Shared Learnings

Medicaid Accelerated eXchange (MAX) Series: Improving Care for High Utilizers

Program Overview

The MAX series is an independent program offered by Care Compass Network and facilitated by qualified MAXny facilitators as part of the DSRIP program. Three full-day workshops were held by the action team to identify key drivers of high utilization and establish a real time identification system of high utilizers.

Start Date: November 2017

End Date: April 2018

Target Population: The community served by Binghamton General Hospital (primarily Broome County residents) with 4 or more inpatient admissions in the past 12 month

Program Goals

Reduce inpatient admissions for high utilizers by 10%

Establish a real-time identification system of high utilizer patients

Learnings

Creating opiate and anxiety care pathways helped the action team focus on patient education materials. Also, developing and updating a community resources brochure turned out to be highly useful. Specifically, having an updated guide with phone numbers for opioid and mental health patients.

The action team had fostered strong partnerships with community-based organizations as part of the MAX series and intended to utilize those relationships to drive patients towards certain partners. The action team considered engaging these partners for direct, definitive, and timely linkages to services beyond the hospital.

Case conferences with community partners—these meetings helped in sharing specific high utilizer cases and understand the needs of this population, including the Social Determinants of Health. Meetings held bi-weekly along with internal meetings held on a monthly basis among the action team were deemed helpful.

Shared Learnings

Medicaid Accelerated eXchange (MAX) Series: Improving Care for High Utilizers

Success Story

A 30-year old male presented to the emergency department with an overdose of Wellbutrin that he took to "ease his feelings". The patient had six emergency department visits, three inpatient psychiatric visits, and three medical admissions since February 2017.

A social worker met with the patient and performed a Drivers of Utilization (DOU) assessment, revealing that the patient was homeless. Upon further assessment, it was identified that the patient had a Medicaid Health Home Case to assist with stable housing placement. The hospital social worker notified the Medicaid Health Home Case Manager that the patient was in the Emergency Department, and worked collaboratively to develop a plan of care.

The Medicaid Health Home Case Manager connected with the patient, helped identify a stable housing placement, and had performed repeat check-ins with the patients after their placement in stable housing. Since engaging the Medicaid Health Home Case Manager and assisting with stable housing placement and follow-up services, the patient had not returned to the emergency department as of April 2018.

Organizational Profile

Organization: UHS Hospitals, Inc

Website: https://www.nyuhs.org/

Contact Information

Care Compass Network

Email: info@carecompassnetwork.org