NEW YORK STATE | Department of Health

Medicaid Accelerated eXchange (MAX) Series Program

Final Report

September 2021 – December 2022

MAX Series: Improving Care for High Utilizers and Sustaining Change

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Foreword from the New York State Department of Health

Since the conclusion of the Delivery System Reform Incentive Payment (DSRIP) program, the New York State Department of Health (DOH) continues to support provider efforts to improve the quality of care, reduce costs to ensure health system sustainability, and benefit under value-based arrangements in Medicaid. The DOH offered hospitals the opportunity to participate in another series of the Medicaid Accelerated eXchange (MAX) program of rapid-cycle continuous improvement (RCCI) technical assistance to address multi-visit patients (MVPs). Despite delays related to the COVID-19 pandemic, the fourth series of the MAX program launched in March 2022.

The program's promising practice of RCCI engaged front-line health care and social service providers over several months in virtual, educational workshops and action periods, similar to when delivered in person, to determine the drivers of potentially preventable emergency department and inpatient hospital utilization for New York's most vulnerable populations. To date, the MAX program has engaged over 100 Action Teams composed of 900 professionals representing different areas of expertise within the healthcare setting.

This report highlights the work of eight Action Teams from across New York who participated in the fourth series of the MAX program to successfully engage MVPs while simultaneously navigating the COVID-19 pandemic and all the activities of day-to-day health care. Teams participated in workshops and received data and technical support during weekly coaching calls. The Action Teams implemented the Core Concepts of the program to identify the root cause of high utilization and employed a team-based approach to the MVP Care Pathway. The goal of the MAX Series is to drive culture change and create positive outcomes for the patient population through innovation and new perspectives. Providers learned tools to systematize how to meaningfully address MVPs in ways that matter to them. This has been previously shown to reduce unnecessary medical utilization when the needs are social or behavioral in nature.

Thank you to the Action Teams who undertook this important work with the DOH to continue the legacy of the promising practices of the DSRIP program. Not all the needs with which patients present can be addressed with the stethoscope. Your dedication and commitment to this effort has had a profound impact on changing the trajectory of human lives.

Sincerely,

Douglas G. Fish, MD
Chief Medical Officer
Office of Health Insurance Programs

Executive Summary

The Medicaid Accelerated eXchange program was originally developed during the Delivery System Reform Incentive Payment (DSRIP) program to apply rapid cycle continuous improvement (RCCI) techniques to engage and empower front-line teams of clinical and social service providers to transform care delivery.

The MAX program initially focused on improving care for high utilizers and integrating behavioral health into primary care. Over the years the program has primarily focused on improving care for high utilizers (referred to as "multi-visit patients," or "MVPs") and has been among the most successful delivery system transformation initiatives of the DSRIP program – as evidenced by over 1,500 interdisciplinary and cross-continuum health and human service professionals across nearly 100 teams who have participated in the program since 2016.

The MAX program engages teams of executive, administrative, clinical, and operational professionals to improve care using RCCI methods. By working together on small-scale tests of change, interdisciplinary teams learn by doing. This is a powerful force for change and an effective strategy to identify improvements that are locally relevant and operationally feasible.

This report highlights the work of the teams who participated in the 2022 MAX program. Prior MAX program reports outline the RCCI methodology and program structure utilized by the MAX Series.

The progress of the MAX Series 2022, originally launched in January 2020, was impacted by the onset and continuation of the COVID-19 pandemic which severely challenged the healthcare sector. Original plans to launch Round 1 with upstate and downstate in-person workshop meetings with all of the recruited hospital Action Teams was paused in March 2020 due to the impact of the pandemic on the recruited hospital teams that included front-line staff. The re-launch of the MAX Series in the Fall of 2020 in virtual format, with specific focus on the Bronx region, was once again put on hold due to the continued challenges in resources related to the pandemic. In September 2021, the MAX Series was again re-launched with focused recruitment in the downstate region of New York followed by the first ever virtual MAX Series workshops initiated with the Cohort 1 Action Teams on March 3, 2022. The virtual format proved successful and continued for the duration of the Cohort 1 programming. Concurrently, recruitment efforts began for upstate New York hospitals with the launch of the Cohort 2 team virtual workshops on May 31, 2022.

The 2022 MAX Action Teams were all provided with the same program structure and clinical, operational, and change management advisement. Each of the Action Teams applied this technical assistance to their own operating environments – working with available assets and working around barriers and limitations. As a result, each of the Action Teams has created improved care for multi-visit patients that is uniquely well suited for their operating environments, at this time. The hallmark of the MAX program is that no two Action Teams implement in the exact same way. Working with the strengths and assets within their influence, the teams applied the MAX program structure to create meaningful change to improve care for MVPs. Teams did the following:

- ✓ 8 of 8 teams adopted a utilization-based definition of MVPs
- ✓ 8 of 8 teams developed a real-time identification system
- ✓ 8 of 8 teams developed a notification system
- ✓ 8 of 8 teams developed the skills to identify the root cause of recurrent utilization
- ✓ 8 of 8 teams more effectively engaged with MVPs at the bedside
- ✓ 8 of 8 teams developed a response plan to address and/or mitigate those root causes
- ✓ 8 of 8 teams developed stronger collaborations with key stakeholders

Although all Action Teams work through the same process, each ends up with its own unique, locally relevant approach. It is possible to improve care for MVPs and develop a systematic approach, based on data, root causes, and mitigating systems issues, and through interdisciplinary and cross-continuum collaboration. A systematic approach, based on root causes, person-centeredness, and team-based care truly makes a difference.

The MAX Series Methodology: Overview

Phase I – Assessment and Preparation

To prepare for the MAX Series, outreach is conducted to hospital senior leadership for recruitment of multi-disciplinary teams of front-line staff for participation. For the MAX Series 2022, eight individual hospital teams, representing the upstate and downstate regions of NYS, were recruited. Individual hospital data over a 12-month prior period was collected to help Action Teams understand their historical volume of MVPs and define their MVP population. Recruited sites selected an Executive Sponsor to lead the development of the Action Team and champion process improvement approaches. The true key to success of the MAX Series lies in putting together a balanced Action Team with the right people, comprising the following roles:

Executive Sponsor – This role is crucial to the success of the Action Team, as well as to the sustainability of the program. Executive sponsors provide overall accountability, sponsorship, and championing of the program. They have the vision on what an improved process should look like and can remove barriers that may prevent the team from being successful.

Action Team Members – The heart of the Action Team is an interdisciplinary group of eight to ten individuals representing different areas of expertise (clinical, administrative, and information technology) and working collaboratively to address the needs of the MVP population. The Action Team consists of representation from across the care continuum, including a diverse set of stakeholders most appropriate to address the medical, social, and behavioral needs of MVPs. As a result, the Action Team should include individuals who can directly enact or facilitate change within and across their respective organizations. Action Teams often comprise the following roles or departments:

- Administrative Champion (Chief, Senior Vice President, or Vice President);
- Clinical Champion (Medical Director, ED physician, Nursing Director, e.g.,);
- Director and/or staff from case management, social work (SW), care transitions, and/or Health Homes;
- Practice manager or care manager from a primary care clinic/setting, and/or behavioral health clinic;
- Information Technology (IT), including data analyst;
- Community-based organizations;
- Skilled-nursing facilities; and,
- Palliative care services.

Subject Matter Professional (SMP) – The SMP serves as an advisor to the Action Teams, tailoring program content to the identified topic, sharing leading practices and industry resources, assisting with monitoring progress and outcomes, and providing ongoing program support. Typically, the SMP is an expert with hands-on experience with the patient cohorts being addressed in the series. For the MAX program, Dr. Amy Boutwell, a national care transitions subject matter expert and consultant, was identified. Since 2008, Dr. Boutwell has been deeply immersed in the clinical, operational, policy, payment, and political aspects of approaches to reduce avoidable hospitalizations and improve care transitions. She is the developer of the MVP Method.

Phase II – Workshops and Action Periods

During Phase II, 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. During this phase, Action Teams generate and prioritize improvement ideas, develop concrete Action Plans, and implement, test, measure, and adjust localized processes for whole-person care delivery for the target population.

Workshops – The MAX Series has historically consisted of three intensive, in-person, daylong workshops designed to bring the Action Teams together to rapidly generate process improvement ideas and plans to achieve results. The MAX Series 2022 workshops, held virtually due to the COVID-19 pandemic, were fast-paced and interactive sessions incorporating group plenary sessions with time for brainstorming. Having a running group chat for each team was strongly encouraged at each session. In the didactic sessions, RCCI theories, PDSA, the theory of constraints, and change management were presented and tailored to the MAX topic. Governing the workshops are ground rules outlined at the beginning of each session, encouraging Action Team members to actively participate and "do something different." The ground rules culminate in the overarching theme for the MAX Series – you must make a change! By the end of the workshop, each Action Team generates concrete and measurable Action Plans to be implemented within a 6-week Action Period immediately following the workshop. A workshop summary report, which captures key takeaways and three action plans, is created by the SMP and shared with the Action Teams following each workshop. This information serves as a demonstration of the work committed, and as an outline for ongoing accountability.

Action Periods – While the workshops are designed to build consensus and momentum amongst the Action Team towards solutions, the Action Periods are where policy truly turns into practice. Each of the three workshops is followed by an Action Period, structured as a PDSA cycle. 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 evaluated and adjusted over compressed time periods. The first Action Period is focused on achieving quick wins and building team confidence in their process improvement capabilities. The second and third Action Periods are typically focused on detailed, process redesign for reliable and sustainable process improvement.

Phase III – Measurement and Reporting

Data measurement and analysis are the foundation of the MAX Series. Action Teams, using their own definitions, begin the program by measuring their historical performance with MVPs in a 12-month prior period. As a requirement for enrollment in the MAX Series, Action Teams must commit to measuring and consistently reporting on specified metrics that track their performance in the program. To be able to fulfill this requirement, ongoing involvement of IT and data analysts in the Action Team is critical. During the Measurement and Reporting phase, Action Teams are expected to document programmatic achievements in a succinct report and continuously collect and analyze MVP performance metrics to track progress and guide process improvement decisions and Action Plans. The measures used in the MAX Series fall into three categories:

Structural – A structural measure tracks the achievement of specific milestones and can be scored with a binary "yes" or "no," e.g., whether an Action Team has assessed MVPs at the bedside, or whether its organization has installed an electronic health record (EHR) flag to help identify MVPs when they check into the hospital.

Process – A process measure examines approach and method, such as the weekly number of MVPs who present in the ED or the number of MVPs for which an assessment was performed.

Outcome – An outcome measure ultimately demonstrates the impact of the Action Teams' efforts on patients' health. In the MAX Series, outcomes are collected through analysis of ED and inpatient data, as well as from patient success stories. These achievements from the four participating Action Teams are outlined within the following sections of this report.

MVP Drivers of Utilization (DOUs)

Drivers of Utilization Terminology

IASUD – Inadequately Addressed Substance Use Disorder

IABH – Inadequately Addressed Behavioral Health

IAGOC – Inadequately Addressed Goals of Care

IASS – Inadequate Services & Supports

PPH – Pattern, Preference, Habit

IALE – Inadequate Living Environment

IAPRI – Inadequate Plan for Recurrent Issue

AAA – Anxious, Afraid, Alone

Third Party – family, friend or other party enabling the patient's patterns of behavior

IACS – Inappropriate Care Seeking

MAX Series Cohort 1 Action Team Findings

Richmond University Medical Center (RUMC)

MVP Focus: Inpatient MVP population

Definition of MVPs: 4+ inpatient admissions in 12 months

Population Data

- From March to June 2022 there were 134 MVPs
- Average age 63
- 54% female
- 35% Hispanic; 33% Caucasian; 22% African American; 10% other
- Average # admissions/12 months: 6

How are MVPs Identified?

- Current inpatient MVP census
- Weekly list of MVPs

Who is Notified?

- MVP list is shared with Director of Case Management, SW Leadership, Chief Hospitalist, Palliative Care
- "This is one of the best things we do!"

How are MVPs Assessed?

Social worker "crackerjack" takes the lead on assessing MVPs to identify who is and who is not involved and what the driver of utilization is – asking what we can do differently, and how we can help.

How is the Process Managed Internally?

- Discuss MVPs daily in interdisciplinary rounds
- CM/SW MVP team will request palliative care consult if needed
- Discuss MVPs weekly with hospital and ED physician champions

How Does the Team Collaborate with External Partners?

- We have brought in several community agencies to provide in-services to our team to foster building our relationships.
- We reach out to those who are involved to collaborate.

How Does the Team Plan?

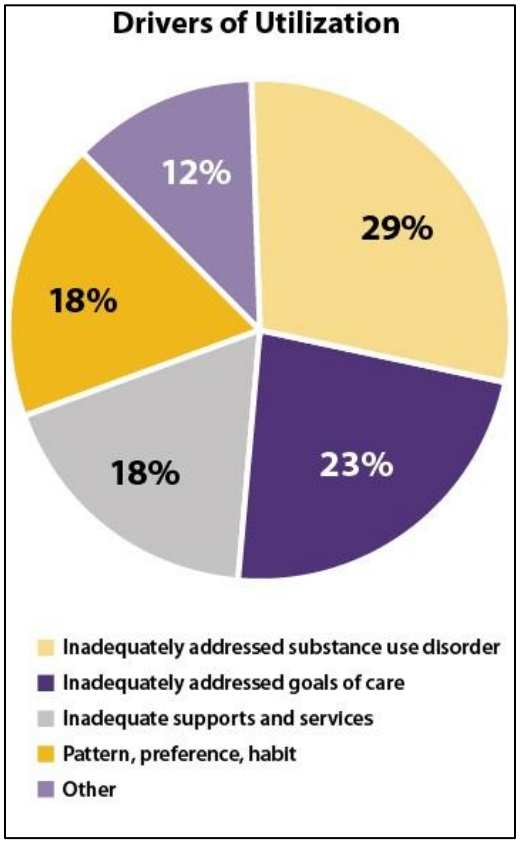
When discussing as a team or reaching out to others to discuss, the team is always working to identify how to avoid this happening in the future.

How are MVPs Tracked?

The team created an MVP Registry to record key information about each MVP.

"Daily email is generated that goes to leadership, chief hospitalist, SW ***leadership, palliative care; it's how we monitor MVPs; it's wonderful – it's one of the best things we did."***

Top Drivers of Utilization (DOU)



DOU – Response IASUD

- Peers in the ED come up to see the patients daily.
- The social workers meet with the patients.
- We provide information about resources.

DOU – Response IABH

- Peers meet with the patients while in the hospital.
- The social workers meet with the patients.
- We provide information about resources.

"The MVP registry is a basic list that we have with the one-*liners, things we have done for them, our ideas on next steps,* ***who's involved, such as if they have a case manager or payer. The Registry has helped us greatly."***

DOU – Response IAGOC

- The Director of Palliative Care receives the MVP list daily.
- We discuss goals and consult for palliative care at daily rounds.

DOU – Response IASS

Agencies come in to provide a brief review and reconnect relationships with them, including the Community Health Action of Staten Island (CHASI), Project Hospitality, the Community Agency for Senior Citizens (CASC).

DOU – Response PPH

Dealt with by individual patient.

Team Members

- Director of Care Management
- Social Work
- Information Technology
- Palliative Care
- Hospital Medicine
- Emergency Medicine
- Peer Substance Use Disorder (SU) program in the ED
- Community Agencies: Nursing Homes, Adult Homes, CHASI, CASC, Project Hospitality, Office of the Aging, Coordinated Behavioral Care (CBC)

"Our MVP social worker engages them and tries to** learn about their situation, especially their non-clinical reasons for coming to the hospital. What can we do differently? How can we help them? She is **able to identify what the driver of utilization is."

Next Steps

- Build the team and increase participation/support of physicians and leadership using registry and MVP utilization data to validate future MVP efforts and collaboration.
- Continue to create more linkages and re-establish relationships with community services to better develop care pathways and supports for MVP Drivers of Utilization.
- One year from now hope to have more assistance/resources to sustain the MVP program.

Richmond University Medical Center

Monthly Outcome Measure Dashboard - Inpatient MVP Focus	Month 1 March 2022	Month 2 April 2022	Month 3 May 2022	Month 4 June 2022
A. Number of MVP discharges in calendar month	55	67	70	80
B. Number of Readmissions = # of discharges in A that were followed by an admission within 30 days	23	28	32	31
C. Readmission Rate (= B/A)	42%	42%	45%	39%
D. Total MVP hospital bed days (and Average)	450 (7)	468 (7)	339 (5)	323 (4)

"A lot of times we have people coming in because they don't like their nursing home or their adult day home. We are close to some of these homes. We have one person who comes to us because he walks from the adult home, so we reached out to the Adult Home Manager to work together."

"This female MVP has sickle cell disease. She has a stable home and lives with her mom. She is unemployed due to her diagnosis and chronic pain. She uses marijuana to manage her symptoms. No other substances. She has had six admissions in the past 12 months, all for pain management. She says at times she feels very isolated. I reached out to CHASI to discuss whether there is a support group for this population. They said they just received a grant to develop a support group."

"One patient would walk over from his adult home to ask for help changing his colostomy bag; they **didn't have the right supplies for** him at the adult home, and he **didn't know how to do it. He had** come in 12 times to have his colostomy changed. So we reached out to the manager of the adult home to work with them on that. This program has helped us **connect better."**

"Male MVP living with sister and her family. Patient had cognitive limitations. It was a situation in which the living environment was not adequate to meet his needs and he had had five admissions. We worked with him and the family to discuss his supportive care needs and he did move to a nursing home; he has only been admitted once since then."

"Female MVP living at home with her 2 teenage children. Diabetes, lupus, hypertension. Five admissions, all due to uncontrolled hypertension. Her children have been assuming a lot of caregiving responsibilities. We recognized the first step would be to get her more help with her disease management in the home, so the first linkage was to home health. I think for her we have decreased her admissions."

Montefiore Hospital – Moses Campus

Why MVPs? Why now?

The hospital is focused on readmissions, patient flow, and throughput across the health system, and connecting clinical and operational priorities.

MVP Focus

Inpatient and Emergency Department MVP Populations

Definition of MVPs

5+ admissions/12 months to the Montefiore Moses campus

Population/Volume Data

Inpatient MVP	ED MVP
MVP volumes are quite large.	10+ ED visits in 12 months
After review of 12-month volume focused efforts on 5+ admissions / 12 months to Moses Campus only	227 ED MVP patients/month
Average of 146 Inpatient (INPT) MVPs /month	333 MVP ED visits/month
Average of 168 IN MVP discharges per month	130 ED revisits/month
Average IN MVP Length of Stay (LOS) of 1,698 bed days per month	ED MVP LOS 3,960 hours/month
Average IN MVP LOS 8.4 days	

How are MVPs Identified?

- Identify MVPs on admission to the inpatient setting.
- On-demand Epic report to show the number of MVPs in-house.
- Identify newly admitted MVPs (<24h) and total inpatient census.
- Average of 130-160 MVPs in-house that fit criteria when report is run.
- Represents an undercount of the true MVP volume at Montefiore as it is not inclusive of other hospitals in the health system.
- These numbers represent the extremely focused group who almost exclusively use the Moses Campus.

Who is Notified?

- Automatic email is generated once the MVP is known.
- When known MVP presents to the ED, alert triggers email to a number of people, many of whom are on complex care team.

"We have been dealing with complex cases for quite some time. But the idea of looking at multi-visit patients had some overlap, but it was a new look. It was something I was really very pleased to have the ***MAX program expand our repertoire and vision."***

"Under our MVP list, behavioral health is a thread that *goes through almost every single case. It is remarkable the impact that has in our patient population and highlights the need for support from behavioral health and we are in active committee meetings requesting more support from behavioral health in the hospital and ambulatory arenas, thanks* ***in part to our experience in the MAX program"***

How are MVPs Assessed?

In our process of assessment, we have expanded the lens through which we look. We realized MVPs and the needs they have are a little different than the experience we have with the complex case population – our Complex Care Team is very much involved in getting patients transitioned, but MVPs are a little different. It's more than just how do we transition them out of the hospital, but really how do we link them to programs and resources that will prevent them from needing to come back. And that's just a little more than episodic case management from the hospital.

How is the Process Managed Internally?

The MVP team meets weekly to review MVP status.

How Does the Team Collaborate with External Partners?

The team is planning to further integrate services with Care Management Organization, which serves as a valued partner and stakeholder for this initiative.

How Does the Team Plan?

The team is initiating collaboration with care management organization to form definitive linkages/options for MVPs.

How are MVPs Tracked?

- The team uses an MVP Registry (see Figure 1 below).
- Epic and Truepoint information includes # IN, # ED visits, # bed days, where admitted, where admitted from.

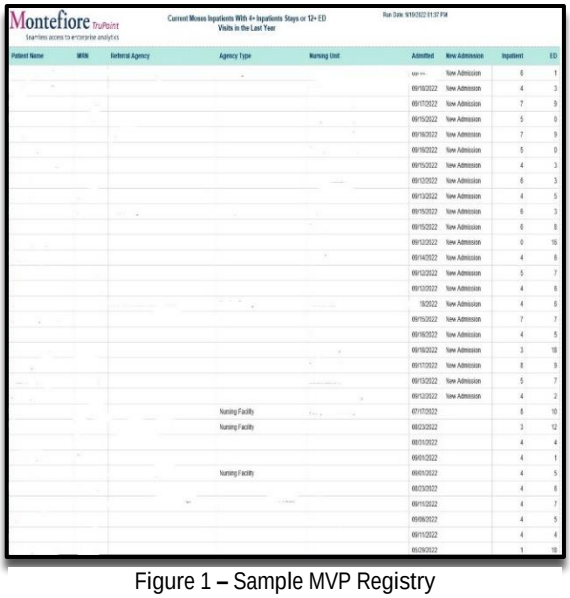
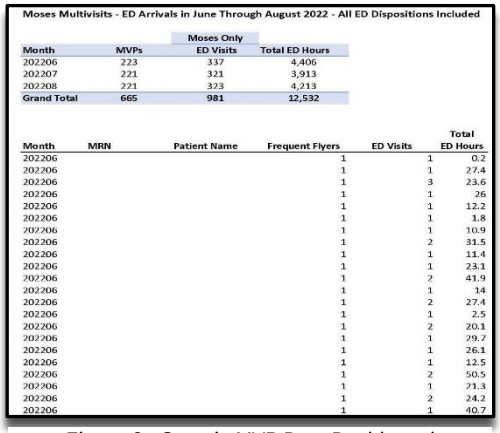


Figure 1 – Sample MVP Registry


Moses Multivisits - ED Arrivals in June Through August 2022 - All ED Dispositions Included

Month	MVPs	Moses Only ED Visits	Total ED Hours
202206	223	337	4,406
202207	221	321	3,913
202208	221	323	4,213
Grand Total	665	981	12,532

Month	MRN	Patient Name	Frequent Flyers	ED Visits	Total ED Hours
202206			1	1	0.2
202206			1	1	27.4
202206			1	3	23.6
202206			1	1	26
202206			1	1	12.2
202206			1	1	1.8
202206			1	1	10.9
202206			1	2	31.5
202206			1	1	11.4
202206			1	1	23.1
202206			1	2	41.9
202206			1	1	14
202206			1	2	27.4
202206			1	1	2.5
202206			1	2	20.1
202206			1	1	29.7
202206			1	1	26.1
202206			1	1	12.5
202206			1	2	50.5
202206			1	1	21.3
202206			1	2	24.2
202206			1	1	40.7

Figure 2 - Sample MVP Data Dashboard

Top Drivers of Utilization

- DOU – Response IALE: Housing at Risk Program, engage ED
- DOU – Response IAGOC: Palliative Care consult
- DOU – Response IASUD: Addiction Team/Peer consult
- DOU – Response IAPRI: Develop adequate plan
- DOU – Response PPH: ED Care Plan

Team Members

- Complex Care Team – experienced on challenging discharges
- Medical Director, Complex Care
- Physician Champion, Department of Psychiatry
- ED Champion, Moses Campus ED
- Assistant Directors, Social Work
- Senior Director, Acute Care Operations
- Clinical Director of Nursing
- Director, Hospital Readmissions Reduction Program
- Associate Director, Care Management Organization
- Information Security Engineer
- Information Technology
- Data Specialist

Next Steps

- One year from now hope to have more assistance/resources to sustain the MVP program.
- Work with Care Management Organization to link to resources.
- Increase collaboration with Social Work and Care Transition Nurse in the ED.
- Increase collaboration with key nursing homes.
- Develop more visible flags in the record.
- Bring the ED into the process.

"We have a number of clinical readmission reduction programs for heart failure (HF) and chronic obstructive pulmonary disease (COPD), but no readmission reduction program can really reach its full potential without many of the aspects of this MVP/MAX program and understanding the true drivers of utilization. We are bringing a lot of this into our other programs. A lot of times it is not just about the ***disease, it's about so many non-clinical, nontraditionally medical issues that affect patients' behaviors*** *and utilization patterns. This will help us take more steps down our population management path for the* ***organization."***

Montefiore Hospital-Moses

Monthly Outcome Measure Dashboard - Inpatient MVP Focus	Month 1 April 2022	Month 2 May 2022	Month 3 June 2022	Month 4 July 2022	Month 5 August 2022
A. Number of MVP discharges in calendar month	179	174	171	167	149
B. Number of Readmissions = # of discharges in A followed by an admission within 30 days	56	68	66	71	57
C. Readmission Rate (= B/A)	31%	39%	39%	43%	38%
D. Total MVP hospital bed days (and Average)	1,340 (8)	1,119 (6)	1,518 (9)	1,639 (10)	1,437 (10)

Monthly Outcome Measure Dashboard - ED MVP Focus	Month 1 April 2022	Month 2 May 2022	Month 3 June 2022	Month 4 July 2022	Month 5 August 2022
A. Number of MVP ED Visits in calendar month	301	385	337	321	323
B. Number of ED Re-Visits = # of ED visits in A that were followed by an ED visit within 30 days	131	204	115	100	102
C. ED Re-visit Rate (= B/A)	44%	53%	34%	31%	32%
D. Total MVP ED Length of Stay - Hours (and Average)	2,892 (10)	4,374 (11)	4,406 (13)	3,913 (12)	4,213 (13)

Montefiore MAX Series Success Stories

“Female MVP with history of COPD, heart failure, anemia, and several other comorbidities with 18 admissions in 2022 and 27 admissions in 2021. She lives in an adult home. We identified the driver of utilization was an inadequately supportive living environment for her medical needs. We reached out to the adult home and family to collaboratively discuss and agree that her living environment was not supportive for her needs. As of August, she agreed to move to a nursing home close to where her daughter is and now has successfully remained out of the hospital for the past 3 weeks which is longer than she has ever been. We attribute the success to identifying the issue at hand and facilitating a plan, incorporating **everyone into developing that plan.”**

“Male MVP with schizoaffective disorder, seizure disorder, coronary artery disease (CAD) status post stents with five admissions for chest pain. As soon as he is admitted, he escalates and leaves without further evaluation. He has a home, phone and primary care physician. It doesn’t appear he has any real supports other than the ED in his life. We thought this was an example of inadequately addressed behavioral health issues. The goal was to understand why he comes in, what he is looking for since he doesn’t want further evaluation and understand his goals. The patient knew he has CAD and comes to the ED just really wanting to know if this is an emergency, but he doesn’t want to be admitted. The goal is to evaluate him in the ED and to reassure him when there is no acute MI and to have psychiatry evaluate him in the ED instead of admitting him to the floor.”

“*It’s been quite a journey for us throughout this MAX program. We* *are a 700-bed hospital and the only safety net hospital in our area. We have come to learn that we share similar issues with other hospitals; what is different for us is the sheer volume of patients at this campus.”*

Staten Island University Hospital (SIUH)

Why MVPs? Why now?

Opportunity

Definition of MVPs

4+ admissions/12 months

How are MVPs Identified?

- "Our CMIO was very quick in establishing real time dashboards that we can look at anywhere anytime to identify these patients."
- Sunrise EMR makes visible any patient with a complex care note.
- Trackerboard has a column for MVPs visible with icon.

How is the Team Notified?

- There is a daily email of overnight MVP admissions.
- Northwell Health's Health Home receives the daily list; screens for eligibility.

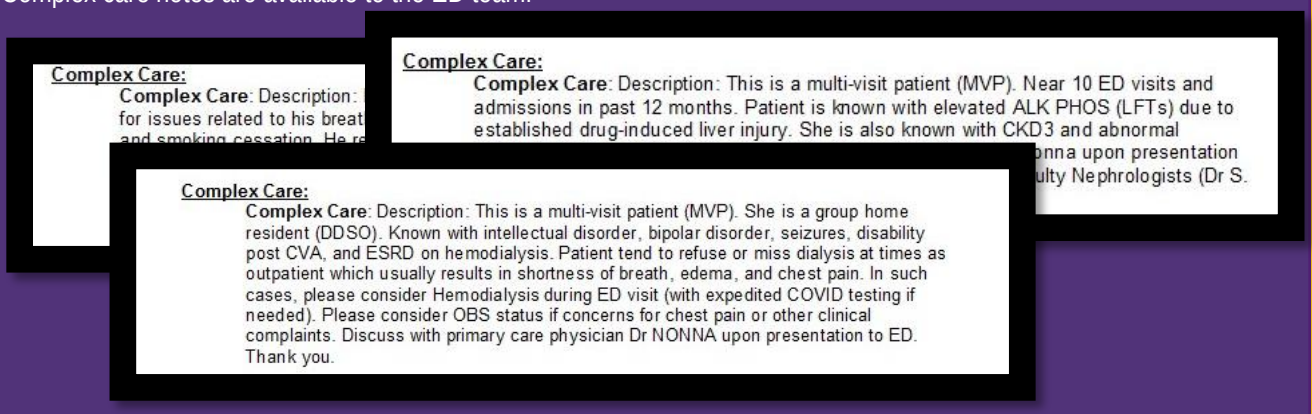
How are MVPs Assessed?

- "The way I approached interviewing MVPs was to not even look at the case medically; start with the overall big picture. Putting this into a daily assessment was a good opportunity for us. It pushed us out of our comfort zone. We always assumed someone else was looking at this."

- "We had never opened up a discussion with the patient about the utilization – the minute you approach it like this, they understand we are ready to talk about the bigger picture issues."

How Does the Team Plan?

Complex care notes are available to the ED team.



How are MVPs Tracked?

- Microsoft Power BI dashboard
    - See all MVPs in-house.
    - Hover over MVPs can see # visits in past 12 months.
- Registry is on a shared drive and anyone on the team can modify it.

DOU – Response IAPRI

- Start by identifying who the key stakeholders are; reach out to those key stakeholders, and work with them to identify opportunities to develop a better plan.
- "A key lesson we learned about reaching out to others is we need to make it clear what we are working and let them know why we are doing it."

DOU – Response IAGOC

- "We huddle with the floor team to advise them this is an MVP, placing consults for Palliative Care, noting that it's an MVP in the request. Palliative Care is great about reaching out to involved parties. The lesson is that our Palliative Care Director is fully involved; he is very receptive to consults and very involved in case discussions and very supportive of the process."

"This has been a great learning opportunity for us. We always focused on readmissions from a clinical sense. When the MVP program was proposed, it was the broader ***perspective that we needed."***

DOU – Response IASUD

- "In our experience, most cases are ETOH related. Our Psychiatry Chair is very involved as is our CATCH team. The lesson we have here is early involvement of the CATCH team while the patient is in the ED is helpful. The CATCH team is always involved, they see the patients in the ED with us."

DOU – Response 3rd Party

Nursing Home and Adult Homes. Identifying who the stakeholders are and reaching out to them. The lesson learned is reaching out is generally very well received. When we reach out, we find things they can work on from their end. The complex care note in the ED really helps us out as well to communicate what we have discussed and put into place, so they are aware.

"We had our clinical leadership, including *hospital medicine, case management and* ***ED on board from the beginning."***

Team Members

"Reaching out has been really well received."

- Hospital Medicine
- Quality improvement
- Case Management
- Social Work
- Emergency Medicine – highly motivated and engaged, they have been a big asset to us in this initiative
- Health Homes – they receive the list of MVPs daily and are actively screening the list for eligibility.
- Nephrologists – they have been very receptive to working with us.
- Nursing Homes – Medical Directors; we are working on warm handoffs with the nursing homes to improve communication and collaboration.
- Adult Homes – we reach out to them every time the patient is admitted; that way we can come to solutions with them.
- CATCH Team – they are very engaged, very open to solutions.
- Pulmonary Medicine
- Health Solutions – close communication with the patient navigators; the patient navigators are always available; they put in input into what they see in the community and collaborate with us.

Next Steps

- Goals for Q4 2022
  - Continue collaboration with the ED.
  - Continue collaboration with the health home.
  - Attain and get better, more effective and more efficient.
- Goal for 1 year from now:
  - In 2023 increase staff and hardwire.
  - Present to hospital leadership what the changes we made with a lean team.
  - Identify the hardwiring needed to make this standard operating process at the hospital.
  - Increase engagement of social work.

"Unique to SIUH is usually this program and these types** of readmissions are case management and social work driven, thanks to our physician champions, we have a lot of physician involvement in these cases and the **physician involvement really helps here."

Staten Island University Hospital - North

Monthly Outcome Measure Dashboard - Inpatient MVP Focus	Month 1 March 2022	Month 2 April 2022	Month 3 May 2022	Month 4 June 2022	Month 5 July 2022
A. Number of MVP discharges in calendar month	137	142	161	166	166
B. Number of Readmissions = # of discharges in A that were followed by an admission within 30 days	48	60	68	77	72
C. Readmission Rate (= B/A)	35%	42%	42%	46%	43%
D. Total MVP hospital bed days (and Average)	925 (7)	1,221 (9)	1,139 (7)	1,170 (7)	1,318 (8)

Staten Island University Hospital - **Prince's Bay**

Monthly Outcome Measure Dashboard - Inpatient MVP Focus	Month 1 March 2022	Month 2 April 2022	Month 3 May 2022	Month 4 June 2022	Month 5 July 2022
A. Number of MVP discharges in calendar month	38	35	44	36	51
B. Number of Readmissions = # of discharges in A that were followed by an admission within 30 days	15	13	17	16	16
C. Readmission Rate (= B/A)	39%	37%	39%	44%	31%
D. Total MVP hospital bed days (and Average)	245 (7)	220 (6)	233 (5)	242 (7)	347 (7)

Staten Island University Hospital MAX Series Success Stories

"With the help of coaching from Dr. Boutwell, the team were able to identify, assess and collaborate to show some real time results. The cases were boiled down to the DOU and we worked to set up linkages to establish appropriate patient centered care and this in turn resulted in a reduction in hospitalizations and ED visits."

"Patient had 16 ED + 10 inpatient chronic SUD; misses dialysis and then has a pattern after missing dialysis to come to the hospital for dialysis, which was her preference. Although we knew her before, the MVP assessment and processes helped us move forward in a different direction. The MVP team, ED and nephrology team developed a plan to divert her and get her to dialysis without using inpatient admissions. Since May, her inpatient admissions significantly reduced; the majority of her encounters were ED treat and release. We shifted her from 16 ED + 10 IN to 7 ED + 8 IN and we have seen great success with her in this program."

"Female resident from a nursing home with end stage renal disease (ESRD) and dialysis presented confined to a wheelchair with six inpatient admissions caused by hypertension due to missed dialysis. On the surface it appeared she was just non-compliant with going to dialysis, but upon diving in deep it appears she is nauseated and sick when she has dialysis in the morning. After this, we switched her to the afternoon, and the MVP team reached out to the Medical Director of the facility and the nephrologist, and we were able to make this adjustment to her schedule. We placed a complex care note in the ED and so if she returned to the ED the ED team could try to observe and treat and release."

"Patient had 7 ED + 9 inpatient admissions when we met with him in June. He is a long-term resident of one of our assisted living facilities; he tells the staff he is not feeling well, and his chest hurts. He will also call 911 himself, not believing that things will be ok. His workup is generally clear. After reaching out to the facility and formulating a care alert in collaboration with them and the ED team the patient's hospitalizations have significantly decreased."

"Female nursing home resident sent to the ED every time there was an issue with dialysis access. Three ED + 9 inpatient admissions. What it boiled down to was that we learned that the nursing facility runs dialysis five days a week, so there was never an emergent need to send the patient to the emergency room. So it was more about changing the culture and discussing with the nursing facility including the nephrologist and the medical director. We were able to identify some outpatient vascular access facilities that they can try to trouble shoot the access issues with rather than going straight to the ED since there was no emergent needs. Since then, the patient has not had any readmissions to the hospital."

New York City Health + Hospitals/Queens

Why MVPs? Why now?

- "This was a second pass participating in MAX for Queens. We really optimized our learning in our work with MVPs. This group is small but significant in terms of our impact on the readmission rate and use and mobilization of resources."
- "We just came through COVID and having our beds available and our precious resource there for patients, makes this work even that much more important so that we are looking for ways to streamline care and have avoidable admissions not come back to the hospital."

MVP Focus

Inpatient MVP population

Definition of MVPs

4+ inpatient admissions/12 months

Population/Volume Data

"We learned we just did not have the bandwidth to go after every MVP, so our goal was to commit to focus to really learn. Our goal was to see two MVP a day, five days a week."

How are MVPs Identified?

Report is produced at 7 am daily to identify MVPs in the hospital.

How is the Team Notified?

List is emailed to an extended MVP team, specifically our MVP SW who is basically the consultant for our MVPs.

How are MVPs Assessed?

- SW identifies two MVPs per day; performs the assessment and literally like the FBI, goes in and investigates everything she can about the patient and then takes her findings and shares it with the clinical staff. She is really responsible for the infusion of the DOU integration into the care plan.
- As we are assessing more and more of these patients there are key take aways. It is really about getting the big picture of what is happening with these patients. Our MVP SW is the FBI agent for these patients. She calls everyone who is involved – rounding, charting, calling family members - to get the story.
- Using the 5 Whys to drill down to identify the driver of utilization is key.
- We also learned that the collaboration between the medical and social perspective is very important and having our doctors on board with us is key to bridging everything together.
- The question "Who's not involved who should be?" was really key because it allowed us to think outside the box in terms of what is best for this patient, who needs to be involved, and it really did identify next steps of what we need to do for these patients.

How is the Process Managed Internally?

SW is essential for us in terms of link and manage over time, keeping us in touch with the stakeholders, family, community resources, and care team. SW is dedicated to this so therefore has the continuity over time to know the patients and they know her.

How Does the Team Collaborate with External Partners?

- We have an interdisciplinary huddle where we are really learning about these patients; every single person adds value in terms of something we have not thought about and bringing a different intervention or service to these patients.

- The SW lead is embedded in care management which has made a big difference because even after the MVP goes home, there are ongoing discussions; we are able to work over time. "The ongoing collaboration is a beautiful thing to see because we are still in touch with the patient even after they have gone and then if they are readmitted, they are able to re-engage and see the patient - what's going on and what brought the patient back and it really builds a bond between our SW and CM and the patient and it's a great thing to see."

How Does the Team Plan?

- We have a Hospital Intervention Note where we house the information about our MVPs.
- We have been working to get alert as visible as possible, within in bounds of what we in an 11-hospital system can do. We are using in-services and liaisons in the ED to let providers know the alerts are present. We want to make it as easy and user friendly as possible.
- For certain patients, the physician champions will review the case to identify the medical perspective – especially for patients who have had recurrent work ups for the same thing.
- Looking for specific medical perspective we can provider to the ED that can give them some reassurance about the case.

How are MVPs Tracked?

The registry contains information about each MVP; we gather information over time, it is a very helpful tool.

Top Drivers of Utilization

DOU – Response IASUD

The majority of our cases were IASUD. We really did not have a definitive link. The resource we found was our chemical dependency unit, which is based in our ED. Prior to us doing this work they only worked in the ED. But after continued collaboration especially with our MVP SW, they now come to the bedside to visit our patients in the hospital. They really help connect to services for this population.

DOU – Response IAGOC

A lot of our patients have a lot of comorbidities, and the goals of care conversations are not happening the way we would like them to happen – a lot sooner. We found we were able to bring our palliative care team on board sooner to help with these cases.

DOU – Response IAPRI

We found we had a group of patients who were missing dialysis – and it turns out the reason was about transportation. A lot of our patients have emergency Medicaid, and so it turned out we needed to link them to access-o-ride and that was huge. That was a lightbulb.

DOU – Response IASS

This is where the "who is not involved" question really came into play because together we were able to figure out who needed to be involved and link to them.

Team Members

- ED Medicine
- Hospital Medicine
- Social Work
- Care Management
- Analytics
- Epic

External Partners

- Dialysis centers
- Care coordination services in the community
- SNFs

Next Steps

- Continue to refine the MVP Note/ED Care Alert optimization process.
- Continue to refine the role of the MD champion.
- In one year, we would love to have clear visibility of the MVP alert in Epic - ideally a one-click pop-up.
- Integrate Staff Education for dissemination of learning across the organization.
- We want to get to a point where everyone knows about MVP alerts – and find it to be helpful.
- Results! We are starting to see a longer time between visits.

"We have every department basically in the hospital participating in the MAX project; we are very fortunate"

New York City Health + Hospitals/Queens

Monthly Outcome Measure Dashboard - Inpatient MVP Focus	Month 1 March 2022	Month 2 April 2022	Month 3 May 2022	Month 4 June 2022	Month 5 July 2022	Month 6 August 2022
A. Number of MVP discharges in calendar month	147	161	159	196	137	141
B. Number of Readmissions = # of discharges in A that were followed by an admission within 30 days	---	56	66	67	60	55
C. Readmission Re-visit Rate (= B/A)	38%	41%	42%	31%	40%	26%
D. Total MVP hospital bed days (and Average)	999 (7)	1,006 (6)	856 (5)	1,324 (7)	1,038 (8)	840 (6)

New York City Health + Hospitals/Queens MAX Series Success Stories

"We had an MVP who preferred to come to the hospital for dialysis instead of his dialysis center. So our MVP SW called the dialysis center and called the nursing home, and she was able to case conference with them to work out a plan with all parties involved, so that if he is coming in, the dialysis center will be able to take the patient. She was able to speak to the NH about the concerns of the patient it was really a great collaboration to make **that all happen."**

"Male MVP with 25 admissions/year; employed and lives alone in community. Prior medical history of hypertension, COPD, ventricular thrombus, severe systolic heart failure, alcohol use disorder. The 25 admissions within 365 days related to cardiac symptoms and alcohol intoxication. He was following with a resident primary care physician, and he kept having different providers. We linked him with a stable attending primary care physician. SW became his continuity quarterback and became very integrated into his care, working to get him connected to SUD supports. We feel really proud about this particular patient – he was our Super MVP! All of his admissions were related to cardiac symptoms and alcohol use and our goal was primarily to link him to chemical dependency team and get Peers First to meet at the bedside then our counselors to meet at the bedside. Every admission he would say yes, then when it came time for action he would back down. We were assessing his readiness level every time he came back and finally during the last admission he said, 'Yes, I'm ready,' and we literally wheeled him to the chemical dependency unit where the team was waiting for him. He was engaged into the program and discharged the following day. He is not connected to a stable primary care physician. He has private insurance, but his insurance has a lot of copays which was a barrier, so we connected him to our pharmacy so now he doesn't have to pay copays. Given he has private insurance he doesn't have access to transportation, so we connected him to access a ride so now he is active with them. He calls us and calls the team to report to us on his progress. He returned to work after his last discharge, which is also a big success. In terms of preparing for his return, it's always a possibility but now we have a community of providers who are stakeholders, and we are making sure his needs are met."

MAX Series Cohort 2 Action Team Findings

Champlain Valley Physicians Hospital

MVP Focus: Emergency Department MVP population

Definition of MVPs: 10+ ED visits / 12 months

How are MVPs Identified?

The current method for identification includes knowledge of who is an MVP, referrals from ED staff, chart review, and periodic review of list generated by Population Health.

Who is Notified?

MVP identification is done manually by the ED social worker who is the "crackerjack" dispatched to meet with MVPs.

How are MVPs Assessed?

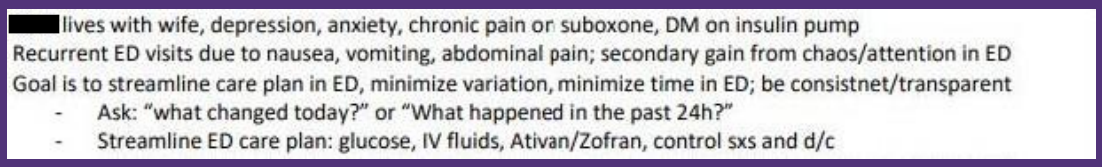
ED social worker meets with MVP in the ED utilizing MVP assessment tool to guide the conversation and identify which driver of utilization best fits MVP's current state.

How is the Process Managed Internally?

- ED social worker utilizes supportive, non-judgmental language and person-centered approach when talking with MVPs. Dispatch in-house community partners, when appropriate (mental health and substance use peers) or email community care team of MVP with updates on ED visit and plan to have continued communication to increase continuity of care.
- ED social worker creates ED care alert with actionable, need-to-know, brief information and place in EPIC under ED care alert tab and print out to have in ED charge RN binder. When ED care alert created, inform the Director of ED and the Medical Director of ED to disseminate to ED staff.

How Does the Team Plan?

- ED social worker creates ED care alert with actionable, need-to-know, brief information in EPIC under ED care alert tab.
- Care alert is printed out and placed in ED charge RN binder.
- When a care alert is created the Director of ED and Medical Director of ED disseminate to ED staff.



How Does the Team Collaborate with External Partners?

Previously a part of community meetings that were in place prior to COVID-19. These will restart and will provide an opportunity to discuss MVPs with community partners.

How are MVPs Tracked?

MVP List generated from Sorian and Epic, MVP Registry, and Implementation dashboard is utilized for MVP tracking.

Top Drivers of Utilization

DOU – Response IASUD

- Historically, a patient would present when intoxicated and we would hold them until they were no longer intoxicated and then discharge them.
- Optimally, we would identify this is a recurrent pattern, gather information (such as labs) needed and prepare for a linkage to detox or other recovery support services from the start of the ED visit.
- We have specific options to definitively link to a detox and/or to peer recovery support staff from our community agencies.

DOU – Response IABH

- Patients would come in under crisis and once evaluated are admitted psychiatrically or discharged to community
- Optimally, if cleared for discharge, connect with their community supports (care manager, counselor, etc.) and have warm handoff.
- National Alliance for Mental Illness (NAMI) peer support is also available to come to the CVPH ED to meet with patient. If they have a care manager, have them come pick patient up from ED. If necessary, have community meeting prior to discharge from the ED.

DOU – Response IABH

- Generally we treat the patient and discharge.
- Ideally we should ask what is lacking in their living environment and what ideal living environment would be. Understand how their living environment is impacting their ED visits.
- If needed, we can refer to Department of Social Services (DSS) emergency housing, provide education around housing options that align with their finances, identify a formal or informal support to assist with housing in the community.

Team Members

- ED Social Worker
- ED Nursing Staff
- Director of ED
- ED Medical Director
- Director of Patient Centered Care Management
- Director of Population Health Resources

External Partners

- National Alliance of Mental Illness
- Behavioral Health Support Network
- Clinton County Department of Social Services
- Champlain Valley Family Center
- Clinton County Mental Health

Next Steps

- Our immediate goal for the next quarter is to have a flag on the ED tracking board to identify MVPs.
- Our goal for one year from now is to have monthly meetings with our community partners to discuss MVP issues on a community scale. We had this in place prior to COVID, and we are looking forward to restarting these collaborations.
- We will continue to refine the role of the MD champion.

Champlain Valley Physicians Hospital

Monthly Outcome Measure Dashboard - ED MVP Focus	Month 1 June 2022	Month 2 July 2022	Month 3 August 2022	Month 4 September 2022	Month 5 October 2022
A. Number of MVP ED Visits in calendar month	148	157	165	154	161
B. Number of ED Re-Visits = # of ED visits in A that were followed by an ED visit within 30 days	103	102	125	112	125
C. ED Re-visit Rate (= B/A)	70%	65%	76%	73%	78%
D. Total MVP ED Length of Stay - Hours (and Average)*	42,180 (285)	45,530 (290)	47,520 (288)	45,584 (296)	49,427 (307)

*MVP ED Length of Stay and Average not available at MVP level. Figures are reflective of overall ED hours.

Champlain Valley Physicians Hospital MAX Series Success Stories

"Female MVP with an unaddressed frontal lobe traumatic brain injury (TBI) who came to the ED chronically homeless, was being financially exploited online by strangers. Through building rapport and a trusting alliance with patient, the MVP team worked to obtain a Social Security Representative Payee Program for her finances and secured her an intensive case manager through NYS to be able to have continued contact and support, as needed. Through collaborating with the patient's care manager, we were able to obtain supportive apartment housing and an intensive weekly therapeutic program. She has gone from over 400 visits in 2021 to decreasing her ED visits by 20%. She was at one point coming to the ED 4 times per day. This case shows that not all MVPs can be "fixed." Due to her TBI, she will always need continued support/collaboration in the community. Her case demonstrates that it is important to celebrate the small victories and to not be discouraged when an MVP backslides. MVP work is not linear, it evolves and sometimes MVPs revert to old habits. With this patient, building the trusting relationship and consistency was the key to improving her utilization. Now she is housed, financially stable and trusting with her support team."

"Male MVP living alone struggling with alcohol use disorder, with an extensive history of trauma and multiple recent losses. Presented to CVPH ED over 40 times in 6 months requesting detox. His identified DOU was IASUD. When a bed at a medical detox was not available, patient would leave once he felt sober enough to walk. Through building a trusting, therapeutic alliance over time with patient, he was able to trust the MVP team and slowly opened up about his goals and desires for when he is able to stay sober. The MVP team was able to secure patient a bed at a medical detox about 2 hours away, after many attempts due to lack of bed availability in our area. He is now living in a local halfway house and has not been to CVPH ED since March 2022. His story demonstrates when working with someone with SUD, to always start where the patient is at. Building a therapeutic alliance over time will ensure the patient will reach out when they are ready for change."

"What we think is the DOU going into an MVP assessment, is not always the true DOU. Do not pre-judge."

Guthrie Cortland Medical Center

MVP Focus: Emergency Department MVP population

Definition of MVPs: 10+ ED visits / 12 months

Population Data

Average 90-100 MVP visits per month

How are MVPs Identified?

Frequent visitor flag on ED track board that calculates MVP status in real time; they are flagged immediately as soon as they register.

Who is Notified?

Registration staff sends a secure chat to the MVP team through EPIC to notify the team that there is an MVP on-site.

How are MVPs Assessed?

- MVP team will conduct MVP assessment.
- We learned that our Psychiatric Evaluator (available onsite at the hospital 24/7 to assess psych patients) is a great person on the team to assess – they see every mental health patient every time, so there is a lot of memory and awareness of collateral resources.
- We also utilized a local university internship program to include interns in conducting the assessment.

How is the Process Managed Internally?

- Once we know what the issues are for the MVPs, we huddle to implement linkages and next steps.
- We meet weekly as an internal and external interdisciplinary team to discuss cases and work together on a week-to-week basis.

How Does the Team Collaborate with External Partners?

There were previously regular meetings with community partners to discuss patient cases. This was disrupted by COVID-19, but partners are interested in resuming the meetings.

"We learned that many/most of our MVPs have behavioral health issues – whether that is a mental health illness, anxiety, or loneliness...when we dig into the story we find these issues."

How Does the Team Plan?

- Work as an interdisciplinary, interdepartmental team to develop response plans.
- Function as a small team that works closely together on a day-to-day basis.
- Utilize huddles to discuss patients in the ED.
- Facilitate a standing weekly meeting to review the MVPs and discuss cases. This has been especially helpful to develop future response plans that are aligned and coordinated between the ED + Psych staff.
- Have a spot in the MVP care flag to insert an ED care plan.
- Developed a smart phrase for the ED care plan so anyone on the team can fill that out.

How are MVPs Tracked?

Utilize an MVP patient registry which is reviewed on a weekly basis.

DOU – Response PPH

- There are several mental health patients who like to be on our mental health unit where there are groups and interactions. They have developed a pattern of coming even when they do not need a hospitalization because they are hoping to return to the unit.
- We developed a way to identify that pattern and utilize a consistent response to that repeated presentation.
- For MVPs in this category, first identify the pattern, then extinguish the habit. To do this, everyone needs to be on the same page to enable a consistent approach that makes sense for the situation. Once there is a shared understanding, an ED care plan is developed that minimizes the secondary gain/benefit of the behavioral pattern.

DOU – Response IACS

- Identify the pathologic/underlying cause of the behavior.
- Develop a clinically optimal response – which is to not perpetuate the behavior by establishing consistent boundaries.
- When creating the ED care plan, it should outline a consistent management approach giving clinically optimal care and not giving inappropriate care.

DOU – Response IASS

- Mobilize adequate supports and services, working collaboratively with community agencies.
- Identify who can mobilize the supports/services, definitively link (quickly), collaborate to ensure resolution.
- Identify a quarterback to be on-point to ensure resolution.

Team Members

- Administrative Director of ED
- Community Projects Program Manager
- ED social worker
- Emergency psychiatric evaluator
- RN Case Managers

- Primary Care Practice care coordinator
- IT/Epic Analyst
- Registration staff

External Partners

- Primary Care Practices

Next Steps

- We want to expand our team to have a larger group to include all of our psychiatric evaluators and all case management/social work. We now know what is successful and we can continue to embrace that.
- Start/ resume collaborations with community partners.
    - They are interested in doing that with us.
    - We have a history of doing this (prior to COVID-19), so success from the past to build on.

Guthrie Cortland Medical Center

Monthly Outcome Measure Dashboard - ED MVP Focus	Month 1 June 2022	Month 2 July 2022	Month 3 August 2022	Month 4 September 2022	Month 5 October 2022
A. Number of MVP ED Visits in calendar month	96	111	109	93	95
B. Number of ED Re-Visits = # of ED visits in A that were followed by an ED visit within 30 days	56	70	82	67	49
C. ED Re-visit Rate (= B/A)	58%	63%	75%	72%	52%
D. Total MVP ED Length of Stay - Hours (and Average)	475 (5)	328 (5)	537 (5)	619 (7)	522 (5)

Guthrie Cortland Medical Center MAX Series Success Stories

"This case is truly our biggest success. The patient is a young mental health patient who had a cluster of 10 visits in one week. His pattern would be to call 911 and say he had abdominal pain; EMS would bring him in and once here, he would escalate in his behavior, because he wanted to be admitted to the psychiatric unit. This pattern repeated over these 10 visits – he even did this same thing at another hospital. We came to understand that he liked the attention that came during these behavioral escalation events – including getting chased down the hall if he was trying to elope and or medicated when he escalated his behavior. We observed that if we didn't clear him medically and by psych this escalation pattern would occur. So we decided we were going to put everything we learned in this series into place and develop a plan for this situation. We put a plan in place to get him seen and evaluated in a timely manner so we could clear him as soon as possible. Then when he says he wants to go, we can safely and appropriately let him go. So this happened, and when he said he was going to leave, he was surprised we were comfortable with letting him go. He returned soon thereafter, and we did the same thing. And we followed our same plan. And that broke the cycle. He has the community supports he needs, and we have a plan to break the cycle."

"We have another young woman with borderline personality disorder and a history of self-harm. The behavioral health unit identified that it was no longer therapeutic for her to be admitted to the unit. She had a series of 14-15 visits in a row and we huddled as a team and developed an alternative plan. We met with all her community resources, her family, and developed a plan. We used to see her several times a week and now we only see her once every several months."

"We have found this a very rewarding *experience; it has been a great learning opportunity and we have definitively seen* ***successes with our patients."***

SUNY Upstate Medical University (SUNY Upstate)

MVP Focus: Emergency Department MVP population

Definition of MVPs: 10+ ED visits / 12mo

Population Data

- 332 MVP ED visits / month, about 10% of all ED visits
- 60% are to main university campus and 40% to our community campus
- These 332 visits accounted for > 2,000 bed-hours (86 days!)

How are MVPs Identified?

We have a new column on the ED track board with a purple star designation for MVPs visible to all.

Who is Notified?

- We have an Epic Shared Patient Lists ("MVP list") to organize lists of MVPs who are on-site or even if they are admitted inpatient which gives us more time to get to them.
- The social workers also notify each other of MVPs during handoff / shift report emails.

How are MVPs Assessed?

A dedicated ED MVP social worker (our "crackerjack") takes the lead on assessing MVPs in real time at the bedside, really building those relationships with the patient while they are here.

How is the Process Managed Internally?

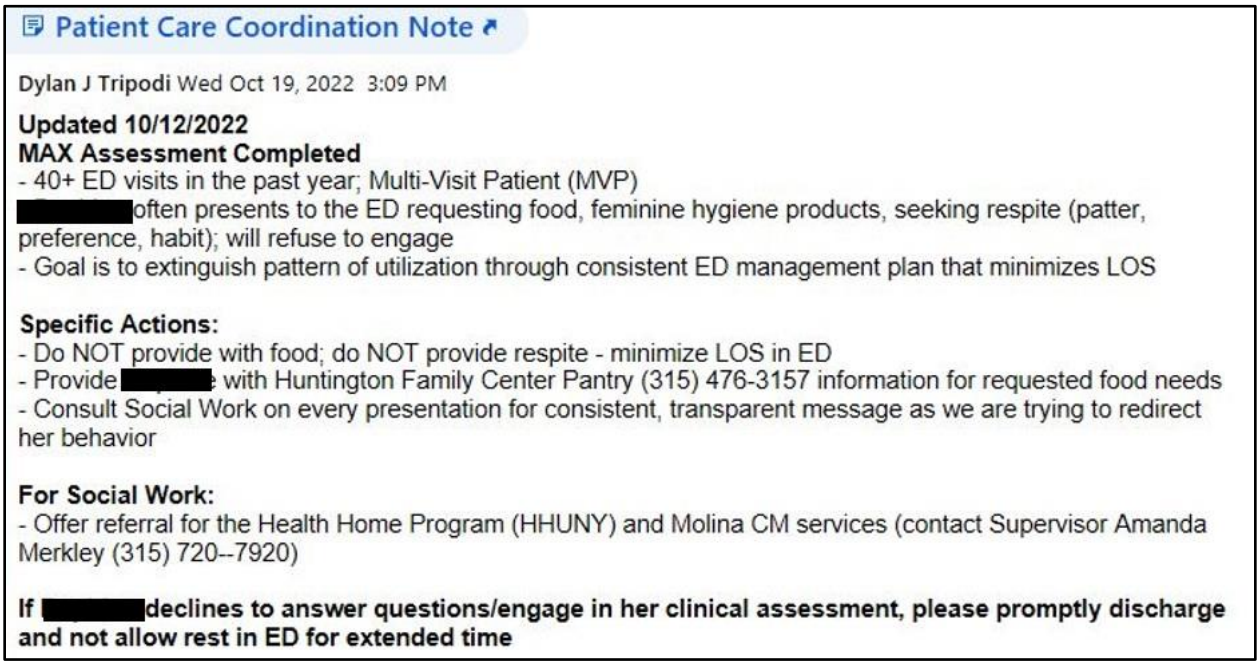
- MVPs are standing agenda items on monthly social work department meetings.
- Shift reports and handoff emails to provide detailed MVP-related updates.

How Does the Team Collaborate with External Partners?

- Working closely with health home leads, meeting on a monthly basis to discuss shared MVPs.
- Recently joined the monthly meeting with Onondaga County Integrated Care Project which is spearheading an initiative to decrease avoidable ED use. This will provide opportunities to establish more quarterback resources.
- Monthly meeting with a payer to discuss shared MVPs.

How Does the Team Plan?

The ED care plan is really helpful to communicate to future ED staff what the issue is and who the involved parties are.



Patient Care Coordination Note

Dylan J Tripodi Wed Oct 19, 2022 3:09 PM

Updated 10/12/2022
MAX Assessment Completed
- 40+ ED visits in the past year; Multi-Visit Patient (MVP)
[redacted] often presents to the ED requesting food, feminine hygiene products, seeking respite (patter, preference, habit); will refuse to engage
- Goal is to extinguish pattern of utilization through consistent ED management plan that minimizes LOS

Specific Actions:
- Do NOT provide with food; do NOT provide respite - minimize LOS in ED
- Provide [redacted] with Huntington Family Center Pantry (315) 476-3157 information for requested food needs
- Consult Social Work on every presentation for consistent, transparent message as we are trying to redirect her behavior

For Social Work:
- Offer referral for the Health Home Program (HHUNY) and Molina CM services (contact Supervisor Amanda Merkley (315) 720--7920)

If [redacted] declines to answer questions/engage in her clinical assessment, please promptly discharge and not allow rest in ED for extended time

How are MVPs Tracked?

One of the biggest challenges so far is the lack of an automated registry of all MVPs. We are working with our internal resources to get that in the future. So far we have developed, and use, a manual Excel spreadsheet. It's a good way to keep track of all the MVPs we are engaging.

DOU – Response IASUD

- This response looks very similar for IABH. We are looking to more adequately address substance use issues in real time from the ED. Luckily we are able to partner with Helio Health that has 24/7 availability for peer support. They are a real go-to human services agency for our MVPs.

DOU – Response IABH

- Consistent, transparent discussion; harm reduction approach.
- Definitive timely linkage to SUD support from the ED.
- ED SW – they bring the optimal response to the bedside.

DOU – Response PPH

- Identify pattern; redirect preference and extinguish habit in the ED.
- Develop sound ED care plan; consistent ED behavioral management approach.
- Identify specific options where people can find the shelter/socialization/food they need.

DOU – Response IALE

- Identify go-to options for definitive linkage.
- Warm collaboration and definitively link to housing/shelter agencies.

Team Members

- Program coordinator
- ED social worker
- ED Social Work Supervisor and Director of Social Work
- Information Management/ Epic Team
- ED staff
- ED leadership
- Director and Associate Director of Transitional Care

External Partners

- Circare/ St. Joseph's Care Coordination Network (SJCCN)
- Onondaga County Integrate Care Project
- Hutchings Psychiatric Center
- Helio Health
- Liberty Resources
- Rescue Mission
- Berkana House
- Nova House

Next Steps

- For our immediate next steps, we are planning to hire 2 MVP social workers dedicated to the Emergency Departments; 2 dedicated FTEs.
- Initiating MVP collaboration with cross-continuum partners (i.e., Onondaga County Integrated Care Project); raising awareness.
- Meeting with ED Leadership and clinical staff to educate on MVP Program processes and operations.
- Rethinking system levels planning.
- In the future we are working with Administration on "Clubhouse" concept; talks in place to help create a safe alternative to the ED designed for patients seeking food, sleep, respite, etc.
- We plan to work to ensure all MVPs have ED Care Alerts within patient's Care Coordination Notes and we will continue to work with Information Management & Technology (IMT) to create streamlined MVP population registry.

SUNY Upstate

Monthly Outcome Measure Dashboard - ED MVP Focus	Month 1 June 2022	Month 2 July 2022	Month 3 August 2022	Month 4 September 2022	Month 5 October 2022	Month 6 November 2022
A. Number of MVP ED Visits in calendar month	229	201	224	248	279	340
B. Number of ED Re-Visits = # of ED visits in A that were followed by an ED visit within 30 days	159	125	162	201	194	219
C. ED Re-visit Rate (= B/A)	69%	62%	72%	81%	70%	64%
D. Total MVP ED Length of Stay - Hours (and Average)	1,956 (9)	1,757 (9)	1,799 (8)	1,584 (6)	1,977 (7)	2,063 (6)
D1. Average ED LOS Hours Per MVP	21	21	21	20	22	22
D2. Average ED LOS Hours Per MVP Visit	8.5	8.7	8	6.4	7.1	6.1

SUNY Upstate MAX Series Success Stories

"Female patient with an extensive behavioral health history with 20 ED visits and 1 inpatient admission in the past year. She frequents both of our campuses. We noticed her presentations were for vague reasons that just didn't add up. So we dug deeper into what was really going on. We learned that she was traveling into town to visit friends, and then would come to the ED with vague complaints and she would end up getting a Medicaid cab ride back home. We engaged all parties who shared in the care of the patient, including her parents, and discussed use of the emergency room and the resources she had available to her closer to home. In the 3 months since we started engaging with her, visits are greatly reduced and that's really because of the collaboration with her, her parents, and her outside care managers as key to our success with this patient."

"Male MVP who is unstably housed had 10 ED visits and 4 inpatient admissions in the past year. Patient presented with vague suicidal ideation, would be seen by our psychiatric team in the ED and often discharged. As we got to know him, we came to appreciate his unstable/inadequate living environment was what was really contributing to his emergency department visits. We have 2 community partners that are respite programs. The typical process is that the patient needs to initiate the contact. We helped facilitate that contact right from the ED. Once there, there are case managers that get assigned to him. So once he was connected, we knew who his respite case manager was, and we would call them right away every time he came. Now he is in a supportive living environment, active with a PROS program and I'm happy to say he has not had any emergency department visits in the past 90 days! Such a big success for this patient!"

"We are going make sure all our MVPs have *ED care alerts and we will make sure* ***everyone in the hospital knows about this."***

Niagara Falls Memorial Medical Center (NFMMC)

MVP Focus: Emergency Department and Inpatient MVP populations

Definition of MVPs: 4+ inpatient admissions / 12 months and 10+ ED visits/ 12 months

Population Data

- We have about 20-30 ED MVP visits per week and about 3 inpatient MVP admissions per week
- On average for inpatient MVPs we have about 15 MVP admissions. When we started, they used 83 to over 100 days per month for an average length of stay of over 5 days. In the most recent month, our average length of stay for inpatient MVPs is down to 3.5 days.
- In September we had 115 ED MVP visits and they accounted to 594 total bed hours, for an average LOS of about 5 hours per MVP visit.
- We track our implementation, and we are currently assessing about 50% of our ED MVPs and 100% of our inpatient MVPs.

How are MVPs Identified?

MVPs are identified upon presentation to the ED. The EMR identifies the patient if they are an MVP.

Who is Notified?

If the patient is an MVP, an email, called a “rhapsody alert” is sent to the MVP team.

How are MVPs Assessed?

- Social worker conducts DOU assessment to determine the patient’s driver of utilization and what supports and / or interventions are needed. Social work team engages in a trusting manner with MVP.
- We learned that if someone in the ED has a transparent conversation with an MVP, the patient will usually be open about what their actual needs are or what they are lacking in terms of support.

How is the Process Managed Internally?

- Collaboration with the Hotspotting Team
- Weekly meetings to review MVP cases
- Depending on the DOU for the patient, appropriate intervention and linkage are completed from the hospital setting by the MVP team. NFMMC has a number of internal resources to link and support patients (pharmacy services, Continuing Day Treatment program).

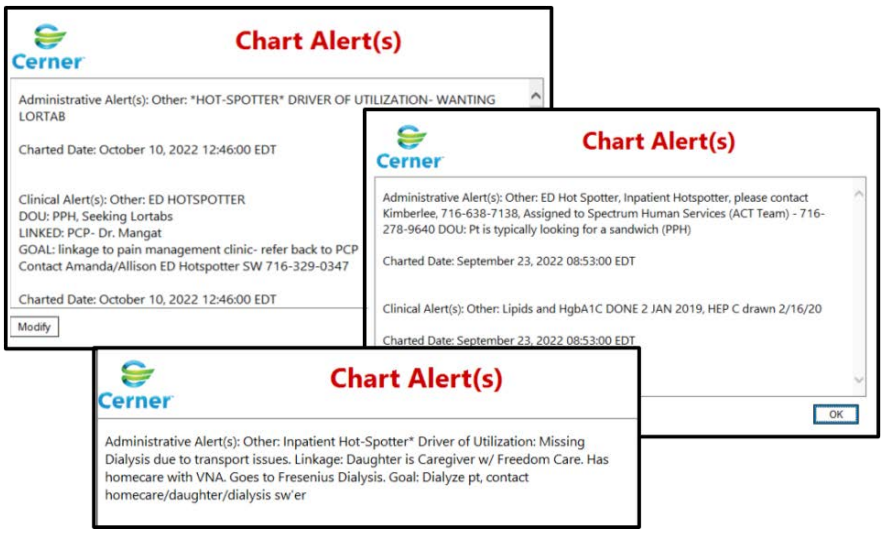
How Does the Team Collaborate with External Partners?

NFMMC has a number of relationships that provide linkages to MVPs for appropriate resources depending on the DOU(s). For example, a patient who has a DOU of Anxious, Afraid, Alone, may benefit from in-home supports available through VNA services. Patients with IASUD may be linked to White Deer Run Rehab, which will come to NFMMC to pick up patients who are in the "action phase." The Continuing Day Treatment Program, Riverview Pharmacy, and medication reconciliations may all be "in-house" resources, but they are also essential to supporting patients in the community.

How Does the Team Plan?

- Social work team completes a pop-up alert detailing why patient normally presents to the ED, who the patient has linkage with currently, what linkages/ services the patient could benefit from, and what the desired outcome/plan would be for the return.

Here are examples of our ED care alerts:



How are MVPs Tracked?

We have real-time emails, a daily list, a weekly list, and a registry. We maintain a weekly dashboard and monthly outcomes tracking.

We review our MVP lists at team meetings using our registry. We also use our registry to describe our MVP population. For example: the average age of our Inpatient MVPs is 58; they are 61% female. 100% of our MVPs are either covered by Medicare (54%) or Medicaid (46%). We noticed for our inpatient MVPs 75% are medical and 25% are behavioral health. We think that is because we have a great team in the ED who really work with our behavioral health clinics and resources to get people what they need from the ED.

For our ED MVP population, the average age is 47. Interestingly there is a higher percentage of male patients (60%) than female (40%). The average number of ED visits per year for our ED MVPs is 16. The majority of our ED MVP patients are covered by Medicaid (66%) followed by Medicare (34%).

*"**We found that often MVPs do have chronic issues, and that** these issues could be addressed on an outpatient basis. However, MVPs come to the emergency room because they **seek an immediate response."***

DOU – Response AAA

- We have patients whose visits are in the context of being anxious, afraid, and/or alone.
- The general response to this situation is to provide more frequent or proactive support and reassurance.
- Optimally, we would increase contact, arrange for tighter community-based linkage, foster a trusting relationship outside of the ED, and help develop a response system and coping strategies to the situations and circumstances that trigger these feelings. Specific community partner options include the Assertive Community Treatment team and Monroe Case Management services.

DOU – Response IALE

- The general response is to change/modify living environment.
- Our optimal response is to develop a helpful, trusting relationship, directly navigate into the housing system, proactively collaborate with key contacts in the housing system, and provide consistent, transparent engagement in the ED. In the ED we utilize DSS a lot, so it's not just sending someone to DSS but connecting with someone at DSS to help facilitate the visit and provide information in advance. Another specific option for linkage includes Gospel Mission.

DOU – Response IAPRI

- The general response is to develop a more adequate plan for the recurrent issue.
- The optimal response is to Identify the recurrent issue, identify the people involved in the plan regarding that issue, convene those people to develop a plan that does not involve the ED, test and reiterate on that plan.
- Specific options include case conference, sometimes involving 5-6 representatives from different community partners to reduce visits.

Team Members

- ED Social Work
- Inpatient Social work
- Director of Social Work
- Director of Outpatient Behavioral Health
- IT
- Administrative staff
- In-house RN who completes medication reconciliations

External Partners

- Visiting Nurses Association
- Continuing Day Treatment Program
- Riverview Pharmacy
- White Deer Run Rehab

Niagara Falls Memorial Medical Center

Monthly Outcome Measure Dashboard - Inpatient MVP Focus	Month 1 July 2022	Month 2 August 2022	Month 3 September 2022	Month 4 October 2022
A. Number of MVP discharges in calendar month	15	15	16	9
B. Number of Readmissions = # of discharges in A followed by an admission within 30 days	2	0	2	0
C. Readmission Rate (= B/A)	13%	0%	13%	0%
D. Total MVP hospital bed days (and Average)	83 (5)	194 (11.4)	57 (3.6)	37 (3.2)

Monthly Outcome Measure Dashboard - ED MVP Focus	Month 1 July 2022	Month 2 August 2022	Month 3 September 2022	Month 4 October 2022
A. Number of MVP ED Visits in calendar month	92	96	115	70
B. Number of ED Re-Visits = # of ED visits in A that were followed by an ED visit within 30 days	76	65	68	30
C. ED Re-visit Rate (= B/A)	82%	68%	59%	42%
D. Total MVP ED Length of Stay - Hours (and Average)	Not available*	Not available*	594 (5)	436 (6)

*MVP ED Length of Stay and Average not available at MVP level for July or August

Niagara Falls Memorial Medical Center MAX Series Success Stories

"Male patient with extensive behavioral health issues resides in a motel. 71 ED visits in the past year. We consistently and transparently engaged with him about his utilization history and pattern. We formed a relationship with him which allowed us to link him to a case manager and a 5 day-a-week day program and the ACT Team. Since meeting him at 71 visits, in the past 120 days his visits are down to only 10!"

"Female patient living in supportive housing with COPD on home oxygen. She had 6 admissions in the past year, all for respiratory distress. When we looked into why this was happening, we learned that although she lived in a supportive living environment, when her oxygen fell off from her nose, the staff were not allowed to help replace it for her. So she would go without her oxygen for a period of time, and develop respiratory distress and then they would send her to the ED. After clarifying that the staff cannot assist her, we determined that her living environment was not adequate to meet her needs. We case conferenced with the supportive living environment and patient and family, and we all came to a shared understanding that a skilled nursing facility was the more appropriate living environment to meet her needs. Since moving to the skilled nursing facility she has not been back to the ED or hospitalized!"

"Female patient with alcohol use disorder, anxiety, depression, GERD, hypertension, sleep apnea, abdominal pain. 18 ED visits and 2 inpatient stays. Although her chief complaints varied widely, when we looked at the overall big picture, we could see that most of the visits were related to consequences of inadequately addressed substance use disorder. When we engaged in consistent, transparent discussions about this with her, she admitted to drinking about a gallon of alcohol a day. We huddled with ED social worker, White Deer Run rehab, collaborated with the ED staff to hold her until the morning so we could make a definitive linkage to SUD treatment, which is what she needed most. Since making that linkage to rehab over 100 days ago, she has not been back to the ED."

*"**We also learned** that the chief complaint is usually not why the patient is actually presenting. There is almost always an underlying issue unrelated to the chief **complaint."***

Conclusion

Over the course of MAX Series 2022, the eight participating Action Teams developed robust care pathways for their MVP populations that followed the four key process steps described in this report: Identify, Assess and Plan, Link, and Manage. The Action Teams leveraged their existing workforce, infrastructure, and budget, demonstrating that improving care for MVPs can be achieved, not by doing more, but by doing something different for the patients who need it most.

MAX Series Results

MAX Series engaged eight New York hospital Action Teams from across the continuum of care, each of which attended 3 workshops and committed to Action Plans focused on improving care for MVPs.

System Integration

100% of Action Teams meaningfully engaged an interdisciplinary, cross-setting team.

100% of Action Teams implemented systems to identify MVPs in the acute care setting.

100% of Action Teams assessed the drivers of utilization to understand the non-medical, human reason as to why the MVP was frequently admitted.

100% of 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.

RCCI Capability

100% of Action Teams convened or planned their own RCCI Workshops.

Overall, Action Teams reported increased confidence in their ability to make change in the following areas: reduce utilization, improve outcomes, successfully implement and sustain improvements to MVP care processes, and work with other organizations across the care continuum.

Acknowledgments

An essential hallmark of the MAX program and the strategy for improving care for multi-visit patients is interdisciplinary and cross-continuum collaboration. Reflecting on all the contributions of those involved in this MAX program demonstrates the power of collaboration and the essential contributions of everyone involved. At a glance, the MAX Action Teams engaged more than 90 clinical and social service providers representing over 50 organizations, even while the COVID-19 pandemic caused uncertainty and stress in the healthcare delivery system. The contributions of each and every person who extended themselves to learn, test, and "do something different" are deeply appreciated and made all the difference in the success of this program.

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Niagara Falls Memorial Medical Center

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Interdisciplinary and Cross-Continuum Partners

Montefiore Medical Center (Moses Division)
Complex Care Team
Social work and CTCC team
Assistant Directors, Social Work
Medicine Physician Service Directors
Emergency Department Director
Care Management Organization
Nursing Facilities
Housing at Risk Program
Behavioral Health Team
IT Team for the Medical Center
IT Data Specialist
Medical Director, Complex Care
Physician Champion, Department of Psychiatry
Information Security Engineer
Director, Hospital Readmissions Reduction
Associate Director, Care Management Organization
Clinical Director of Nursing

Senior Director, Acute Care Operations
Richmond University Medical Center
Community Health Action of Staten Island (CHASI)
Office of the Aging
Coordinated Behavioral Care
Project Hospitality
Palliative Care
ED SUD Peers
Physician Leadership
Regional Cross-hospital Collaboration
Director of Care Management
Social Work
IT
Hospital Medicine
Emergency Medicine
Nursing Homes
Adult Homes
Community Agency for Senior Citizens
Staten Island University Medical Center
Emergency Department
Health Homes
Nephrologists
Nursing Homes
Adult Homes
Psychiatry (Chairman, CATCH Team)
Pulmonary
Health Solutions
CATCH Team
Quality Improvement
Case Management
Social Work
Emergency Medicine
Hospital Medicine
New York City Health + Hospitals/Queens
IT/Data/EMR
LEADs Team
Assertive Community Treatment Team/community
Transportation
HD Centers/ Dialysis Centers
Care Coordination Services in the community
ED Care Management
ED Providers
Ambulatory Clinics
Pharmacy
Skilled Nursing Facility
ED Medicine
Hospital Medicine
Social Work
Case Management

Champlain Valley Physicians Hospital
ED Medical Director
ED Nursing and Clinical Staff
National Alliance on Mental Illness
Behavioral Health Support Network
Clinton County DSS
Champlain Valley Family Center
Clinton County Mental Health
Guthrie Cortland Medical Center
Administrative Director of ED
Community Projects Program Manager
ED social worker
Emergency psychiatric evaluator
RN Case Managers
Primary Care Practices/ Primary Care Practice care coordinator
IT/Epic Analyst
Registration
SUNY Upstate Medical University
Program Coordinator
ED Social Work
ED Social Work Supervisor/Director of Social Work
Information Management & Technology (IMT)
ED Leadership and Staff
Director and Associate Director of Transitional Care
Circare
St. Joseph's Care Coordination Network
Onondaga County Integrated Care Project
Hutchings Psychiatric Center
Helio Health
Liberty Resources
Rescue Mission
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Continuing Day Treatment Program
Riverview Pharmacy

Report prepared by olanin
on behalf of the 2022 MAX Series Program Team

For more information on the MAX Series please visit the
NYS Department of Health MAX Series Webpage at
https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/pps_workshops/max.htm