NUMC Hub Sees Success with MAX Series and Beyond

Through the work of the Nassau University Medical Center (NUMC) DSRIP Hub, NUMC has seen success in reducing 30-day readmissions and avoidable hospital use. The Hub has implemented new patient-care related processes that came about from participating in the New York State Department of Health's (NYS DOH) Medicaid Accelerated eXchange (MAX) Series–a rapid-cycle, continuous improvement program that brings together frontline providers to redesign the way health care services are given. Initially an 8-month program, the NUMC Hub completed the program in June of 2017, and is moving forward with continuous improvement efforts derived from the principles of the program.

The Hub's target population are individuals who had four or more hospital admissions within a year.

"We put together an interdisciplinary Action Team that is directly involved in meeting the target population's diverse medical, behavioral, and social needs," says **Sadia Choudhury, MPA, senior DSRIP project manager, NUMC Hub**. "The success of our efforts relies heavily on direct patient interaction and post-discharge follow up."

Each day, the Hub receives an admissions report that allows members of the target population to be identified. Once identified, a member of the Action Team meets bedside with each patient and conducts an interview with the intent of determining what lead the patient to be readmitted.

"We found that causes for frequent readmissions include substance abuse, health literacy and behavioral health problems," Choudhury explains. "With this in mind, our Action Team members form a bond with the patient and work with them to ensure that they are getting the necessary care within the community setting."

As part of the Action Team's "action plan," each patient receives calls from the Action Team 24-hours after discharge to ensure that they understood their care plan and to address any concerns they may have. Subsequent follow-up calls are made weekly for the next 30 days. All incoming calls from high-utilization patients are also monitored and tracked. Additionally, the team follows up with all appropriate interdisciplinary partners and community care organizations to assess patients' progress.

Although the team has seen success, there are challenges to overcome before success is achieved. "For efforts such as this to work, clinicians have to train themselves to realize that there are other things—such as housing or chronic illnesses—that often contribute to the readmission cycle," says **Gilbert Burgos, MD, MPH, medical director, Nassau Queens PPS**. "There are also staffing challenges to overcome, including getting staff to consistently use the system processes that are newly created through these efforts which entails doing something different than what they are used to."

In the near future, the Action Team will begin to focus efforts on Emergency Department high utilizers.

Action Team members include **Estralla Perez, RN; Samia Qazi, MD**; **Lisa McLaughlin, Clinical Director of Social Work, NUMC**; **Valerie Tanis, DSRIP and IT Manager, NUMC**; **Nicole Beltrez, Director, CBO and Provider Engagement, NUMC**; **Judith Smith, PhD**; and **Manasa Muthu, Account Director of Strategic Alliances**.