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The MVP Method has been implemented in these and other value-based programs:

- ▶ New York State Delivery System Reform Incentive Payment (DSRIP) Program
- ▶ Massachusetts Health Policy Commission Community Hospital Acceleration, Revitalization, and Transformation Investment (CHART) Program
- ▶ Vizient, MVP Practice Transformation Collaborative

Introduction

The multi-visit patient (MVP) method is a delivery system transformation strategy developed to deliver more effective care to patients experiencing a cycle of high utilization of the hospital or emergency department. The MVP Method was developed by Dr. Amy Boutwell, drawing from the best of what has worked for the most teams in the widest variety of settings based on her work over the past 12 years leading delivery system transformation initiatives to improve care and deliver value by reducing recurrent acute-care use. The MVP Method has been implemented by over 275 healthcare teams in 40 states, making it the most widely disseminated high utilizer strategy in the US.

Background

Multi-visit patients ("MVPs") are people who are experiencing a cycle of recurrent utilization of the acute-care setting. Commonly referred to as "frequent fliers," and "bounce backs," health care teams often label MVPs "difficult" or "disengaged." Value-based care teams may disenroll MVPs because they don't respond to outreach efforts and are lost to follow up. Payers, policymakers, and measure developers, in an effort to be fair to providers and in contracts, may systematically exclude MVPs because they are "outliers." The result is recurrent, low-value care for a group of people who are clearly experiencing a phase of instability in their lives. This, states Dr. Amy Boutwell, is the manifestation of structural and systemic inequity playing out within the walls of hospitals and emergency departments, every day. A high-performing healthcare system cannot achieve equitable high-value care by systematically ignoring those who are in and out of the hospital and emergency rooms at the highest rates.

From her unique perspective leading dozens of readmission reduction and care transformation initiatives at the regional, state, and national levels over the past decade, Dr. Amy Boutwell saw the impact of narrowly constructed payment policies, disease-specific performance goals, and measurement methods that suppress recurrent utilization in an effort to be "fair" to providers. She also saw value-based care and readmission reduction teams across the country systematically exclude those with the highest return to acute care rates because they were not included in the measurement of value. Clearly, from a population perspective this was bad strategy on all levels: it was not data-informed, it was not person-centered, it was not high-quality, and it was objectively discriminatory. In response, and as the nation's expert on [reducing readmission at the state level](#) and having led the Agency for Healthcare Research and Quality's work to [define the strategy to reduce Medicaid readmissions](#), Dr. Boutwell created,

Key Learnings

- ▶ Multi-visit patients experience structural and systemic inequity when VBC contracts allow care teams to exclude MVPs as outliers; creating an MVP care pathway is an opportunity at the intersection of equity and value
- ▶ Every hospital, ED, ACO, and payer has multi-visit patients, a care pathway approach is effective in coordinating the people, processes and partnerships needed to identify and address the underlying “driver of utilization”

tested, and refined a clinically credible, operationally feasible, locally adaptable, and effective strategy specifically designed to deliver equitable, high value care to multi-visit patients.

Approach

The essence of the MVP Method is that it is a care pathway, designed specifically for multi-visit patients. Care pathways are tools to facilitate the highly reliable execution of a process that requires consistent, timely sets of actions, delivered by different roles, across different settings, over time. The classic example of a care pathway that exists across the country is for response to a heart attack: from first responder in the field to the cardiac cath lab, a known, replicable, series of actions is delivered consistently to provide best-possible outcomes. Given that most hospitals, emergency departments, accountable care organizations and payers have multi-visit patients presenting to the acute care setting every day, the MVP Method uses the care pathway approach to help teams develop a systematic approach to be ready to identify and respond to multi-visit patients, coordinating the efforts of on-site and community-based care teams, over time.

There are three distinctive elements of the MVP Method.

01

The first is that it uses a threshold approach: every patient who meets the utilization definition of MVP is served by the MVP care pathway. This is important because there is no pre-determination of “impactability.” Just as we respond to heart attack patients with a consistent response, we too respond to patients experiencing high utilization with a consistent response.

02

Second, the primary objective of the team is to determine the underlying “driver of utilization”. This is distinct from the chief complaint or diagnosis and distinct from other health-related social needs.

03

Third, the priority focus of the team is to address or mitigate the underlying driver of utilization. Just as a first responder cannot herself mobilize and train the EMTs, procure the ambulances, interpret an EKG, or place a catheter in the cardiac arteries, a front-line clinician working in the existing acute care setting cannot mobilize the people, process, partnerships, or infrastructure needed to adequately address the underlying drivers of utilization. Indeed, this is why the system failure persists. This is where the leaders of care delivery transformation are called into action: to create the processes, partnerships and other relevant infrastructure needed to systematically respond to the issues driving utilization in the MVP population. MVP teams build that response system by convening an interdisciplinary and cross-continuum team that is charged with creating “definitive linkages” to the services and teams that exist in their community. This includes linking to payer-based care management, ACO-based care teams, and community-based services.

The MVP Method has been intentionally designed to avoid detailed prescription, leaving lots of room for local implementation that allows the frontline individuals to build programs that work for their particular situation. The MVP method has been successfully deployed by the full spectrum of healthcare workers, including navigators, community health workers, social workers, nurse case managers, quality improvement professionals, program managers and physician and executive champions - always in collaboration with community partners. Implementation of the MVP Method Implementation Coaching Program incorporates the Institute for Healthcare Improvement's Breakthrough Series method, using a hands-on approach during implementation for quick results (and feedback) and better provider engagement by avoiding traditional didactic teaching situations that can sometimes frame strategies like the MVP method as merely conceptual.

Challenges with Implementation

The most common three challenges are: prioritizing data/IT infrastructure requests; the time required to build a new care pathway; and the impact of turnover on the skill developed during implementation coaching.

The first step of the MVP care pathway is to identify a multi-visit patient upon arrival to the acute care setting. This is not technically challenging, but because this involves an IT/EMR request, teams can experience delays in getting this request prioritized among competing priorities. An executive sponsor is needed to prioritize this request. As with most transformation efforts, if this is implemented like other quality improvement project, with a cadence of weekly meetings, it can take a year to develop the full suite of capabilities recommended. Finally, as with any capacity-building effort, losing personnel trained in the MVP method can be incredibly costly. Persistence of the MVP institutional knowledge requires a wide array of individuals with at least some degree of training. A dedicated MVP team is ideal although most organizations have deployed existing staff to implement the MVP care pathway.

Results to Date

The MVP Method is the most widely disseminated high utilizer delivery system transformation strategy in the US. This speaks to its relevance and adaptability across all types of care teams and settings. Examples of its success include:

- ▶ Massachusetts Health Policy Commission Community Hospital Transformation ("CHART") Program: The Massachusetts Health Policy Commission invested \$100M in capability development to accelerate community hospitals' readiness for value-based care. Twenty-seven (27) hospitals were eligible for this investment program. Teams identified populations experiencing the highest rates of recurrent acute care utilization, irrespective of payer. Applying the concepts of the MVP Method, 83% of all teams achieved their utilization reduction goals for these highest-use populations and 100% achieved their value-based capability development goals. ([MA Health Policy Commission](#)).

Key Learning

- ▶ Implementation challenges include mobilizing needed IT resources, dedicated work effort, and staff turnover

Key Learning

- ▶ The MVP Method has been used by thousands of interdisciplinary and cross-continuum healthcare professionals and has been found to be clinically credible, locally adaptable, and effective

About the Institute

The Institute for Advancing Health Value (the Institute) is a non-profit organization with a mission to accelerate the readiness of health care organizations to succeed in value-based payment models. Founded by former Secretary of Health and Human Services, Gov. Mike Leavitt, and former Administrator of the Centers for Medicare and Medicaid Services, Dr. Mark McClellan, the Institute serves as the foundation for health care stakeholders across the industry to collaborate on improving the care delivery system. To learn more about the Institute, visit advancinghealthvalue.org. The Institute is formerly known as the Accountable Care Learning Collaborative (ACLC).



- ▶ New York Department of Health Medicaid Accelerated eXchange ("MAX") Program: The MAX Program was the signature delivery system transformation initiative for high utilizers, engaging 100 hospital-based, interdisciplinary, cross-continuum teams. Widely considered one of the most successful transformation initiatives of DSRIP 1.0, the MAX Program demonstrated that over 90% of all participating teams were able to implement the core elements of the MVP Method. The program goal was to reduce MVP readmissions by 10% in the first year of the program; results published by the New York State Department of Health in June 2018 reported that MVP readmissions were reduced by 18% - far exceeding the goal ([Health Affairs](#)).
- ▶ Vizient, MVP Method Practice Transformation Collaborative: In the CMS Partnership for Patients, the Vizient Hospital Engagement Networks (HEN) and Hospital Innovation and Improvement Networks (HIIN) and Transforming Clinical Practice Initiative (TCPI) were actively engaged in working with Dr. Boutwell and the ASPIRE and MVP Methods to implement whole-person, systems-based, person-centered, payer-agnostic, and disease non-specific strategies to reduce recurrent acute care utilization. The [MVP Method \(High Utilizer\) Practice Transformation Collaborative](#) was the most popular practice transformation collaborative in Vizient's history, engaging over 80 teams in 32 states.

About Collaborative Healthcare Strategies

Collaborative Healthcare Strategies (CHS) is the sole authorized vendor partner to provide the MVP Implementation Coaching Program. Collaborative Healthcare Strategies serves federal and state agencies as a prime or subprime contractor, state and national healthcare industry associations, healthcare systems, and community-based organizations, and payers seeking to implement the MVP Method. Collaborative Healthcare Strategies advises teams on how to leverage their IT/EMR/data assets to support the MVP care pathway workflow and related population analytics, performance analytics and outcomes trending.

Additional Resources

For more information on the MVP Method, visit these Institute companion resources:

- ▶ Listen to this Race to Value Podcast featuring Dr. Amy Boutwell, President of Collaborative Healthcare Strategies, [The "High Utilizers": Transforming Care for Multi-Visit Patients \(MVPs\)](#)
- ▶ Read our [Case Study Brief on Harris Health](#)

