Impact Super-Utilizer PATIENTS

A relatively small number of patients utilize a large percentage of health care resources. Very frequently, a separate underlying, unmet need is driving their utilization.

Labels associated with these patients, like *frequent flyers*, *boomerangs* and *high utilizers,* can de-personalize care, lead to implicit bias, and create an environment where care teams feel their ability to have a positive impact is limited. Coach your teams to replace these terms with "multi-visit patient" as one step in a paradigm shift to destigmatize care.

National care transitions subject matter expert, consultant, and health care influencer Amy Boutwell, MD, MPP, encourages us to "Be Anti Un-Impactable." She recommends viewing high utilization as a "symptom" to assess rather than a "problem." Effective inter-agency and inter-disciplinary collaboration to co-manage community plans of care for patients is key. Collaboration and focusing on implementing interventions that address the medical, behavioral health and social needs that are the root cause of multiple visits are ways that clinicians *can* impact this select group who are not effectively supported with traditional strategies.

To learn more about implementation, including measuring effectiveness, contact Melody.Brown@allianthealth.org for coaching and mentoring support.

The Approach:

Gather and Analyze data to identify super-utilizers. (The Centers for Medicare and Medicaid defines Medicare beneficiary super-utilizers as patients with four or more ED visits and/or four or more hospitalizations in a year.)

Engage patients to assess and determine drivers of need.

Develop personalized plans of care and care alerts.

Link patients with community services.

Collaborate with providers across the care continuum.

Source: Amy Boutwell, MD, MPP, NYSDOH Medicaid Accelerated eXchange (MAXny) Series

Focus Areas	Resources
Data • **Electronic Health Record (EHR)** • **CMS Claims** • **Health Information Exchange (HIE)**	AHRQ Data Analysis and Readmission Review AHRQ All-Payer Claims Databases CMS Identifiable Data Files HealthIT.gov
Social Determinants of Health (SDOH)	AHC Health-Related Social Needs Screening Guide PRAPARE Screening Tool HealthBegins American Academy of Family Physicians (AAFP) AHS Health Literacy Video
Community Plans of Care	NYS MAX Program MHA Care Alert Sprint MHA Hardwiring Care Alert Sprint AHRQ Whole-Person Transitional Care Planning and ED Care Plan
Collaboration and Community Links	AHRQ Cross Continuum Collaboration Tool, Community Resource Guide, and Community Resource Inventory ACL Connecting people to Services Patient Centered Medical Home Aunt Bertha AHS Community Coalition Guide: Recruiting Community Stakeholders

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