Multi-Visit Patients (MVP): A New Transitional Care Model of Care
Sanford USD Medical Center

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Background/Significance
Reducing hospital readmissions, a national priority
Hospital readmissions are often associated with poor patient outcomes and high costs.
- As healthcare evolves in the US, quality measures are continually being developed to ensure accountability of hospitals to their patients.
- In 2012, The Centers for Medicare & Medicaid Services established the Hospital Readmissions Reduction Program (HRRP), which reduces reimbursement by up to 3% of Medicare dollars. As a result, readmission reduction is a major hospital focus for quality and effective care (Centers for Medicare and Medicaid Services, 2010).
- Medicare Payment Advisory Commission determined that up to 37% of readmissions are avoidable (McIlvennan, 2011)
- Approximately 7% of patients admitted to the hospital account for up to 60% of 30-day readmissions. Often this 7% is left out of programs to address readmissions due to complex issues such as homelessness, substance abuse, no phone, etc. (Boutwell, Goodson, Neal & John, 2018)
- Sanford USD Medical Center has partnered with Vizient for a six month trial with five other major hospitals around the United States. This approach uniquely examines Multi-Visit Patients (MVPs) with 4 or more unplanned admissions in 12 months, addressing social determinants of health.

"MVP method is an effective strategy to slow the cycle of high utilization... and has been successfully implemented by over 100 teams in the past three years" (Boutwell, Goodson, Neal & John, 2018)

Do
Main action team for daily patient interactions included two Transitional Care Nurse Practitioners and a part-time RN Case Manager
MVP Assessment Process:
1. Identify patients daily
2. Identify track and trend
3. Assess the DOUs
4. Manage over time
5. Plan for the return to the hospital

Do:
Goal: To reduce MVP readmissions by 10%.

MVP Notification steps:
1. Daily email sent to hospitalist nurses and case managers
2. MVP notification in Sticky Note to Physicians
3. Case Manager communication alert
4. Interviews completed with MVPs while in-house utilized one RN Case Manager to assist with conducting the interviews (Agency for Healthcare Research and Quality, 2017).
5. Monthly Vizient coaching calls, quarterly virtual workshops with entire Sanford Enterprise, and weekly Sanford MVP action team meetings were held.
6. A community coordination group (MVP-ED round) was created including multiple interprofessional Sanford and community resources with weekly meetings.
7. The most challenging patients were discussed at weekly Extended Stay Rounds and MVP ED rounds.
8. ED Plans of Care were expanded to provide guidelines for inpatient care.

Study
Results and what was learned:
- Average number of MVP patients per week: 20
- Estimated MVP as percent of total admissions: 5.4%
- Number of MVP patients with ED Care Plans: 8.2%
- MVP percent of ACR (estimated using 2018 data): 44%
- Percent of MVP patients expired during study: 26.6%

Changes to the process:
- Develop automated daily MVP report for sustainability.

Next steps:
- Grow Transitional Care (TC) services to encompass post hospital follow-up and home visits.
- Continue data collection through end of June for measurement of achieving goal of 10% reduction in MVP readmissions.
- Develop additional action plans
- Cultivate community partners for MVP-ED round
- Work with IT to develop easily identifiable MVP alert within Epic
- Increase care coordination for MVP with various roles along the continuum.
- Incorporate initial DOU-driven interview at the bedside, then bring in TC APPs for more complex/patient needs assessments
- Increase Transitional Care presence at unit-based ED rounds
- Replicate the MVP process within the Sanford Enterprise as applicable.

Plan
Team Development:
The project was carried out by an action team at Sanford USD Medical Center, lead by Transitional Care, Quality and Safety, ED and Inpatient Case Management, Palliative Care, and Mental Health departments, along with support from the Vice President of Nursing and Clinical Services.

Patient population defined: Adult (18 or older), non-OB patients with four or more unplanned admissions to Sanford USD Medical Center within the past 12 months.

Developed action plans:
- Identified action team
- Identified track and trend
- Identified Drivers of Utilization (DOUs)
- DOU Response system
- Manage over time
- Plan for the return to the hospital

Act

Changes to the process:
- Develop automated daily MVP report for sustainability.

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References
- Boutwell, E. M., Goodson, M. E., Neal, M. K., & John, A. J. (2018). Hospital readmissions reduction program: An effective strategy to slow the cycle of high utilization and has been successfully implemented by over 100 teams in the past three years. Health Leaders Media.
- Zorniok, S. J., & Allen, L. A. (2015). Hospital readmissions reduction program. Top 4 DOUs: Chronic, unstable with healthcare barriers, fall risk, and up to 3% of Medicare dollars. As a result, readmission reduction is a major hospital focus for quality and effective care (Centers for Medicare and Medicaid Services, 2010).
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