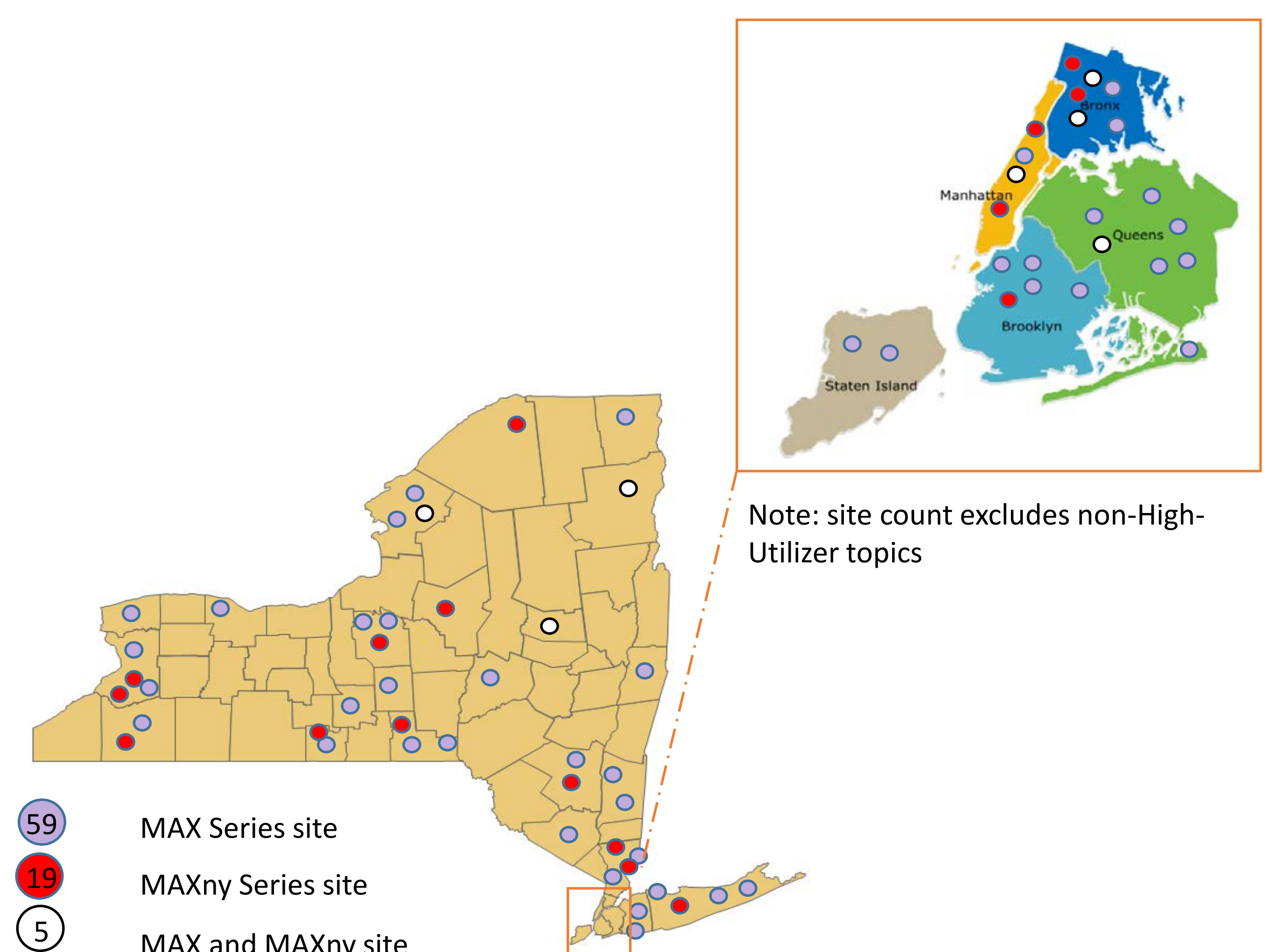
Phase III – Outcomes: Data, Measurability, and Accountability

Analytics play a pivotal role in the MAX Series as teams use data to inform change and decision-making, as well as guide process improvement outcomes. Action Teams measure a baseline prior to implementation of process improvement approaches, and over the course of the MAX Series, drive, measure, analyze, and report on informed process improvement initiatives.

Train-the-Trainer Program | MAXny Series

The Train-the-Trainer (TTT) Program complemented and directly aligns with the three phases of the MAX Series. This program was designed to scale and sustain process improvement work by training senior-level clinicians and administrators in the same methodology used in the MAX Series to run their own independent RCCI workshops. Over the course of the program, participants followed a "See one, Do one, Lead one" approach to facilitating by observing, co-facilitating, and eventually leading MAX workshops In parallel, participants were supported in building a Sustainability Plan which outlined their site, target population, and Action Team for their independently run RCCI workshop series, coined the MAX New York (MAXny) Series.

MAX Series and MAXny Series High Utilizer Programs have been scaled across New York State



67 sites across New York State have run High Utilizer programs through the MAX Series and MAXny Series

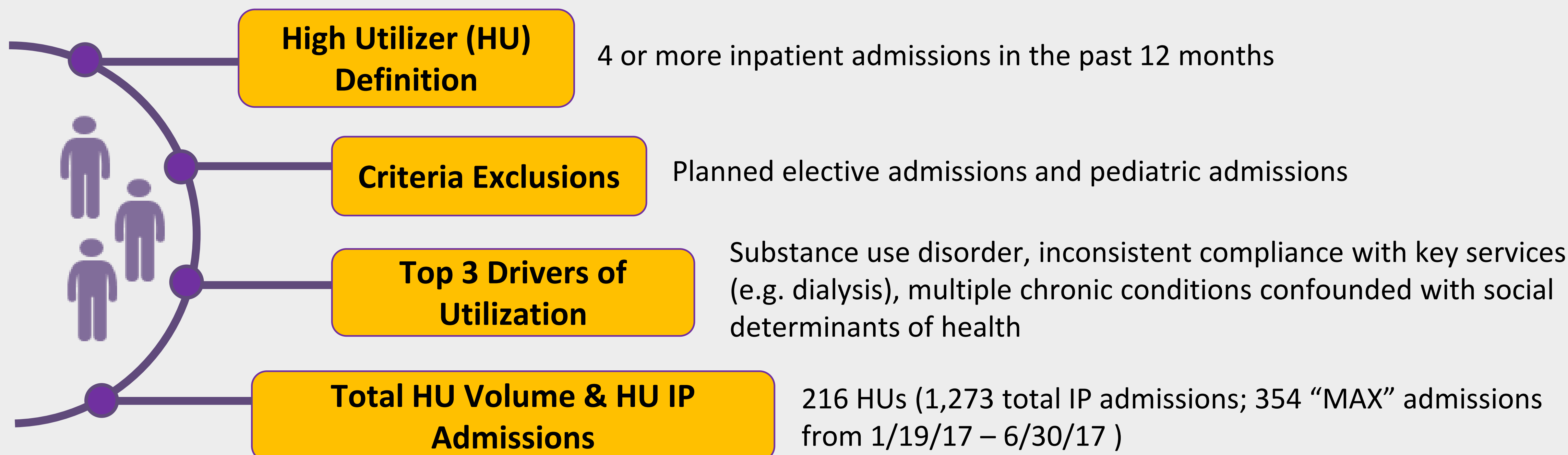
3. Action Team Posters

NEW YORK STATE | Department of Health

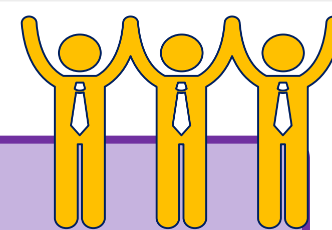
The MAXimizers

Advocate Community Providers, Jamaica Hospital

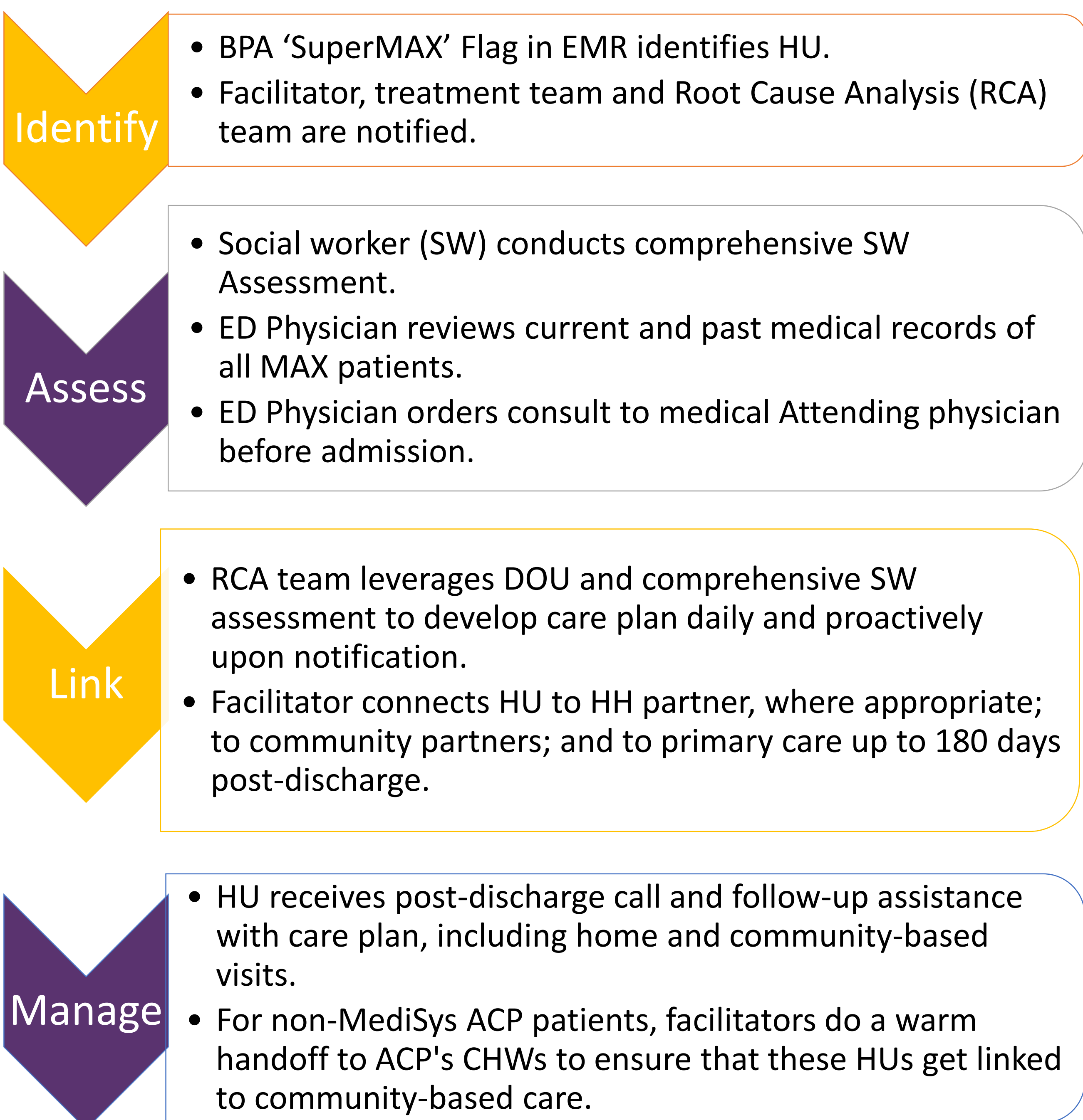
Our High Utilizer Population



Our Actions



HU Care Pathway



Success Story

A middle-aged male receiving dialysis treatment 3x/week. Patient has alcoholic cirrhosis of liver with anemia, hypertension and thrombocytopenia, with four admissions prior to index visit.

Driver of Utilization:

Difficulty accessing dialysis; undocumented status (ER Only Medicaid); lack of connection to primary care.

How we addressed DOUs:

RCA Team:

- Implemented recommendation to provide a procedure related to cirrhosis in the outpatient setting.
- Recommended palliative care consult to address goals of care given patient's prognosis.

Facilitator:

- Obtained dialysis treatment slot for patient at a center close to the patient's home.
- Assisted patient in obtaining financial aid through the hospital and connected patient to a PCP in one of the hospital-affiliated clinics.
- Made regular contacts with patient and family caregiver to support compliance with care plan.

Impact to date:

- Patient has not been admitted for over three months, and is compliant with outpatient care.

Our Impact

Partnerships

1. **Advocate Community Providers:** Increases community linkage through ACPs CHWs.
2. **Substance Use Providers:** Provide continuum of community-based substance use and social support services for HUs.
   - **PAC Program**
   - **Odyssey House**
   - **Samaritan Village**
3. **Mental Health Providers:** Provide outpatient mental health services for HUs.
   - **MediSys Behavioral Health**
   - **Long Island Consultation Center**

Unique Accomplishment

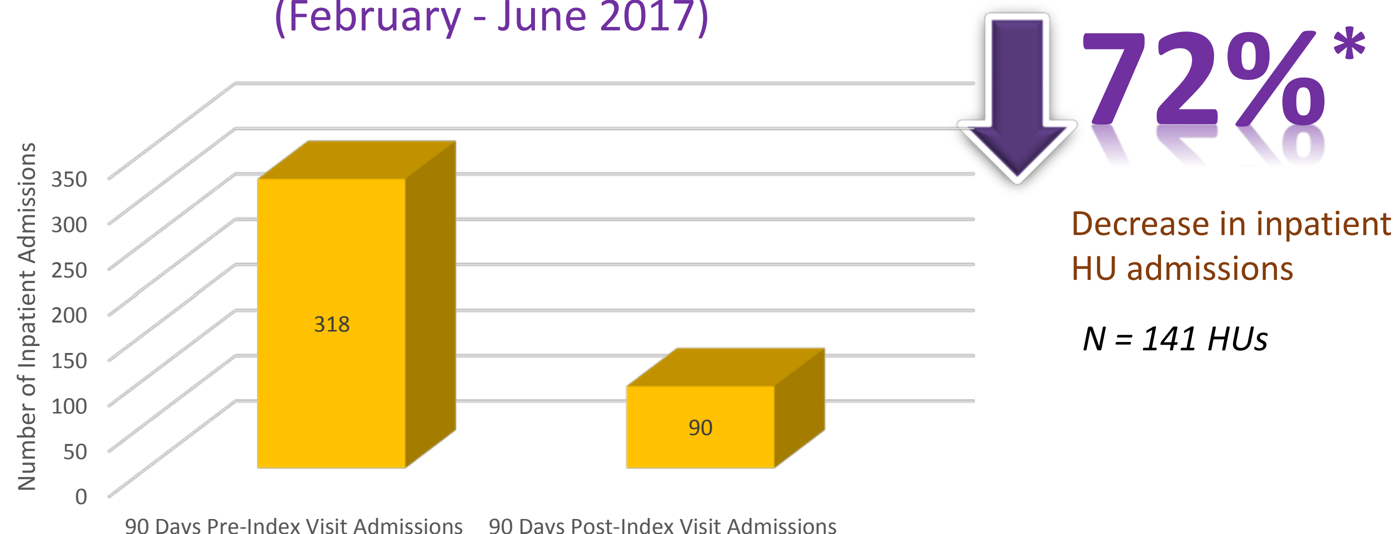
Automated HU list generated from Super MAX Flag Best Practice Alert. Identifies HUs in the ED and IP settings and alerts care providers to intervene.

Outcome Metrics

90 Days Pre vs. Post Index Visit Hospital Utilization		
90 Days Pre-Index Visit Admissions	90 Days Post-Index Visit Admissions	% Change
318	90	-72%

The index admission is the first admission for each HU after the program start date that meets HU criteria (e.g. fourth or higher admission).

HU 90-Day Pre- vs. Post-Hospital Utilization (February - June 2017)



72%*

Decrease in inpatient HU admissions

N = 141 HUs

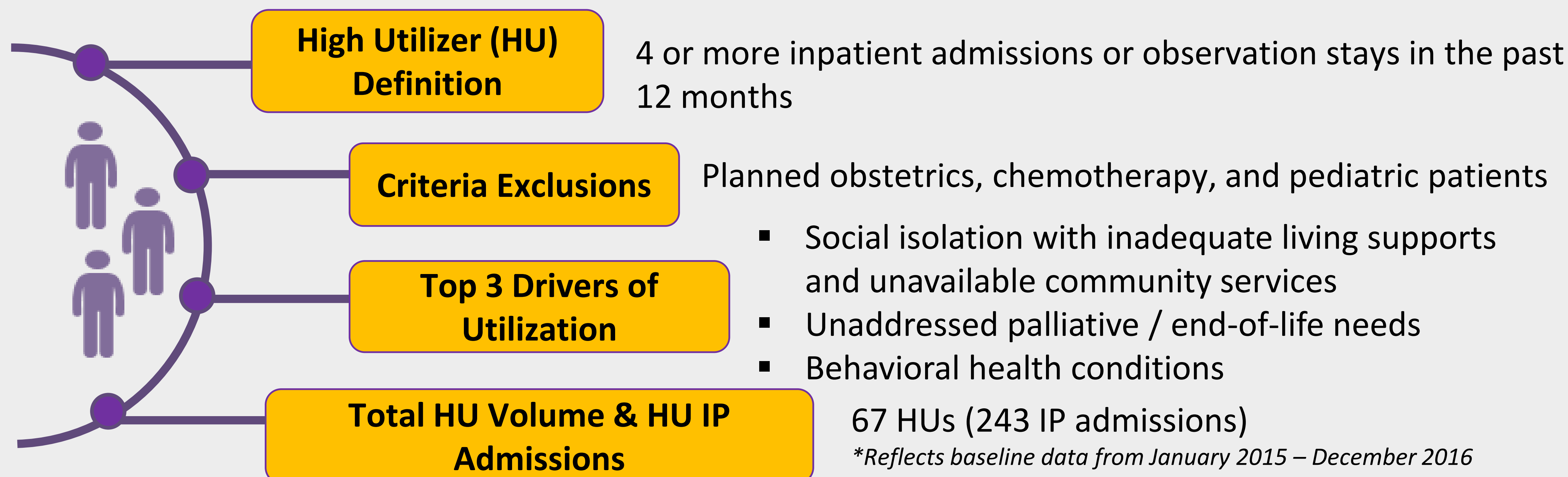
**Does not account for the impact of regression to the mean*

NEW YORK STATE | Department of Health

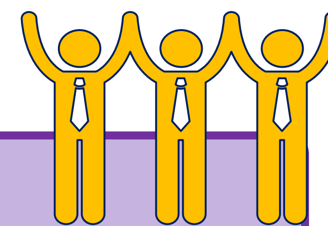
High Peaks Care Collaborative

AHI, Adirondack Medical Center at Saranac Lake

Our High Utilizer Population



Our Actions



HU Care Pathway

Identify
- As HUs are identified, they are flagged in the hospital's EMR, which anyone with access can view.
- As HUs are admitted to IP unit, the EMR system alerts the care team via email for team to mobilize their HU care pathway.

Assess
- Social workers or case managers engage HUs at bedside and perform assessment to determine DOUs (M-F and some Saturday coverage).
- Once patients have been assessed, the care team determines best referral and linkage needs and coordinated for patients' connection to most appropriate resources and programs.

Link
- Developed resource directory that has been implemented across hospital departments. Users access to quickly find most appropriate resources for HU patients.

Manage
- All HUs receive post-discharge follow-up phone call within 48 hours.
- Weekly case conference discussions with CBOs to review all HU patients individually for patient follow-up, next steps, care plans, and long-term management.
- Hospital social worker transitioned to focus on community follow-up and management.
- County-level multidisciplinary meetings expand weekly case conferencing to county entities (police/fire departments/EMT).

Success Story

An elderly male with developmental disabilities and mental illness, living in residential housing.

Driver of Utilization:
Patient was placed on a strict dietary plan at his residential housing facility. When he was admitted to the IP unit, staff unknowingly reinforced negative behaviors, including patient's choice of snacks (e.g. Mountain Dew) and aggressive behavior toward other residents and staff.

How we addressed DOUs:
- Held case conference with residential housing staff, ultimately identifying that a consistent dietary regimen for the patient in the hospital setting should be kept, which aligned with his housing facility.
- This information was additionally shared with outpatient offices for consistency across the patient's care continuum.

Impact to date:
- Patient had been admitted six times in previous 12 months.
- Patient has not been readmitted since these changes were implemented.

Our Impact

Partnerships

1. **Southern Franklin County Multidisciplinary Team:** Collaboration with county entities (e.g. police/fire department/EMT) to develop plans of action for HU interactions in the community.
2. **Mercy Care:** Volunteers meet with patients at the bedside to build trusting relationships with patients resistant to home care visits/services.

Unique Accomplishment

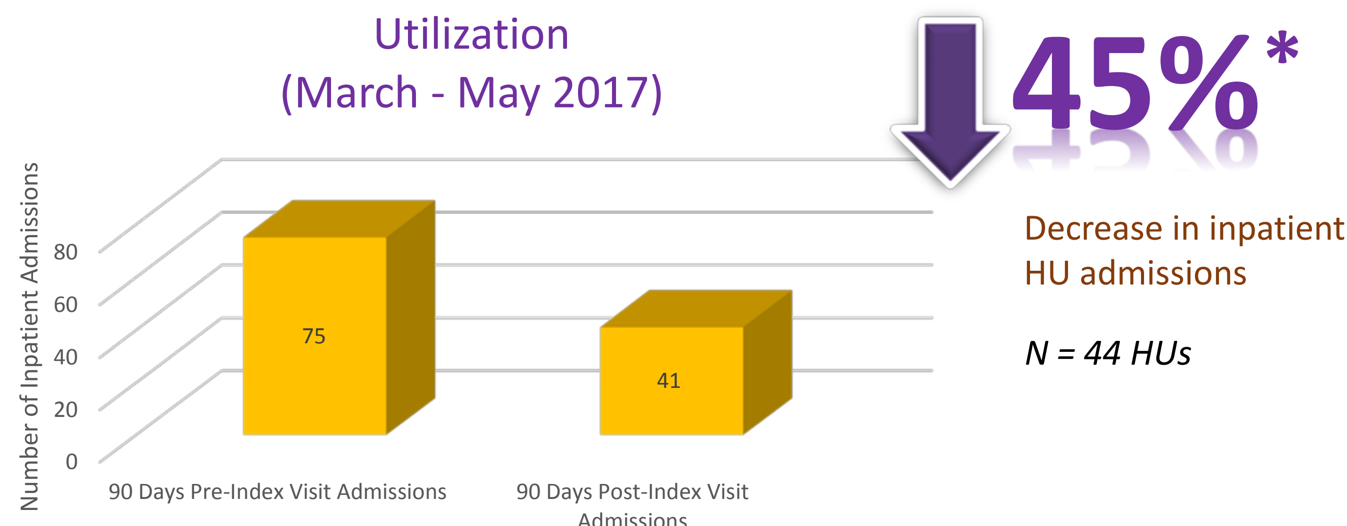
Social workers and case managers conduct driver of utilization assessments and update in the EMR.

Outcome Metrics

90 Days Pre vs. Post Index Visit Hospital Utilization		
90 Days Pre Index Visit Admissions	90 Days Post Index Visit Admissions	% Change
75	41	-45%

The index admission is the first admission for each HU after the program start date that meets HU criteria (e.g. fourth or higher admission).

High Utilizer 90-Day Pre- vs. Post- Hospital Utilization (March - May 2017)

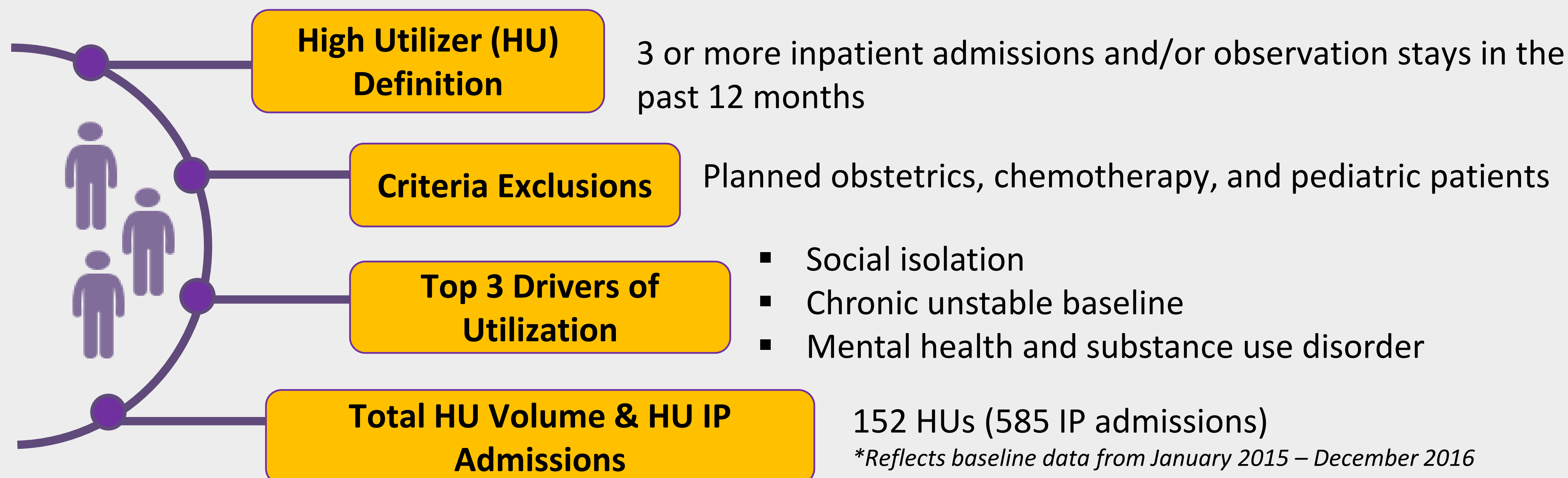


*Does not account for the impact of regression to the mean

Fulton County

AHI, Nathan Littauer Hospital

Our High Utilizer Population



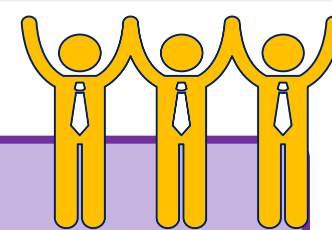
High Utilizer (HU) Definition: 3 or more inpatient admissions and/or observation stays in the past 12 months

Criteria Exclusions: Planned obstetrics, chemotherapy, and pediatric patients

Top 3 Drivers of Utilization:
- Social isolation
- Chronic unstable baseline
- Mental health and substance use disorder

Total HU Volume & HU IP Admissions: 152 HUs (585 IP admissions)
**Reflects baseline data from January 2015 – December 2016*

Our Actions



HU Care Pathway

Identify
- Care Coordination runs daily census report in hospital's EMR (Meditech), which coordination manager uses to identify HUs daily. Care Coordination then identifies HUs during morning multidisciplinary rounds.

Assess
- Prior to meeting with patients, care team meets in daily multidisciplinary rounds to discuss patients previous admissions and gaps in care.
- Social worker engages patients at bedside and performs driver of utilization assessments.
- Patients provided with a simplified and organized discharge packet.
- Before discharge, case conference discussions take place as needed for more difficult assessment and management.

Link
- Warm handoffs to external medical and social resources.
- Outpatient behavioral health appointments are guaranteed for patients requiring services within 24 hours.
- Connected to 1 of 4 community navigators that meet patients at bedside and provide ongoing follow-up with patients and hospital.

Manage
- Monthly readmission meetings for cross-discipline strategy for HU needs and approaches.
- ED monitors for HUs presenting to ED that have disengaged with their community navigator. Care Coordination received phone or email alert to reconnect patient to appropriate care.

Success Story

Older male with COPD and other comorbidities; admitted to inpatient setting every two weeks.

Driver of Utilization:
Patient lives alone with no caregiver. Because the patient does not drive, he relies on Medicaid transportation to get appointments. When COPD symptoms worsen, the patient's anxiety increases, which eventually leads him to call 911 and go to the ED.

How we addressed DOUs:
- Held case conference discussions to brainstorm how to better support and meet needs of patient and tele-monitoring was recommended through his in-home health agency.
- Daily calls to the patient from a nurse were established, as well as meeting the patient face-to-face several times a week.

Impact to date:
Patient previously was admitted approximately every two weeks. Since the intervention, the patient has had no readmissions and only two ED visits in the past two months.

Our Impact

Partnerships

1. **Family Counseling Center:** Guaranteed patients behavioral health appointments within 24 hours of discharge.
2. **Community Navigation Post Discharge:** Navigators provide patient long-term follow-up and management post discharge.

Unique Accomplishment

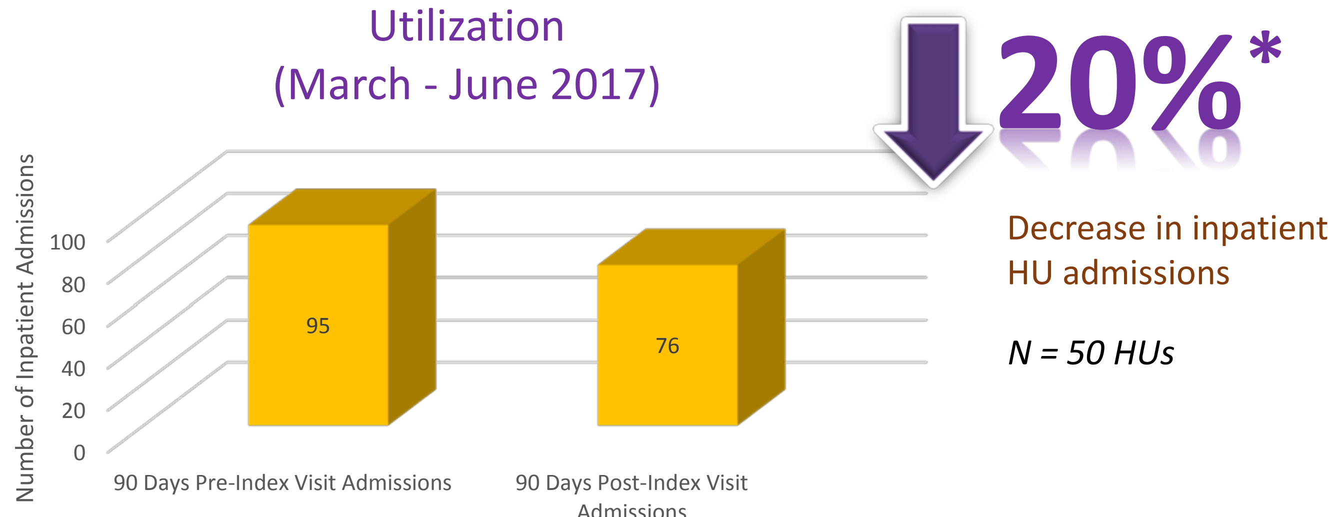
Discuss patients and create care plan in multidisciplinary rounds with hospitalist, SW, PT, dietary, and respiratory care team.

Outcome Metrics

90 Days Pre vs. Post Index Visit Hospital Utilization		
90 Days Pre Index Visit Admissions	90 Days Post Index Visit Admissions	% Change
95	76	-20%

The index admission is the first admission for each HU after the program start date that meets HU criteria (e.g. fourth or higher admission).

High Utilizer 90-Day Pre- vs. Post- Hospital Utilization
(March - June 2017)



20%*
Decrease in inpatient HU admissions

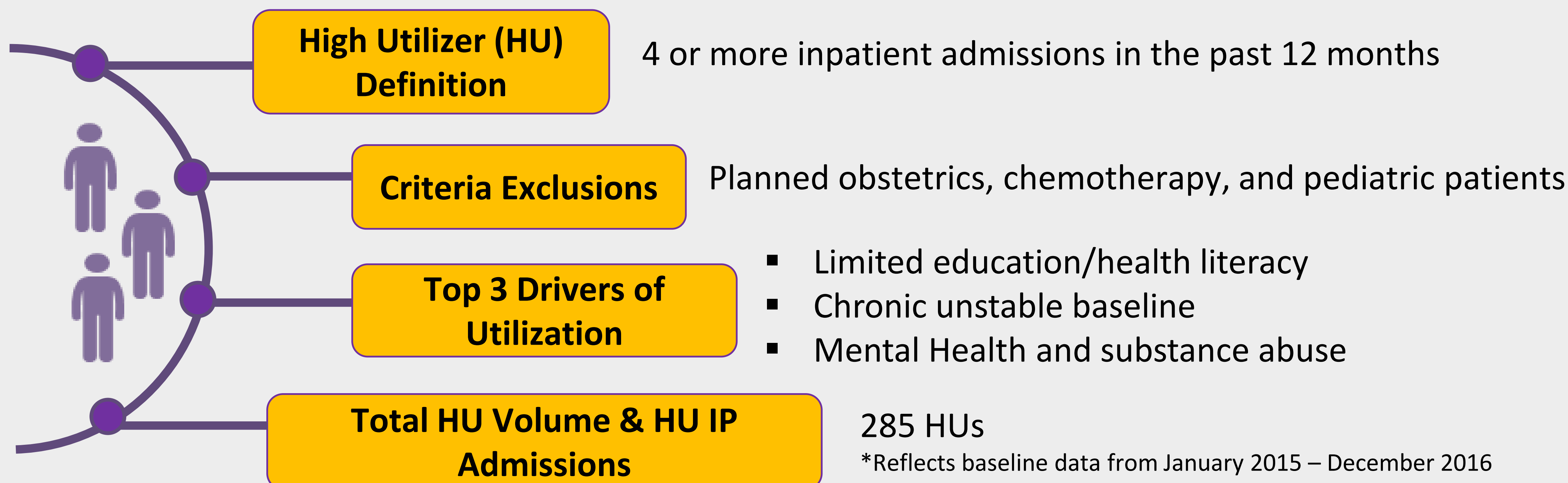
N = 50 HUs

**Does not account for the impact of regression to the mean*

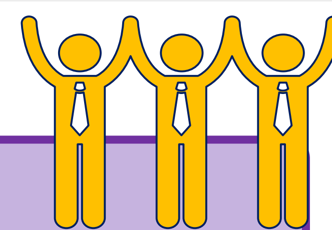
Uncle Sam's Angels

Alliance for Better Healthcare, Samaritan Hospital

Our High Utilizer Population



Our Actions



HU Care Pathway

Identify
- Case management runs daily census report in hospital's EMR, which then alerts IP care staff via email, M-F.
- Index cards created for newly identified patients.

Assess
- Meet in daily rounds to discuss high utilizer patients.
- Air Traffic Controller (ATC) engages patients, conducts DOU assessment and teaches patients how to manage chronic illness relative to their baseline condition (utilizing Zone Sheets).

Link
- Some external partners meet patients at bedside.
- ATC completes warm handoffs to other resources, receiving providers and programs.
- Community service worker meets patients at bedside before discharge and determines Health Home eligibility, enrollment, and hands off to Health Home manager.

Manage
- Case conference discussions with CBOs as needed for patients that are more difficult to assess and manage.
- Patients managed over time across continuum by Zone Sheets.
- Community service worker provider ongoing management for patients not yet accepted into Health Home or some other program/service.
- Emergency Room case managers use Zone Sheets to notify the ATC if HU patient presents in ED.

Success Story

Middle-aged male with 8 admissions since February 2017.

Driver of Utilization:
Patient has history of medical and behavioral health comorbidities, was admitted with inability to ambulate. Compounding driver of utilization is caregiver (patient's mother) who has difficulty caring for him at home, including lack of independence to manage his transfers.

How we addressed DOUs:
- ATC met with patient and patient's mother to discuss care setting options.
- ATC coordinated discharge plan with the care team prior to patient's transfer to short-term rehab facility.
- ATC and Community Service Worker completed application for the Health Home prior to discharge.

Impact to date:
Patient previously had 8 admissions across 4 months. Patient returned home May 31st, 2017, from sub-acute rehabilitation facility, and has not yet been readmitted to Samaritan Hospital.

Our Impact

Partnerships

1. **Medical Answering Services:** Better inform patients and cross continuum staff on accessing transportation resources.

Unique Accomplishment

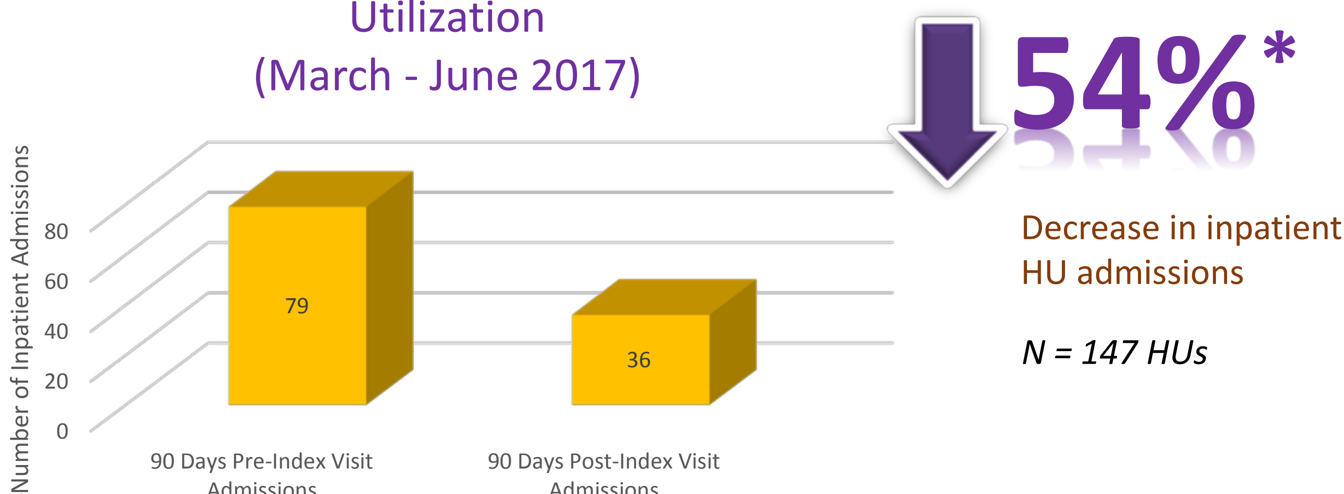
Internal Air Traffic Controller conducts drivers of utilization assessments and determines needs and next steps for patient linkages, documents in EMR.

Outcome Metrics

90 Days Pre vs. Post Index Visit Hospital Utilization		
90 Days Pre Index Visit Admissions	90 Days Post Index Visit Admissions	% Change
79	36	-54%

The index admission is the first admission for each HU after the program start date that meets HU criteria (e.g. fourth or higher admission).

High Utilizer 90-Day Pre- vs. Post- Hospital Utilization (March - June 2017)

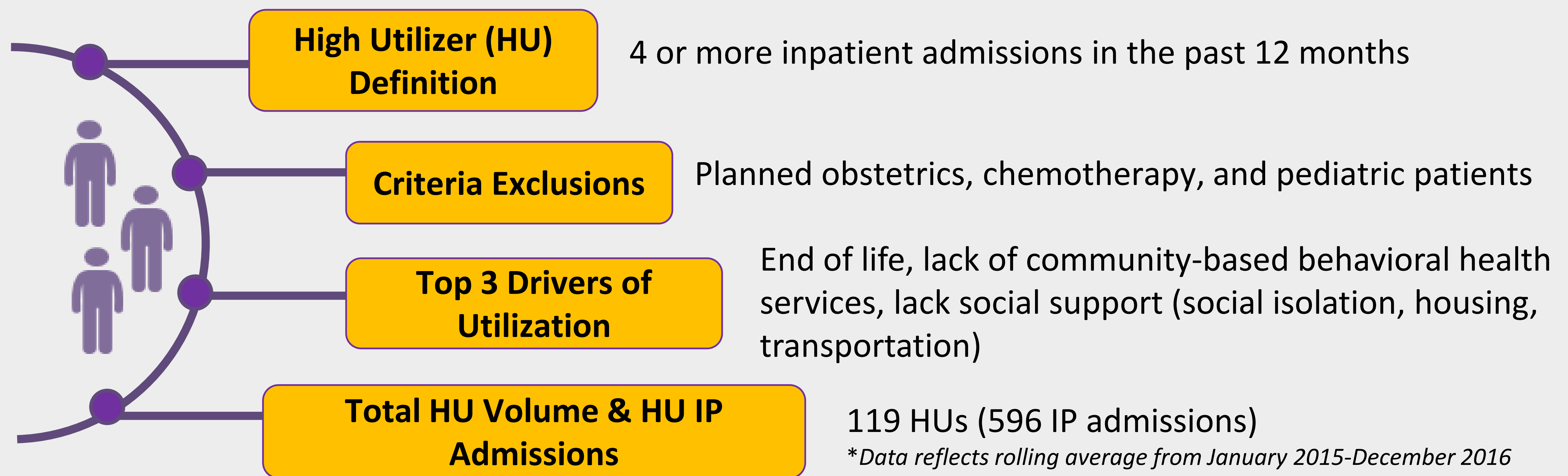


*Does not account for the impact of regression to the mean

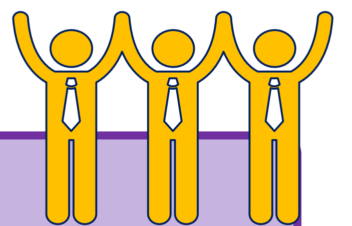
MAD MAX

Care Compass Network, Cortland Regional Medical Center

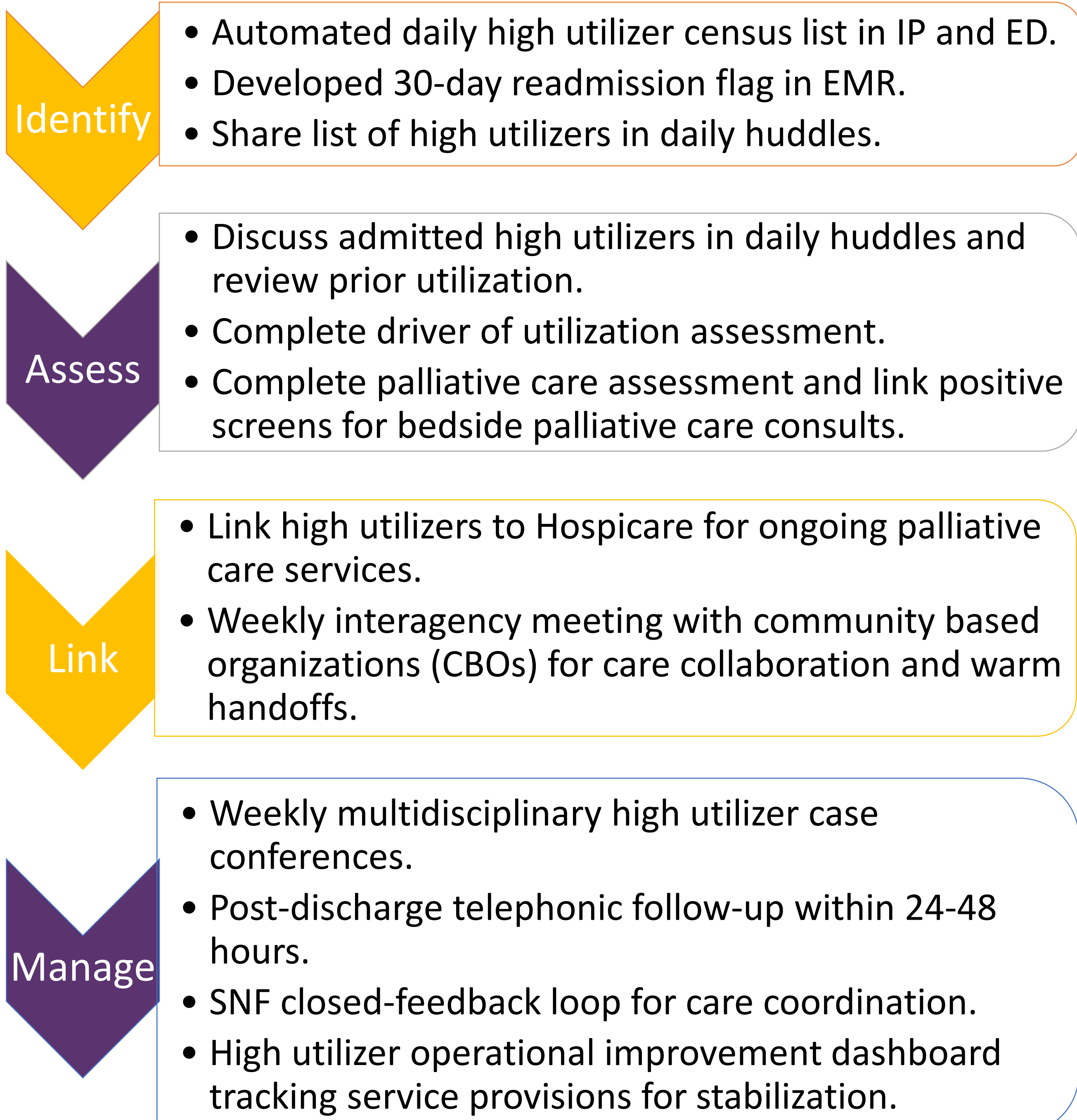
Our High Utilizer Population



Our Actions



HU Care Pathway



Identify
- Automated daily high utilizer census list in IP and ED.
- Developed 30-day readmission flag in EMR.
- Share list of high utilizers in daily huddles.

Assess
- Discuss admitted high utilizers in daily huddles and review prior utilization.
- Complete driver of utilization assessment.
- Complete palliative care assessment and link positive screens for bedside palliative care consults.

Link
- Link high utilizers to Hospicare for ongoing palliative care services.
- Weekly interagency meeting with community based organizations (CBOs) for care collaboration and warm handoffs.

Manage
- Weekly multidisciplinary high utilizer case conferences.
- Post-discharge telephonic follow-up within 24-48 hours.
- SNF closed-feedback loop for care coordination.
- High utilizer operational improvement dashboard tracking service provisions for stabilization.

Success Story

Elderly male; admitted to inpatient setting in mid-May.

Driver of Utilization:
Patient unable to self-manage recurrent symptoms due to cognitive deficits (lack of mental functions).

How we addressed DOUs:
- Enrolled patient in Care Transitions Program, provides 30 day post-discharge follow-up and linkages to community resources/support services.
- Provided care management to assist patient with low sodium diet to reduce high blood pressure and other cardiac complications.
- Care Transitions Manager assisted patient with appointment adherence telephonic reminder phone calls.

Impact to date:
- Patient utilization has decreased from five admissions over a 10 month period, to zero ED presentations or IP admission since being engaged in high utilizer program.

Our Impact

Partnerships

1. **Hospicare & Palliative Care Services**: Provide bedside palliative care consults for high utilizer with positive assessment outcomes.
2. **Cortland County Area Agency on Aging**: Provide post-discharge community care coordination services.

Unique Accomplishment

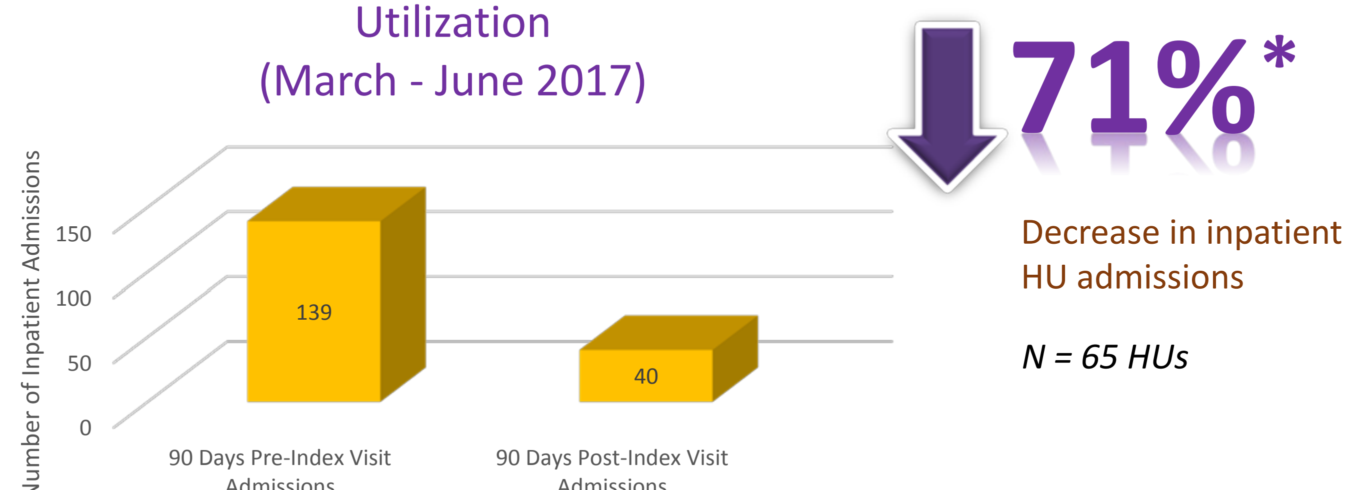
Developed formal process with external palliative care provider (Hospicare) to perform bedside consults and link patients for ongoing care through PATH program.

Outcome Metrics

90 Days Pre vs. Post Index Visit Hospital Utilization		
90 Days Pre-Index Visit Admissions	90 Days Post-Index Visit Admissions	% Change
139	40	-71%

The index admission is the first admission for each HU after the program start date that meets HU criteria (e.g. fourth or higher admission).

High Utilizer 90-Day Pre- vs. Post- Hospital Utilization
(March - June 2017)

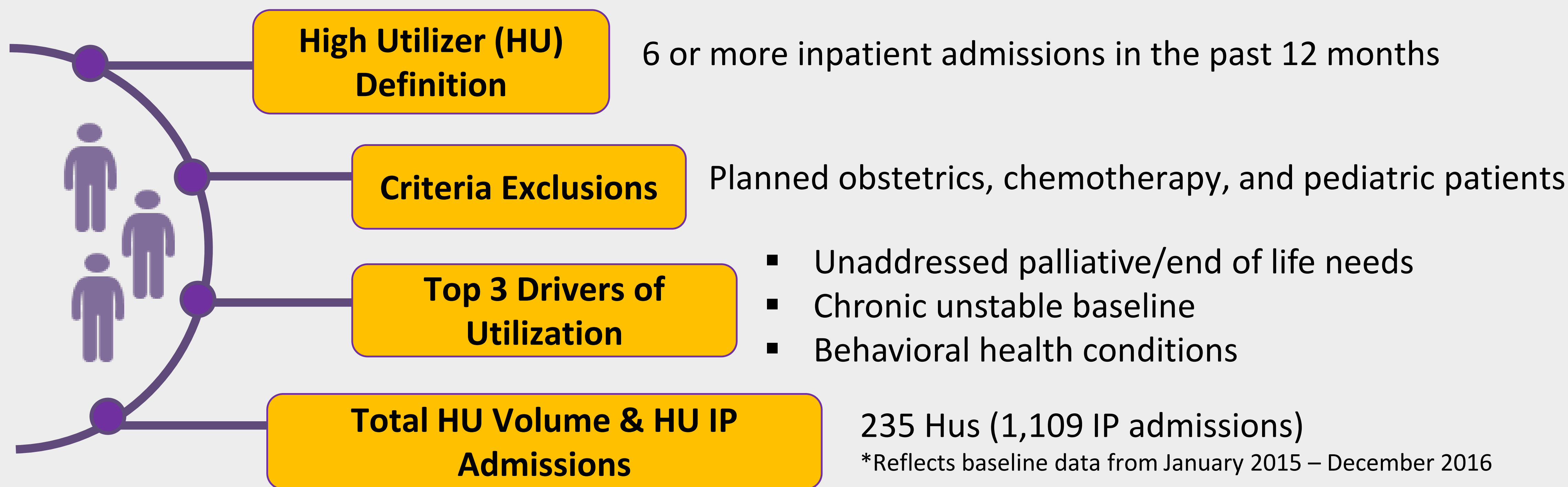


*Does not account for the impact of regression to the mean

CNY-Change Acceleration Partnership

CNYCC, SUNY Upstate University Hospital

Our High Utilizer Population



High Utilizer (HU) Definition: 6 or more inpatient admissions in the past 12 months

Criteria Exclusions: Planned obstetrics, chemotherapy, and pediatric patients

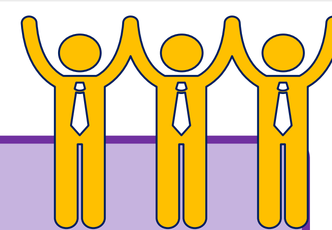
Top 3 Drivers of Utilization:

- Unaddressed palliative/end of life needs
- Chronic unstable baseline
- Behavioral health conditions

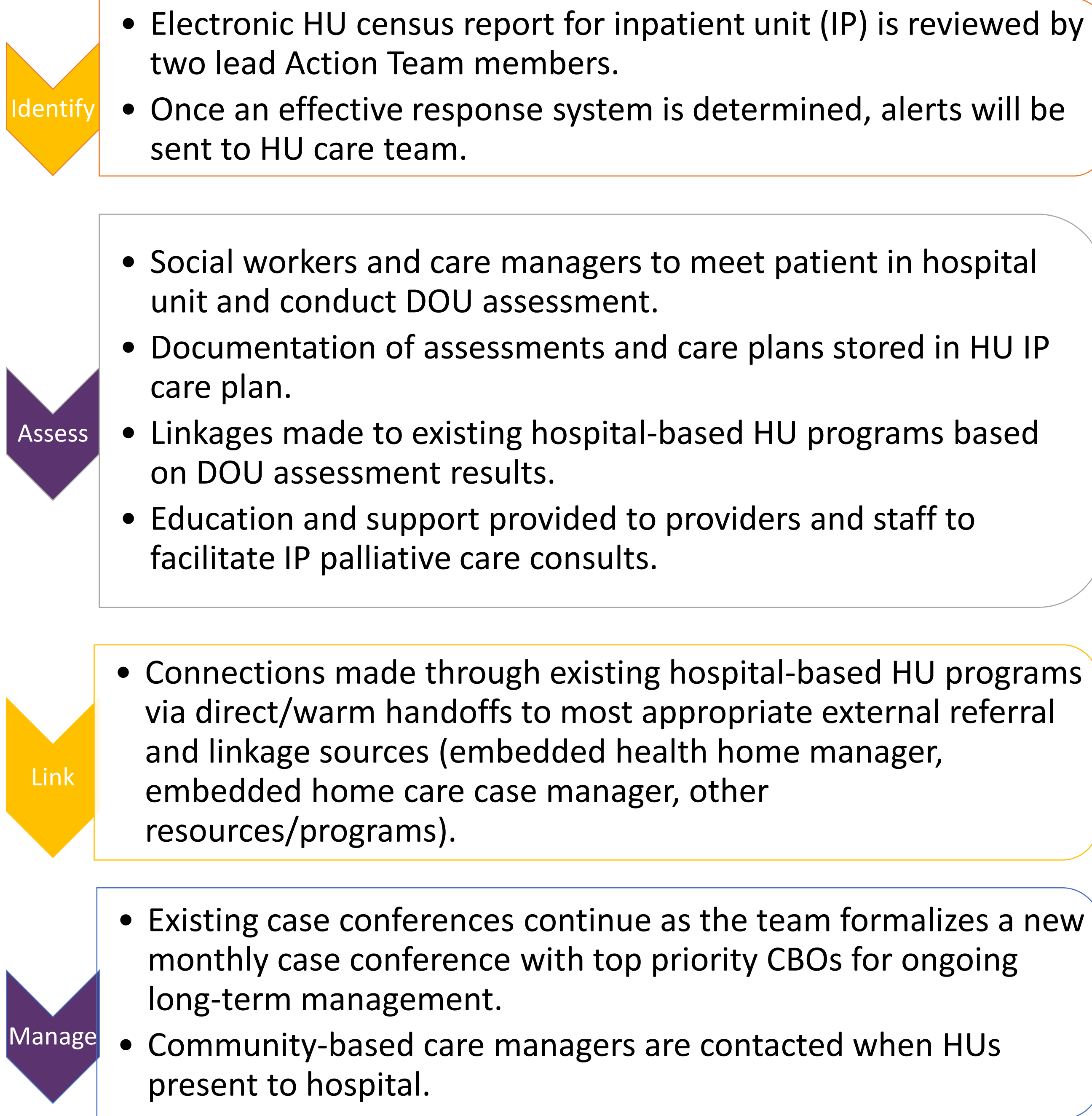
Total HU Volume & HU IP Admissions: 235 Hus (1,109 IP admissions)

*Reflects baseline data from January 2015 – December 2016

Our Actions



HU Care Pathway



Identify

- Electronic HU census report for inpatient unit (IP) is reviewed by two lead Action Team members.
- Once an effective response system is determined, alerts will be sent to HU care team.

Assess

- Social workers and care managers to meet patient in hospital unit and conduct DOU assessment.
- Documentation of assessments and care plans stored in HU IP care plan.
- Linkages made to existing hospital-based HU programs based on DOU assessment results.
- Education and support provided to providers and staff to facilitate IP palliative care consults.

Link

- Connections made through existing hospital-based HU programs via direct/warm handoffs to most appropriate external referral and linkage sources (embedded health home manager, embedded home care case manager, other resources/programs).

Manage

- Existing case conferences continue as the team formalizes a new monthly case conference with top priority CBOs for ongoing long-term management.
- Community-based care managers are contacted when HUs present to hospital.

Success Story

60 year old male; admitted to inpatient setting in early March.

Driver of Utilization:
Patients was routinely presenting to hospital because he was homeless and living in a shelter.

How we addressed DOUs:

- Intensive Transitions Team (ITT) facilitated a medical team transfer to address more complex clinical and pharmaceutical needs.
- Provided palliative care consult and determined goals of care to be physical rehabilitation, ability to live independently and rebuild relationships with her children.
- Facilitated family meetings.
- Referrals made to Health Home and Pathways to Independence for post-acute follow-up.

Impact to date:
Patient discharged to rehab after 30-day hospital stay, with a transition to Pathways to Independence to address patient's homelessness.

Our Impact

Partnerships

1. **Circare Health Home:** Positive shift in perception of high utilizers and persistent efforts to give them more chances.
2. **Hospice of Central New York:** Sharing of case conference best practices and focus on social determinants of health.

Unique Accomplishment

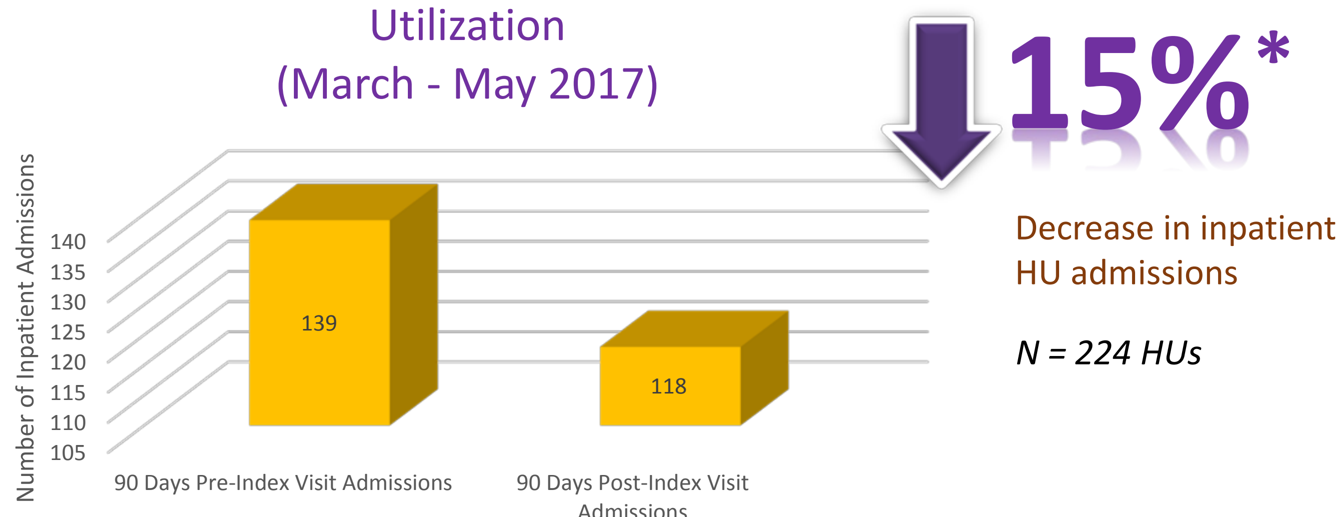
Manual ED and IP flag inputted in EPIC via Best Practice Advisory (BPA) viewable to all with access to EPIC.

Outcome Metrics

90 Days Pre vs. Post Index Visit Hospital Utilization		
90 Days Pre Index Visit Admissions	90 Days Post Index Visit Admissions	% Change
139	118	-15%

The index admission is the first admission for each HU after the program start date that meets HU criteria (e.g. fourth or higher admission).

High Utilizer 90-Day Pre- vs. Post- Hospital Utilization
(March - May 2017)



Decrease in inpatient HU admissions

N = 224 HUs

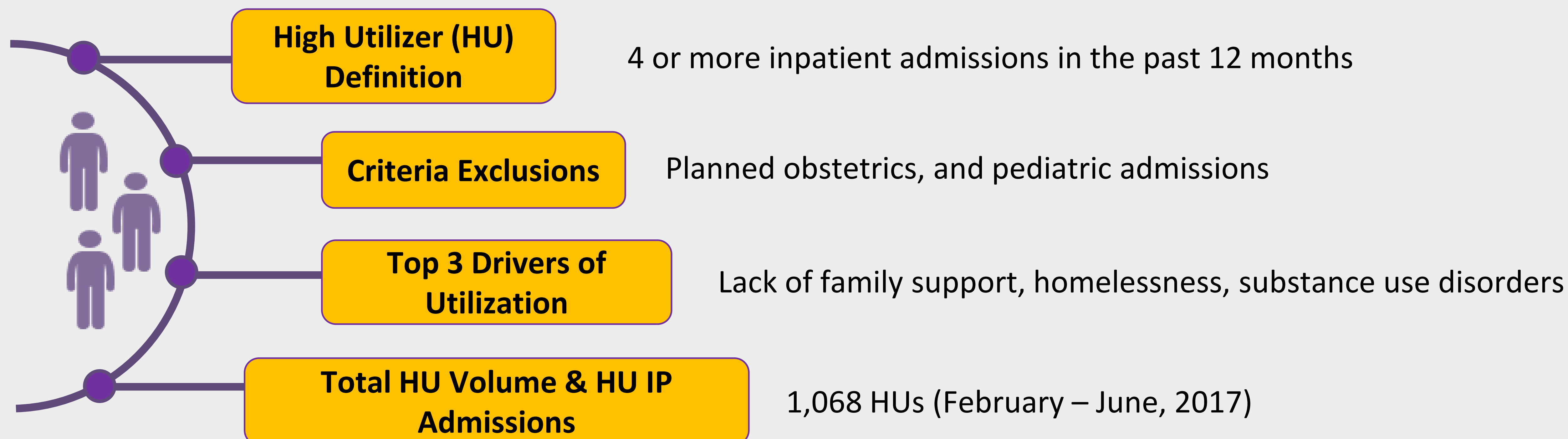
Does not account for the impact of regression to the mean

Improving Transitional Care for HU We Engage

Community Care of Brooklyn, Maimonides Medical Center

NEW YORK STATE | Department of Health

Our High Utilizer Population



Our Actions

HU Care Pathway

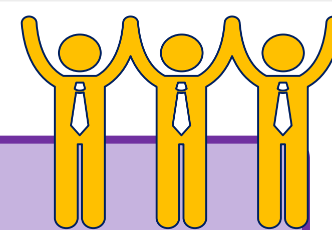
Identify
- Daily HU list is sent to Transitional Care Team and Action Team.
- Transitional care team (TCT) reviews list.

Assess
- TCT Nurse conducts DOU interview.
- Team engages skilled nursing facility (SNF) and HH for discharge planning.

Link
- Clinical liaison warm handoff to primary care physician (PCP), SNF, and HH, when applicable.

Manage
- 5 step discharge protocol provided to each high utilizer; in-person meeting, 24-hour post-discharge call, pre-appointment reminder call, post-visit call, and ongoing communication.
- Weekly multidisciplinary care conferences with Action Team and key staff.

Success Story



Female patient with sickle cell anemia, depression, and history of strokes with residual weakness, who had seven admissions in prior 12 months.

Driver of Utilization:

Domestic verbal and physical abuse, social anxieties.

How we addressed DOUs:

- TCN and CM connected with PCP and Hem Oncologist, which resulted in improved attendance for follow up appointments.
- TCT reached out to Maimonides' Pain Management nurse – sees patient weekly to help her manage her pain and corresponding meds.
- TCN and Health Home CM coordinated efforts and completed a home visit together.
- TCT coordinated with Health Home, Legal Aid, and Case Worker. Patient entered a domestic violence shelter.

Impact to date:

- Patient has not been admitted to the hospital for Sickle Cell crisis since leaving her home environment (last admission April 12, 2017).
- Continues to see Pain Management nurse.

Our Impact

Partnerships

1. **Boro Park:** Skilled Nursing Facility (SNF) that provides long-term support services and improves continuity of care for high utilizers beyond the hospital.
2. **Housing Works:** Provides transitional housing support.
3. **Brooklyn Health Home:** Involved in planning with transitional care team in order to strengthen connection to services for HUs.

Unique Accomplishment

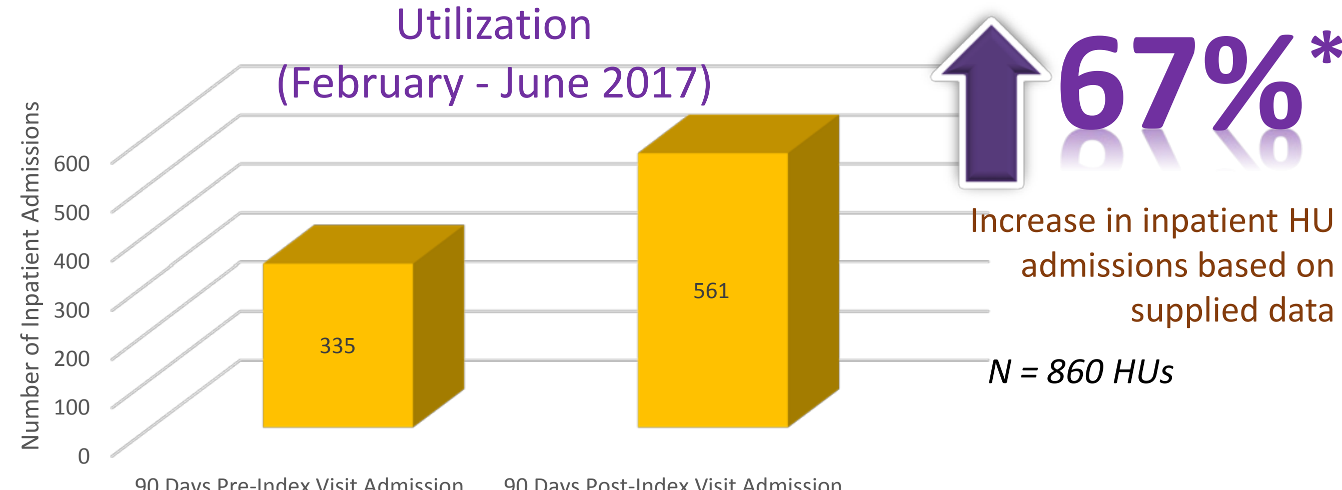
Utilizing transitions of care nurses for continuity of care in and out of hospital with 5 step touch point protocol post discharge to increase HU patient engagement.

Outcome Metrics

90 Days Pre vs. Post Index Visit Hospital Utilization		
90 Days Pre-Index Visit Admissions	90 Days Post-Index Visit Admissions	% Change
335	561	67%

The index admission is the first admission for each HU after the program start date that meets HU criteria (e.g. fourth or higher admission).

High Utilizer 90-Day Pre- vs. Post-Hospital Utilization (February - June 2017)



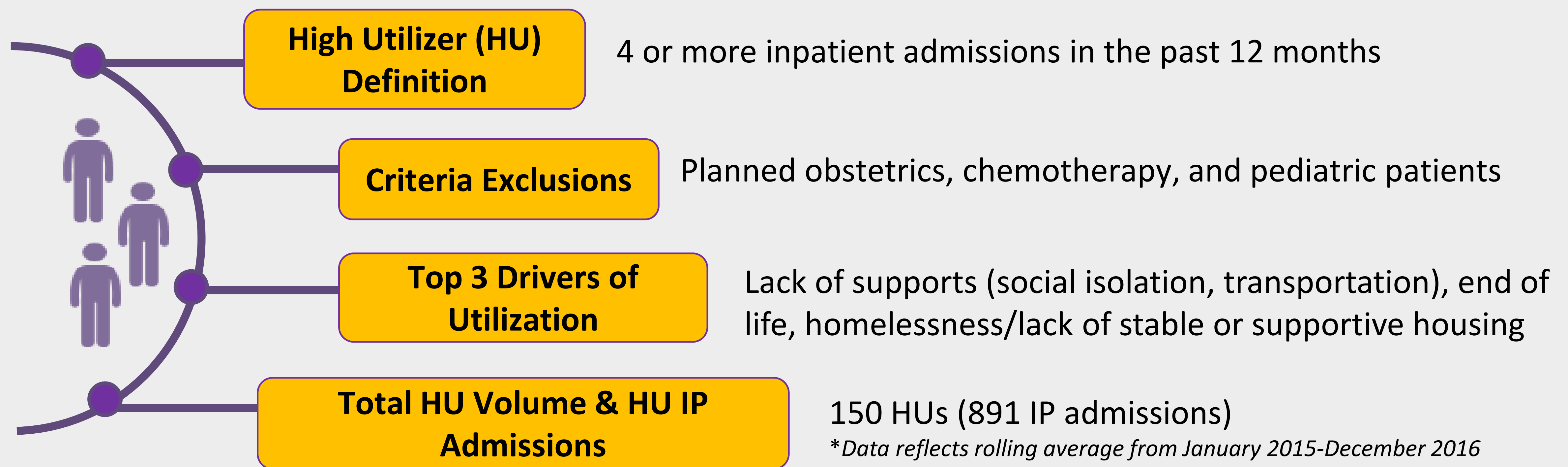
*Does not account for the impact of regression to the mean

Chemung County Choppers

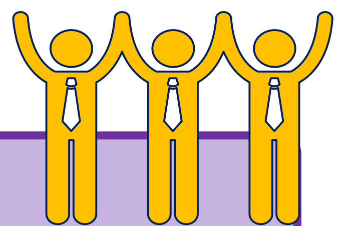
Finger Lakes Performing Provider System, Arnot Ogden Medical Center

NEW YORK STATE | Department of Health

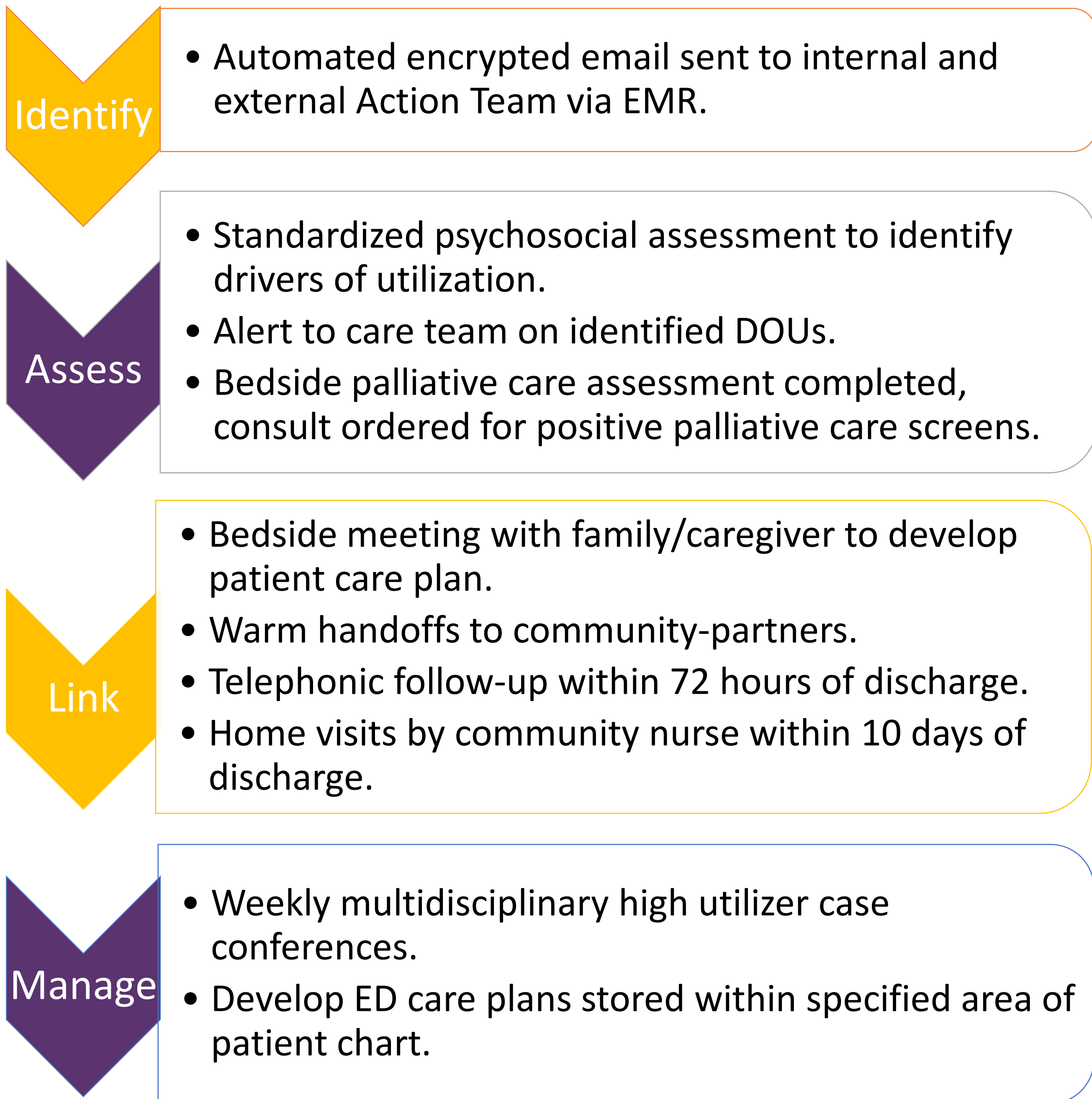
Our High Utilizer Population



Our Actions



HU Care Pathway



Success Story

Middle-aged female admitted to inpatient setting in late February.

Driver of Utilization:
Utilized emergency department as primary source for care provision for diabetes control complicated by gastroparesis.

How we addressed DOUs:
- Convened multidisciplinary care team to discuss patient needs and develop a care plan.
- Outpatient case manager from primary care physician (PCP) office conducted weekly follow-up calls.
- Care team arranged bi-monthly primary care appointments for general and advanced medical care.
- Provided education to contact PCP at onset of symptoms as an alternative to emergency department (ED).

Impact to date:
- Patient utilization has decreased from seven admissions in two months period, to one ED presentation and IP admission since being engaged in high utilizer program.

Our Impact

Partnerships

1 **CareFirst Palliative Care Services**: Provide bedside palliative care consults for high utilizer with positive assessment outcomes.

Unique Accomplishment

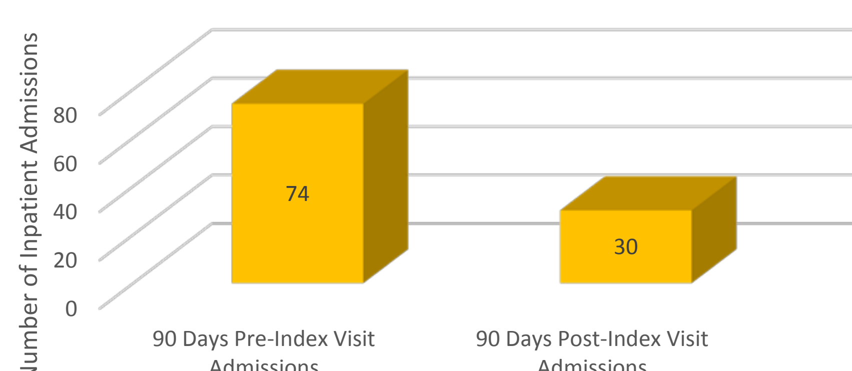
Conduct assessments for palliative care needs, and perform bedside consults with CareFirst – a partner palliative care provider.

Outcome Metrics

90 Days Pre vs. Post Index Visit Hospital Utilization		
90 Days Pre-Index Visit Admissions	90 Days Post-Index Visit Admissions	% Change
74	30	-60%

The index admission is the first admission for each HU after the program start date that meets HU criteria (e.g. fourth or higher admission).

High Utilizer 90-Day Pre- vs. Post- Hospital Utilization
(March - April 2017)



60%* Decrease in inpatient HU admissions

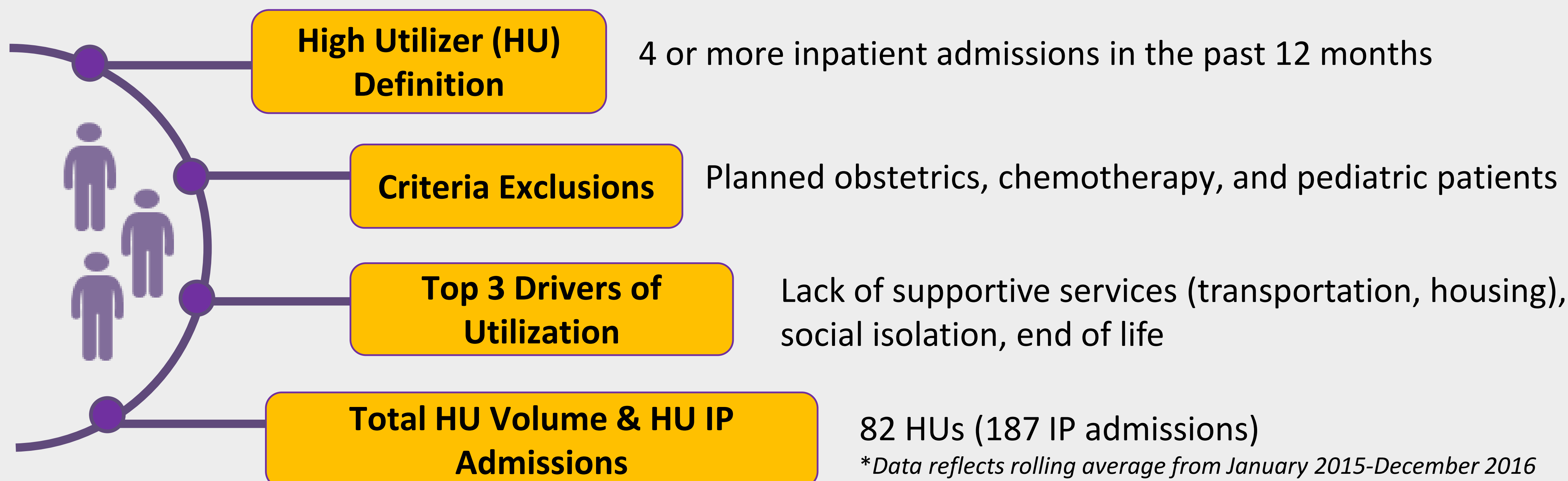
N = 58 HUs

Does not account for the impact of regression to the mean

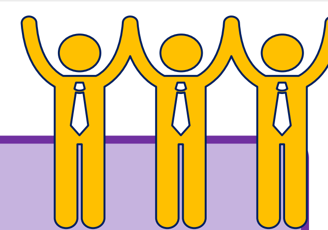
A.O. Fox Community Partnership

Leatherstocking Collaborative Health Partners, A.O. Fox Memorial Hospital

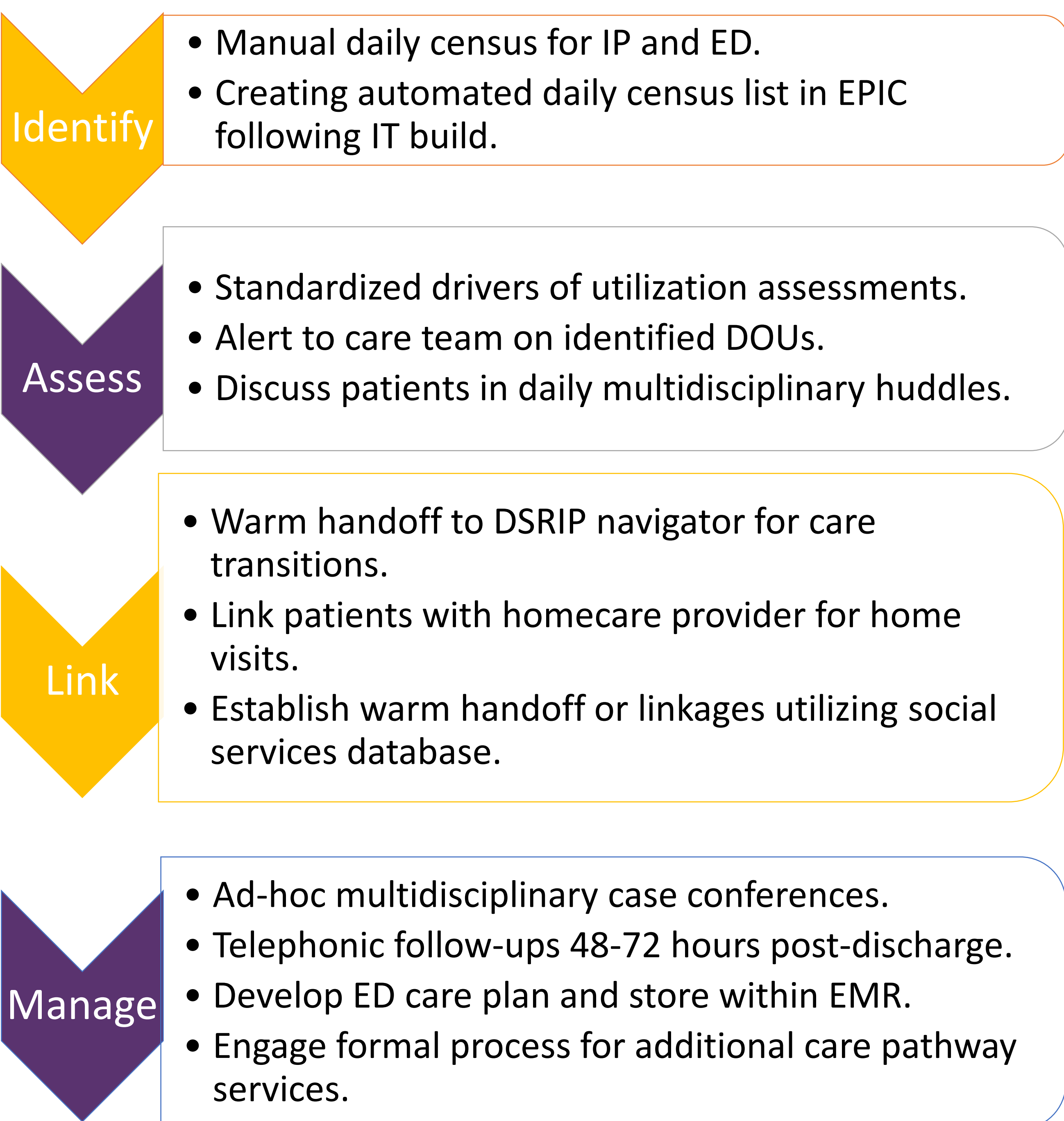
Our High Utilizer Population



Our Actions



HU Care Pathway



Success Story

Older male patient admitted to inpatient setting in late May.

Driver of Utilization:
Patient Engagement Coordinator identified patient presenting to hospital due to substance abuse issues compounded by multiple comorbidities.

How we addressed DOUs:
- Conducted drivers of utilization assessment at bedside.
- Arranged multidisciplinary bedside huddle with patient and care team to develop plan of care.
- Linked patient to short-term rehabilitation services.
- Located child care for patient's young child to allow patient to transition to short-term rehabilitation and advanced care services.

Impact to date:
- Patient utilization has decreased from four admissions over a three month period, to zero presentations or admissions since being engaged in high utilizer program.

Our Impact

Unique Accomplishment

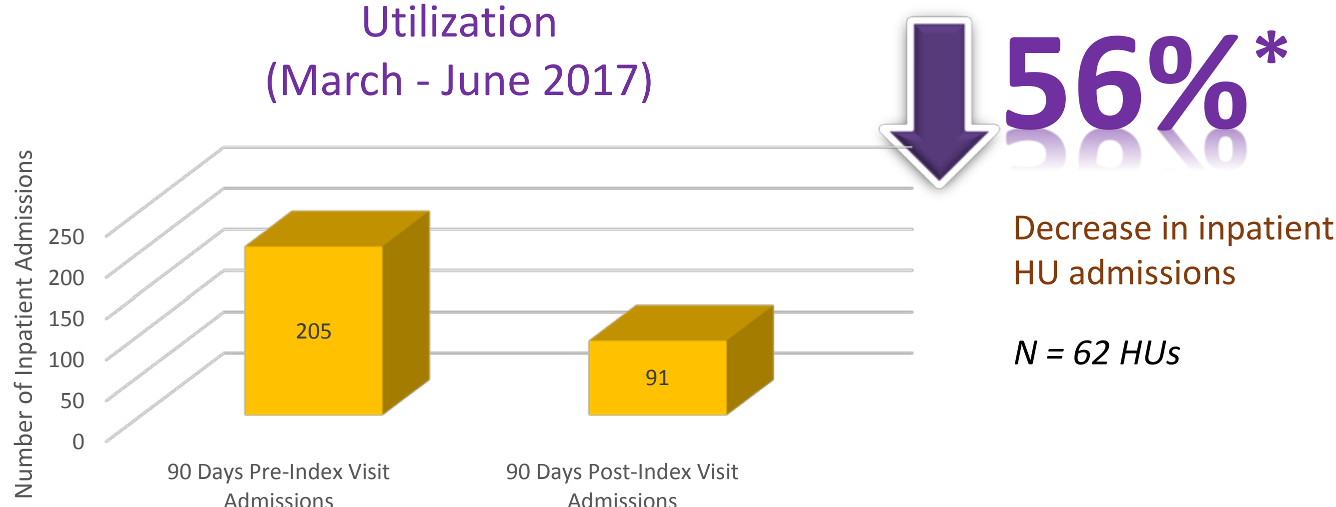
Restructured discharge planning department into care management and transitions program for high utilizers and 30-day readmission patient services.

Outcome Metrics

90 Days Pre vs. Post Index Visit Hospital Utilization		
90 Days Pre-Index Visit Admissions	90 Days Post-Index Visit Admissions	% Change
205	91	-56%

The index admission is the first admission for each HU after the program start date that meets HU criteria (e.g. fourth or higher admission).

High Utilizer 90-Day Pre- vs. Post- Hospital Utilization (March - June 2017)

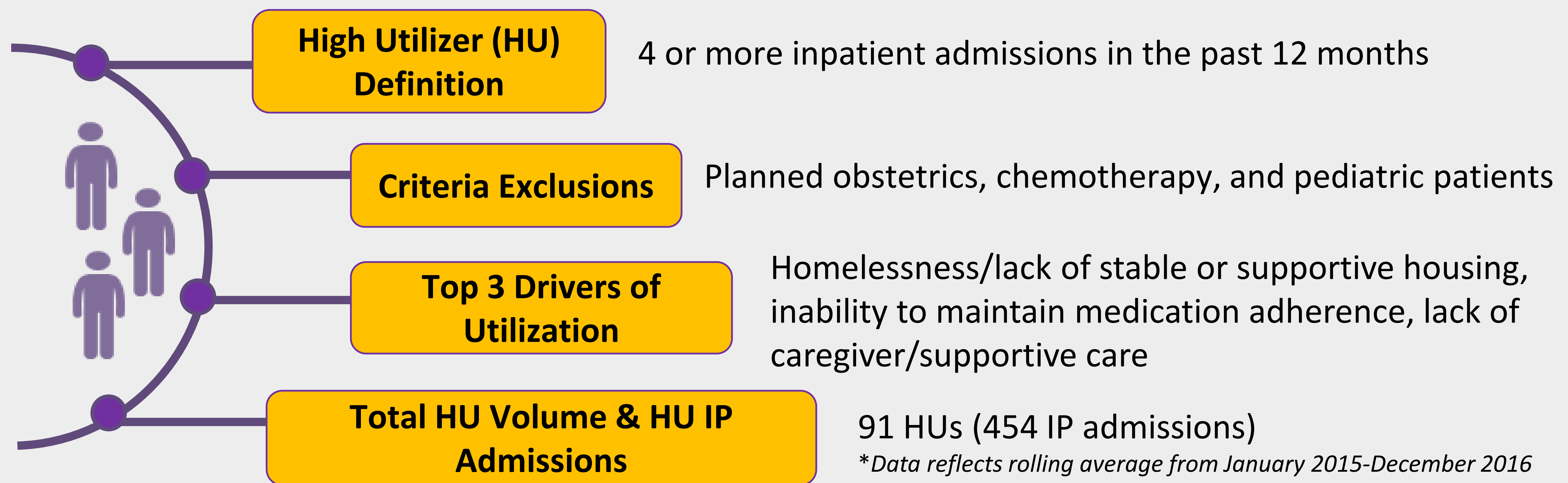


*Does not account for the impact of regression to the mean

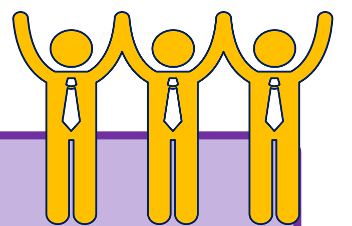
C² Niagara

Millennium Collaborative Care, Niagara Falls Memorial Medical Center

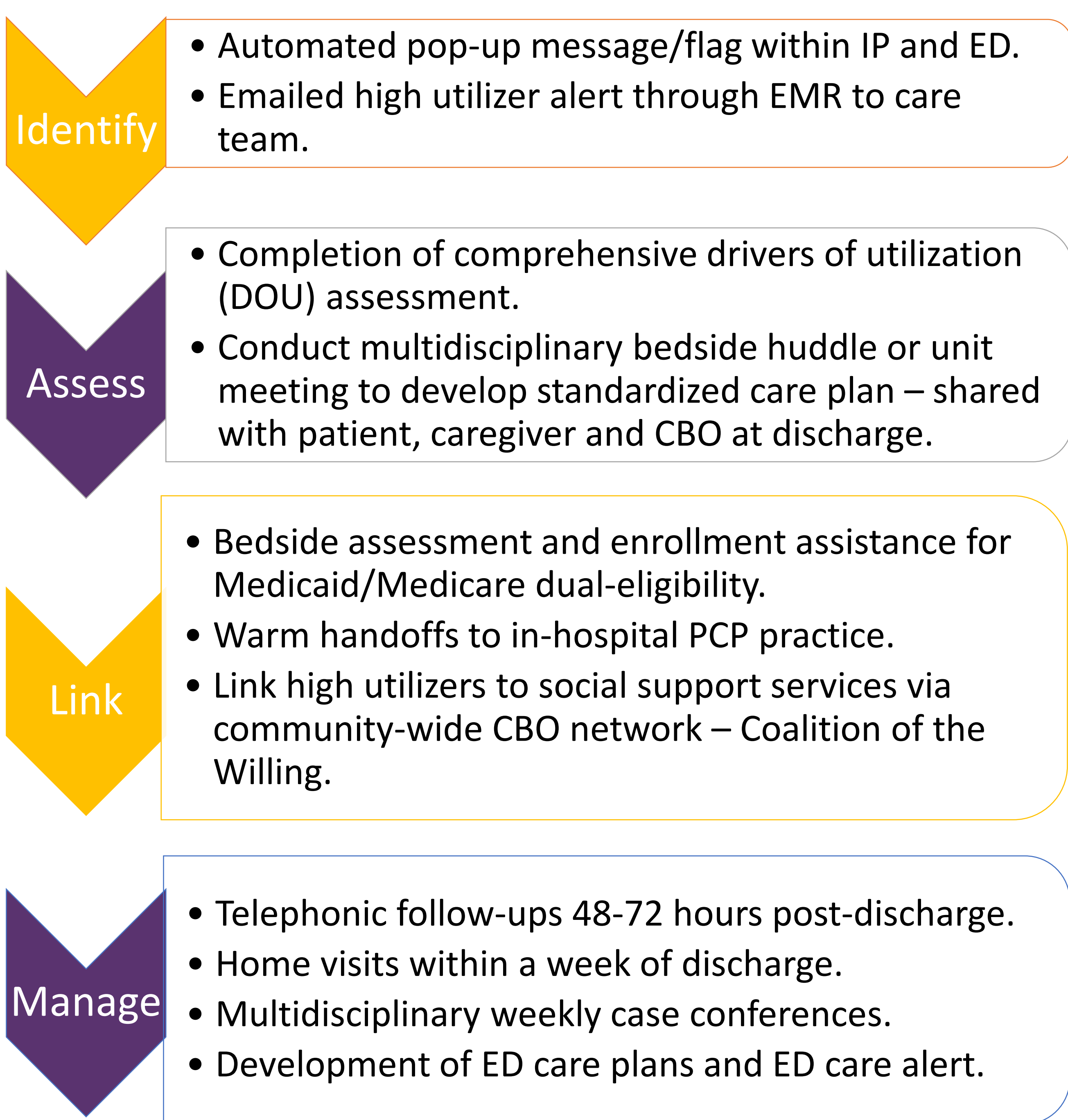
Our High Utilizer Population



Our Actions



HU Care Pathway



Success Story

Young female admitted to inpatient setting in early April.

Driver of Utilization:
Patient routinely presenting to hospital for solace from living situation stressors, including self-mutilation behaviors to de-stress.

How we addressed DOUs:

- Identified existing patient therapist and engaged are part of care team.
- Conducted bedside huddle to gain full understanding of patient needs.
- Developed care plan that included increased engagement with patient's therapist (weekly appointments) and trauma reduction service linkages.

Impact to date:

- Patient utilization has decreased from four admissions over a12 month period, to zero presentations or admissions since being engaged in high utilizer program.

Our Impact

Partnerships

1. **Niagara County Mental Health**: Engaged high utilizers in need of supportive housing services.

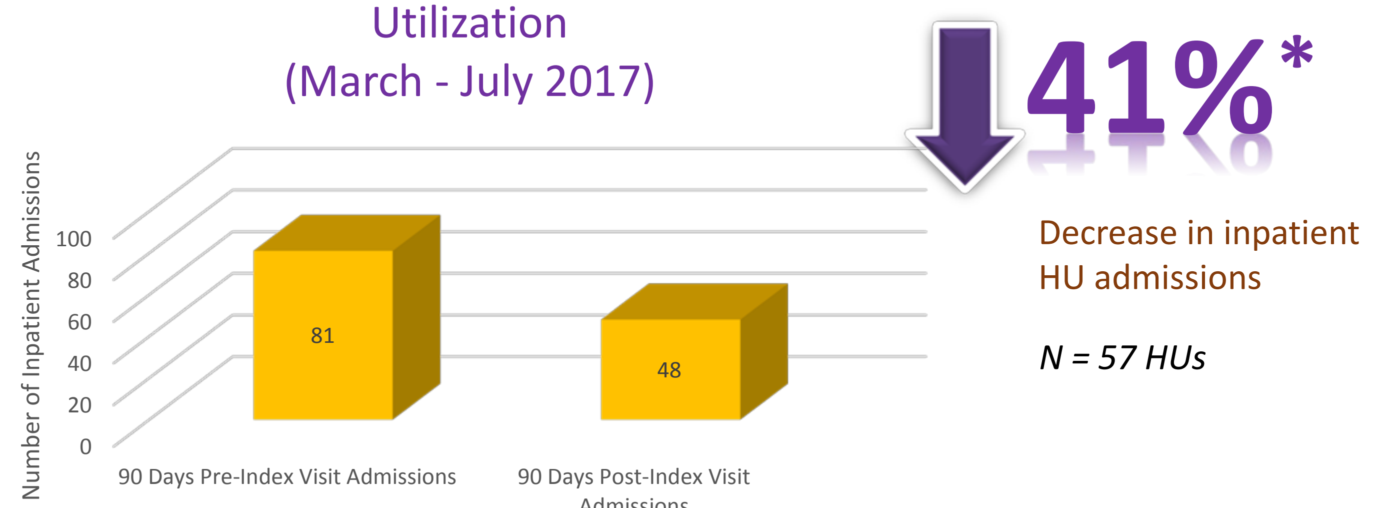
Unique Accomplishment

Developed community-wide resource of CBOs, known as the "Coalition of the Willing", to mutually engage for various patient needs associated with social determinants of health.

Outcome Metrics

90 Days Pre vs. Post Index Visit Hospital Utilization		
90 Days Pre-Index Visit Admissions	90 Days Post-Index Visit Admissions	% Change
81	48	-41%

The index admission is the first admission for each HU after the program start date that meets HU criteria (e.g. fourth or higher admission).

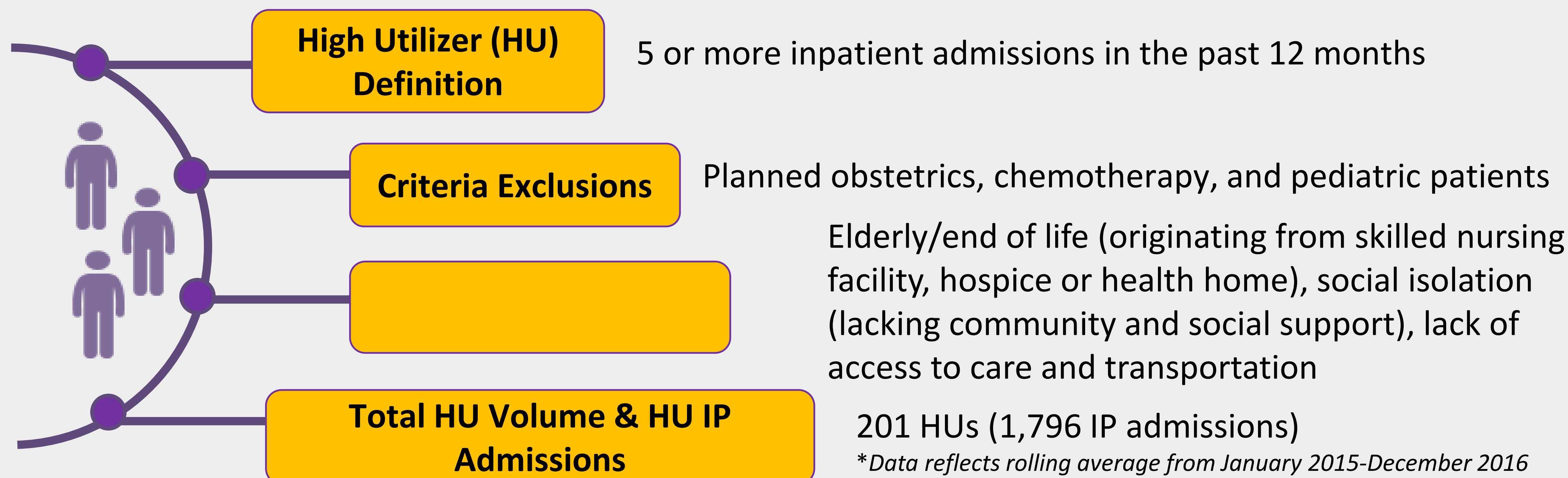


*Does not account for the impact of regression to the mean

Readmission Warriors

Montefiore Hudson Valley Collaborative, Vassar Brothers Medical Center

Our High Utilizer Population



High Utilizer (HU) Definition: 5 or more inpatient admissions in the past 12 months

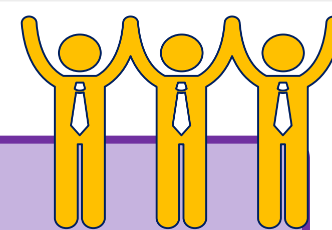
Criteria Exclusions: Planned obstetrics, chemotherapy, and pediatric patients

Elderly/end of life (originating from skilled nursing facility, hospice or health home), social isolation (lacking community and social support), lack of access to care and transportation

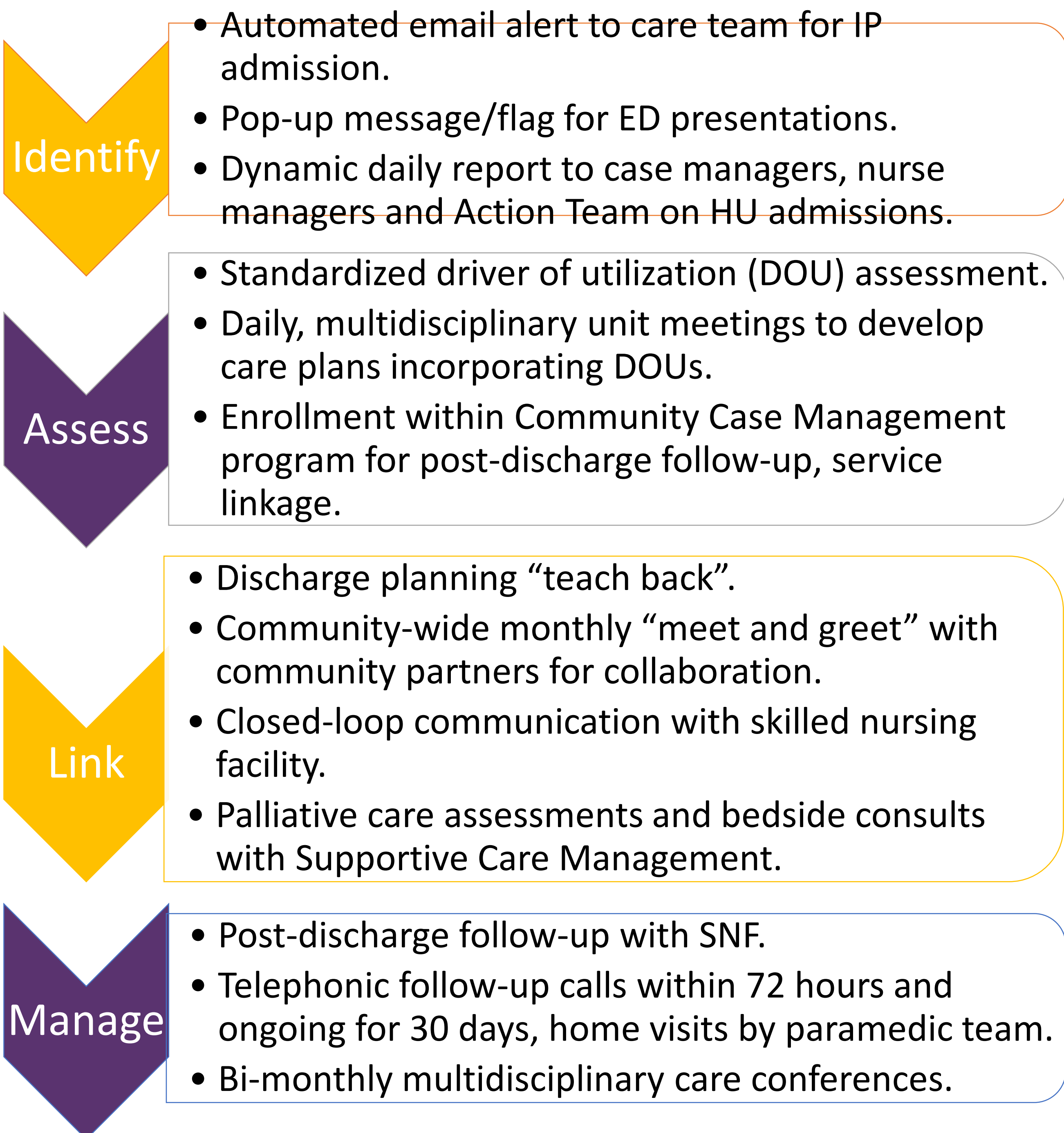
Total HU Volume & HU IP Admissions: 201 HUs (1,796 IP admissions)

**Data reflects rolling average from January 2015-December 2016*

Our Actions



HU Care Pathway



Identify
- Automated email alert to care team for IP admission.
- Pop-up message/flag for ED presentations.
- Dynamic daily report to case managers, nurse managers and Action Team on HU admissions.

Assess
- Standardized driver of utilization (DOU) assessment.
- Daily, multidisciplinary unit meetings to develop care plans incorporating DOUs.
- Enrollment within Community Case Management program for post-discharge follow-up, service linkage.

Link
- Discharge planning “teach back”.
- Community-wide monthly “meet and greet” with community partners for collaboration.
- Closed-loop communication with skilled nursing facility.
- Palliative care assessments and bedside consults with Supportive Care Management.

Manage
- Post-discharge follow-up with SNF.
- Telephonic follow-up calls within 72 hours and ongoing for 30 days, home visits by paramedic team.
- Bi-monthly multidisciplinary care conferences.

Success Story

Geriatric female patient admitted to inpatient setting in mid-March.

Driver of Utilization:
Patient lacked identifiable primary care physician and was non-compliant with medications.

How we addressed DOUs:
- Case manager met with patient to identify primary drivers of utilization, determined patient was non-compliant with medications resulting in chronic heart failure.
- Patient lacked knowledge of primary care provider for ongoing care management.
- Care team connected patient to outpatient primary care provider as well as supportive services (Meals on Wheels and homecare).
- Case manager provided ongoing patient follow-up for PCP appointment adherence and additional care needs.

Impact to date:
- Patient utilization has decreased from 14 admissions over a 12 month period, to one ED presentation and IP admission since being engaged in high utilizer program.

Our Impact

Partnerships

1. **Wingate Healthcare**: Additional skilled-nursing facility engaged in closed-feedback loop and post-discharge follow-up.
2. **HealthQuest Supportive Care Management**: Provide bedside palliative care consults and post-discharge palliative care services.

Unique Accomplishment

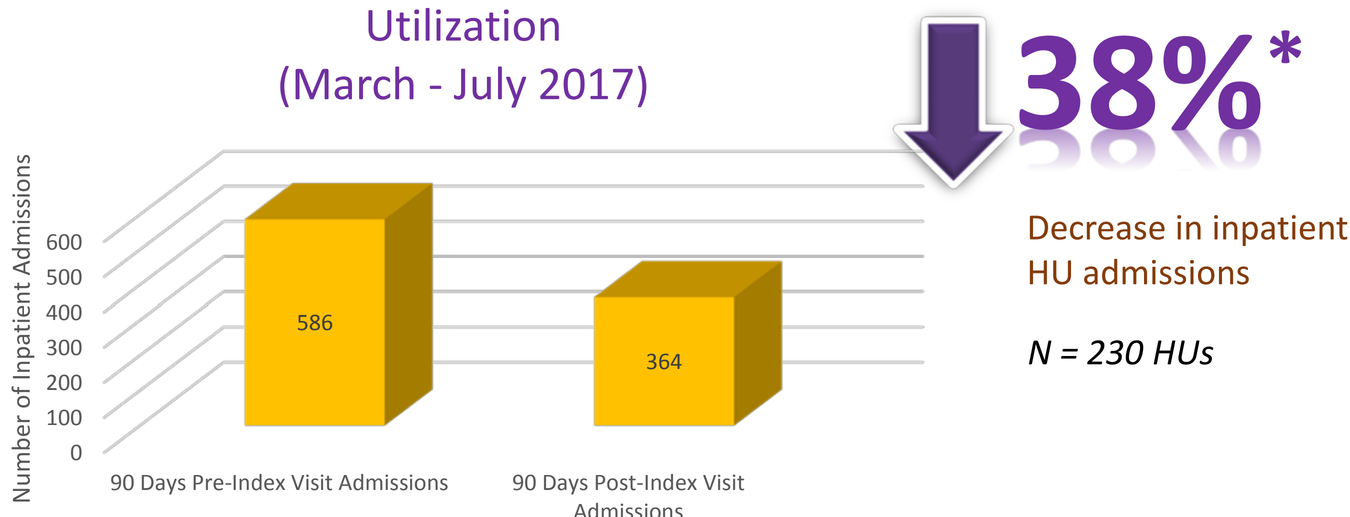
Developed two-way warm handoff and closed-feedback communication with skilled-nursing facilities for care planning and readmission reduction.

Outcome Metrics

90 Days Pre vs. Post Index Visit Hospital Utilization		
90 Days Pre-Index Visit Admissions	90 Days Post-Index Visit Admissions	% Change
586	364	-38%

The index admission is the first admission for each HU after the program start date that meets HU criteria (e.g. fourth or higher admission).

High Utilizer 90-Day Pre- vs. Post- Hospital Utilization
(March - July 2017)

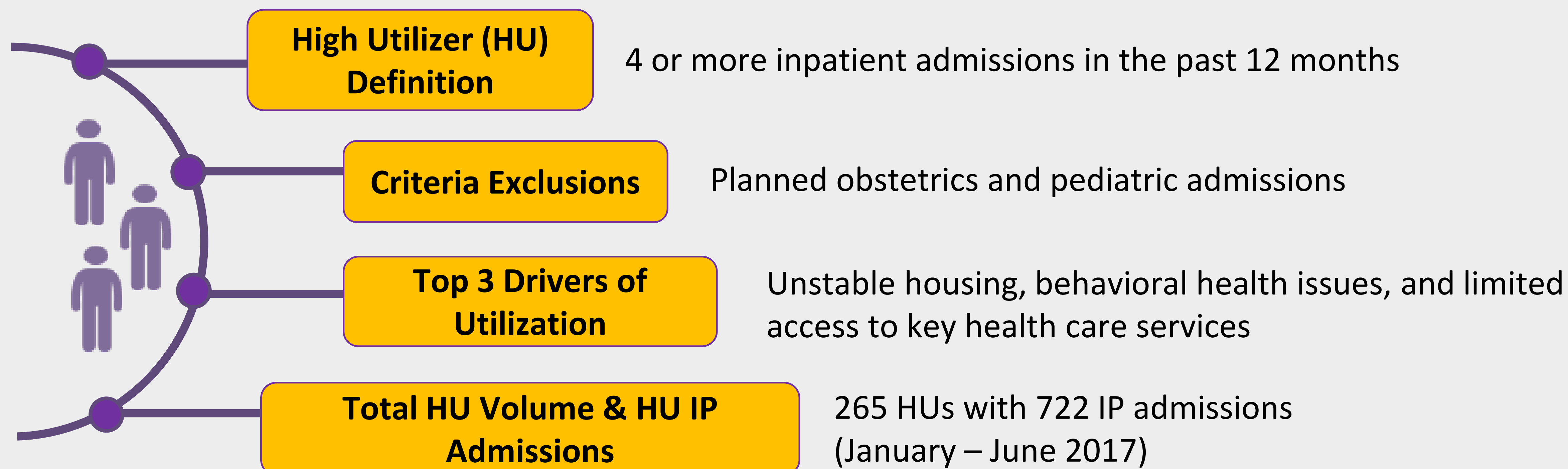


**Does not account for the impact of regression to the mean*

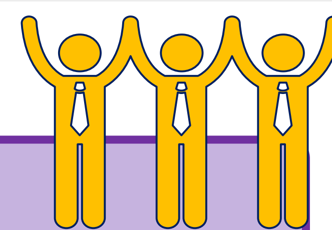
BK Bridges

Mt. Sinai PPS, The Brooklyn Hospital Center

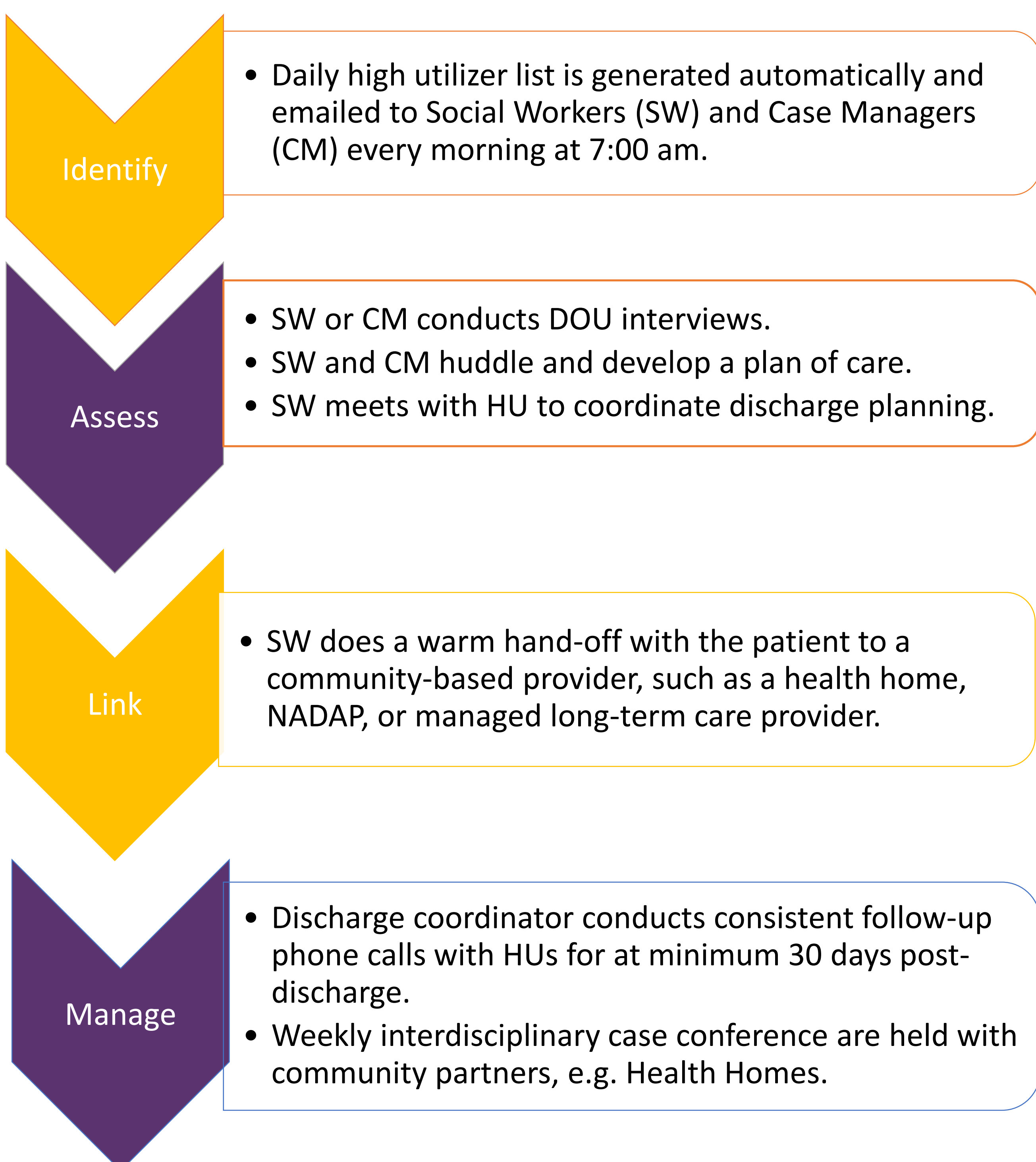
Our High Utilizer Population



Our Actions



HU Care Pathway



Success Story

Older male patient with end-stage renal disease and congestive heart failure, with four admissions and 13 ED visits from Feb to April 2017.

Driver of Utilization:

Identified dialysis center is far from the patient's home, and the patient preferred to come to the ED for dialysis.

How we addressed DOUs:

- The Action Team assessed the possibility to switch the patient's dialysis center to TBHC, however, it was determined that changing facilities was very challenging.
- Additionally, the Action Team contacted the patient's case manager at the assigned dialysis center, who then visited the ED for an in-person introduction.
- The ED leadership sent an ED alert to the team with the case manager's contact information and instructions to transfer the patient to his assigned dialysis site when the patient arrives.

Impact to date:

- Since the team made these changes, the patient has not had any inpatient admissions, and no ED visits since mid-April 2017.

Our Impact

Partnerships

1. **NADAP:** Community-based organization that provides care coordination, employment, substance use assessments, and health insurance enrollments.
2. **Village Care:** Provides HUs social support services and linkages to Medicaid enrollment services.
3. **Visiting Nurse Service (VNS) of New York:** Improves the transitions of care for patients by providing at-home medical support services post-discharge.

Unique Accomplishment

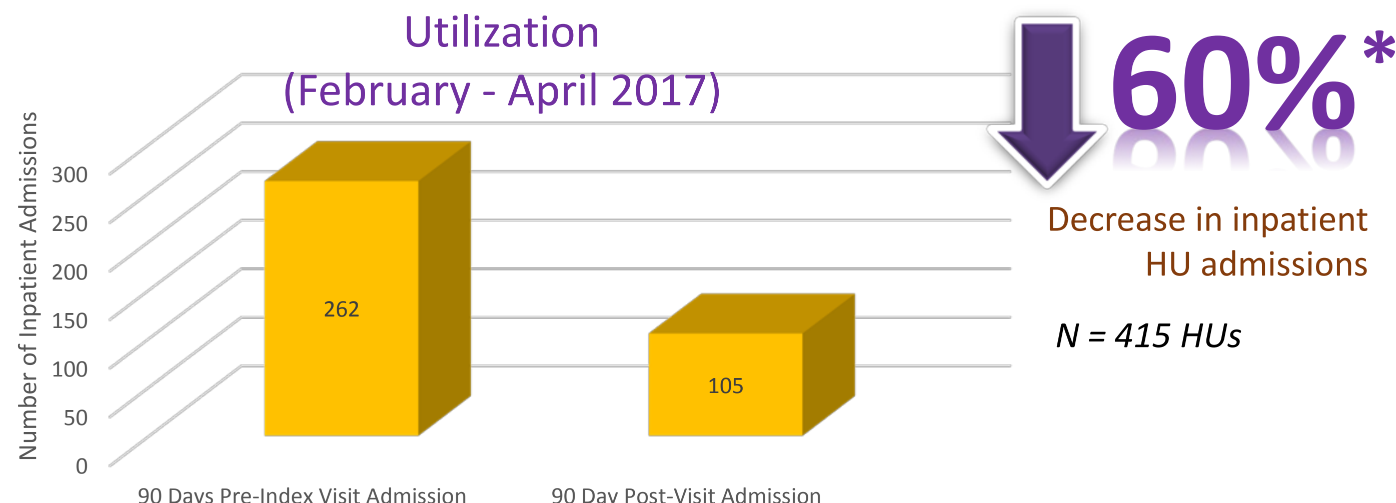
Weekly Case Conferences with Health Home partners to discuss high utilizer patients' transition and care plans.

Outcome Metrics

90 Days Pre vs. Post Index Visit Hospital Utilization		
90 Days Pre-Index Visit Admissions	90 Days Post-Index Visit Admissions	% Change
262	105	-60%

The index admission is the first admission for each HU after the program start date that meets HU criteria (e.g. fourth or higher admission).

High Utilizer 90-Day Pre- vs. Post-Hospital Utilization (February - April 2017)



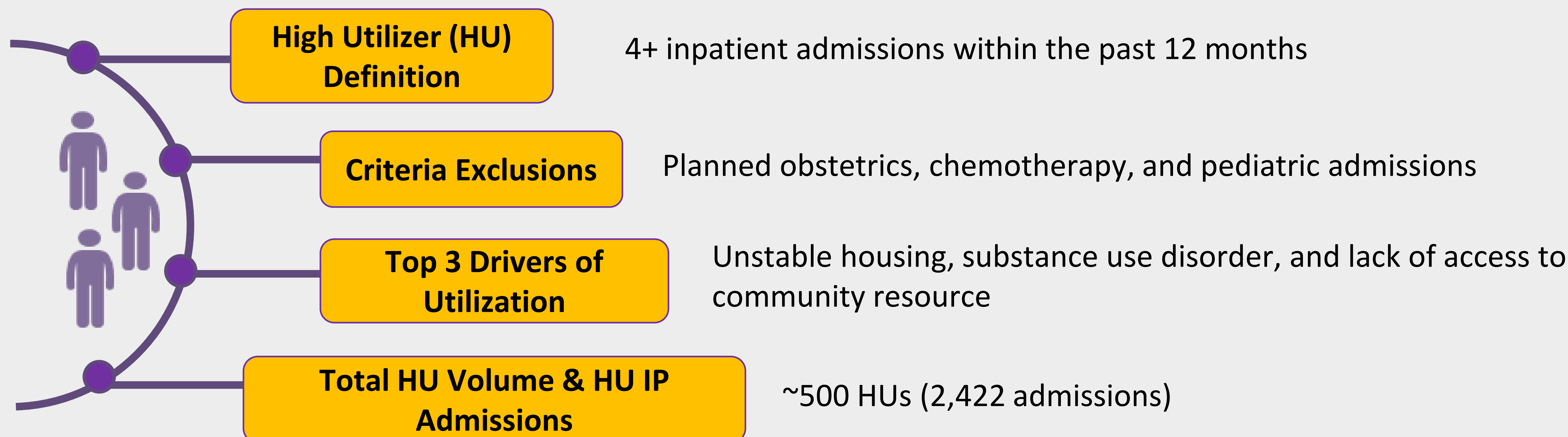
*Does not account for the impact of regression to the mean

Department of Health

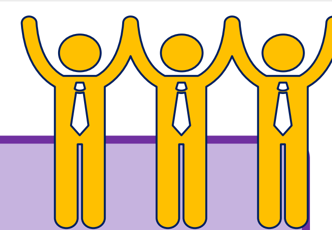
Nassau University High Utilizer Treatment Team

Nassau Queens PPS, Nassau University Medical Center

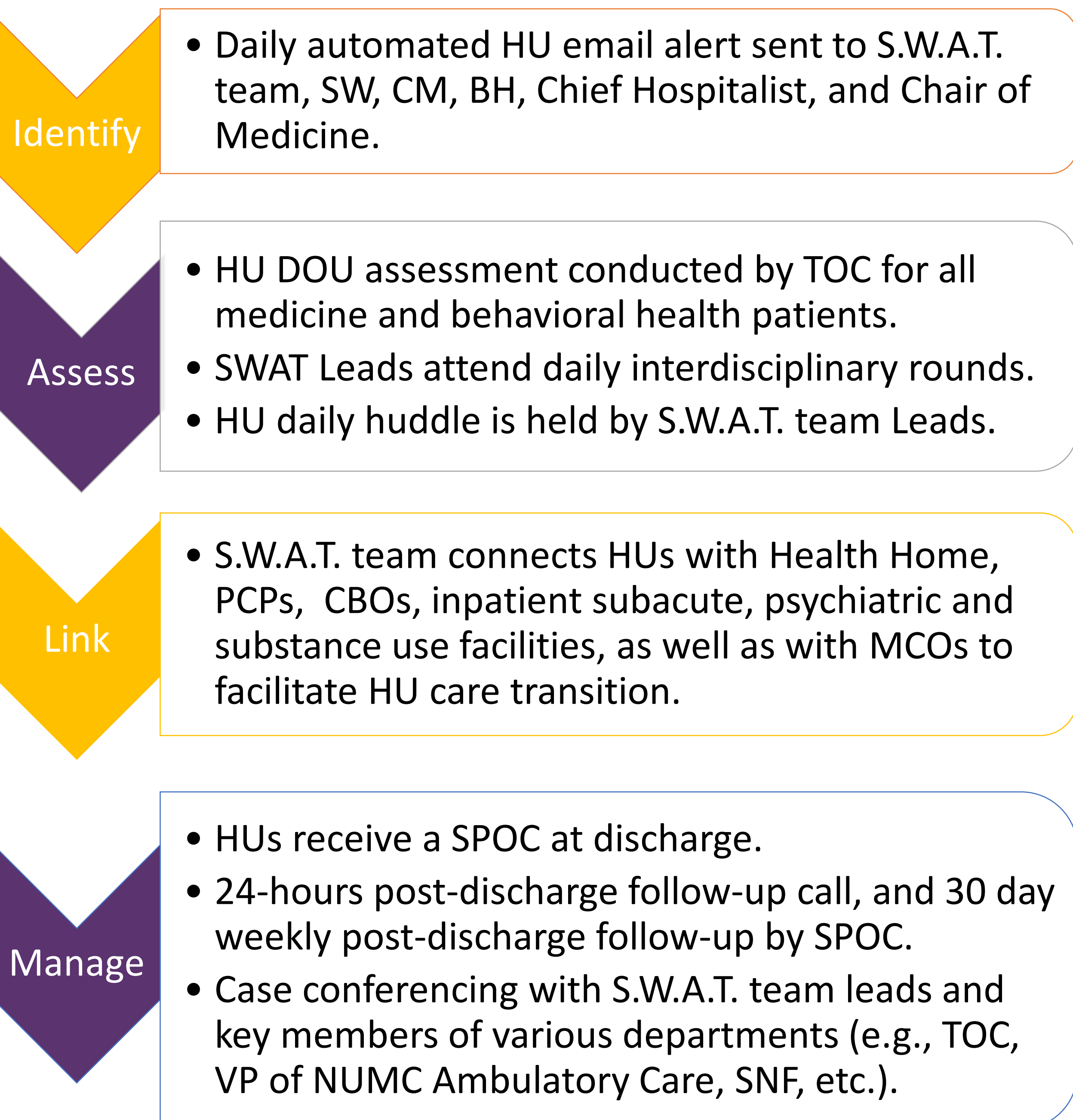
Our High Utilizer Population



Our Actions



HU Care Pathway



Success Story

Middle-aged female with COPD, severe malnutrition, mental illness, substance use disorders, and multiple sclerosis (MS), who had six admissions prior to index visit.

Driver of Utilization:

Drug seeking behavior, not following discharge plan, anxiety, lacking health literacy, and absence of transportation.

How we the Action Team addressed the DOUs:

- Connected with HU's CM for intensive case management.
- SW assisted with application for transportation service.
- Connected HU to SNF after last inpatient admission.
- Connected with discharging MD to resolve issues regarding administration of discharge medications.
- Weekly follow-ups with SNF and HH to ensure proactive transition and collaboration.

Impact to date:

- Since the team made these changes, the patient has not been back for an admission or ER visit in the past 8 weeks.
- Patient is receiving visits from Occupational and Physical Therapists, and a visiting nurse.

Our Impact

Partnerships

1. **Healthfirst:** Offers increased linkages into the community for high utilizers, especially related to care management, home health care, and transportation.
2. **Central Nassau Guidance Health Home:** Improve linkages into the community for high utilizers post-discharge, including intensive care management services.

Unique Accomplishment

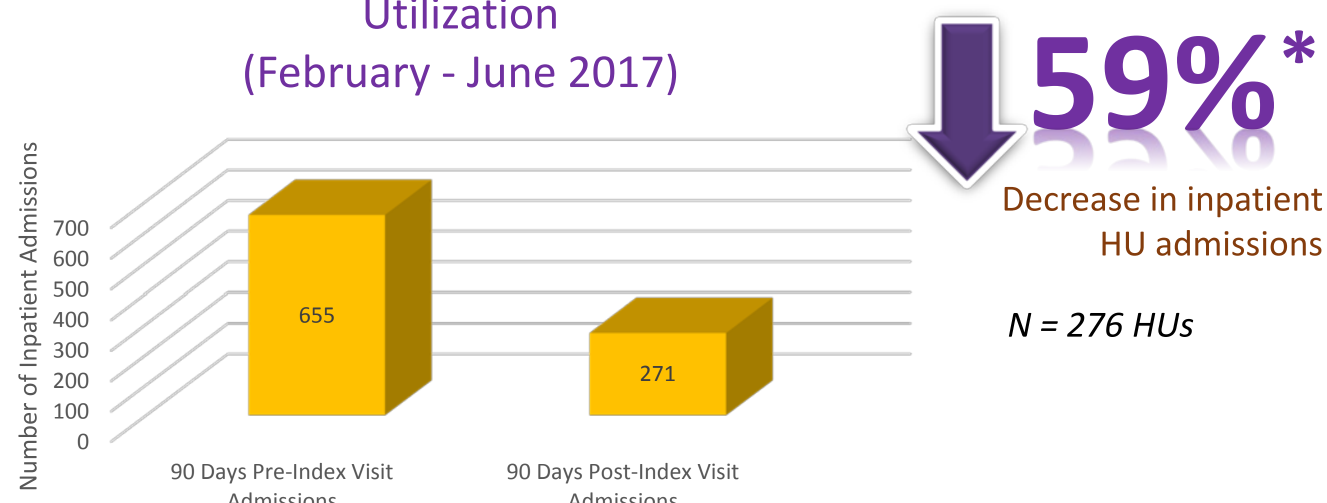
Dedicated single point of contact (SPOC) post discharge for all HUs to serve as a central point of care coordination post discharge.

Outcome Metrics

90 Days Pre vs. Post Index Visit Hospital Utilization		
90 Days Pre-Index Visit Admissions	90 Days Post-Index Visit Admissions	% Change
655	271	-59%

The index admission is the first admission for each HU after the program start date that meets HU criteria (e.g. fourth or higher admission).

High Utilizer 90-Day Pre- vs. Post-Hospital Utilization (February - June 2017)



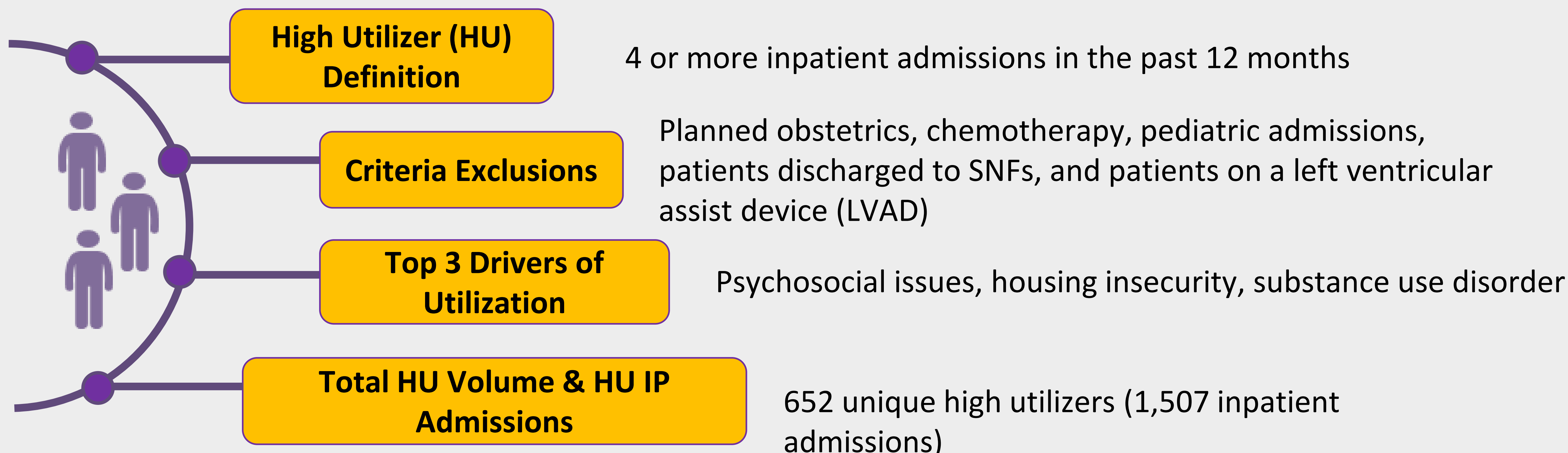
*Does not account for the impact of regression to the mean

NEW YORK STATE | Department of Health

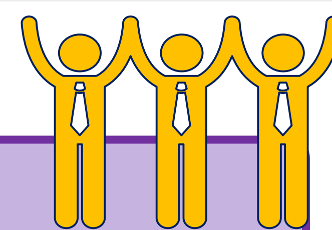
We Won’t See You In A Weill

New York Presbyterian, Weill Cornell Medical Center

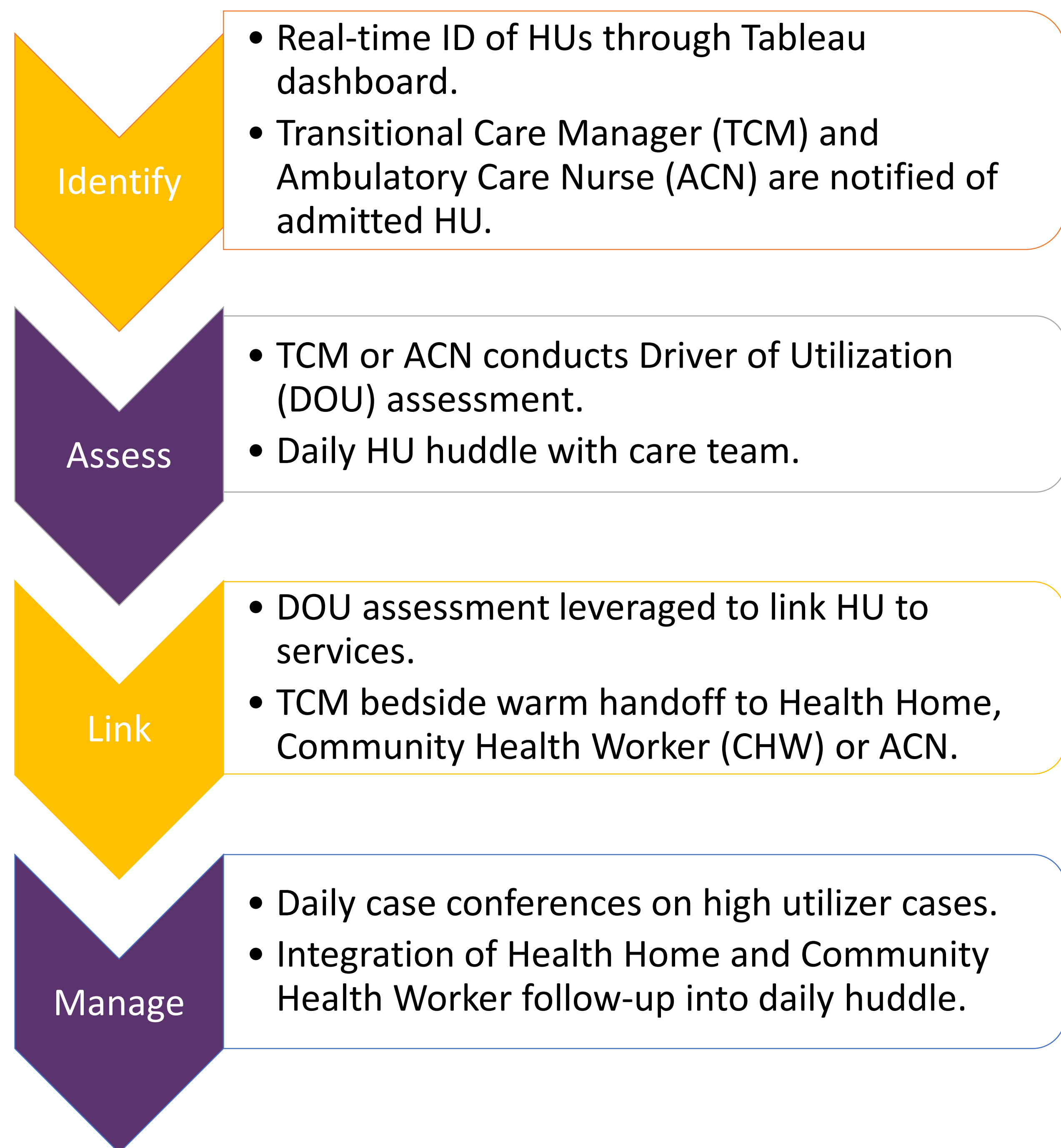
Our High Utilizer Population



Our Actions



HU Care Pathway



Success Story

Older male with four admissions in 12 months. Patient has chronic osteomyelitis, diabetes mellitus and lymphoma.

Driver of Utilization:

Lack of transportation, physical limitations in his home environment (i.e. stairs), inadequate living conditions – crowded basement with wife and disabled son, and food insecurity.

How we the Action Team addressed the DOUs:

- The Action Team connected the patient to a home visiting PCP and set him up with in-home IV infusion.
- CHWs conducted an in-home assessment, filled out a “Access-a-ride” application, and linked the patient to housing applications.
- The Action Team provided the family with referrals for food stamps, God’s Love We Deliver meal delivery, and a Health Home Care Manager.

Impact to date:

- The patient has not been back since June 3rd for an admission or ER visit.

Our Impact

Partnerships

1. **God’s Love We Deliver:** For high utilizers living with food insecurity and inadequate housing, this partnership serves to address these needs.
2. **The Bridge:** Provides housing, services for behavioral health, and substance abuse treatment, all of these which are common drivers of utilization at NYPH.

Unique Accomplishment

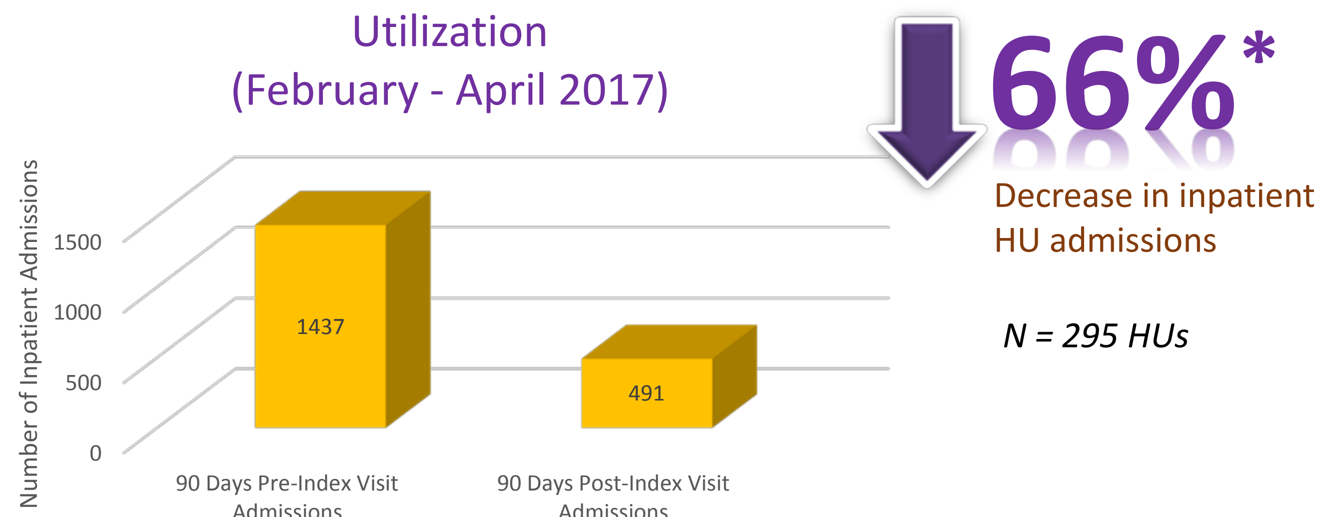
Dedicated Transitional Care Nurses (2 – 3) immediately respond upon receiving HU admission alert, to perform DOU interview at bedside.

Outcome Metrics

90 Days Pre vs. Post Index Visit Hospital Utilization		
90 Days Pre-Index Visit Admissions	90 Days Post-Index Visit Admissions	% Change
1,437	491	-66%

The index admission is the first admission for each HU after the program start date that meets HU criteria (e.g. fourth or higher admission).

High Utilizer 90-Day Pre- vs. Post-Hospital Utilization (February - April 2017)



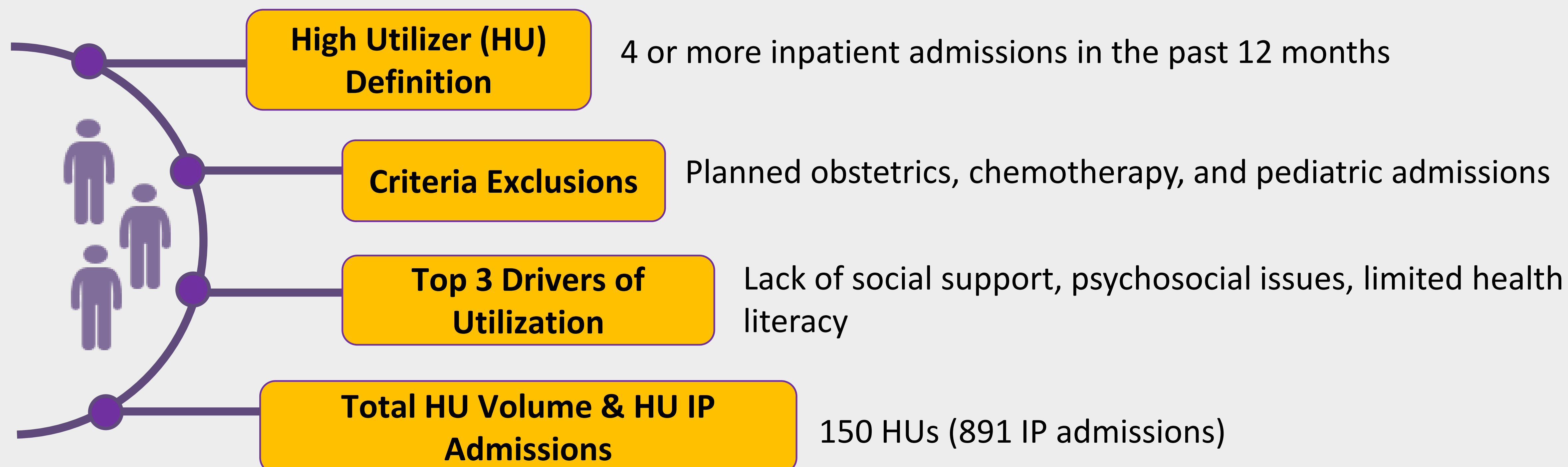
*Does not account for the impact of regression to the mean

The Mighty Queens

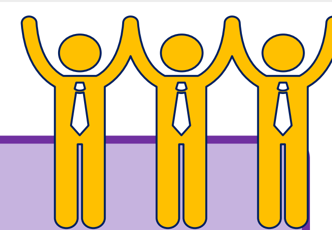
New York Presbyterian Queens

NEW YORK STATE | Department of Health

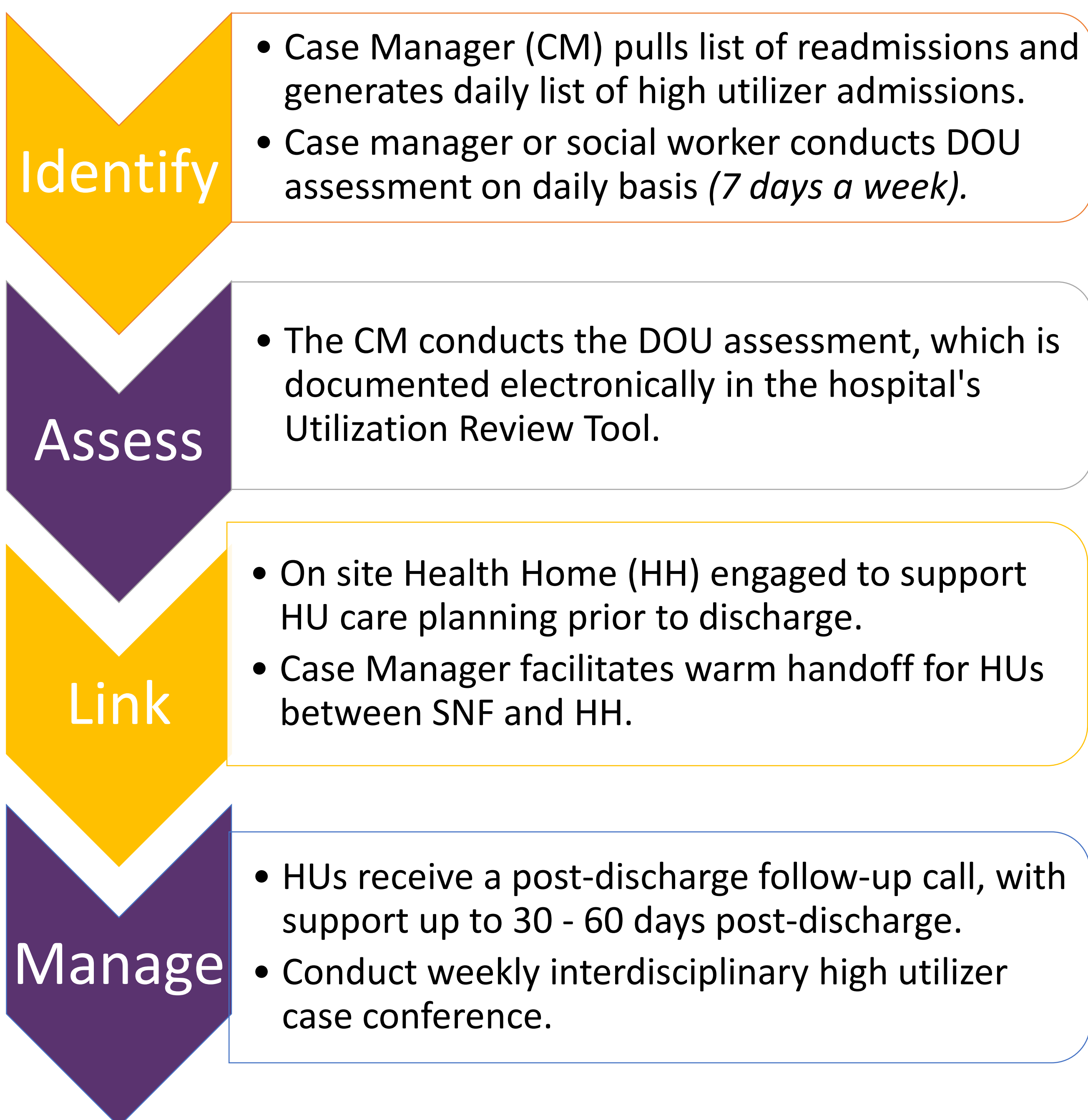
Our High Utilizer Population



Our Actions



HU Care Pathway



Success Story

Geriatric male patient with Alzheimer's was repeatedly sent from a SNF. Patient had 5 admissions in 12 months, and 4 admissions during the month of his index visit.

Driver of Utilization:

Social worker DOU assessment revealed that the patient was being prematurely sent to ED.

How we the Action Team addressed the DOUs:

- Social worker engaged members of the Action Team who spoke directly to the Director of Nursing about the patient's care and needs, as well as to why the patient was being referred to the ED repeatedly.
- A warm handoff was done for HU from hospital to SNF, with both hospital and SNF being more aware of patient's needs and care plan.
- SNF worked with patient and family to sign a Medical Orders for Life Sustaining Treatment (MOLST) form that would help guide future treatment and end-of-life care planning for the patient.

Impact to date:

Patient has not been admitted to hospital since the warm handoff to SNF and signing of MOLST form.

Our Impact

Partnerships

1. **Silvercrest SNF:** Provides long-term or palliative care services for HUs, with warm handoffs and closed-loop communication with hospital.
2. **Franklin SNF:** Provides long-term or palliative care services for HUs, with warm handoffs and closed-loop communication with hospital.

Unique Accomplishment

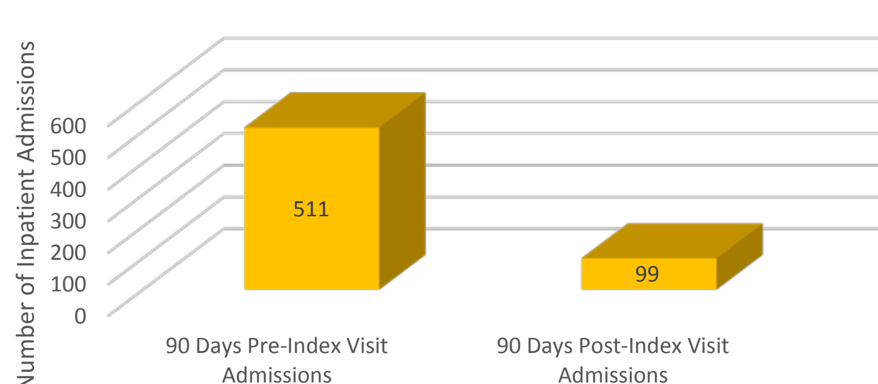
Enhanced communication with skilled nursing facility partners resulting in established care pathway with feedback loop.

Outcome Metrics

90 Days Pre vs. Post Index Visit Hospital Utilization		
90 Days Pre-Index Visit Admissions	90 Days Post-Index Visit Admissions	% Change
511	99	-81%

The index admission is the first admission for each HU after the program start date that meets HU criteria (e.g. fourth or higher admission).

High Utilizer 90-Day Pre- vs. Post-Hospital Utilization (February - May 2017)



81%*

Decrease in inpatient HU admissions

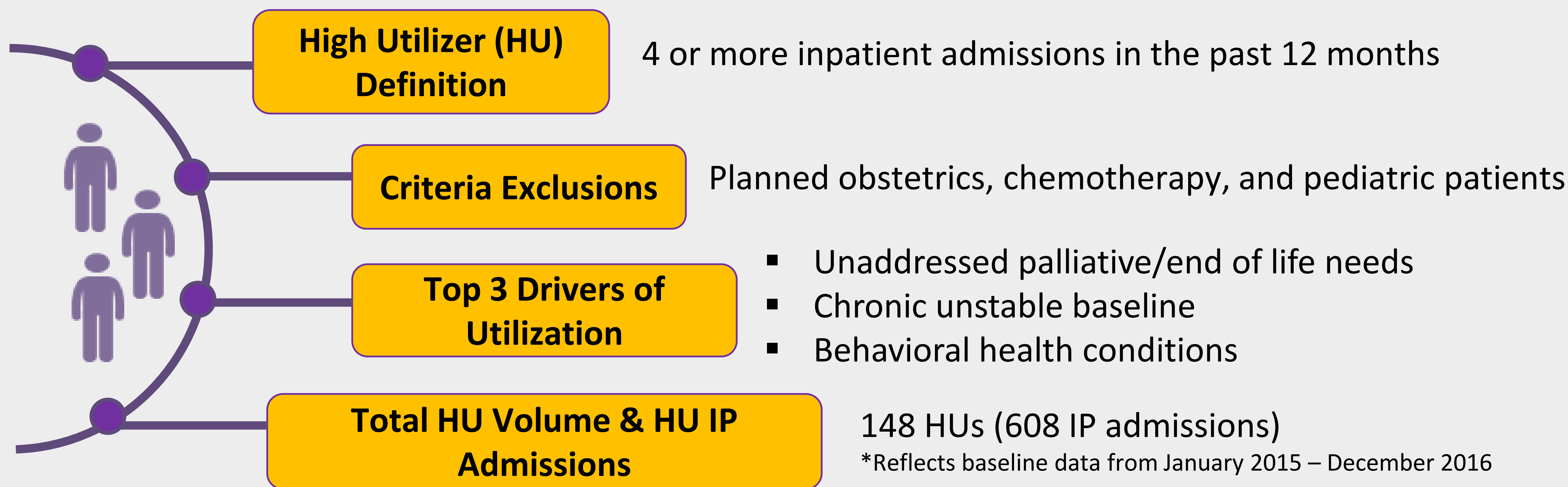
N = 176 HUs

**Does not account for the impact of regression to the mean*

E3 A-Team

North County Initiative, Samaritan Medical Center

Our High Utilizer Population



High Utilizer (HU) Definition: 4 or more inpatient admissions in the past 12 months

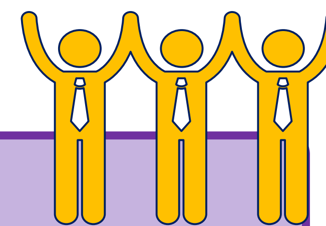
Criteria Exclusions: Planned obstetrics, chemotherapy, and pediatric patients

Top 3 Drivers of Utilization:
- Unaddressed palliative/end of life needs
- Chronic unstable baseline
- Behavioral health conditions

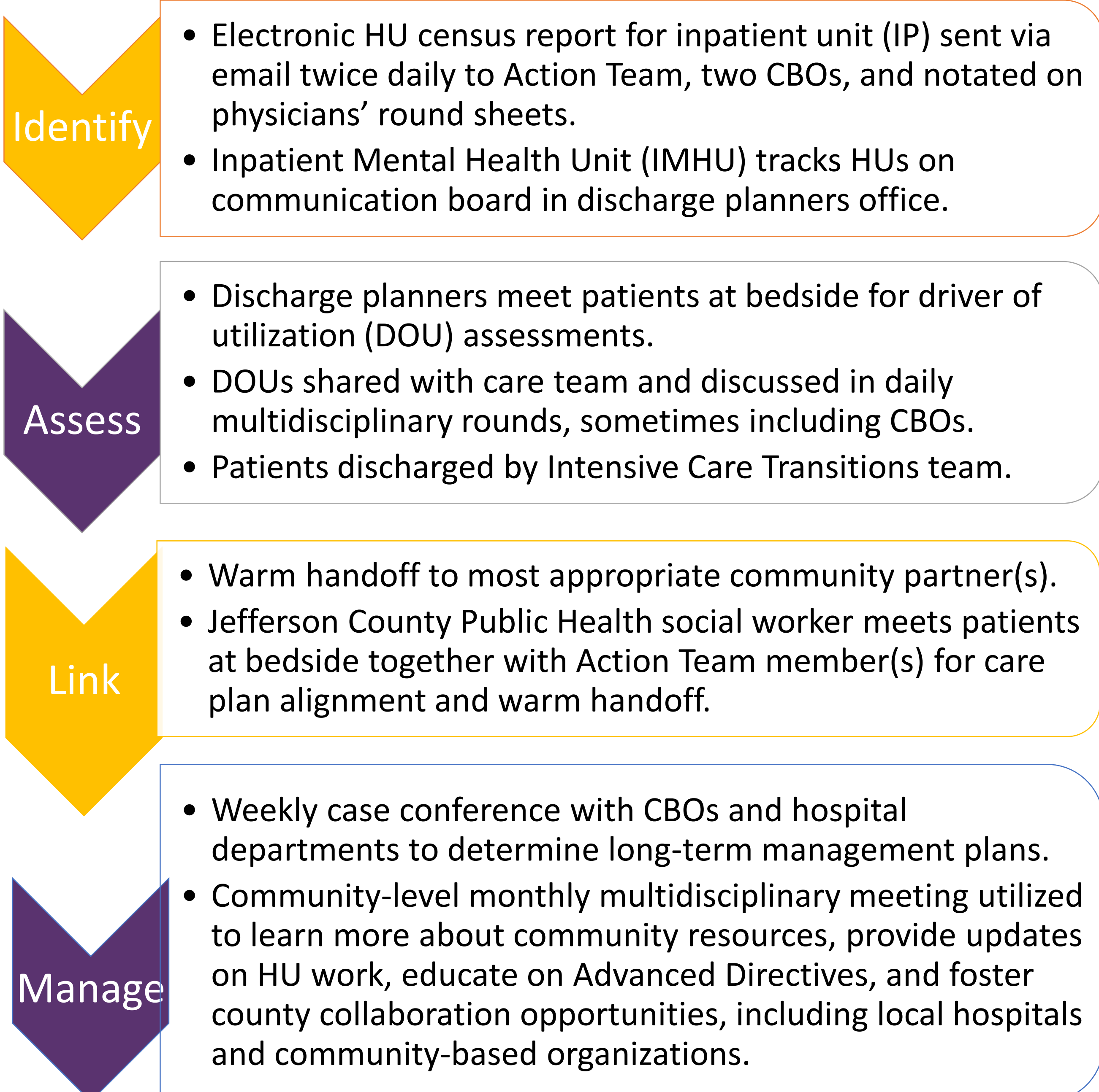
Total HU Volume & HU IP Admissions: 148 HUs (608 IP admissions)

*Reflects baseline data from January 2015 – December 2016

Our Actions



HU Care Pathway



Identify
- Electronic HU census report for inpatient unit (IP) sent via email twice daily to Action Team, two CBOs, and notated on physicians' round sheets.
- Inpatient Mental Health Unit (IMHU) tracks HUs on communication board in discharge planners office.

Assess
- Discharge planners meet patients at bedside for driver of utilization (DOU) assessments.
- DOUs shared with care team and discussed in daily multidisciplinary rounds, sometimes including CBOs.
- Patients discharged by Intensive Care Transitions team.

Link
- Warm handoff to most appropriate community partner(s).
- Jefferson County Public Health social worker meets patients at bedside together with Action Team member(s) for care plan alignment and warm handoff.

Manage
- Weekly case conference with CBOs and hospital departments to determine long-term management plans.
- Community-level monthly multidisciplinary meeting utilized to learn more about community resources, provide updates on HU work, educate on Advanced Directives, and foster county collaboration opportunities, including local hospitals and community-based organizations.

Success Story

Geriatric female with dementia and chronic aspiration.

Driver of Utilization:
Patient exhibited end of life symptoms, but lacked advanced directives of palliative care services. Family not accepting of home care and palliative care/hospice conversations.

How we addressed DOUs:
- Initiated ethics consult to address appropriate level of care, given diminished stage of quality of life.
- Placed feeding tube to address medical needs, as requested by family.
- Engaged clergy in care planning.
- Discussions with family led to acceptance of DNR and home care.
- Jefferson County Public Health social worker met at bedside and followed patients post-discharge.

Impact to date:
- Patient previously had 9 admissions in previous 12 months.
- Since the Action Team intervened at patient's last discharge (April 20th), patient has not had an admission.

Our Impact

Partnerships

1. **Northern Regional Center for Independent Living:** Linking HUs to community peer-to-peer supports for mental health and disabilities.
2. **North Country Family Health Center & Samaritan Family Health Network:** PCPs rebuilding patient relationships and sharing planning, follow-up and management with hospital.
3. **Jefferson County Public Health:** Linking HUs to home health services and follow-up.

Unique Accomplishment

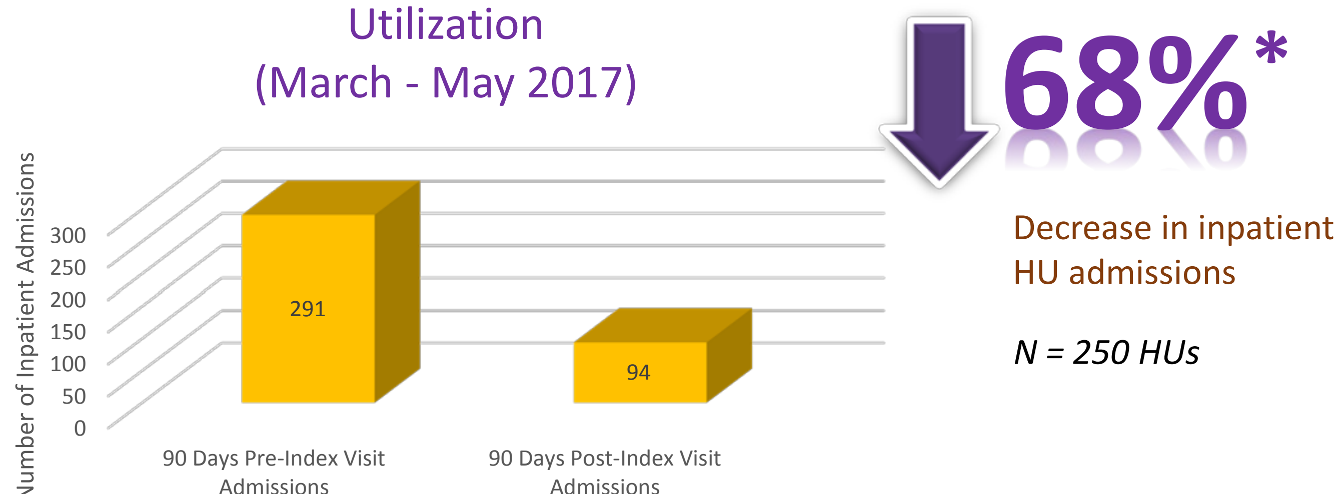
Dynamic HU report sent twice daily via Meditech automatic scheduler to hospital Action Team and two CBOs.

Outcome Metrics

90 Days Pre vs. Post Index Visit Hospital Utilization		
90 Days Pre Index Visit Admissions	90 Days Post Index Visit Admissions	% Change
291	94	-68%

The index admission is the first admission for each HU after the program start date that meets HU criteria (e.g. fourth or higher admission).

High Utilizer 90-Day Pre- vs. Post- Hospital Utilization (March - May 2017)



68%*

Decrease in inpatient HU admissions

N = 250 HUs

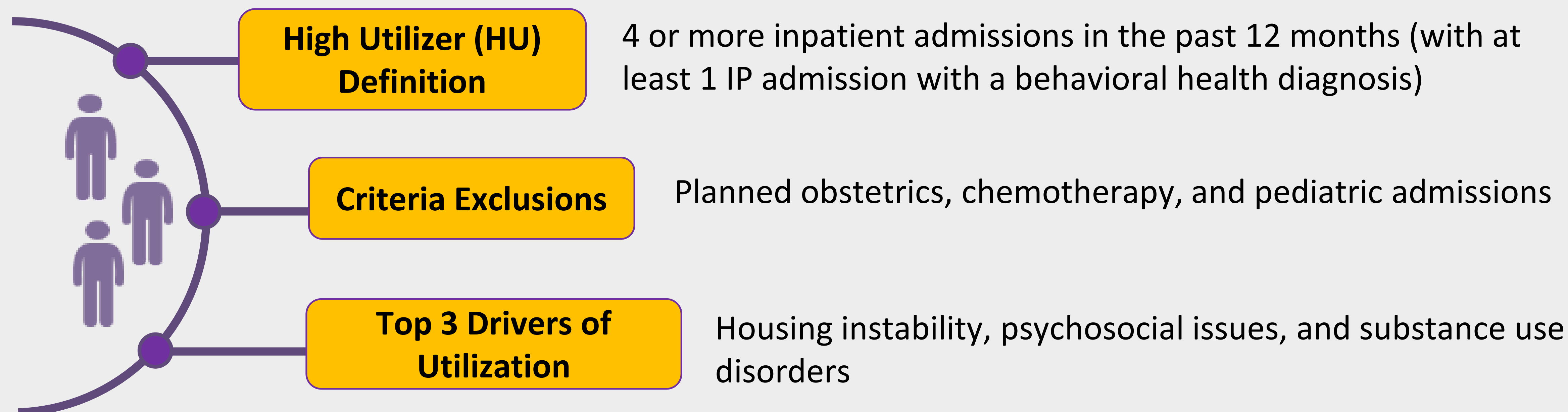
*Does not account for the impact of regression to the mean

Department of Health

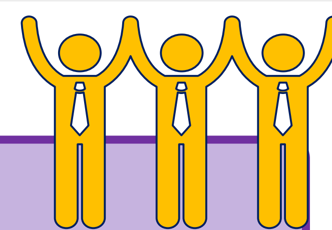
Brooklyn Interventional Specialists (the BIZ)

NYU Lutheran PPS, NYU Lutheran Medical Center

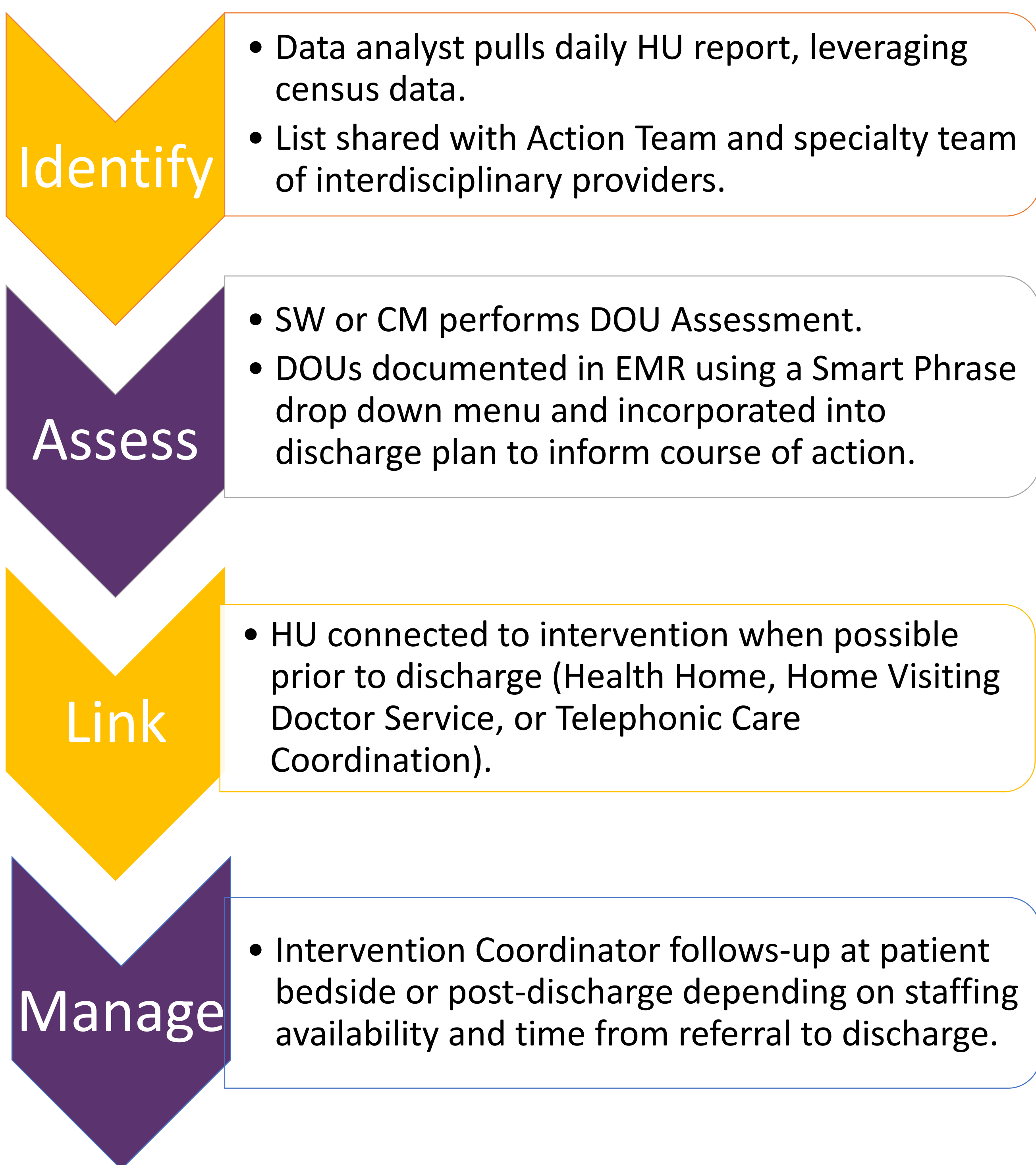
Our High Utilizer Population



Our Actions



HU Care Pathway



Success Story

Geriatric female patient with COPD, DM type 2, asthma, CHF, and CAD. Patient had four admissions prior to index visit regarding her chronic conditions.

Driver of Utilization:

Social isolation (living alone), utilizing ED when not feeling well, and medication management issues identified as DOUs.

How we addressed DOUs:

- Connected patient to PCP at the hospital, through the Family Health Center.
- Provided registered nurse and Home Health Aide services for medication management and ongoing care assessments.
- Followed-up with patient via house calls and referred patient to the CAMBA Health Home.

Impact to date:

- Since the team made these changes, the patient has not been back for an admission or ER visit.

Our Impact

Partnerships

1. **CAMBA:** Improves the referral process to Health Home. Throughout this partnership the referral process has become fully automated, increased efficiency, and has a 100% success rate.
2. **Healthfirst:** Assists with additional care coordination services for HU patients, such as home health care, care management, and medical social services.

Unique Accomplishment

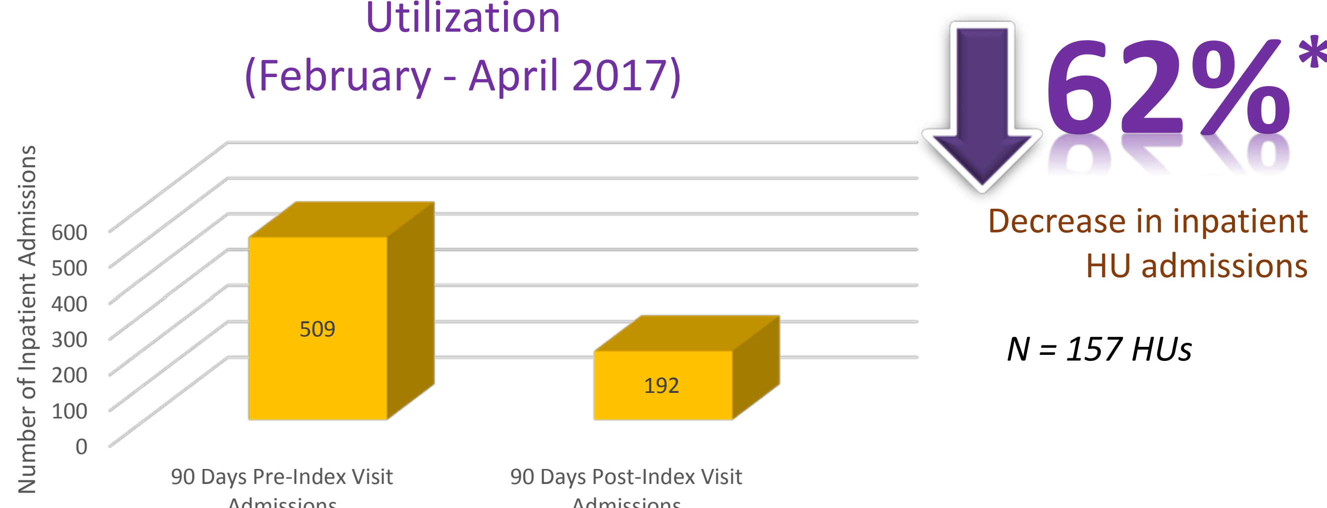
Creating and utilizing a tool called Smart Phrase that captures the DOU in the EMR, which social workers and care mangers employ when doing a DOU assessment upon notification.

Outcome Metrics

90 Days Pre vs. Post Index Visit Hospital Utilization		
90 Days Pre-Index Visit Admissions	90 Days Post-Index Visit Admissions	% Change
509	192	**-62%**

The index admission is the first admission for each HU after the program start date that meets HU criteria (e.g. fourth or higher admission).

High Utilizer 90-Day Pre- vs. Post-Hospital Utilization (February - April 2017)

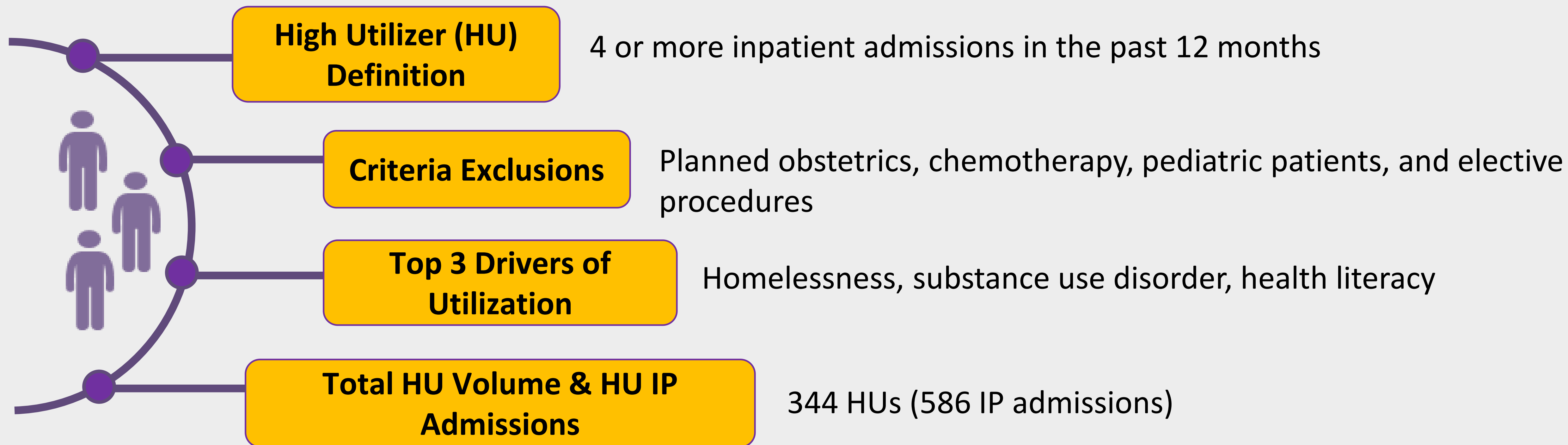


*Does not account for the impact of regression to the mean

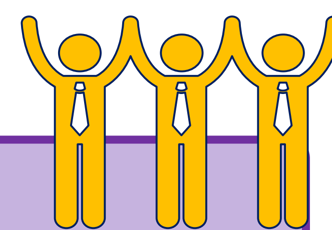
Cut Avoidable Admissions Through Teamwork

OneCity Health, Bellevue Hospital

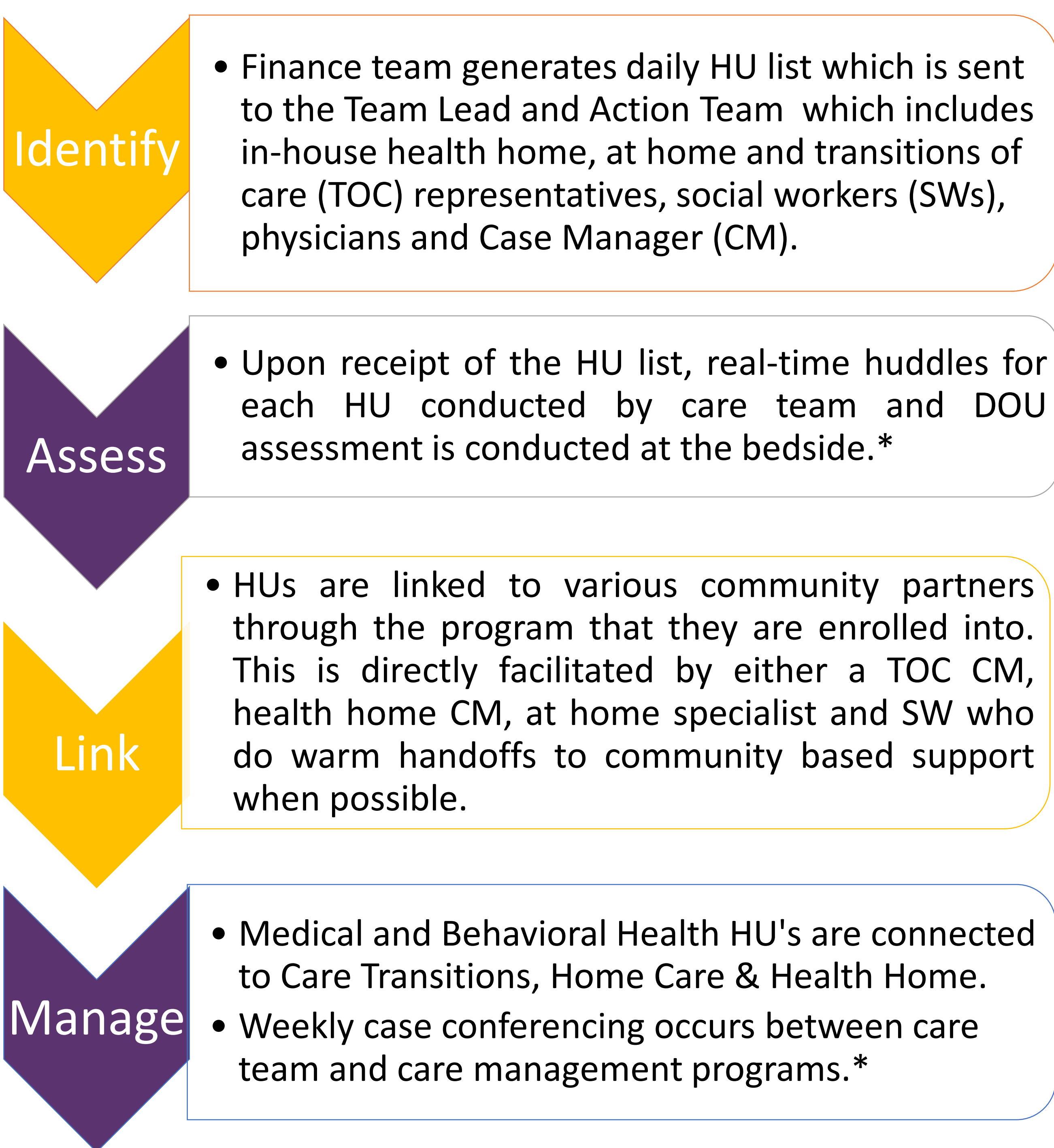
Our High Utilizer Population



Our Actions



HU Care Pathway



Success Story

Geriatric female who was undocumented with no family and no income. Patient diagnosed with heart failure, obstructive sleep apnea with a history of hypertension, arthritis, and breast cancer. Patient had 3 admissions prior to her index visit.

Driver of Utilization:

Patient was struggling with pain/weakness and needed ongoing care coordination. Lack of family support and limited health literacy exacerbated her situation.

How we addressed DOUs:

- Case manager referred patient to Home Care, which assigned a registered nurse to do home visits to provide medical and social supports.
- Home Care also arranged for a physical therapist to do home visits (3+ visits made), and a Social Worker to help navigate immigration issues.
- The Action Team case conferenced with the patient's community PCP, and worked with the Health Home Care Coordinator to reconnect the HU to the PCP.
- For ongoing support, the case was also reviewed with Care Transitions.

Impact to date:

Patient had one ED visit and no readmissions in 60 days since inpatient discharge.

Our Impact

Partnerships

1. **Department of Homeless Services (DHS):** Resource for team to provide transitional support housing for high volume of HUs with this need.
2. **OneCity Health PPS:** Provides behavioral health transitions of care personnel to better link Bellevue HUs to community-based care.

Unique Accomplishment

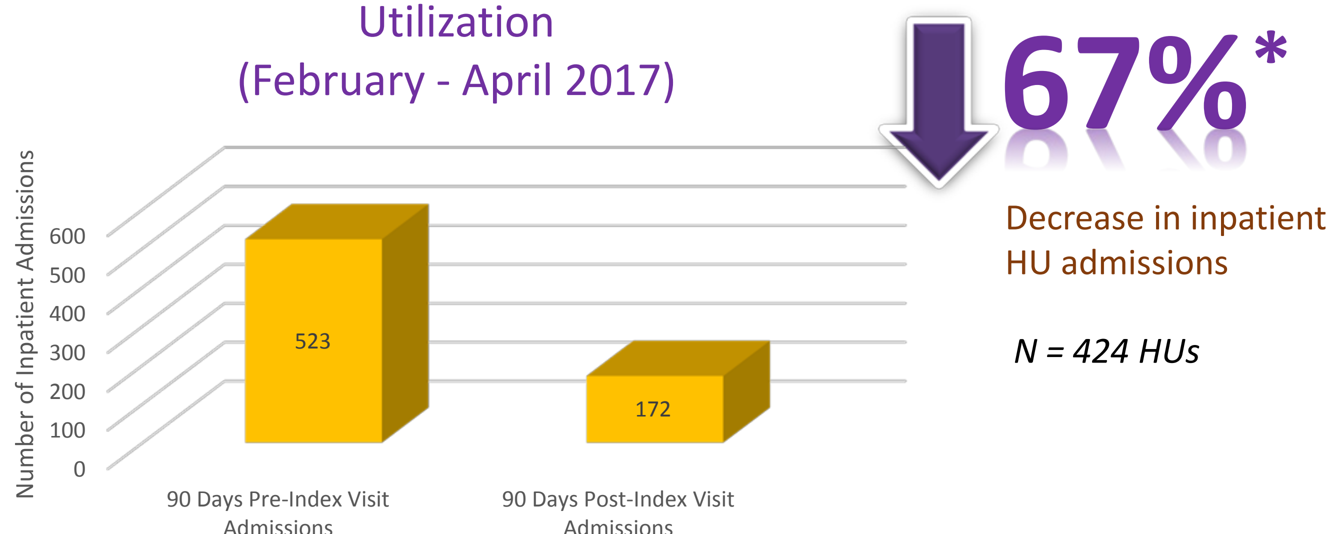
Care coordination departments (At Home, Health Home, Transition of Care) receive HU list upon notification of HU being admitted to begin early planning for care.

Outcome Metrics

90 Days Pre vs. Post Index Visit Hospital Utilization		
90 Days Pre-Index Visit Admissions	90 Days Post-Index Visit Admissions	% Change
523	172	-67%

The index admission is the first admission for each HU after the program start date that meets HU criteria (e.g. fourth or higher admission).

High Utilizer 90-Day Pre- vs. Post Hospital Utilization (February - April 2017)



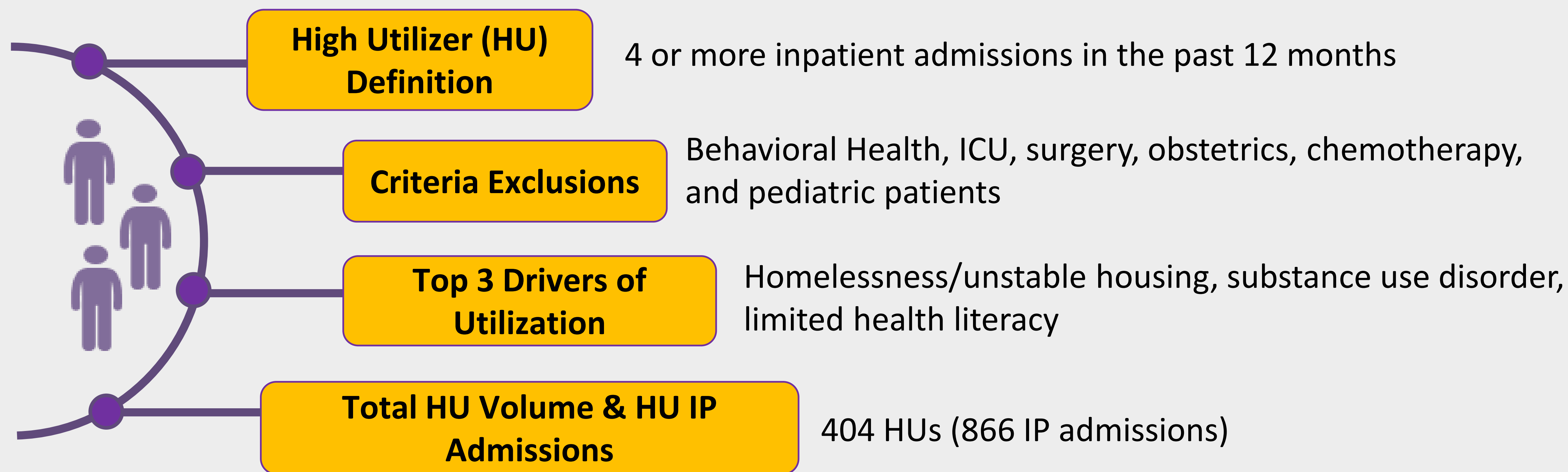
*Does not account for the impact of regression to the mean

Lincoln Cares

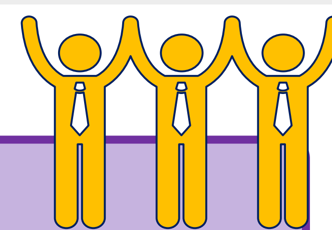
OneCity Health, Lincoln Hospital

New York State Department of Health

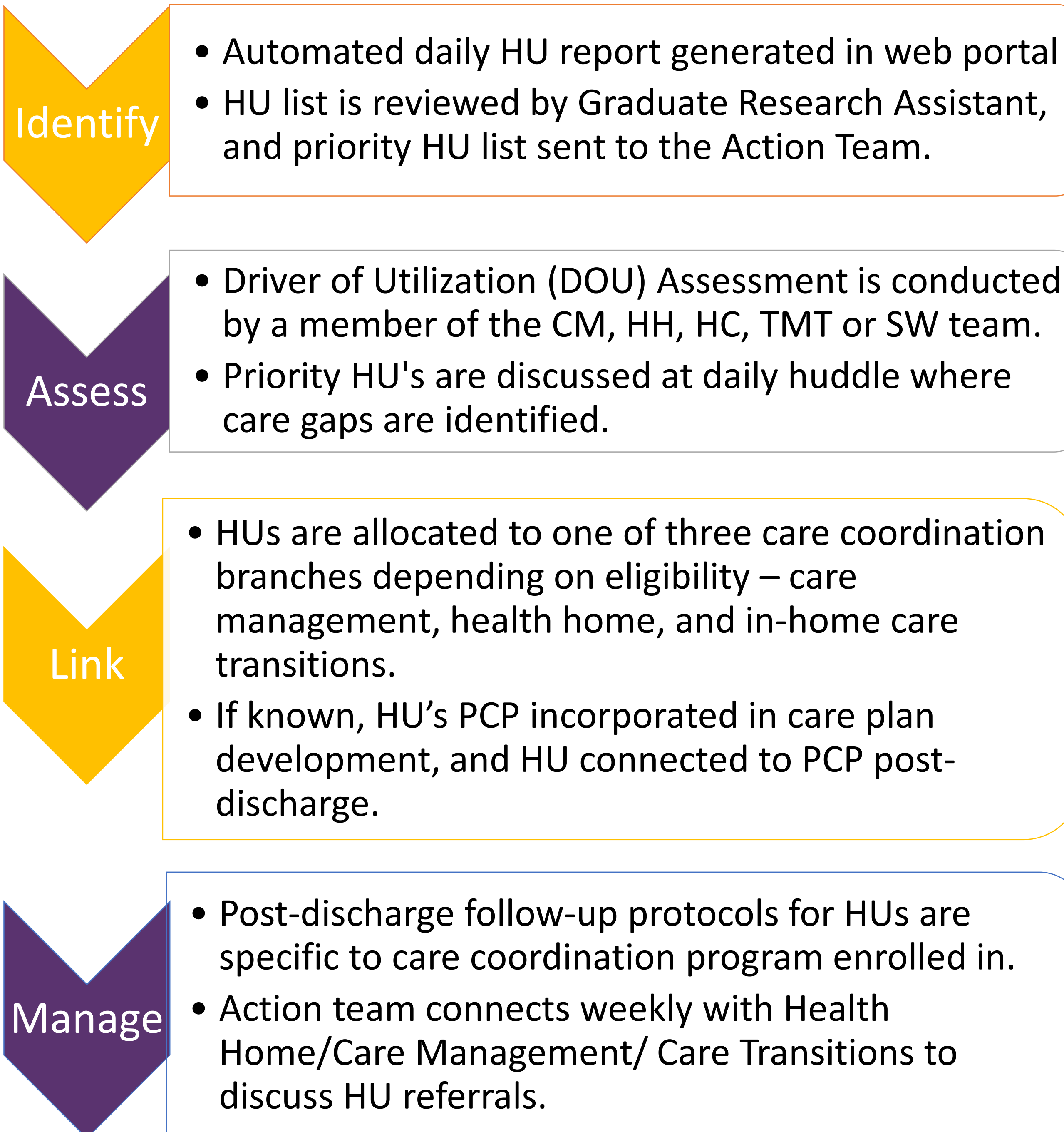
Our High Utilizer Population



Our Actions



HU Care Pathway



Success Story

A middle-aged male with diabetes and reoccurrence of colon cancer which has metastasized to his lungs. Currently has a colostomy bag, lives independently, and requires HHA services. He had 2 ED visits, and 2 inpatient admissions in the past 12 months.

Driver of Utilization:

Lost interest in improving health and had little to no social support.

How we addressed DOUs:

- Patient was connected with primary care doctor at Lincoln. The coordinator attended his oncology appointment along with all diagnostic procedures.
- Transportation was provided to medical appointments. Patient re-engaged in care, and had surgery on 6/12/2017 to remove malignancy (Chemo will be set to begin).
- A case conference was set to discuss post-op treatment. The care coordinator continues to encourage the patient to maintain care.
- Discussion on home care pending to ensure support is provided in home during the course of chemo.

Impact to date:

Prior to Health Home enrollment with current coordinator, the patient had multiple ED visits. Since April 2017, the patient has only returned to the ED one time post-op due to pain. Patient is now more involved in his care and improving his own health.

Our Impact

Partnerships

1. **Bronx Works:** Provides safe, housing solutions for HUs post discharge.
2. **Boom Health:** Provides a variety of social support services, including substance use care.
3. **At Home Solutions:** Provides medical and social support services for HUs in their home.
4. **Regional Aid for Interim Needs Inc. (RAIN)**: Supports transitional care for elderly HUs.

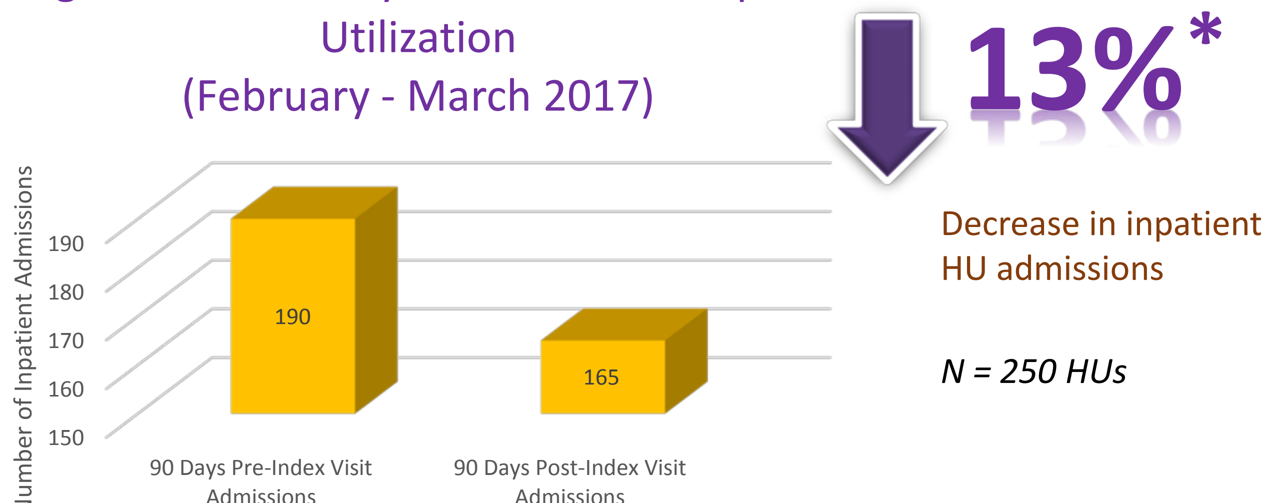
Unique Accomplishment

Embedded a dedicated Health Home coordinator in the ED to make Health Home referrals early in discharge planning.

Outcome Metrics

90 Days Pre vs. Post Index Visit Hospital Utilization		
90 Days Pre-Index Visit Admissions	90 Days Post-Index Visit Admissions	% Change
190	165	**-13%**

The index admission is the first admission for each HU after the program start date that meets HU criteria (e.g. fourth or higher admission).

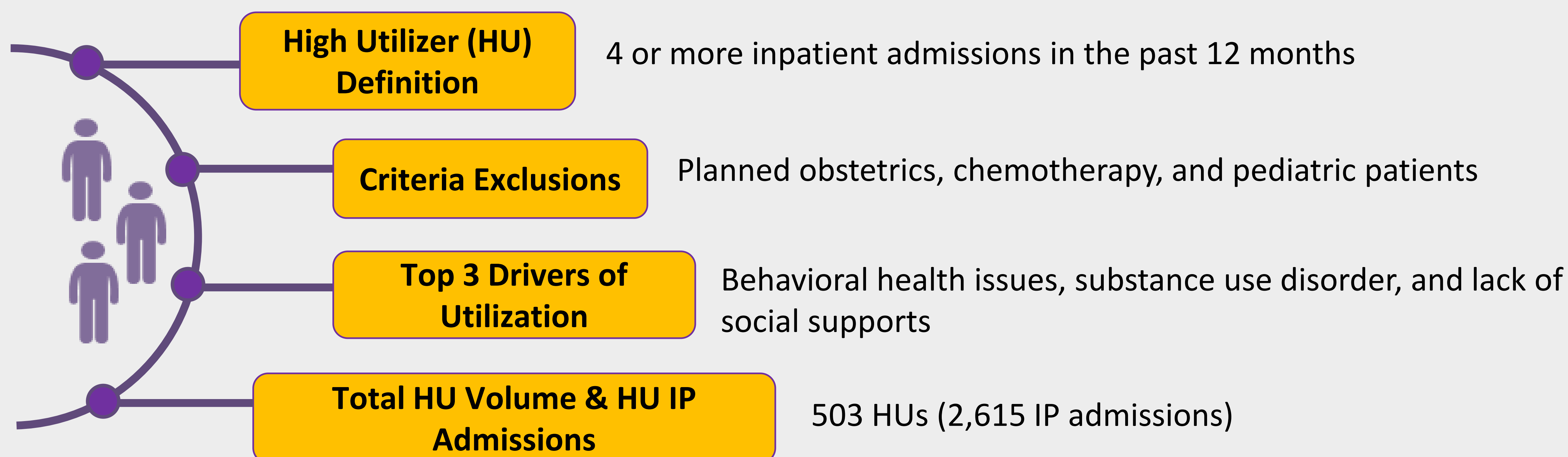


*Does not account for the impact of regression to the mean

SAM-I-AM

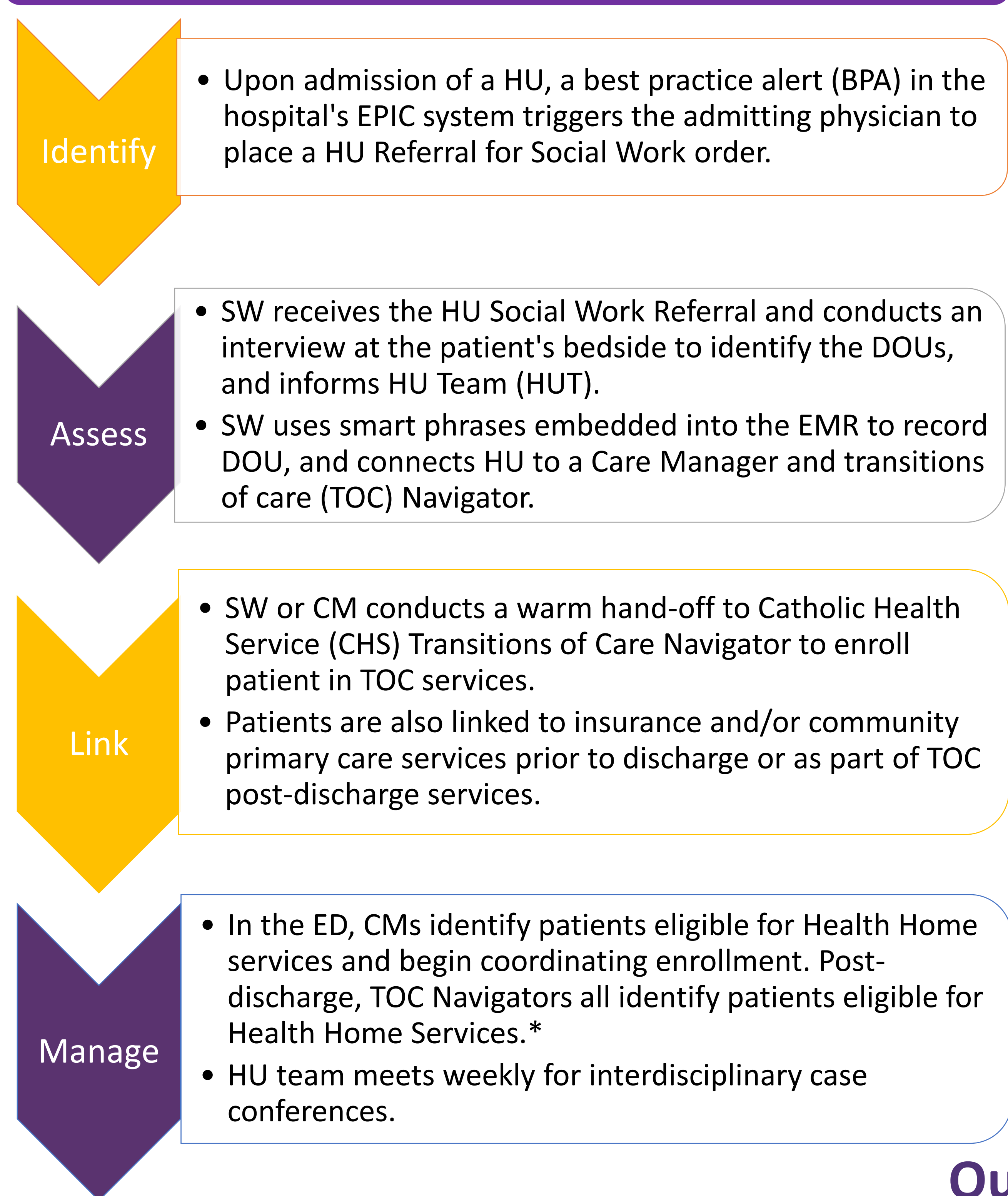
Suffolk Care Collaborative, Good Samaritan Medical Center

Our High Utilizer Population



Our Actions

HU Care Pathway



Success Story

An older male patient with seven admissions in the past 12 months, including five hospitalizations within a 5-6 week period. Patient was last admitted with a diagnosis of chronic obstructive pulmonary disorder (COPD).

Driver of Utilization:

Patient had no support system, in addition to the following issues: lack of housing, financial instability, unaddressed psychosocial need, and significant substance use.

How we addressed DOUs:

- The Social Worker (SW) referred the patient to a Peer Support Program to assist him with receiving social support services, and a social service agency to assist with housing solutions based on medical and psychosocial needs.
- Patient was connected to Assisted Living and provided education about the facility and transportation to his appointments by his SW and TOC navigator.

Impact to date:

- Patient was screened, interviewed and accepted into the Assisted Living program in April 2017.
- Patient has not been admitted since March 2017, and has kept in touch with his Transitions of Care (TOC) navigator, reporting that he is happy and so thankful!

Our Impact

Partnerships

1. **Catholic Health Services of Long Island (CHS):** Partnership provides care transitions team to facilitate warm handoffs of HUs to community support services post discharge.
2. **Catholic Health Services of Long Island Physician Partners (CHS-PP):** Partnership facilitates warm handoffs of HUs prior to discharge for enrollment into 30-day post-discharge TOC services.
3. **Good Shepherd Hospice:** Provides end-of-life and bereavement services for HUs requiring hospice care.

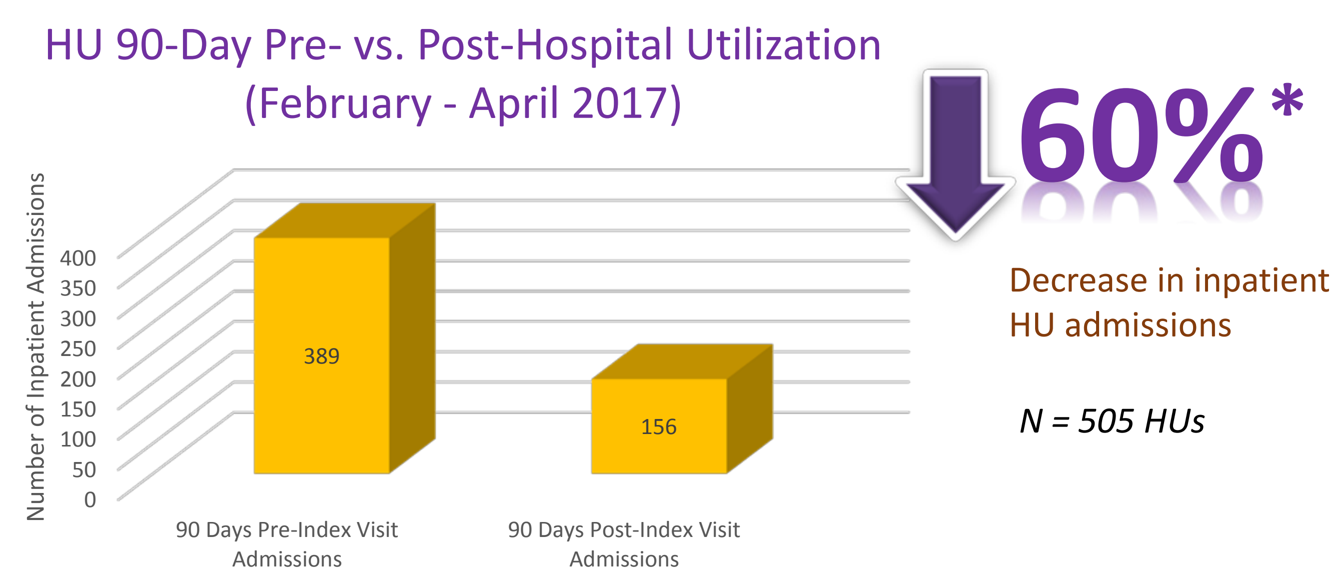
Unique Accomplishment

Warm handoffs are made between Social Workers to Transitions of Care nurses in house for continuity of care post discharge.

Outcome Metrics

90 Days Pre vs. Post Index Visit Hospital Utilization		
90 Days Pre-Index Visit Admissions	90 Days Post-Index Visit Admissions	% Change
389	156	-60%

The index admission is the first admission for each HU after the program start date that meets HU criteria (e.g. fourth or higher admission).

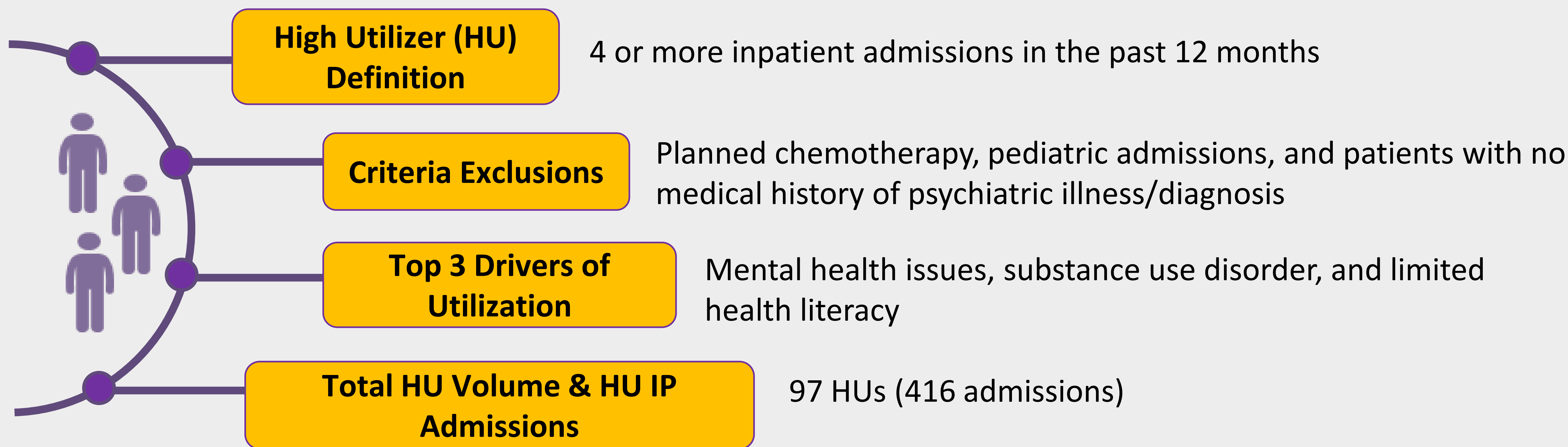


*Does not account for the impact of regression to the mean

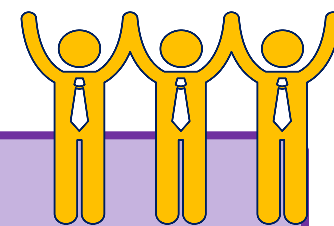
Care Accelerated Redesign Team

WMCHealth, Bon Secours Community Hospital

Our High Utilizer Population



Our Actions



HU Care Pathway

- An automated HU identification tracker board is in place in Emergency Department (ED) that signifies when a HU enters the ED and/or is admitted.
- Designated behavioral health clinician, Social Worker (SW), immediately responds upon being alerted and notifies the clinical leaders.

- Readmission risk assessment tool used for interviewing HUs in order to determine the driver(s) of utilization.
- Readmission Risk Assessment is conducted by a SW, CM or nurse manager at the patient bedside.
- HU patients are discussed in clinical rounds and a "Special Needs Meeting" is organized with participation of outpatient providers, local government unit, care mangers and peer supports.

- SW or CM identify resources for outpatient follow-up in community.
- Collaboration with Independent Living Inc. Peer Bridger program to provide peer support to HUs post-discharge.

- Peer Diversion Specialist follows patient in the community post-discharge to ensure HU follows his/hers plan of care.
- HUs receive follow-up phone calls post-discharge to support their care in the community.

Success Story

Middle-aged male admitted due to extremity weakness. Patient has a history of readmissions within 24 hours of previous discharge, with four admissions prior to his index visit.

Driver of Utilization:

The main driver of utilization was food insecurity: The patient did not have any food in his house and was uncertain of where the next meal would come from.

How we addressed DOUs:

- The team engaged a case manager who worked with patient to identify the last physician the patient saw outside of the hospital, and to coordinate care that would address the patient's needs.
- In order to support transition of care from hospital to the community, the case manager provided food for the patient at the point of discharge to take home.
- The care manager arranged for home care services to work with the HU in his home, and help him identify a sustainability food source, and receive nutrition counselling.

Impact to date:

Since the team connected the patient to the case manager and home care on February 22, 2017, the patient has not been readmitted to the hospital.

Our Impact

Partnerships

1. **Independent Living Inc.**: Partnership has been very successful in ensuring that patients will follow-up with their discharge plans.
2. **Orange County Department of Mental Health:** Served as an integral resource to connect HUs to mental health services post-discharge.
3. **Atlantic Health System:** Provides support for the care transitions protocol for HU patients.

Unique Accomplishment

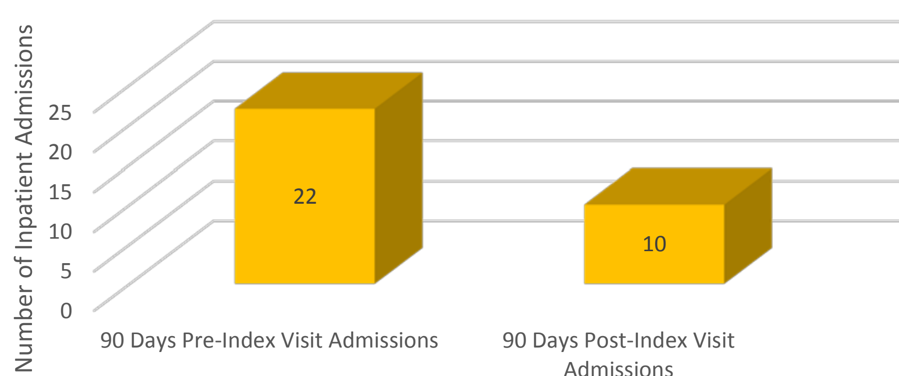
Created an automated color-coded tracker board in the emergency department that signals when a HU is present.

Outcome Metrics

90 Days Pre vs. Post Index Visit Hospital Utilization		
90 Days Pre-Index Visit Admissions	90 Days Post-Index Visit Admissions	% Change
22	10	-55%

The index admission is the first admission for each HU after the program start date that meets HU criteria (e.g. fourth or higher admission).

High Utilizer 90-Day Pre- vs. Post-Hospital Utilization (February 2017)

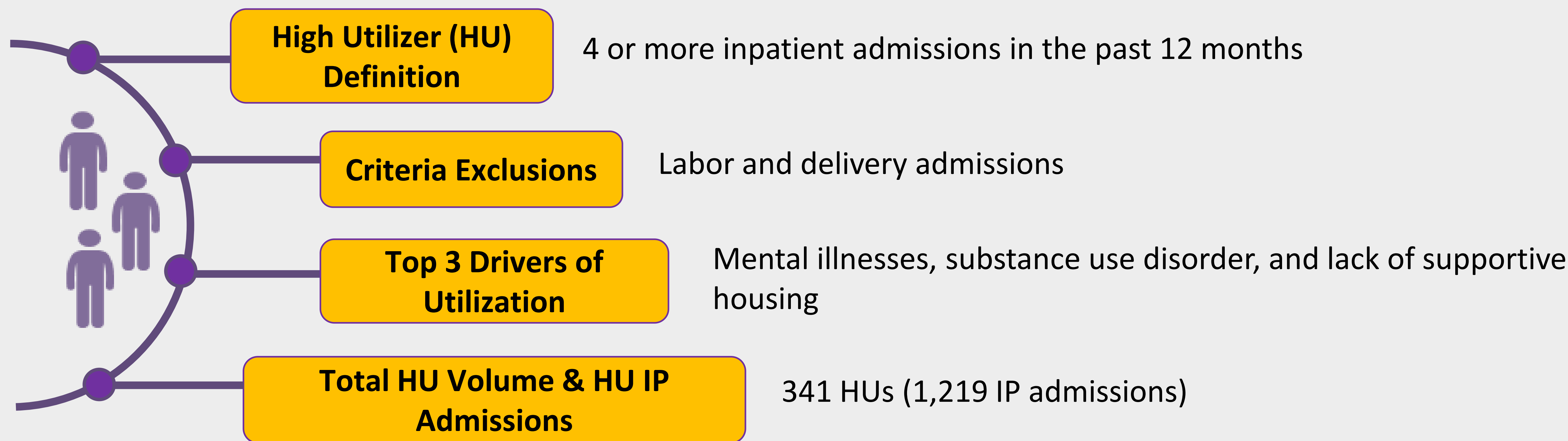


*Does not account for the impact of regression to the mean

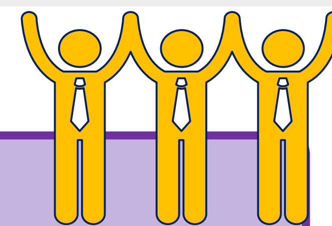
Good Health Gladiators

WMCHealth, HealthAlliance of the Hudson Valley

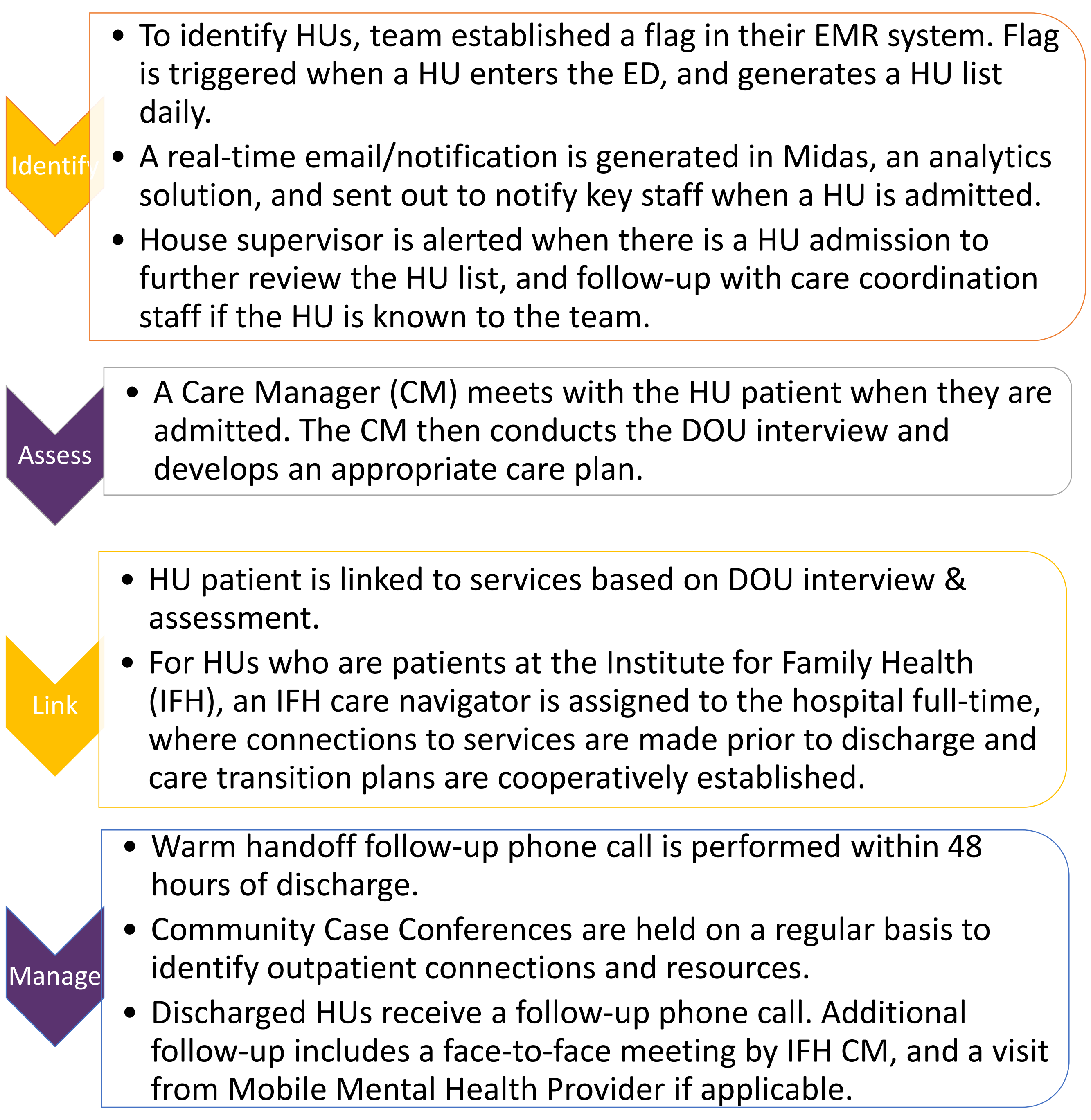
Our High Utilizer Population



Our Actions



HU Care Pathway



Success Story

Female with mental health illness, medical co-morbidities and 9 admissions last year.

Driver of Utilization:

It was determined that the patient was in need of both supportive housing and physical support. The patient was residing in a boarding home where her physical and behavioral needs were not being met.

How we addressed DOUs:

- The Action Team explored the patient's reasoning behind previous resistance to nursing home placement and worked on developing a feasible solution.
- Additionally, the Action Team provided supportive counseling and psycho-education to reduce the patient's anxiety regarding nursing home placement.

Impact to date:

- The patient was referred to a nursing home setting to address both her physical and mental health needs.
- As a result, she is now receiving the necessary physical and mental support, and has not been re-admitted since being placed in the nursing home nearly 5 months ago.

Our Impact

Partnerships

1. **Institute for Family Health:** Partnership to improve the transition process of HU from inpatient care to primary care.
2. **Ulster County Department of Mental Health:** Integral resource in connecting HUs to mental and social services post-discharge.
3. **Westchester Medical Center:** Data analytics support to track progress and impact of the team's HU program and care coordination.

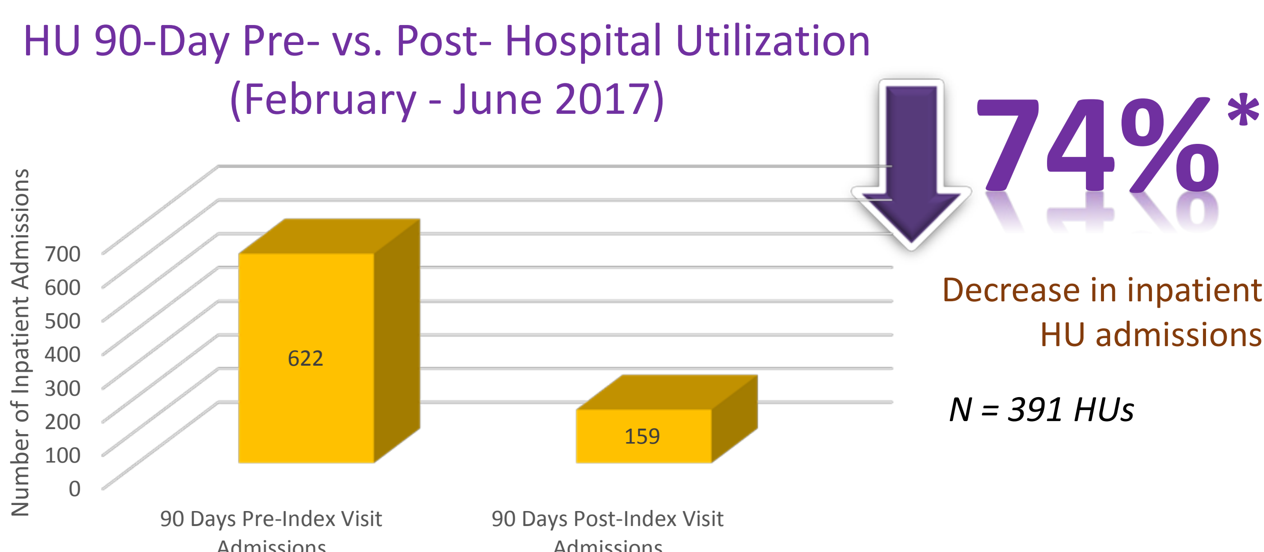
Unique Accomplishment

Referrals based on social determinants of health using technology application Healthify with trained staff to use the system.

Outcome Metrics

90 Days Pre vs. Post Index Visit Hospital Utilization		
90 Days Pre-Index Visit Admissions	90 Days Post-Index Visit Admissions	% Change
622	159	-74%

The index admission is the first admission for each HU after the program start date that meets HU criteria (e.g. fourth or higher admission).



*Does not account for the impact of regression to the mean

MAX Series Final Reports

For more information on the MAX Series, please refer to the following reports on the New York State Department of Health DSRIP website:

Improving Care for Super Utilizers

- https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/pps_workshops/docs/2017-01_imp_care.pdf

Integrating Behavioral Health and Primary Care Services

- https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/pps_workshops/docs/2017-01_ibh-pcs.pdf

MAX Series: Improving Care for High Utilizers and Sustaining Change (January 2017 - July 2017)

- https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/pps_workshops/docs/2017-jan-jul_imp_care_for_high_utilizers.pdf

For more information, contact the MAX Team or reach out to MRTUpdates@health.ny.gov.