The MVP Method

Clinically credible - operationally feasible - locally adaptable - effective

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Developer, STAAR, ASPIRE, MVP Methods
President, Collaborative Healthcare Strategies

COLLABORATIVE HEALTHCARE STRATEGIES

The MVP Method
Multi-Visit Patients

Agenda

- Who are MVPs? What is the MVP Method? ~30 minutes
- MVP Method in Action: University of Vermont Medical Center ~30 minutes
- 5 Steps to Get Started, Q&A, Discussion ~30 minutes

Questions are welcome in the chat at any time!

COLLABORATIVE HEALTHCARE STRATEGIES

The MVP Method
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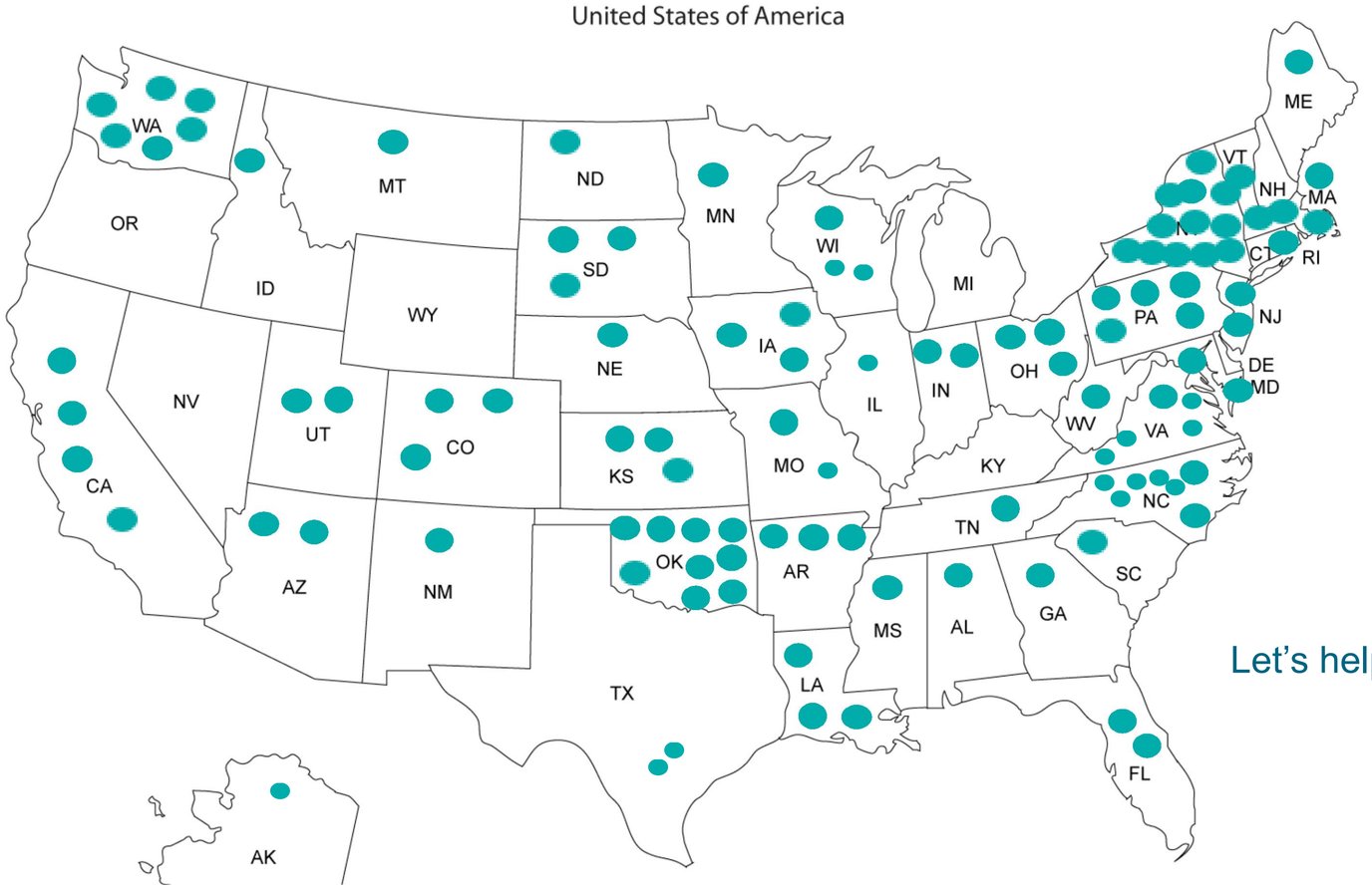
Objective: Every Hospital has an *MVP Care Pathway*



Let’s help YOU build an MVP care pathway

Over 200 sites in 40 states

COLLABORATIVE HEALTHCARE STRATEGIES

The MVP Method
Multi-Visit Patients

Who are Multi Visit Patients (MVPs)?

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Multi-Visit Patients

MVPs: Multi Visit Patients

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

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Multi-Visit Patients

MVPs: Defined by Setting

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

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IN MVPs: Key Stats

Inpatient MVP: multiple admissions to the acute care setting in the past 12 months

4+

7% - 25% - 58%

36% v. 8%

85%

AHRQ HCUP Statistical Brief #190 May 2015
CHIA Hospital-wide All Payer Readmissions in Massachusetts June 2019

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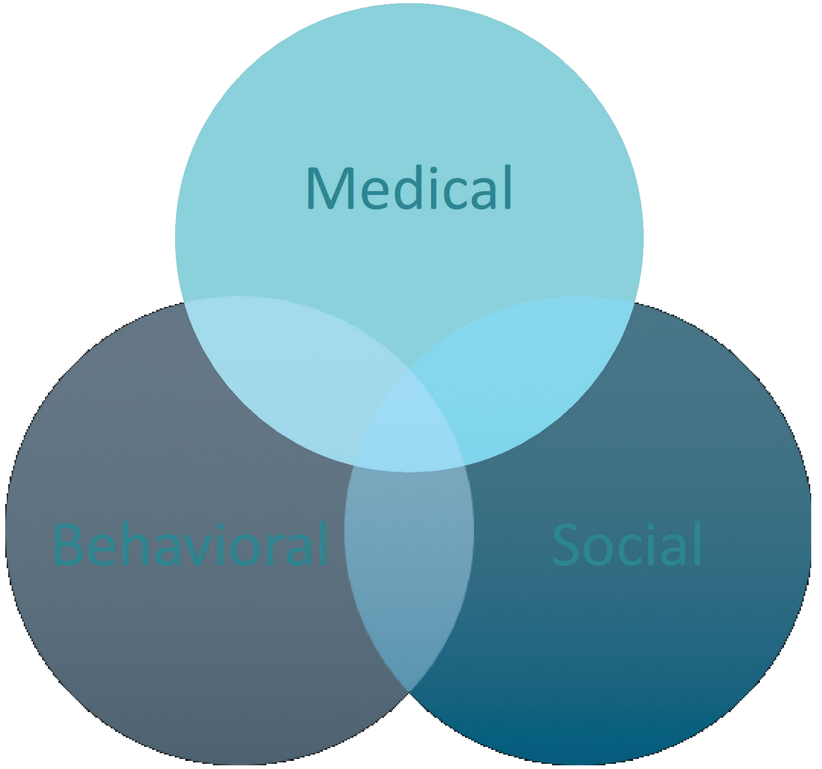
MVPs: Top 10 Discharge Diagnoses

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

➢ *Combination of medial, behavioral and social issues*

➢ *“MVP syndrome”*



AHRQ Statistical Brief #190

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J.B.

“I need housing, not a shelter. I need someone to help make sure I take my medicines. In a shelter they don't do that and they kick you out every morning. I need a stable residence and no one is able to help with that."

- J.B.

“I’m thinking of throwing a brick through a window to get sent back to prison

At least they’ll take care of me there."

- J.B.

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Too sick

Too complex

Too disengaged from care

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“un-impactable”

It is possible

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What is the MVP Method?

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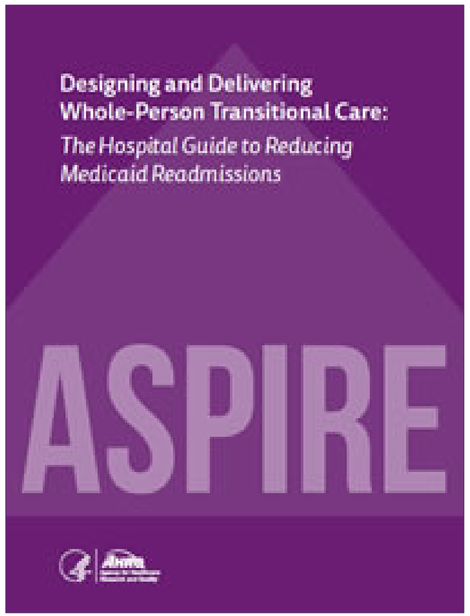
MVP Method Rooted in 10 years Readmission Reduction Experience



- Know your data
- Understand root causes
- Cross-continuum team
- Behavioral, social services
- Effective engagement
- Whole-person needs
- Find MVPs on-site
- Have a care pathway
- Reliably implement
- Plan for the return
- Alert next provider
- ED Care plans

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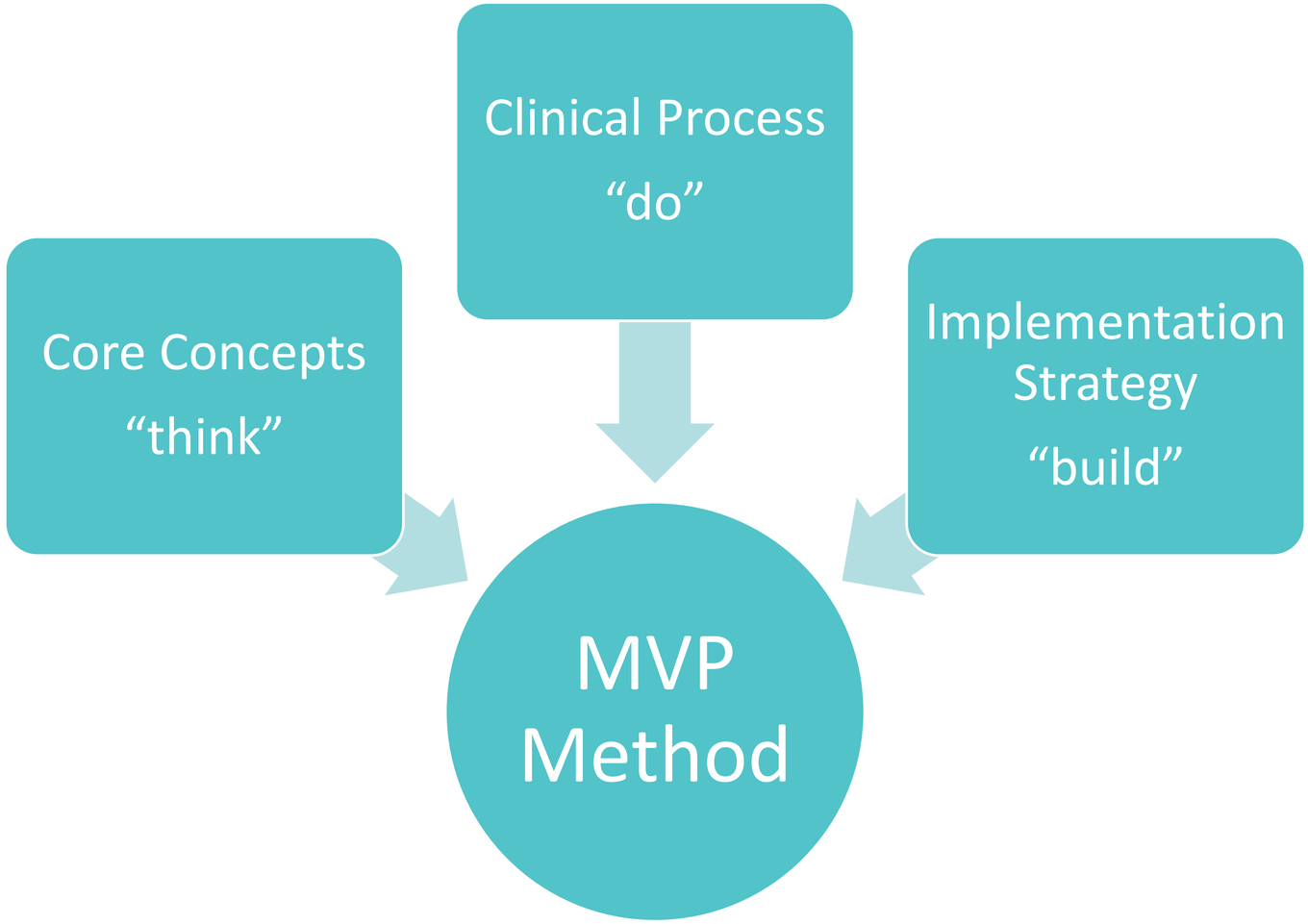
Design Thinking



COLLABORATIVE HEALTHCARE STRATEGIES

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MVP Method was Design for Scale – Applicable Across Settings, Populations

HealthAffairs

HEALTH AFFAIRS BLOG

DIFFUSION OF INNOVATION

RELATED TOPICS:
ACCESS AND USE | ORGANIZATION OF CARE | ACUTE CARE | DSRIP | EMERGENCY DEPARTMENTS | POPULATIONS | PATIENT TESTING | PATIENT ENGAGEMENT | BEHAVIORAL HEALTH CARE | IMPROVING CARE

MAX: Achieving Large-Scale Transformation By Engaging Front-Line Action Teams

Jason A. Helgerson, Amy Boutwell, Douglas Woodhouse, Peggy Chan, Douglas Fish

MARCH 30, 2018 **DOI:** 10.1377/hblog20180327.761736

https://www.healthaffairs.org/do/10.1377/hblog20180327.761736/full/

Given our focus on achieving statewide results, the design of the MAX program was intended for scale—to be applicable and replicable across a variety of settings and populations. Contrary to defining a model and training teams to rigorously implement it, we consciously applied concepts from rapid-cycle continuous improvement to our design: We identified a set of methods and concepts instead of specifically defined protocols or models; we expected adaptation in local implementation; we encouraged learning from operational challenges and successes; and we refined our core methods over several cycles of implementation.

The MVP Method

MVP Core Concepts

Identify, engage on-site

Identify the DOU

Don’t over-medicalize

”Do something different”

”Definitive, timely linkage”

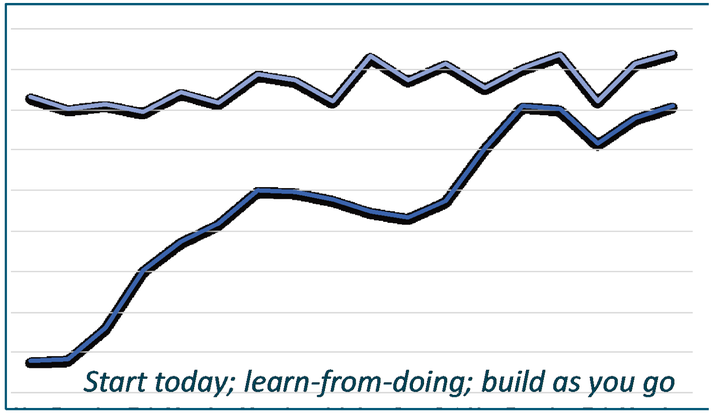
Helpful, trusting relationship

Be proactive, persistent

Manage to achieve stability

Plan for the return, ED Alerts

Implementation Strategy



*An interdepartmental, cross-setting **Action Team** leads the development of the MVP Care Pathway*

COLLABORATIVE HEALTHCARE STRATEGIES

The MVP Method
Multi-Visit Patients

MVP Core Concepts

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

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

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

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

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

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

COLLABORATIVE HEALTHCARE STRATEGIES

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Multi-Visit Patients

MVP Care Pathway

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

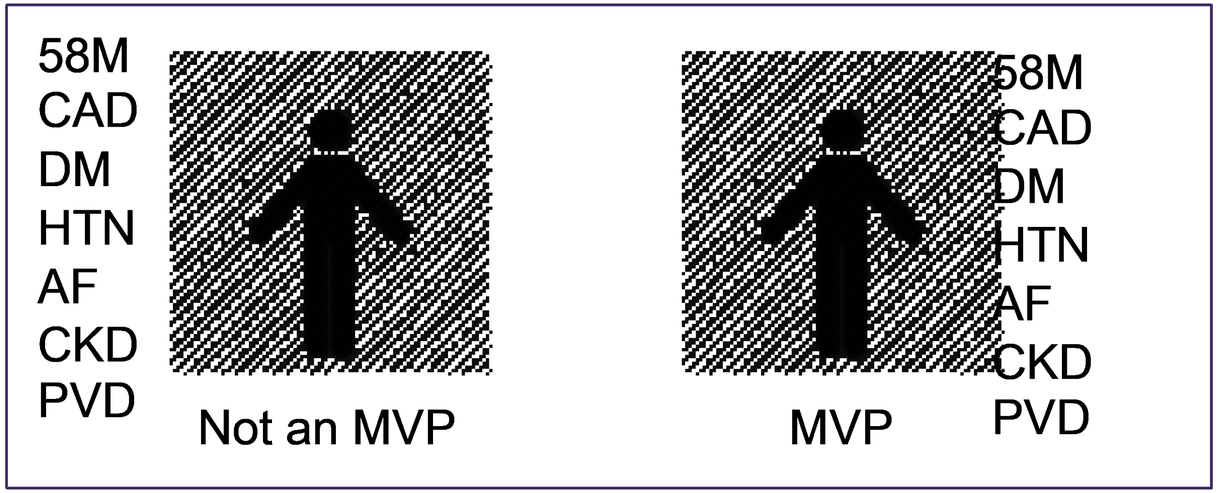
COLLABORATIVE HEALTHCARE STRATEGIES

The MVP Method
Multi-Visit Patients

Assess the *"Driver of Utilization"*

"Why is this person, with these needs and comorbidities, coming to the hospital so frequently, when someone else like them is not?"

- ✓ **Ask "why" 5 times**
- ✓ **Ask – Listen – Observe**
- ✓ **Don't over-medicalize**



Information + Observation = Assessment

COLLABORATIVE HEALTHCARE STRATEGIES

The MVP Method
Multi-Visit Patients

Identify the "*Driver of Utilization*"

- Ask "why"
- Be curious
- Listen and ask, "tell me more"
- Put aside the diagnoses as much as possible
- Don't over-medicalize, focus on the human element and the delivery system failures
  - Look for the care seeking patterns, the practice patterns, the logistics
  - Listen for the element of urgency, convenience, uncertainty
  - Observe: anxious/concerned? withdrawn/avoidant? normalized/routine? is there a 3rd party?
- Information + observation = assessment

Identifying the Driver of Utilization is a new skill in the MVP Method

COLLABORATIVE HEALTHCARE STRATEGIES

The MVP Method
Multi-Visit Patients

Develop a “DOU – Response” System

- Drivers of utilization are often not adequately addressed by tools in our existing tool box
- We need to identify “who” can help address various DOUs
- Start with general response – build out your local specific options

Driver of Utilization	General Response	Local Specific Options
Inadequately addressed goals of care	Adequately address goals of care	(eg) inpatient palliative care consult (eg) telemedicine palliative care consult (eg) family meeting
Inadequate plan for chronic recurrent issue	Develop adequate plan for the recurrent issue	(eg) case conference (eg) symptom response plan doesn’t default to hospital (eg) hospital at home, paramedicine, same-day response
Inadequately managed behavioral health issue	Adequately manage behavioral health issue	(eg) identify triggers and coping strategies (eg) teletherapy (eg) support groups
Inadequately addressed substance use	Adequately address substance use	(eg) harm reduction (eg) motivational interviewing (eg) recovery supports, coaches, groups, etc
Inadequate living environment	Change/modify living environment to be adequate	(eg) home safety evaluation (eg) supportive housing (eg) housing placement/replacement
“Third Party”	Work with the third party to develop alternative plans	(eg) case conference (eg) family meeting (eg) response plan that doesn’t rely on hospital

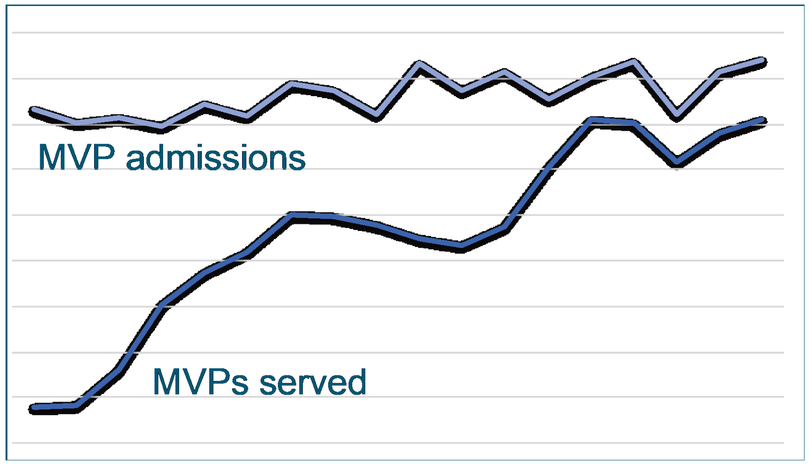
COLLABORATIVE HEALTHCARE STRATEGIES

The MVP Method
Multi-Visit Patients

MVP Care Pathway Implementation: Build-As-You-Go, Improve Week to Week

Prioritize how we are changing MVP service delivery

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



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The MVP Method
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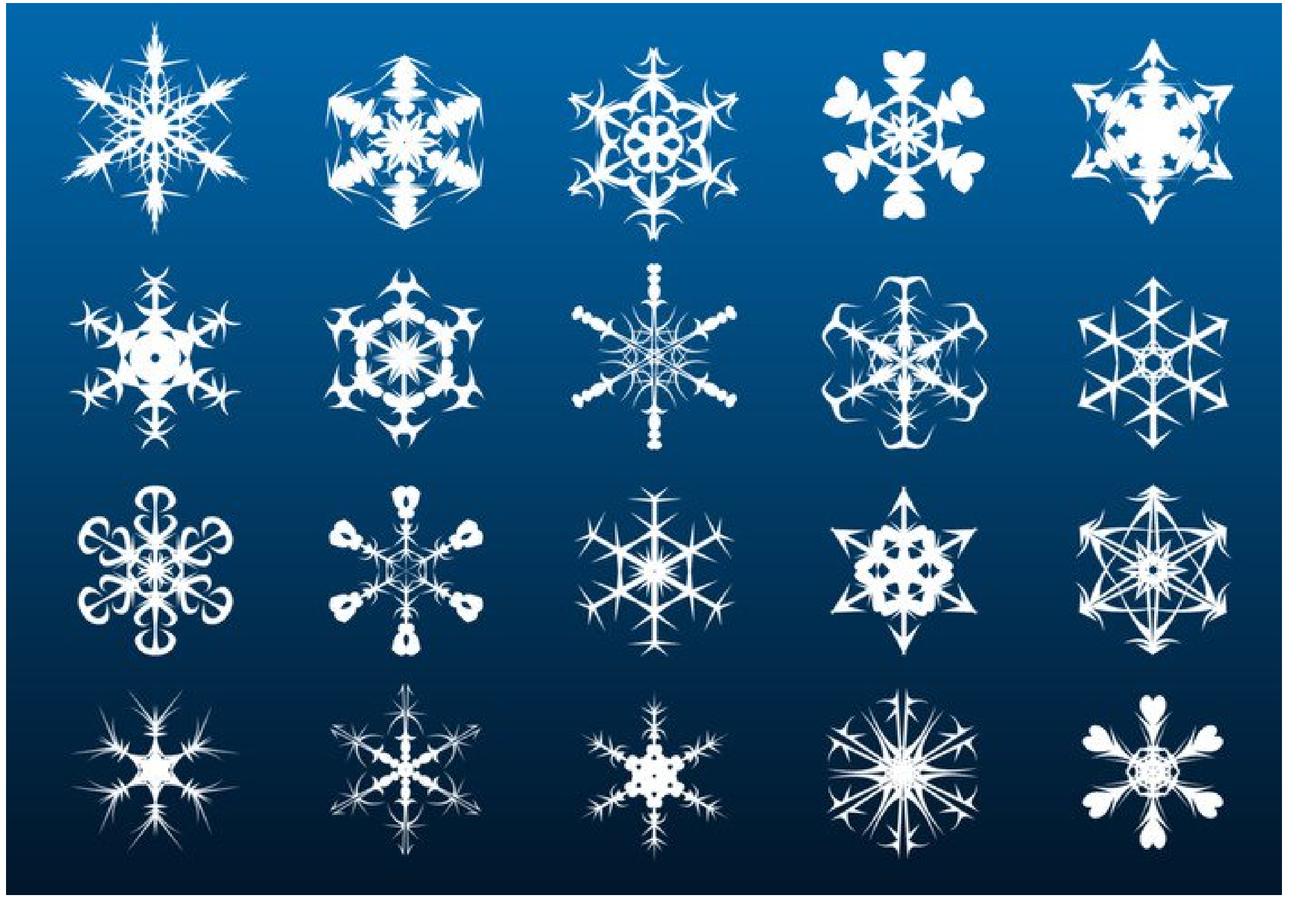
Universal Method → Individualized, Unique Programs



COLLABORATIVE HEALTHCARE STRATEGIES

The MVP Method
Multi-Visit Patients

Examples from the Field

COLLABORATIVE HEALTHCARE STRATEGIES

The MVP Method
Multi-Visit Patients

The “MAX” Program in NY

- >80 teams implemented the MVP Method in New York
- >1,200 healthcare and social service providers directly engaged in implementation
- Rural, suburban, urban; community, teaching, academic medical centers
- ED HU, IN HU, and special populations, such as: BH, HIV, sickle, COPD, homeless
- >90% teams implemented > 90% of MVP care processes – feasible, relevant, credible
- 18% readmission reduction in first year

NEW YORK STATE

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

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

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

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

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

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

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

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

COLLABORATIVE HEALTHCARE STRATEGIES

The MVP Method
Multi-Visit Patients

Vicky: 24 ED visits, 12 admissions past year

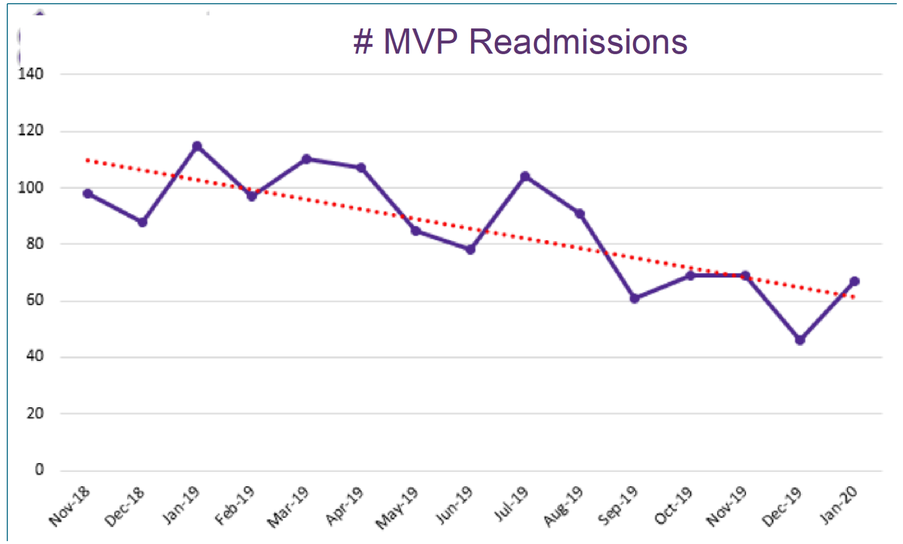
James: 100+ ED visits past 2 years

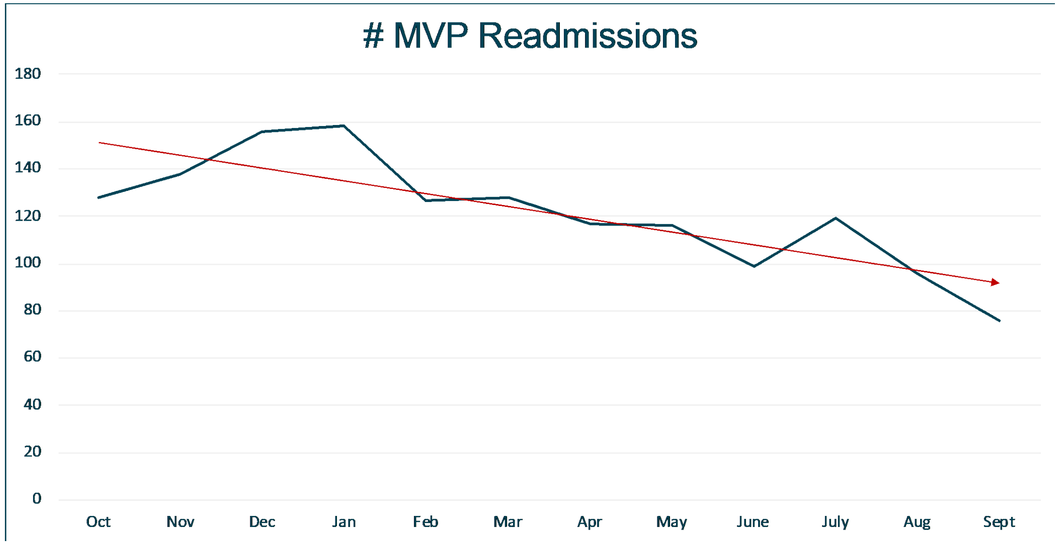
https://www.youtube.com/watch?v=JM24uEted_U

COLLABORATIVE HEALTHCARE STRATEGIES

The MVP Method
Multi-Visit Patients

Successes





"When we first started we had 5-6 MVP admissions per day, now we are down to 1 per day. We have had a remarkable decrease in readmissions. The hospital executives and the board are thrilled!"

The number of MVP readmissions per month has decreased from ~125 to ~75 in the first year

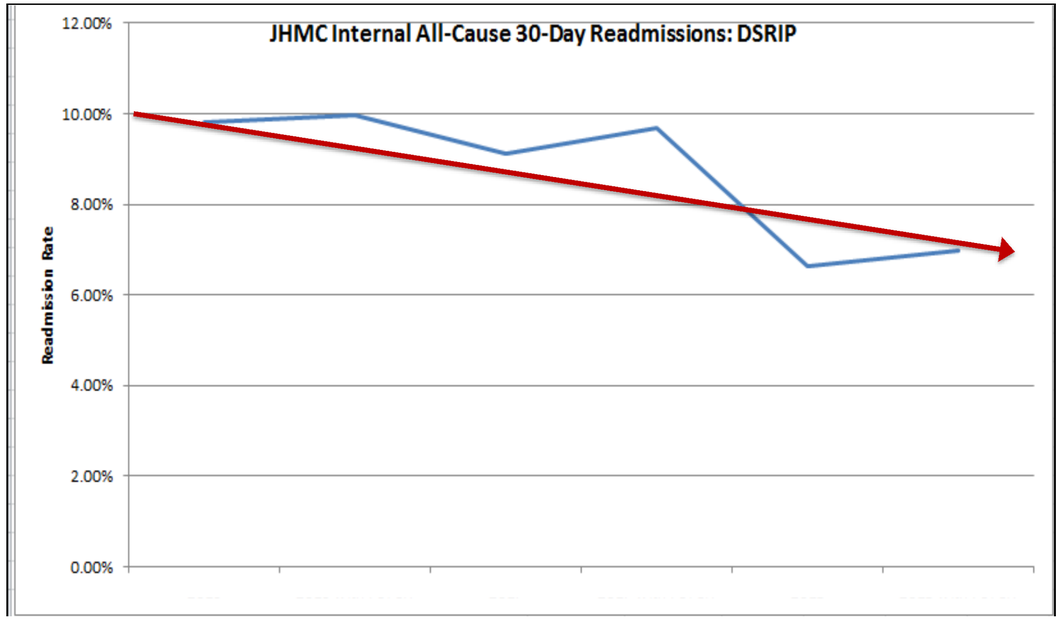
COLLABORATIVE HEALTHCARE STRATEGIES

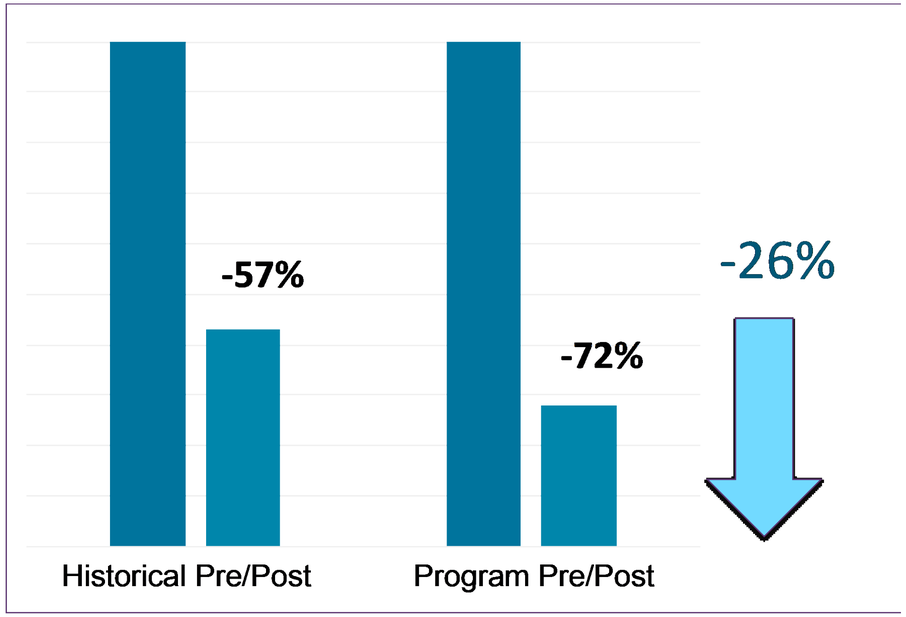
The MVP Method
Multi-Visit Patients

Successes

"Our most common causes for failure are related to lack of appreciation for human nature, behavior, and social factors.

We looked for the magic and we found that it is not magic. It is as simple as a decent meal and a supportive hand from a friend and advocate."





COLLABORATIVE HEALTHCARE STRATEGIES

The MVP Method
Multi-Visit Patients

MVP Method: Key Take-Aways

- *Universal method implemented across a wide variety of settings & populations*
  - ✓ *Core concepts*
  - ✓ *Care Pathway*
  - ✓ *Rapid-cycle continuous improvement*
  - ✓ *Interdisciplinary, cross-setting action team*

- *Every hospital can implement the MVP Method to develop feasible, effective MVP care pathway*

COLLABORATIVE HEALTHCARE STRATEGIES

The MVP Method
Multi-Visit Patients

UVMMC Multi-Visit Patient (MVP) Program

Amanda Kiruthi LICSW, MVP Case Manager
Lindsay Morse, RN, UVMHN Director Care Coordination

THE University of Vermont MEDICAL CENTER

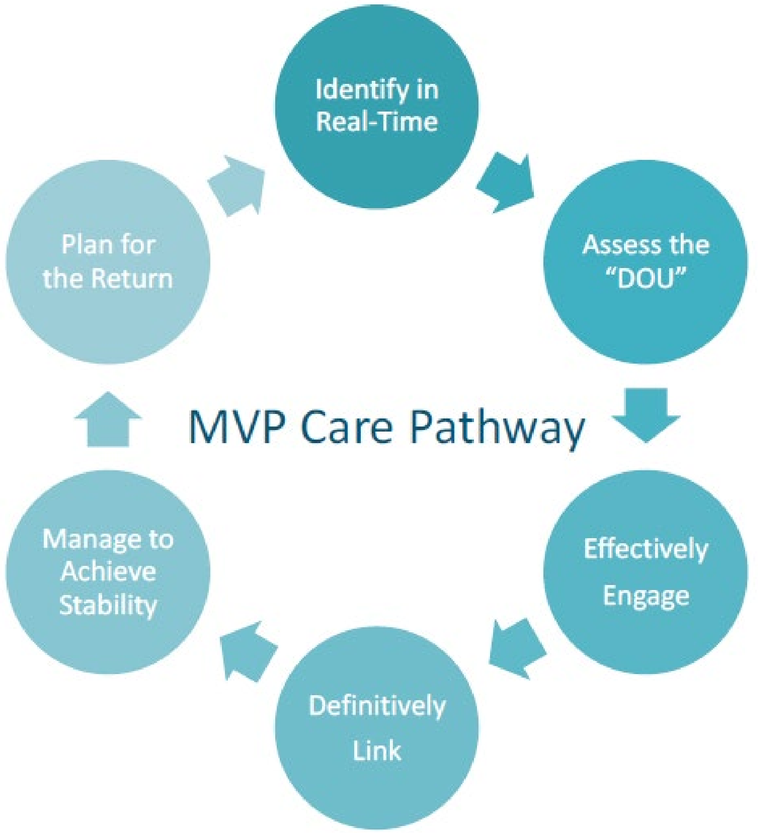
Our “Why” – Why Transform Care for MVPs?

- **MVP Purpose - “Do something different”**

- **Collective ah-ha moment**
  - Current practice when interacting with an MVP
    - **“Look to see what we did last time to successfully discharge....and do it again.”**
  - The moment we knew things needed to change

Getting Started: Implementing Process at UVMMC

- The Basics:
  - MVPs are INPATIENTS who have 4 or more INPATIENT stays in the past 365 days
  - Daily list sent to MVP Case Manager with the admissions and their # of INPATIENT stays *(and ER Visits for awareness in the past 30 and 365 days)*
  - Excluded are OB, Pediatrics, and Planned Readmissions



Who are IN MVPs at UVMMC?

- What we learned about our MVPs:
  - 53% Male, 47% Female
  - Age 21-95, 59% >65
  - 91% White/ Caucasian
  - 18% Burlington, 12% South Burlington, 10% Essex Junction, 9% Winooski
  - Payer:
    - Medicare 12%, Medicare ACO 40%
    - Medicaid 8%, Medicaid ACO 16%
    - Medicare Advantage 12%
    - BlueCross/Shield 6%

MVP Core Concept: Identify the *"Driver of Utilization"*

MVP Syndrome

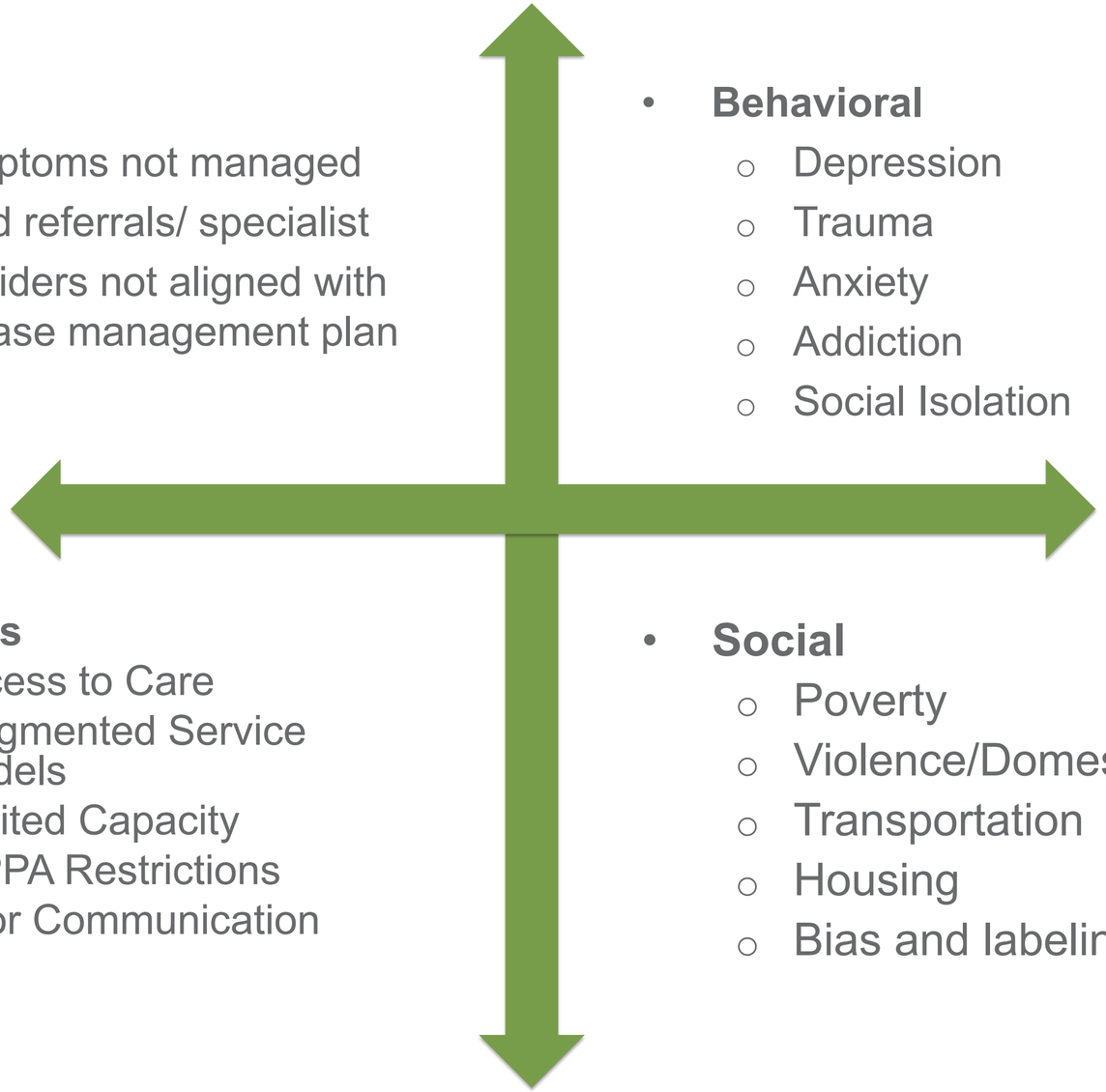
- Most MVP patients have co-occurring medical, behavioral and social needs.
- Multiple visits are a symptom of an unmet or inadequately addressed issue.
- A symptom is a manifestation of an underlying issue.
    - Just as there are many causes of fever, there are many causes of high utilization. We assess and identify that underlying issue, or **"driver of utilization".**
- We must effectively address the underlying issue in order to resolve the symptom.
    - We can expect recurrent utilization until we effectively address the "driver of utilization", the root cause of their returns.
- This requires us to "do something different". We need to change what we do and how we do it.

Drivers of Utilization at UVMC

***** "NON-COMPLIANT" is NEVER a DOU*****

- **Medical**
  - Symptoms not managed
  - Need referrals/ specialist
  - Providers not aligned with disease management plan

- **Behavioral**
  - Depression
  - Trauma
  - Anxiety
  - Addiction
  - Social Isolation



- **Systems**
  - Access to Care
  - Fragmented Service Models
  - Limited Capacity
  - HIPPA Restrictions
  - Poor Communication

- **Social**
  - Poverty
  - Violence/Domestic Abuse
  - Transportation
  - Housing
  - Bias and labeling

MVP Care Pathway Elements

- **Identify** high utilization using technology
  - Patient Ping – see hospital utilization outside of UVMMC in same time period

- All MVPs are **screened for and linked to** inpatient consults for:
  - Palliative Care
  - Smoking

- Actively **link to and collaborate with** community resources:
  - Para-Medicine Program Connection and Engagement
  - Initial MVP Assessments sent to Primary Care Offices and others as appropriate
  - Primary Care/TOC work positive relationships and communication (Internal and External)

Key Breakthrough: Screen all MVPs with Palliative Care Tool

PALLIATIVE CARE SCREENING TOOL

Criteria – Please consider the following criteria when determining the palliative care score of this patient

1. *Basic Disease Process* (2 points each)

a. Cancer (Metastatic/Recurrent)
b. End stage renal disease on dialysis
c. Advanced COPD
d. Advanced cardiac disease- CHF with low ejection fraction
e. Stroke with severe functional deficits
d. Other life-limiting illness

2. *Other Disease Processes* (1 point each)

a. Liver disease
b. Moderate congestive heart failure
c. Moderate renal disease
d. Moderate COPD
e. uncontrolled diabetes

3. *Functional status of patient (Score as specified)*

Using ECOG Performance Status (Eastern Cooperative Oncology Group) / ECOG Grade Scale

Grade 0 - Fully Active, able to carry on all pre-disease activities without restriction. (Score 0)

Grade 1- Restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature, e.g., light housework, office work. (Score 0)

Grade 2- Ambulatory and capable of all self-care but unable to carry out any work activities. Up and about more than 50% of waking hours. (Score 1)

Grade 3- Capable of only limited self-care; confined to bed or chair more than 50% of waking hours. (Score 2)

Grade 4- Completely disabled. Cannot carry on any self-care. Totally confined to bed or chair. (Score 3)

4. *Other criteria to consider in screening (1 point EACH)*

The patient:

a. is not a candidate for curative therapy _____
b. has a life-limiting illness and chosen not to have life prolonging therapy _____
c. has unacceptable level of pain >24 hours _____
d. has uncontrolled symptoms (i.e. nausea, vomiting) _____
e. has uncontrolled psychosocial or spiritual issues _____
f. has frequent visits to the Emergency Department (>1 x mo for same diagnosis) _____
g. has more than one hospital admission for the same diagnosis in last 30 days _____
h. has prolonged length of stay without evidence of progress _____
i. has prolonged stay in ICU or transferred from ICU to ICU without evidence of progress _____
j. Is in an ICU setting with documented poor or futile prognosis _____

TOTAL SCORE _____

SCORING GUIDELINES:
TOTAL SCORE = 2 No intervention needed
TOTAL SCORE = 3 Observation only
TOTAL SCORE = 4 Consider Palliative Care Consult

- ✓ Screen every MVP
- ✓ 4+ = pall care consult
- ✓ MVP Team can place the consult
- ✓ Notice how many MVPs screen +
  - Presence of serious illness
  - Limited functional status
  - Multiple visits
  - Poorly controlled symptoms

Definitive and timely linkage

- “Referrals” do **NOT** work for this population

- Important to Link to someone who will **directly help** (“Buddy”)
  - *Example: family, friend, SASH, VCCI, case manager, etc…*

- MVPs require a **DEFINITIVE** and **TIMELY LINKAGE**
  - In-person
  - Warm Handoffs
  - Timely Contact (less than 48 hours)

Definitively Link - Actively Manage Over Time

- Primary Care Offices
- Medical Home Case Managers (RN/SW)
- Home Health & Hospice
- SASH
- AgeWell
- VNAs
- SARs
- Hemodialysis
- Designated Agencies
- Howard Center
- And More…

CREATING PATHWAYS BASED ON DRIVERS OF UTILIZATION IS CRITICAL TO OUR PARTNERSHIPS AND COMMUNITY LINKAGE PROCESS

The best part: our successes

Mr. X

- Diagnosis: GI Bleed
- Admitted from: Home
- 6 inpatient stays in 12 months (3 of them in 1 month- June)

- **MVP CM**
  - Motivational Interviewing- gained patient perspective
  - Record review: Patient Ping, Epic, Telephone Encounters, called PCP (VA) office, read outpatient visit notes.
  - Contacted community supports- spoke with RN and MSW from UVM HHH to gain home health's perspective.
  - Identified Mr. X had been drinking more due to stress at home.
  - Driver of utilization= Behavioral/Social
  - Through motivational interviewing, patient agreed he needed to go to alcohol rehab. MVP CM helped support phone interview with inpatient alcohol rehab.
  - Worked with medical respite to secure a "safe place to stay" while awaiting rehab bed to open up (given triggers for drinking were at patient's home).
  - Identified the "Buddy" in community- a female friend who supported his plan and spoke with him on phone while hospitalized.
  - MVP CM and primary CM on unit worked closely together to support MDs and treatment team to keep patent an extra few days in hospital to allow the plan to unfold (Pt "medically cleared" for days; educated MDs on MVP).
  - Linkage: MVP CM communicated back to RN/MSW at HHH. Forwarded email with things that might need addressing if the plan fell through after discharge.

Mr. Y

- Diagnosis: COPD exacerbation
- Admitted from: Home
- 17 inpatient stays in 12 months (10 admissions since May 1, 2020)

- **MVP CM**
  - Motivational Interviewing
  - Palliative screen- positive (notify MD)- to date palliative engagement fluctuates
  - Record Review, Communication w/ HHH RN, MSW, Manager, SASH, PCP office
  - Driver of Utilization identified= Behavioral (anxiety, isolation, ETOH, smoking)
  - CHT Smoking Cessation Specialist referral made
  - Pt adamantly refuses SAR- discharge complicated
  - Intensive MVP case management: CFC application, spoke RN from state to get clinical approval expedited, ALF applications, frequent visits w/ patient
  - Ongoing collaboration with primary treatment team (CM, MD) d/t positive rapport. Strengths-based documentation. Countering narrative of “pt won’t change”.
  - Patient not home long enough between hospital stays to get services in place, plus challenges in reaching patient when home.
  - Supported Zoom Mtg with CFC CM to completed ILA for service plan while patient in hospital.
  - Goal may not be to decrease readmissions. Small improvements, such as 3 weeks home between stays vs. 1-6 days, and quality of care, quality of life.
  - Routed MVP notes to PCP at CHCB.

Ms. Z

- Diagnosis: ETOH withdrawal (secondary: C.Diff, pain, tachycardia)
- Admitted from: Home
- 10 inpatient stays in 12 months (5 admissions since May 1st)
-
- **MVP CM**
  - Motivational Interviewing
  - Record Review, Communication w/ Howard Center CM (CRT)
  - Driver of Utilization= Behavioral/Social (severe mental illness, domestic abuse, ETOH)
  - Palliative screening positive- palliative hosted team mtg with medicine, palliative and spiritual care, recommendations enacted with positive outcome (pain control, emotional/spiritual support).
  - MVP CM multiple engagements of motivational interviewing- pt moving from ambivalence to change closer to making a choice, valid fears and anxieties surrounding options/choices.
  - Ongoing collaboration with primary treatment team (CM, MD) d/t MVP CM positive rapport- addressed some bias, strengths-based.
  - Home visiting therapy direct referral- plus post-discharge follow-up.
  - Routed MVP notes to PCP at CHCB.

Getting Started – Tips – Questions

COLLABORATIVE HEALTHCARE STRATEGIES

The MVP Method
Multi-Visit Patients

5 Steps to Start to Build your MVP Care Pathway

1. Identify your "why" --> focus on ED (10+) or IN (4+) – develop a flag or daily list
2. Learn by doing: assess the "driver of utilization" – find a "crackerjack" to lead the way
3. Use the acute care setting to "do something different" - effectively engage, definitively link
4. Develop working relationships with people who can help address the DOUs that you find in your MVPs
5. Create ED Care Alerts to "plan for the return" – collaborate with ED staff on content and location in chart

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The MVP Method
Multi-Visit Patients

5 Steps – in Action

	Discussion - What questions do you have? What could you try?
1. Identify your “why” – choose ED or IN –” identify”	
2. Learn by doing – “assess the DOU”	
3. Use hospital to engage, link, “do something different”	
4. Working relationships with DOU helpers “manage/time”	
5. Create ED care alerts, work with ED “plan /return”	

COLLABORATIVE HEALTHCARE STRATEGIES

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Discussion

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Thank you to the UVMMC MVP team for sharing your experience with us!

Thank you for your commitment to improving care for multi-visit patients!

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