SDOH: What are we looking for? How? and What can we do about it?

Practical, Feasible and Effective Lessons from the "MVP Method"

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President, Collaborative Healthcare Strategies

COLLABORATIVE HEALTHCARE STRATEGIES

Multi Visit Patient

Agenda

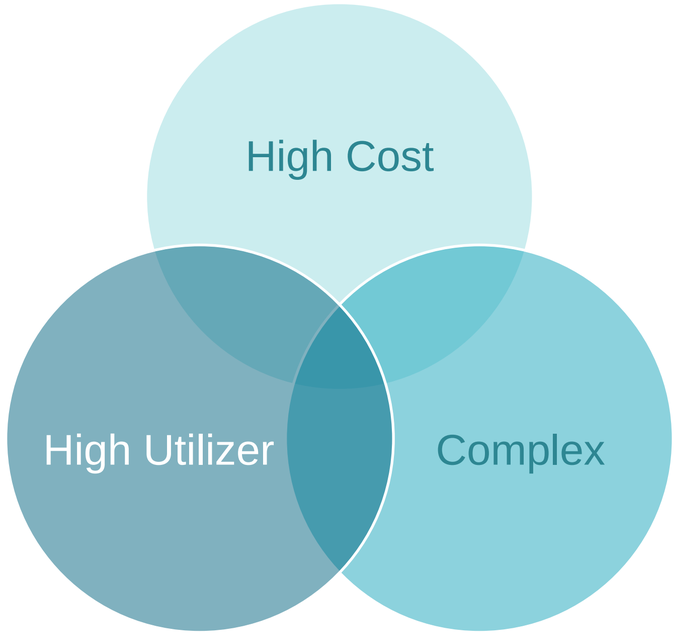
- SDOH: Why? Why now? Why us?
- The MVP Method
  - Key Definitions
  - Key Concept: The "*Driver of Utilization*"
  - Key Concepts: "Do Something Different"
- Examples and Results
- 3 Key Take-Aways

SDOH: Why? Why Now? Why Us?

Who are Multi Visit Patients (MVPs)?

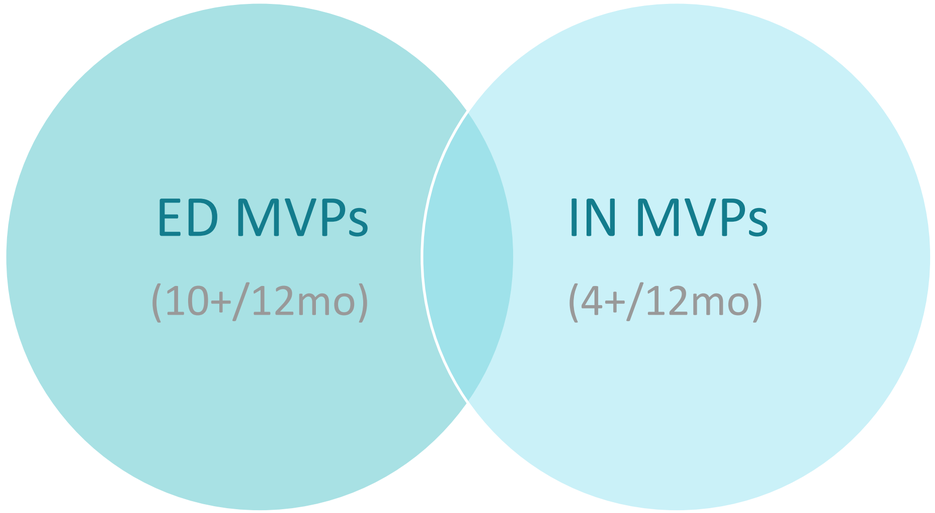
MVPs: Multi Visit Patients

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



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



IN MVPs: Key Stats

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

4+

7% - 25% - 58%

38% v. 8%

85%

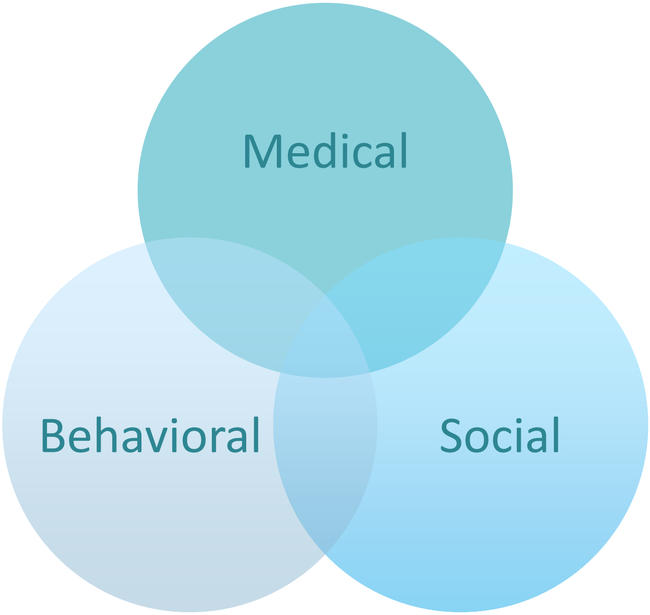
AHRQ HCUP Statistical Brief #190 May 2015
CHIA Hospital-wide All Payer Readmissions in Massachusetts June 2018

COLLABORATIVE HEALTHCARE STRATEGIES

Multi Visit Patient

MVP: 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

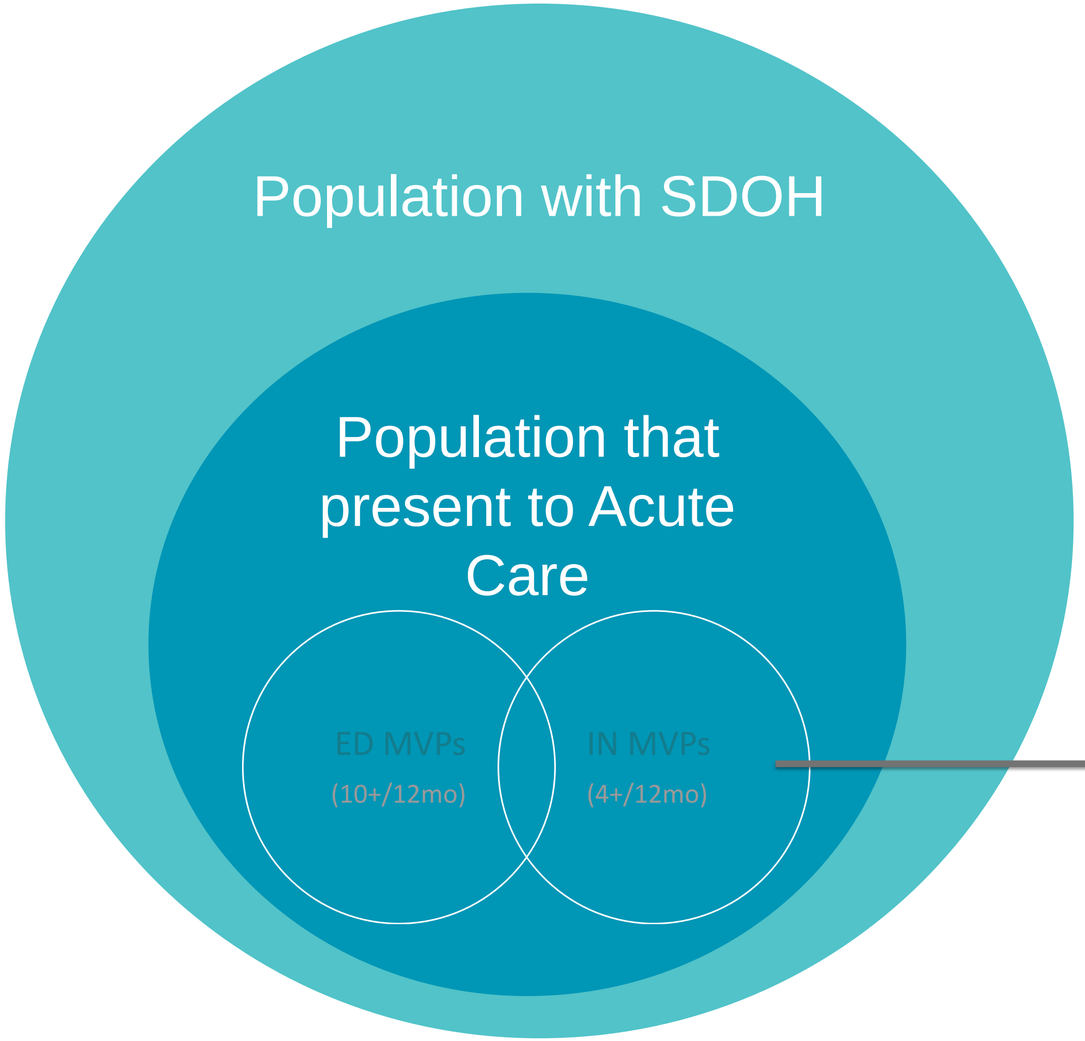
➢ MVPs to have an “overlap syndrome”, the “MVP Syndrome”

AHRQ Statistical Brief #190

COLLABORATIVE HEALTHCARE STRATEGIES

Multi Visit Patient

Multi-Visit Patients: Key Definitions in the MVP Method



7% of hospitalized patients
25% of all hospitalizations
58% of all readmissions

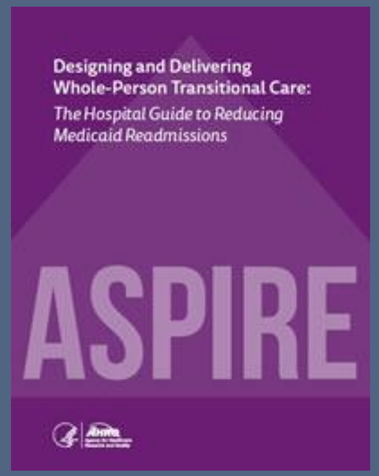
COLLABORATIVE HEALTHCARE STRATEGIES

Multi Visit Patient

The MVP Method

Core concepts, clinical-operational process, implementation strategy, cross-setting team

MVP Method Developed from 10 years Large Scale Readmission Reduction Efforts



- 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

COLLABORATIVE HEALTHCARE STRATEGIES

Multi Visit Patient

MVP Method Theory of Change

- The **MVP Syndrome**

  Most MVPs have co-occurring medical, behavioral, and social needs; assess for and expect to find these needs

- Multiple visits are a **symptom**

  Multiple acute care 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 (using interview and observation) and identify the "driver of utilization"

- We must effectively address the **underlying issue** in order to resolve the symptom

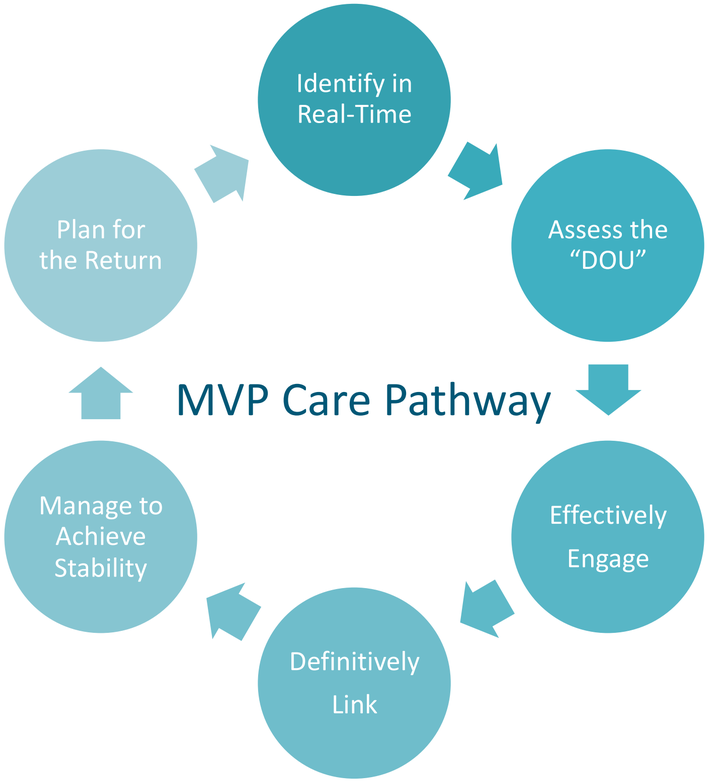
  *We can expect recurrent utilization until we effectively address the **"driver of utilization"***

Elements of the MVP Method:

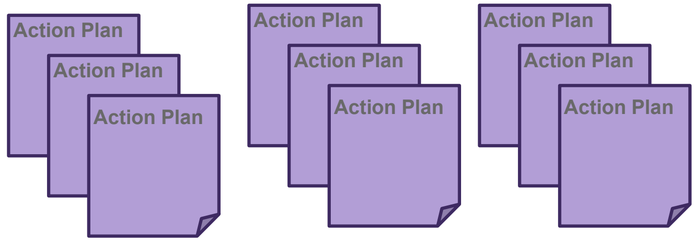
Core Concepts + Clinical Operational Process + Implementation Approach + Action Team

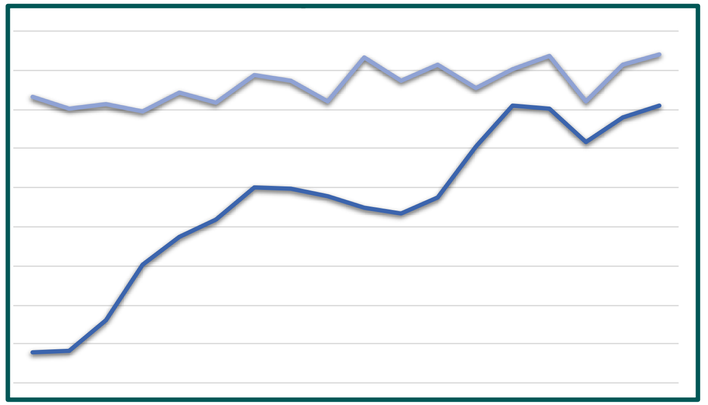
MVP Core Concepts

- 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



MVP Implementation Strategy





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

COLLABORATIVE HEALTHCARE STRATEGIES

Multi Visit Patient

MVPs: Daily Admission Volume is Key to Feasible Implementation

MVP Measure	
# patients* with 4+ admissions in the past 12 months	100
# admissions among those patients	650
Average # admissions per day (=650 / 365 days per year)	1-2 MVP admissions/day

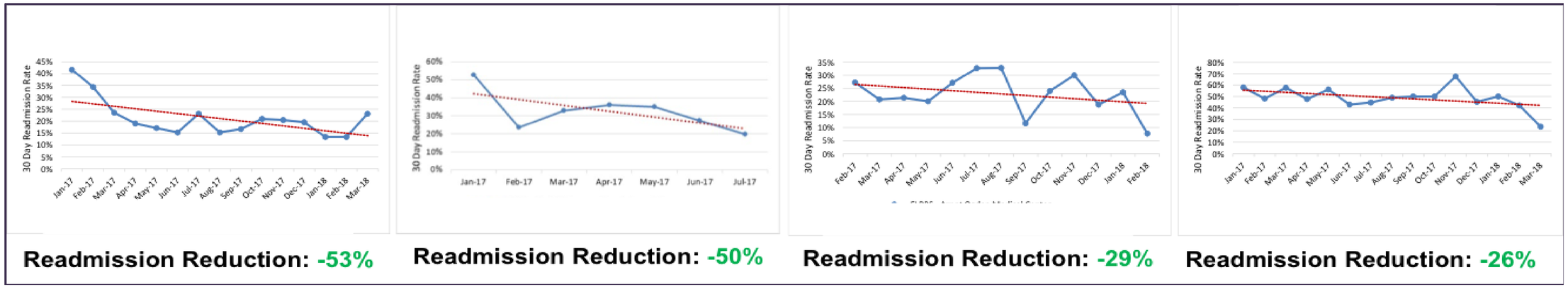
* adult, non-OB, exclude admissions for chemotherapy or radiation

MVP Method: Build-As-You-Go, Improve Week to Week, Measure

Prioritize 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%)

30-day readmission or revisit

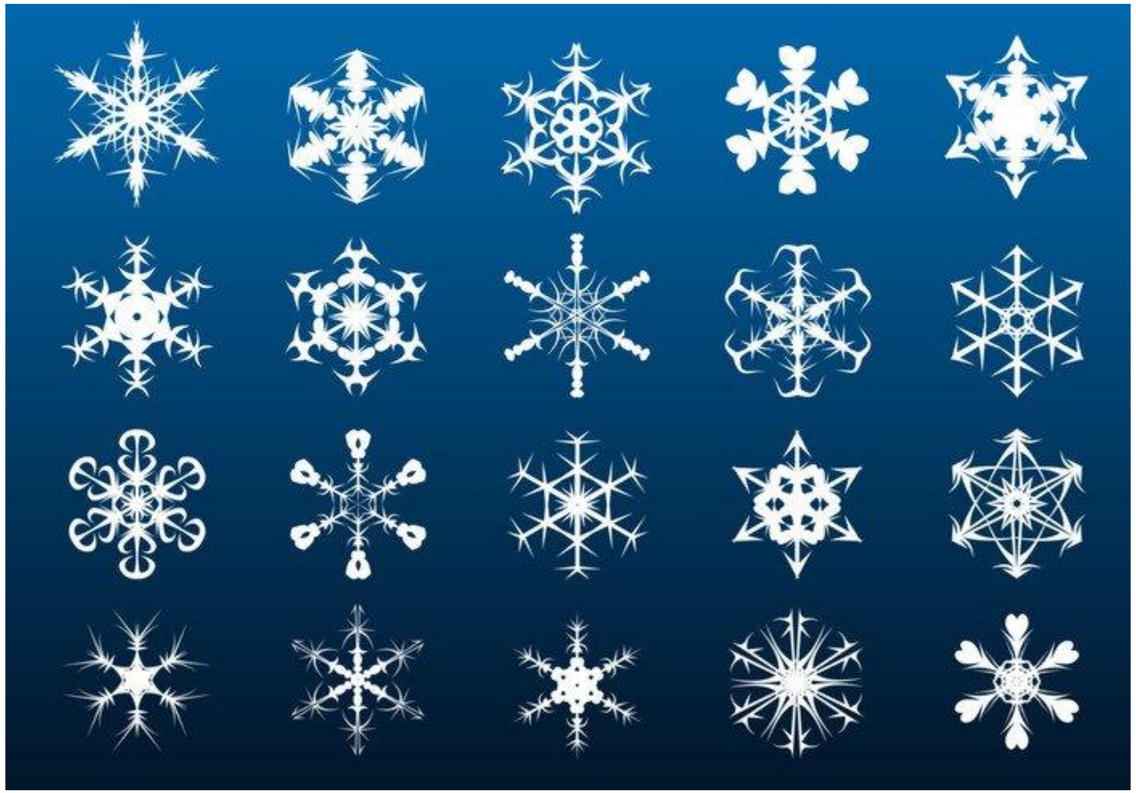


The MVP Method developed a novel method to measure pre-post utilization, using the concept of an internal historical control (not described here)

COLLABORATIVE HEALTHCARE STRATEGIES

Multi Visit Patient

Universal Method → Individualized, Unique Programs



MVP Method

Designed for scale

- Universal method, not a prescriptive model
- The *method* is what can be used by any team for any MVP population

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.

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

Clinically credible, operationally feasible, locally adaptable

- >90% of teams implemented >90% of key processes
- >97% of action team members would recommend to process a colleague

Effective

- Year 1: team-specific successes
- Year 2: cohort analysis
  - ***18% reduction in readmissions***
  - ***8% reduction in hospitalizations***

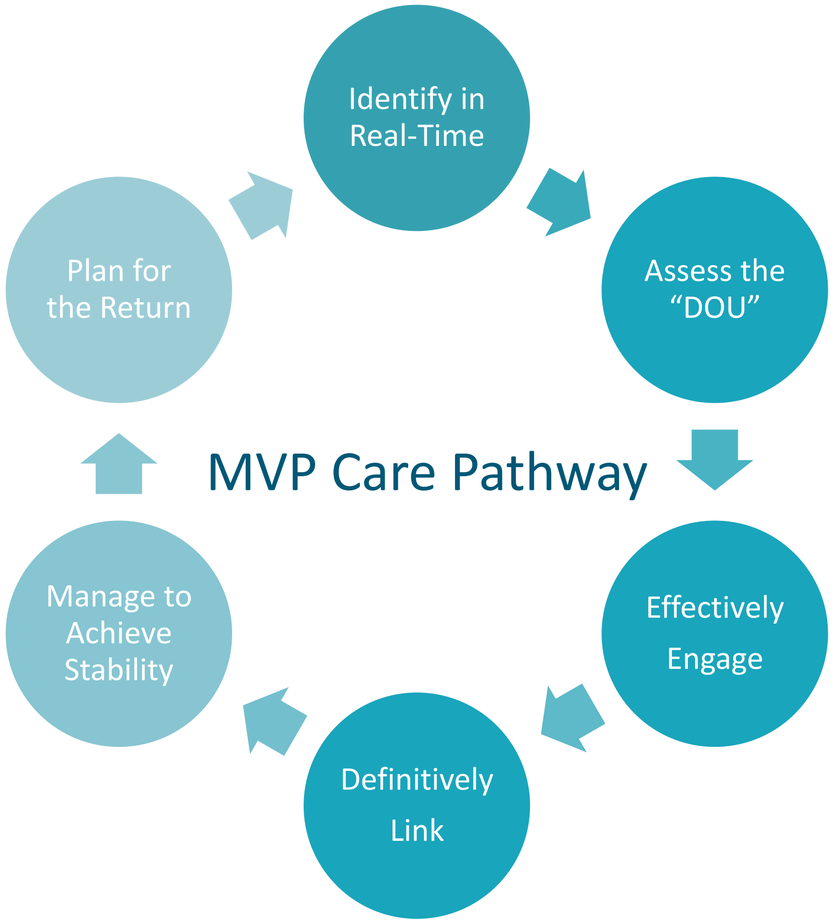
https://www.health.ny.gov/press/releases/2018/2018-06-19_mrt.htm

COLLABORATIVE HEALTHCARE STRATEGIES

Multi Visit Patient

MVP Method: Clinical-Operational Process

1. Identify based on utilization
2. Assess the “driver of utilization”
3. Effectively engage
4. ”Do something different”
5. “Don’t over-medicalize”
6. Ensure “definitive timely linkage”
7. Actively “manage to achieve stability”
8. Plan for the return



Core Concept: The "Driver of Utilization"

Why is this person coming to the hospital so much, when others like him are not?

Mr B

- 61M p/w SOB
- 8 admissions this year alone for SOB
- AF, systolic / diastolic HF, COPD, OSA, morbid obesity, deconditioned, doesn't use CPAP, smokes
- I meet him at the bedside…..

"ah honey, I'm in here every couple of weeks…it's always takes about 4-5 days to tune me up…

The Driver of Utilization

- Not the chief complaint
- Not the primary diagnosis
- Not the problem list
- Not found in the physician's history and physical
- Not found in the nurse's admission assessment
- Not found in social worker's biopsychosocial interview

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
- ✓Interaction, not a checklist

58M
CAD
DM
HTN
AF
CKD
PVD

Not an MVP

MVP

58M
CAD
DM
HTN
AF
CKD
PVD

Information + Observation = Assessment

Identifying and Addressing the Driver of Utilization is Central to the MVP Method

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

Identifying the Driver of Utilization is a learned and teachable skill

Addressing the Driver of Utilization, Changes Lives, Gets Results

Vicky had **26** emergency department visits and **12** inpatient admissions in a **six-month period**.

Before linking to the **SUNY Upstate High Utilizer Action Team**, Vicky was living in **unsuitable housing**, and had **little personal or social support**.

The **SUNY Upstate MAX Action Team** decided to *do something different*.

https://www.youtube.com/watch?v=JM24uEted_U&feature=youtu.be

Addressing the Driver of Utilization, Changes Lives, Gets Results

The **Niagara Falls Memorial Medical Center "Hotspotter" Action Team** worked closely with James, identifying a variety of **"drivers of utilization"**, including **anxiety, depression, PTSD, and alcohol use**.

The Action Team visited James in jail, and **connected him to supportive housing**. The team continues to support him through **ongoing care management** and **social service navigation**.

Today, James is **sober and regularly attending AA meetings**. James continues to attend his **behavioral health and primary care appointments** and is **reunited with his father and children**.

COLLABORATIVE HEALTHCARE STRATEGIES

https://www.youtube.com/watch?v=JM24uEted_U&feature=youtu.be

Multi Visit Patient

Practice: Assess the DOU

- Take 10 minutes at the bedside with an MVP: ***Ask – Listen – Observe***
  - SW, community health workers, navigators, advocates are natively well suited
  - We medical professionals can learn with practice to not over-medicalize

- Summarize ***3 bullets*** about the patient:
  1. Medical 1-liner
  2. Utilization history and pattern
  3. The DOU, in a short phrase

- ***Discuss*** these brief summaries with your team
  - Start to ***identify recurrent DOUs*** in your MVP population
  - ***Reach out and collaborate*** *with agencies that can help address the DOUs in your MVP population*

Develop a Differential Diagnosis (DDx) for the Driver(s) of Utilization (DOU)

Driver(s) of Utilization*

1. **Survival needs** are met by being in the hospital
   - *Food, shelter, warmth, safety, security*
2. **Emotional needs** are met by being in the hospital
   - *Companionship, caring, concern, attention, socialization, reassurance*
3. **Pathologic needs** are met by the hospital
   - *Inappropriate medications, inappropriate attention*
4. **Inadequate attention** to overarching goals and/or anticipatory guidance
   - *Palliative care, hospice, goals of care, family meetings*
5. **Inadequate attention** to patterns, preferences, habits, concerns, convenience
   - *Reliance on 911, hospital is "best care or "one stop shopping," same-day access, after work*
6. **Inadequate supports and services** and/or difficulty navigating or advocating for supports and services
   - *Personal care, housekeeping, benefits, behavioral health care, transportation, legal status, justice-involved*
7. **Third party** (not the patient) is driving the utilization
   - *Overwhelmed caregiver, PCP, dialysis, SNF, assisted living, group home*

**partial list*

Develop a “Treatment/Response” for each DOU

DOU	Treatment / Response
• Survival Needs	• Food assistance resources • Housing case management agencies • Heating assistance • Domestic violence resources
• Emotional Needs	• Socialization venues – congregate meals, home visiting agencies, volunteers, coaches
• Pathologic Use	• Care plans to promote consistency
• “Third Party”	• Direct engagement / problem solving regarding referral/use patterns based on data and root causes

Core Concept: “Do Something Different”

Effective Engagement – Definitive, Timely Linkage – Manage to Achieve Stability

“Do Something Different:” *Effective Engagement*

- Engage while in-house
- Face to face in-hospital
- Helpful, trusting relationship
- Don’t over-medicalize
- Address the patient’s pressing priority
- Involve social support structure
- Take an “opt-in” approach…”our next step is….”

“Do Something Different:” Definitive, Timely Engagement

1. “Refer” does not apply to MVPs
    - If an MVP needs something then we arrange for it
    - A referral never has worked, nor shall we expect it to

2. MVPs require “definitive, timely linkage”
    - If they need it, then we definitively link them with the service
    - In-person connection
    - Warm handoff
    - Timely contact (<48h)

3. Link…to someone who will directly help
    - Break from the medical paradigm
    - MVPs need a person – navigator, peer, CHW, SW, ToC RN, team – to help
    - Develop strong collaborative partnerships and processes with CBOs

”Do Something Different:” Manage, Over Time, to Achieve Stability

- Frequent contact
- Problem solving over time
- Interdisciplinary
- Inter-agency
- Case conferencing
- Navigate, link
- Advocate
- Behavioral change
- Coaching

Mr Eison: Effective Engagement, Definitive Linkage, Manage to Achieve Stability

https://www.youtube.com/watch?v=t80ikD-UG94

Examples, Results

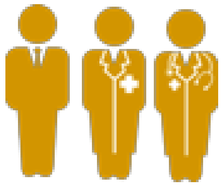
St Mary's Hospital: Daily Collaboration with CBOs to Assess, Link, Engage, Manage

Objective

Increase collaboration and direct, patient engagement through care coordination and bedside huddles involving community-based organizations (CBOs) and collaborative partners.

Daily, engaged CBOs receive a daily distribution list of High Utilizers in St. Mary's inpatient unit

CBOs with shared High Utilizer patients are encouraged to come to the hospital to meet their patients at the bedside, i.e. a "bedside huddle"



CBOs also have the opportunity to participate in daily rounds and collaborative care planning discussions with members of the care team

By participating in daily rounds, the care team is able to share critical information in real-time across the care continuum

Outcome

As a result of bedside "huddles", High Utilizer patients are developing trusted relationships with internal and external providers. Additionally, members of the care team from across the care continuum are able to collaborate on the patient's needs, ensuring a whole-person approach for each High Utilizer patient.

COLLABORATIVE HEALTHCARE STRATEGIES

Multi Visit Patient

Ellenville Hospital: Address SDOH to Address ED MVPs with Chronic Pain

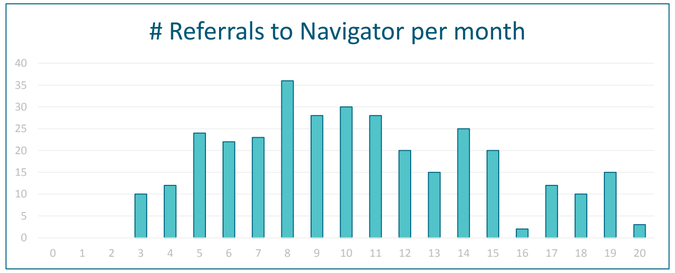
Target population: MVPs with 5+ ED visits for pain

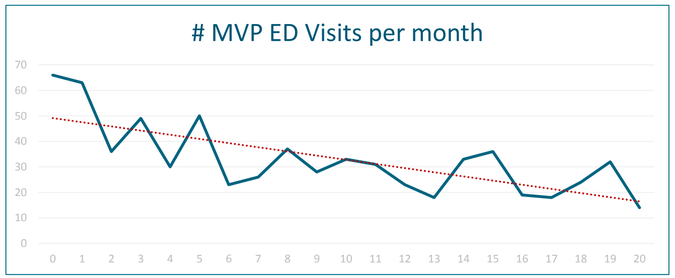
Identify
- Flag HU at registration
- Alert action team

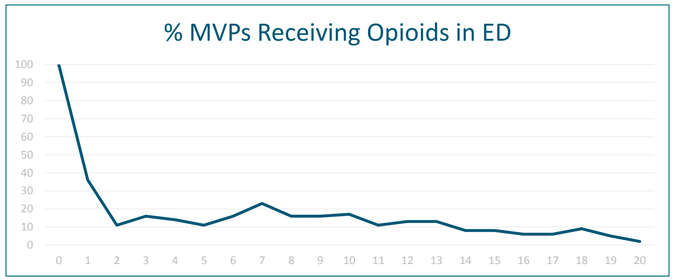
Assess
- Identify the DOU
- Identify needs

Link
- Ensure link with primary care
- Warm handoff/referrals

Manage
- Implement a chronic pain policy
- Dedicated Navigator provides in-person, in-home support
- Education, outreach to PCPs to use pain contracts







COLLABORATIVE HEALTHCARE STRATEGIES

https://www.youtube.com/watch?v=TNlK0bW7od8&feature=youtu.be

Multi Visit Patient

Jamaica Hospital, Queens NY

Identify
- SUPERMAX Symbol – real time identification 4+/ 12mo
- Treatment team, RCA committee, facilitators all notified

Assess
- SW assessment, identify Driver of Utilization
- ED – Attending level huddle to align on decision to admit
- Executive RCA Committee discuss & develop new plan

Link
- MVP Facilitators (Navigators) attend daily RCA, understand DOU and execute new plan

Manage
- Facilitators connect patients to various services over time
- Facilitators directly support via home, community visits

“sustainable, leadership-driven culture change”

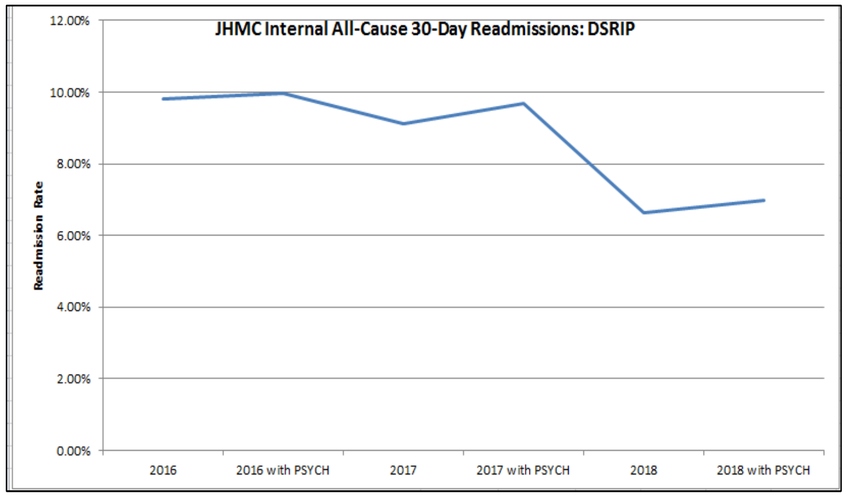
COLLABORATIVE HEALTHCARE STRATEGIES

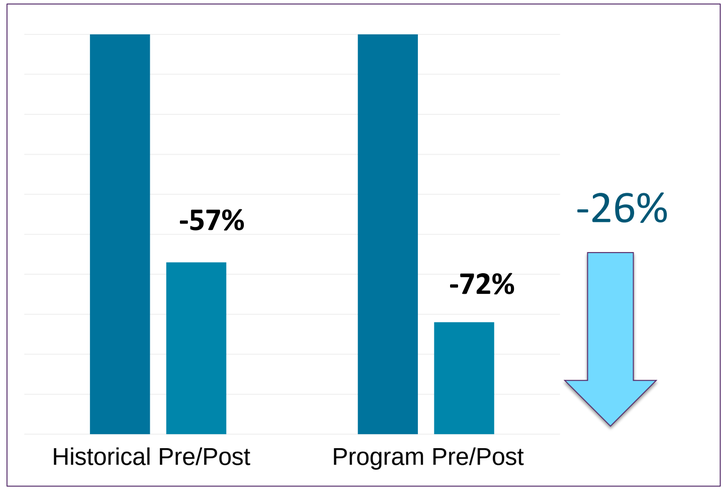
Multi Visit Patient

Jamaica Hospital, Queens NY

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.





Coin awarded to our program by CMS on 2/22/2018 at a National Grand Rounds presentation on behalf of their Quality Improvement and Innovation Group.

COLLABORATIVE HEALTHCARE STRATEGIES

Multi Visit Patient

3 Take-Aways

3 Take-Aways

1. **Consider starting your SDOH screening/intervention work on your MVP population**
   - A meaningful, measurable, and high-impact focus – allowing growth to non-MVPs over time

2. **Learn how to identify the "Driver of Utilization" (DOU)**
   - An assessment based on *ask – listen – observe*

3. **When we effectively address the DOU, we slow acute care utilization – and improve lives**
   - The DOU is the social, behavioral, interpersonal, human need that has gone unaddressed

Thank you for your commitment to addressing SDOH and improving lives

Amy E. Boutwell, MD, MPP
President, Collaborative Healthcare Strategies
Developer, MVP Method™ of Improving Care for Multi-Visit Patients
Developer, Designing and Delivering Whole-Person Transitional Care (the AHRQ “ASPIRE” Guide)

COLLABORATIVE HEALTHCARE STRATEGIES

Multi Visit Patient