Bringing the Focus to Complex Care

February 16, 2023

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Please Chat In…

- Who is on the webinar with us today,
- What organization you are with,
- Where are you located, and
- Your role within your organization?

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IPRO QIN-QIO Complex Care Series Session 2

NYC Health + Hospital | Queens
Improving Care to the Super-Utilizer Population

NYC Health + Hospitals | Queens Experience & Outcomes from Participation in the New York State Department of Health Medicaid Accelerated eXchange (MAX) Series

February 16, 2023

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NYS Department of Health Medicaid Accelerated eXchange (MAX) Series

- Led by the NYS Department of Health & Multi-Visit Patient (MVP) Method developer Dr. Amy Boutwell.
- Focuses on improving care for individuals whose underlying unmet needs result in high utilization of hospitals and emergency departments.
- Engages and empowers front-line hospital teams of clinical and social service providers to make changes that are locally relevant and feasible by leveraging available resources.
- Supports creation of new on-site workflows incorporating community connections to address root causes of high utilization.
- Provides a vehicle for front-line provider teams to improve care, reduce the costs associated with avoidable admissions, and benefit under value-based payment (VBP) arrangements.
- Structured as three virtual, rapid-cycle continuous improvement workshops convened over an eight-month period with weekly touchpoints with each Action Team.

https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/pps_workshops/max.htm

Special Thanks!

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NYC Health + Hospitals | Queens

NYS Department of Health MAX Series Foundation & Approach

- Focus on the need to improve care for multi-visit patients (MVPs)
- Create a high-level MVP Care Pathway
- Develop a method to Identify-Notify-Track In-House (IT tools)
- Identify who is responsible to assess MVPs and how
- Develop Drivers of Utilization (DOU) Response System
- Establish collaboration with interdisciplinary, cross-continuum partners
- Create plan to manage MVPs over time
- Plan for Return – establish ED alerts
- Share and celebrate stories of success

Why Improve Care for MVPs

Why MVPs?	We learned from our prior experience in the MAX Series that MVPs represented 2.7% of all our patients, 11% of all admissions, and were 4X more likely to be re-admitted. ○ This small cohort has a major impact on resources ○ And presents us with a significant opportunity to close gaps in care delivery.
Why Now?	We have always been committed to streamlining our care delivery systems to better manage demand, access, cost, and quality. ○ The pandemic and other unprecedented stressors to our healthcare system made it imperative to focus on MVP's. ○ Reducing avoidable admissions preserves resources and supports patient safety.
Why Us?	Core Team of MVP subject matter experts: SW Champions, Physician Champion, Care Manager Champion, Administrative Champion, Nursing Champion, Data Analytics ○ Added over time: ED LEAD SW and Peers; Hospital Medicine Physician Champion; ED Care Manager Champion; ED Physician Champion; Pharmacy, Patient Accounts, Managed Care, Patient Transportation, Electronic Health Record specialists, and Ambulatory Care
Queens MVP Stats	4+ IN / 365 [# MVP visits / mo] = 1046 [# MVP patients /mo] = 532 [# MVP LOS / mo] = 6.7

Our Current MVP Care Pathway At-A-Glance

Dedicated MVP Subject Matter Expert embedded into Care Management

Identify / Notify

- **Daily list** at 7am of our MVPs
- MVP list **sent to MAX Team** (ED, Inpatient Medicine, Inpatient RN, CM, SW, ED LEADs Team)

Assess

- MVP Social Services Subject Matter Expert (SME) identifies 2+ MVPs for **daily DOU Assessment**
- MVP SME writes the **MVP note** (we call it the Multi-visit Assessment & Follow-up Note)
- MVP SME serves as the **hospital-wide consultant** to care teams to integrate findings into the treatment plan and discharge plan

Engage / Link

- Reach out to **key stakeholders**, including family, community resources, case managers, Hemodialysis Centers, etc. to address DOU
- MVP SME serves as the interim **"Quarterback"** until community based "Quarterback" is in placed

Manage /Plan for Return

- **Huddle** to develop the next steps in **planning for the return** (MVP team & key stakeholders)
- **ED Care Alert** (called a "Hospital Intervention Note") is written
- **Continuous Improvement**: Weekly cross functional team conducts **case conferences** to improve care delivery

Method to Identify-Notify-Track In-House

Identify

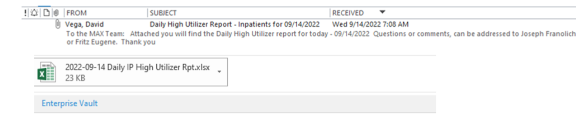
Daily- excel spreadsheet from our electronic health record

Daily MVP Report

Notify

By 7am all MVP stakeholders receive the excel spreadsheet via email

Daily MVP Email



Track

MVP List

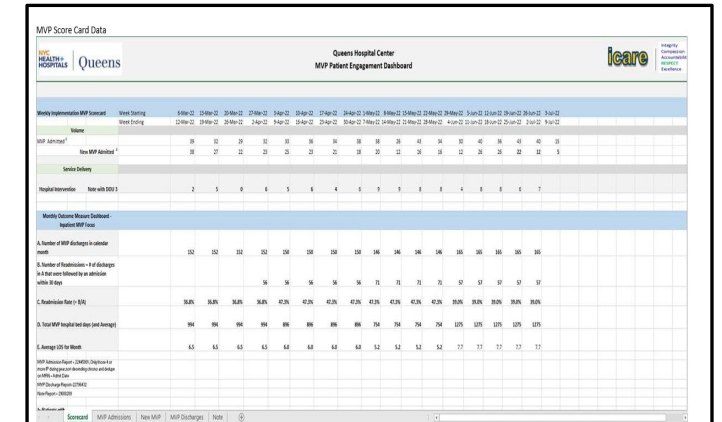
NYC HEALTH + HOSPITALS / QUEENS
Daily High Utilizer
April 19, 2022

Hosp Last 365 Days	LoS	Age	Sex	Department	Room and Bed	Hosp Last 90 Days	ED Vis Last 365 Days	ED Vis Last 90 Days	Num of Enc	Admit Date and Time	ReAdmit	PCP	Last primary care visit date	Next Appt Details	Primary Dx
20	5	55	Male	QU IP 3BW ICU	QU 3BWICU01 QU 3BWICU01 01	8	28	9	6	4/14/2022 6:50	Yes	Mohsen Alshamam	8/9/2021	04/26/2022 (Queens CT G62 Room 2; Queens CT Imaging)	Upper GI bleed
10		62	Male	QU IP 4BE MED/SURG	4844 QU 4844 01	4	14	2	0	4/18/2022 0:30		Yogesh Kumar		No appointments scheduled in next 30 days.	Diabetic ulcer of toe of left foot associated with type 1 diabetes mellitus, with necrosis of bone (HCC)
9	2	78	Female	QU IP 5BE MED	5814 QU 5814 01	4	6	2	17	4/17/2022 15:44		Fenden Mahautmr	4/4/2022	04/29/2022 (Joshua Rickard, PharmD; Queens Geriatic Medicine)	Fall, initial encounter
9	3	58	Male	QU IP 5BE MED	5836 QU 5836 02	5	7	4	20	4/16/2022 12:05	Yes	Maxine Hines	1/10/2022	04/20/2022 (Nicole Pearlstein, MD; Queens Palliative Care)	Urinary tract infection with hematuria, site unspecified
7	5	63	Female	QU IP 3BE SD	QU 3BESD07 QU 3BESD07 01	2	6	2	9	4/14/2022 11:40		Theresa Osei	10/18/2021	04/22/2022 (Debra Ferman, MD; Queens Hematology Oncology)	Multifocal pneumonia
6	15	65	Male	QU IP 4BW MED/SURG	4825 QU 4825 01	2	12	5	31	4/3/2022 23:02	Yes	Olga Slootsky		No appointments scheduled in next 30 days.	Gastric adenocarcinoma (HCC)
6	32	77	Female	QU IP 4AE MED/SURG	4446 QU 4446 01	2	5	1	12	3/18/2022 12:46	Yes	Julianne Lee	3/9/2022	04/20/2022 (Susan Sanelli-Russo, MD; Queens Neurology)	ESRD (end stage renal disease) on dialysis (HCC)
6	22	61	Female	QU IP 4AW MED/SURG	4433 QU 4433 01	3	6	3	19	3/28/2022 21:14	Yes	Umme Zaman	6/15/2021	04/28/2022 (Isabel Herrera-Klarberg, PA; Queens Cardiology Clinic)	Malfunction of tracheostomy stoma (HCC)
5	13	60	Female	QU IP 4BW MED/SURG	4831 QU 4831 01	5	4	3		4/6/2022 11:43	Yes	Patient Does Not Have A Pcp		04/22/2022 (QU Infusion Pod C; Queens Infusion Center)	Post-op pain
5		79	Male	QU IP 4BE MED/SURG	4836 QU 4836 01	1	5	1	5	4/18/2022 15:10		Emmanuel Francis	9/20/2021	No appointments scheduled in next 30 days.	Fever, unspecified fever cause
5	3	89	Male	QU IP 3BE SD	QU 3BESD06 QU 3BESD06 01	5	5	5		4/15/2022 23:04	Yes	Julia David		No appointments scheduled in next 30 days.	None
5	4	87	Female	QU IP 4AW MED/SURG	4435 QU 4435 02	2	5	2	11	4/15/2022 18:03	Yes	Julianne Lee	3/30/2022	05/05/2022 (Syed Naqvi, MD; Queens Neurology)	Sepsis due to gram-negative urinary tract infection (HCC)

MVP Registry

Week #	Total Assessments	MVP #	Encounter #	Age	Gender	Race /Ethnicity	Payor/ACO	Team	One Liner	DOU	Linked to: Point Person/Agency
March 6-March 12 (Week # 1)	1	1	3/9/2022	68	Female	Black	Empire BCBS Medicare Advantage	[illegible]	[illegible]	Inadequate supports & services	Patient Accounts
March 6-March 12 (Week # 1)	2	#2 (1 out of 4)	3/10/2022 & 4/4/2022 & 4/20/2022 & 5/2/2022	55	Male	Black	Emergency Medicaid	[illegible]	[illegible]	[illegible]	Substance Abuse Program & EAP during 5/2 admission
March 13-March 19 (Week # 2)	3	3	3/14/2022	52	Male	Asian Indian	Emergency Medicaid	[illegible]	[illegible]	Inadequate plan for recurrent issues + Inadequately addressed substance use issues + Inadequate living environment	Addiction counselor
March 13-March 19 (Week # 2)	4	4	3/14/2022	78	Female	Black	Emergency Medicaid	[illegible]	[illegible]	Inadequate plan for recurrent issues	Everyone appears involved but not coordinated
March 13-March 19 (Week # 2)	5	5	3/15/2022	71	Female	White	Wellcare MCR Advantage	[illegible]	[illegible]	Inadequate plan for recurrent issues + Inadequate living environment + Inadequately addressed behavior health issues + Inadequate supports & services	APS referral
March 13-March 19 (Week # 2)	6	6 (1 out of 2_	3/15 and 4/14/2022	83	Male	Black	Empire BCBS Medicare Advantage	[illegible]	[illegible]	[illegible]	Substance Abuse Program & Self-Help
March 13-March 19 (Week # 2)	7	7	3/16/2022	64	Male	Asian Indian	HealthFirst Compete Care HMO SNP	[illegible]	[illegible]	Inadequately addressed goals of care	Health Home Care Coordination
March 27- April 2 (Week # 4)	8	8 (1 out of 2)	3/28/2022 & 4/27/2022	68	male	Asian Indian	Emblem Health Medicare	[illegible]	[illegible]	[illegible]	Substance use program
March 27- April 2 (Week # 4)	9	9	3/29/2022	74	Female	Asian Indian	HealthFirst Life Improvement HMO SNP	[illegible]	[illegible]	Inadequate plan for recurrent issues	CHHA –Home Health Care Coordinator
March 27- April 2 (Week # 4)	10	10	3/29/2022	71	Male	Black	Emergency Medicaid	[illegible]	[illegible]	Inadequate plan for recurrent issues	none
March 27- April 2 (Week # 4)	11	11	3/30/2022	61	Male	Black	Medicaid Medicare	[illegible]	[illegible]	[illegible]	Behavioral Health

MVP Dashboard



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Assess

Important to **gather information about the big picture** – from the chart, from rounds, from the patient, and from others in the community who share in care (family, caregivers, providers, etc.).

Target those **who know the patient best.**

“Who’s not involved” is a critical consideration. It triggers questions that result in identifying next step actions.

MVP team maintains **continuity of issues & gains insight** to formulate more effective prevention strategies.

The collaboration with stakeholders who reflect medical and social perspectives keeps the **focus on the whole person.**

Drivers of Utilization (DOU) Response System

DOU	General – Optimal – Specific Response

IAPRI
Inadequately Addressed Plan for Recurrent Issues
	• Develop a more adequate plan for recurrent issue
	• Identify the people involved
	• Reach out and collaborate with those stakeholders to develop a more adequate plan
	  • Subgroup missed Hemodialysis - turns out it was about transportation
	  • Goals of care discussions such as, palliative care, not taking place with disease progression

IASUD Inadequately Addressed Substance Use Disorders	• More adequately addressed substance use • Consistent, transparent, harm reduction, motivational interview/stages of change • LEADS team gets the MVP list and proactively reviews it to get to the bedside • Definitive linkage to the ED Leads Team - SW and Peers • Warm handoff to SUD/recovery programs • Will continue where they left off upon return – consistent, relationship, etc.
IASS Inadequately Addressed Services and Supports	• Mobilize adequate services and supports • Identify what is needed (who's not involved & who should be) • Huddle as a team – we discuss on rounds and collaborate with the CM-MVP SME about options • Definitively link, doing the work to make the linkage happen

Interdisciplinary and Cross-Continuum Partners

Internal & External Partners	How Did We Created This Partnership / Story of Success
IT/Data/EMR	They are embedded in our team and actively participate in our meetings. This enables them so they understand what we need and why. They prioritize requests. *Data Analyst was so connected to MAX program that he wrote his Master's Capstone on how data can support MVP's.
LEADs Team	Substance use DOU patients triggered their immediate intervention at bedside. They develop the plan for return. Contact information & recommended programs are pre-identified. And the team reaches out to MVPs in the community.
ACT Team/Community	MVP Team consistently identified and engaged while MVP was in house. We successfully re-engaged MVPs with their ACT team & community Quarterbacks.
Transportation	Access A Ride contacted & we learned how to expedite referrals. A top problem linked to a solution.
HD Centers	Identified the right person at the HD center to collaborate. New Quarterbacks identified.
Care Coordination Services	We investigated and linked MVP to care managers and community supports like MLTC Managed Long Term Care program - engaged them to become Quarterbacks.
ED Care Management	In place from 1st Pass of MAX MVP work. ED Care Alert Champions - flag, review MVP notes & engage ED team planning when MVPs present to the ED.
ED Providers	Commitment to develop a truly helpful ED alert; ease of identification and use.
Ambulatory Clinics	High priority appointments & continuum of care.
Pharmacy	Key partners to recommending medication strategies to support patients in community.
Skilled Nursing Facility	Prevent return by MVP Lead Social Work providing subject matter expert support at the nursing home during case conferences. Bring the MVP learning to the community.

Manage Over Time

Tools used to manage over time:

1. MVP Registry
2. ED Care Alert
3. Shared Electronic Health Records

Dedicated Social Service MVP SME embedded in Care Management Department – key to managing over time:

- The bridge between hospital and follow-up
- Knowledgeable over each admission – cumulative impact
- A resource for community provider and internal staff
- Connects the dots and provides the firm hand-off

Adding internal and external resources:

- MAX team able to add resources that are becoming available, such as community liaisons and peers
- Community partnerships developing
- Reaching out to existing resources, such as insurance-based care managers that are unknown or under utilized by patients

Plan for Return

Electronic Health Record Flags for ED Care Alert

ED Care Alert

Storyboard “FYI” flag

The combination of moving the Hospital Intervention Note “ED Care Alert” from the Filter Section to the shortcuts section provides the greatest opportunity to make providers aware the ED Care Alert exists.

Filter Approach

y/o male, history significant for ESRD and serious mental illness, has ACT team, patient has frequent admissions for hypertensive emergency in setting of missed HD sessions. Driver of Utilization is pattern, preference, habit.

Patient does not have a permanent HD Center in the community. Leaves AMA prior to being connected to HD center.

Contact VNS ACT Team M.S. 646-XXX-XXXX, ACT Psychiatrist Dr. A.T. 718-XXX-XXXX for meds reconciliation. Grandmother 718-XXX-XXXX. Consider involving psychiatry for capacity early in hospital stay.

y/o male with history of repeated admissions due to alcohol use and non-compliance with anti-epileptics. Patient gets admitted, restarted on his anti-epileptics, and is discharged without any seizures witnessed as inpatient. If coming in with breakthrough seizure, patient should be restarted on his antiepileptics and discharged home with follow up from ACT team, as inpatient admissions have been of limited utility.
Actively involved with patient are NYC Health + Hospital Providers:
PCP: Dr. N. 718-883-XXXX
Community Health Worker: GC 718-883-XXXX

y/o female with ischemic cardiomyopathy with multiple admissions for heart failure. She has a history of obstructive sleep apnea, noncompliant with CPAP. Additionally, she has a history of medication noncompliance with her diuretics. Please contact Dr. SA via Epic Chat or 718-883-XXXX for more information regarding this patient. She is currently following with our cardiology clinic and unless hypoxic or significantly fluid overloaded, contact care management for short term cardiology clinic follow up.

Community support is her daughter 718-XXX-XXXX. Community Care Manager: J.D. from Integra Managed Long Term Care 929-XXX-XXXX

Stories of Successes (How We Worked Together Differently)

- Our MVP Model has a **dedicated Social Services MVP SME**. She is embedded in the Care Management Department and made a tremendous difference. Her pre-work & interim Quarterback role addresses a missing link for continuum of care.

- Many team members were involved in the MAX Series 1st Pass. We have been able to leverage past experience to develop a more effective MVP Model & DOU response plans.

- We have returned to interdisciplinary-interdepartmental collaborations; meeting weekly to review MVP's & enhance MVP interventions.

- We built an extensive interdisciplinary and interdepartmental team who see MVP improvement as value added so they make the time to participate.

- This improvement work has been warmly received; it allows us to get back to the business of improving care.

MVP Success Stories:
Our Example of “Trust in the MVP Model”

Employed male lives alone in community. Prior medical history of HTN, COPD, Ventricular Thrombus on Eliquis, Severe Systolic Heart Failure, Alcohol Use Disorder. 1199 insurance. 25 Inpatient Admissions within 365 days related to cardiac symptoms and alcohol intoxication. AMA pattern of discharge.

Assessment: Inadequately addressed substance use disorder. During MVP assessment, patient reported that if he had a “consistent” person he would be more likely to follow-up with medical care.

DOU-Response: Addressed readiness for change regarding Alcohol dependence. Integrated change motivating factor “consistent” person into the response plan.

Definitively Link: He developed trust over time with the ED Lead Social Worker & Social Service MVP SME. The prescribed “consistency” was achieved, and he fully engaged in the recommended care plan.

Result: MVP kept PCP appointment for 1st time after discharge & had 1st Chemical Dependency evaluation. Developing trust relationship with patient and consistent messaging over time was effective.

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Stories of Successes (How We Worked Together Differently)

Assess

Punjabi/Hindi speaking female with a past medical history of HTN, HLD, Hypothyroidism, Ischemic cardiomyopathy s/p 2 PCI in 2016, HFrEF (20%) s/p BiV ICD on 5/9/17. No behavioral health or substance use history. Patient resides alone with limited family involvement.
Admission complaint is shortness of breath.

In May 2022, her utilization pattern of 5 IP admissions triggered MAX MVP intervention. Two subsequent readmissions in January 2023 and February 2023 triggered her for MVP case conference.

DOU – Response

Inadequately Addressed Goal of Care

Advanced Heart Failure symptoms

Follows recommended medication regime and medical providers, yet symptoms are not stable

Goals of Care Review

Transferred to higher level of care:
Advanced cardiac treatment admission and OPD follow-up at Bellevue Hospital

Counseling to help patient understand and accept disease progression

Inadequate Supports and Services in Community

Not following up with Green Card renewal

Difficulty accessing transportation services to medical appointments

Unable adequately care for herself, but embarrassed to ask for help

Identify Needed Community Supports and Link

Link to Health Home for Care Coordination in the community

Linked to Medicaid Homecare & referral for Long Term Care

Link to community Quarterback

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Definitively Link

Care & Team reflects cultural and language needs

Without trust links are not effective

- Care is being provided in patient's primary language by providers who share her cultural background. Their unique perspective helped formulate an approach that engaged patient & gave her the "permission" to accept outside help.
- Optimal communication using Epic medical record - everyone can review care in the different treatment settings.
- Major success - Queen's MVP Hospital Intervention note was incorporated into the documentation & care planning at Bellevue Hospital - supporting continuity of care.

Result

Background on MVPs (Multi-Visit Patients)

4+ Inpatient Admissions
10+ Emergency Room Visits

High utilizing patients are....

MVP Model vs Non-MVP Model

	Patients	Hospitalizations	Average number of Hospitalizations
Max Patients:	123	808	6.57
Non Max Patients:	1616	11686	7.23
Total	1739	12494	7.18

MVP Patients enrolled in the MAX Program had significantly fewer hospitalizations than MVP Patients not enrolled in the program.

Next Steps & Key Take-Aways

- Continue to refine the MVP Note/ED Care Alert optimization process
- Continue to refine the role of the MD champion
- In 1 year, we would love to have clear visibility of the MVP alert in Epic - ideally a one click pop up
- Integrate Staff Education for spread
- We want to get to a point where everyone knows about MVP alerts – and find them to be helpful
- Results! We are starting to see a longer time between visits

Preview

ESSMENT ...

ED Alert Note

Transitional Care Coordinator Name and Contact: Nadira Etwaroo
Planned discharge disposition: No data recorded
Planned discharge transportation: No data recorded
Date of admission: 2/8/2023
Date of discharge: ***

Patient confidence to manage at home
No data recorded

One sentence summary of admission
No data recorded

Interdisciplinary assessment of drivers of utilization
No data recorded

Clinical, behavioral health, and social services in place
No data recorded

Recommendations from interdisciplinary team
No data recorded

Comments
***

Open Discussion

Upcoming Best Practice Learning Circles

Date	Time	Activity
02/23/2023	12-12:30pm 12:30-1pm	SmartCare - Massachusetts Mobile Integrated Healthcare Wrap-up and Discussion