Assess patients at risk for multiple admissions and readmission

MAP Program

August 18, 2022

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Objectives

- Identify the causes for admission and readmission of the multiple-admission patient.
- Identify strategies for identifying multiple-admission patients by using a standardized risk assessment tool.
- Determine the reason for admission or readmission from the patient and care partner's perspective
- Engage MAP program team members to mitigate risks.

What is a multiple-admission patient?

EQIC defines a MAP as an individual who has four or more admissions in a 12-month period.

Designing and Delivering Whole-Person Transitional Care. Content last reviewed June 2017. Agency for Healthcare Research and Quality, Rockville, MD. https://www.ahrq.gov/patient-safety/settings/hospital/resource/guide/index.html

Braet, A., Weltens, C., Sermeus, W. and Vleugels, A. (2015), Risk factors for hospital re-admissions. J Eval Clin Pract, 21: 560-566. https://doi.org/10.1111/jep.12320

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Multiple-admission Patient
Program Framework

STEP 1: Design your MAP program

- Create an internal multidisciplinary team
- Identify and invite community-based organizations to collaborate with your team
- Define program goals and measures
- Evaluate and adopt MAP program tools and resources
- Develop staff education for the MAP program

STEP 2: Identify patients that meet MAP program criteria

- Develop data sources for reports
- Review and determine eligible patients
- Develop EMR notifications
- Create a plan for healthcare team communication

STEP 3: Assess readmission risk

- Evaluate readmission risk using a standard assessment tool
- Gather information from patient and care partner
- Regularly review risk data to identify and mitigate risk trends
- Identify and address any health equity and social determinants of health concerns for the patient

STEP 4: Customize interventions

- Create an individualized plan for each patient
- Coordinate a discharge plan with the MAP program team
- Engage emergency department staff in MAP program
- Ensure follow-up communication with post-discharge provider(s) occurs
- Provide post-discharge support and follow up

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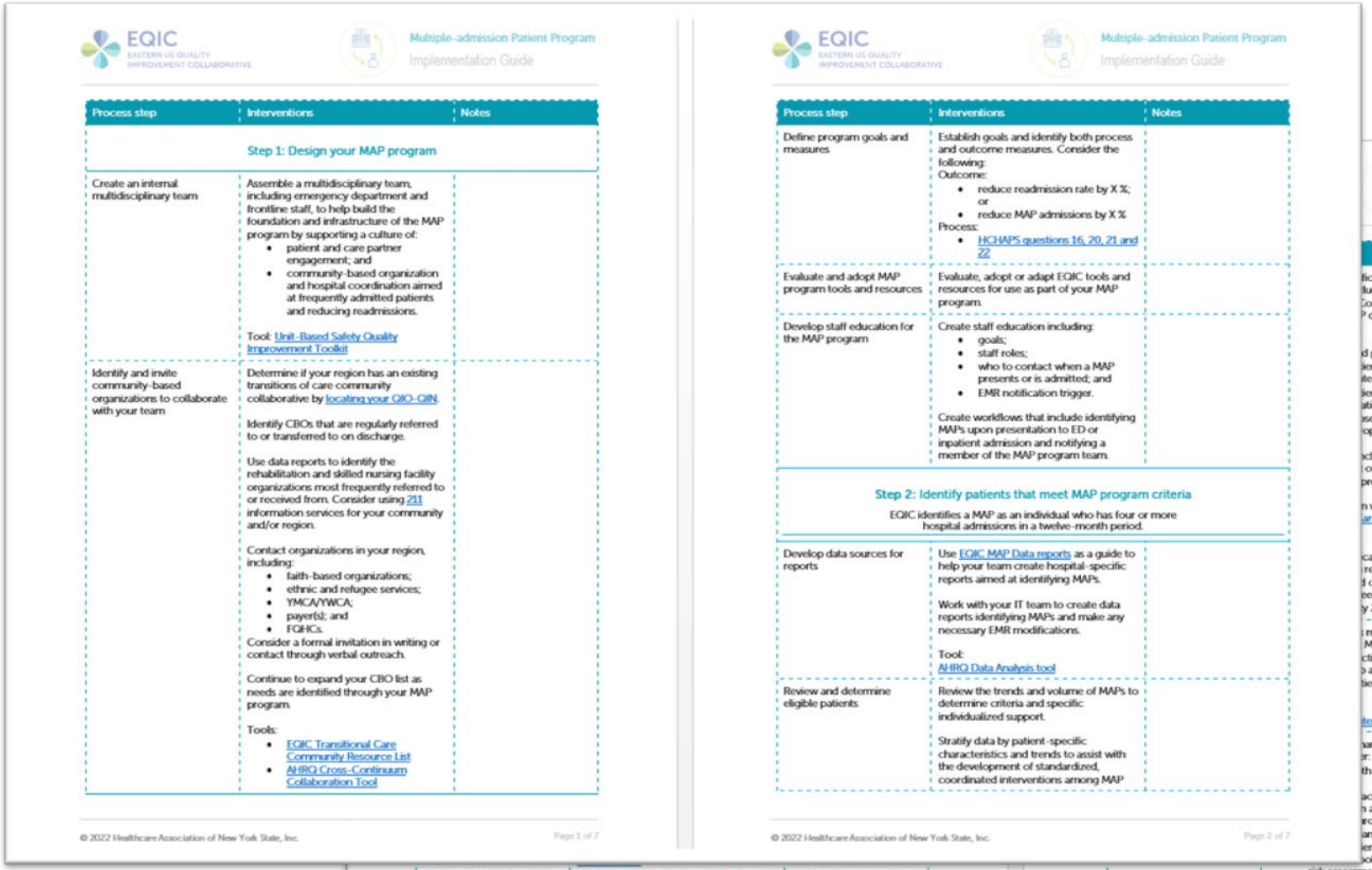
MAP Program Implementation Guide



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Multiple-admission Patient Program
Implementation Guide

Process step	Interventions	Notes
Step 1: Design your MAP program		
Create an internal multidisciplinary team	Assemble a multidisciplinary team, including emergency department and frontline staff, to help build the foundation and infrastructure of the MAP program by supporting a culture of: • patient and care partner engagement; and • community-based organization and hospital coordination aimed at frequently admitted patients and reducing readmissions. Tool: Unit-Based Safety Quality Improvement Toolkit	
Identify and invite community-based organizations to collaborate with your team	Determine if your region has an existing transitions of care community collaborative by locating your QIO-QIN. Identify CBOs that are regularly referred to or transferred to on discharge. Use data reports to identify the rehabilitation and skilled nursing facility organizations most frequently referred to or received from. Consider using 211 information services for your community and/or region. Contact organizations in your region, including: • faith-based organizations; • ethnic and refugee services; • YMCA/YWCA; • payer(s); and • FQHCs. Consider a formal invitation in writing or contact through verbal outreach. Continue to expand your CBO list as needs are identified through your MAP program. Tools: • EQIC Transitional Care Community Resource List • AHRQ Cross-Continuum Collaboration Tool	

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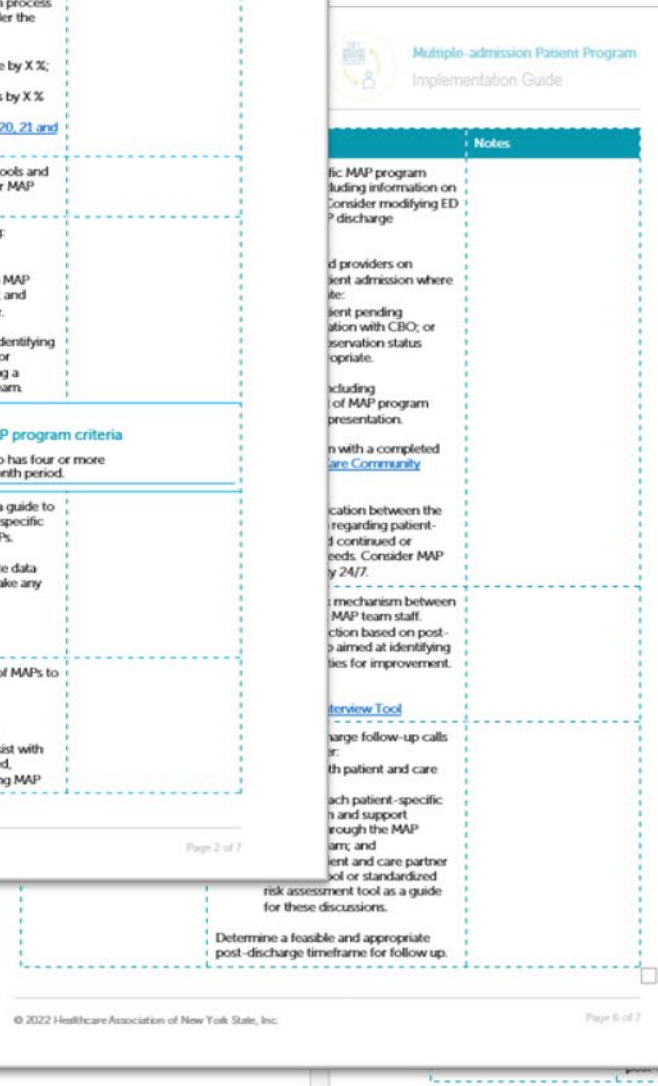
Multiple-admission Patient Program
Implementation Guide

Process step	Interventions	Notes
Define program goals and measures	Establish goals and identify both process and outcome measures. Consider the following: Outcome: • reduce readmission rate by X %; or • reduce MAP admissions by X % Process: • HCHAPS questions 16, 20, 21 and 22	
Evaluate and adopt MAP program tools and resources	Evaluate, adopt or adapt EQIC tools and resources for use as part of your MAP program.	
Develop staff education for the MAP program	Create staff education including: • goals; • staff roles; • who to contact when a MAP presents or is admitted; and • EMR notification trigger. Create workflows that include identifying MAPs upon presentation to ED or inpatient admission and notifying a member of the MAP program team.	
Step 2: Identify patients that meet MAP program criteria EQIC identifies a MAP as an individual who has four or more hospital admissions in a twelve-month period.		
Develop data sources for reports	Use EQIC MAP Data reports as a guide to help your team create hospital-specific reports aimed at identifying MAPs. Work with your IT team to create data reports identifying MAPs and make any necessary EMR modifications. Tool: AHRQ Data Analysis tool	
Review and determine eligible patients	Review the trends and volume of MAPs to determine criteria and specific individualized support. Stratify data by patient-specific characteristics and trends to assist with the development of standardized, coordinated interventions among MAP	

Engage emergency department staff in the MAP program	Use MAP program notifications/flags created by IT.	



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Determine a feasible and appropriate post-discharge timeframe for follow up.

Multiple-admission Patient Program
Implementation Guide

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Step 1: Design your program

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- Develop staff education for the MAP program

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Define program goals and measures

Measures for consideration

Outcome

- reduce readmission rate by X %; or
- reduce MAP admissions by X %

Process

- HCAHPS questions 16, 20, 21 and 22

Step 2: Identify patients who meet MAP criteria

- Develop data sources for reports
- Review and determine eligible patients
- Develop EMR notifications
- Create a plan for healthcare team communication

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Do you know your data?

- EQIC hospital-specific reports
- AHRQ data analysis tool
  - Use this tool to pull your data and patient-specific information

Develop EHR notification/flag

- Work with IT to develop EHR notification or flag for MAP program patients
- Design communication among healthcare team for identification and presentation of MAPs
  - ED team - who do they call/notify?
  - Admitting clinical team - how do they notify the MAP team a patient has been admitted?

Step 3: Assess readmission risk

- Evaluate readmission risk using a standard assessment tool
- Gather information from patient and care partner
- Regularly review risk data to identify and mitigate risk trends
- Identify and address any health equity and social determinants of health concerns for the patient

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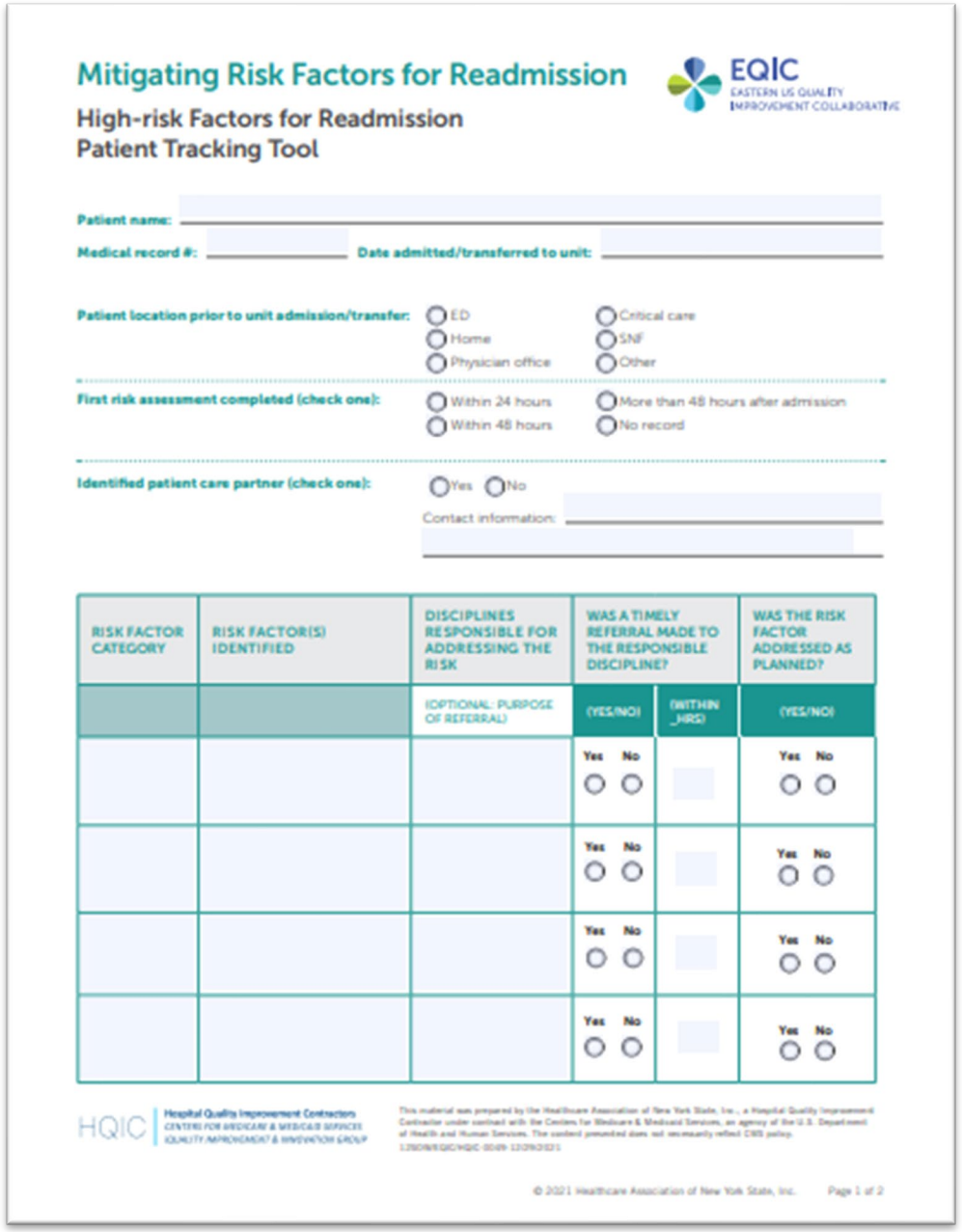
Evaluate readmission risk using a standard assessment tool

- Review and modify existing readmission risk tool to ensure targets align with the MAP program.
- Adapt or adopt the EQIC High-risk Factors for Readmission Tracking Tool.
- Include the patient and care partner when completing risk assessment.
- Consider tools and plan for emergency department upon MAP patient presentation.

https://qualityimprovementcollaborative.org/focus_areas/readmissions/docs/mitigating_risk_factors_for_readmission.pdf



Mitigating Risk Factors for Readmission

High-risk Factors for Readmission Patient Tracking Tool

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Patient name: _____

Medical record #: _____ **Date admitted/transferred to unit:** _____

Patient location prior to unit admission/transfer:
- ED
- Home
- Physician office
- Critical care
- SNF
- Other

First risk assessment completed (check one):
- Within 24 hours
- Within 48 hours
- More than 48 hours after admission
- No record

Identified patient care partner (check one): Yes No

Contact information: _____

RISK FACTOR CATEGORY	RISK FACTOR(S) IDENTIFIED	DISCIPLINES RESPONSIBLE FOR ADDRESSING THE RISK	WAS A TIMELY REFERRAL MADE TO THE RESPONSIBLE DISCIPLINE?		WAS THE RISK FACTOR ADDRESSED AS PLANNED?
		(OPTIONAL: PURPOSE OF REFERRAL)	(YES/NO)	(WITHIN _HRS)	(YES/NO)
			Yes No		Yes No
			Yes No		Yes No
			Yes No		Yes No
			Yes No		Yes No

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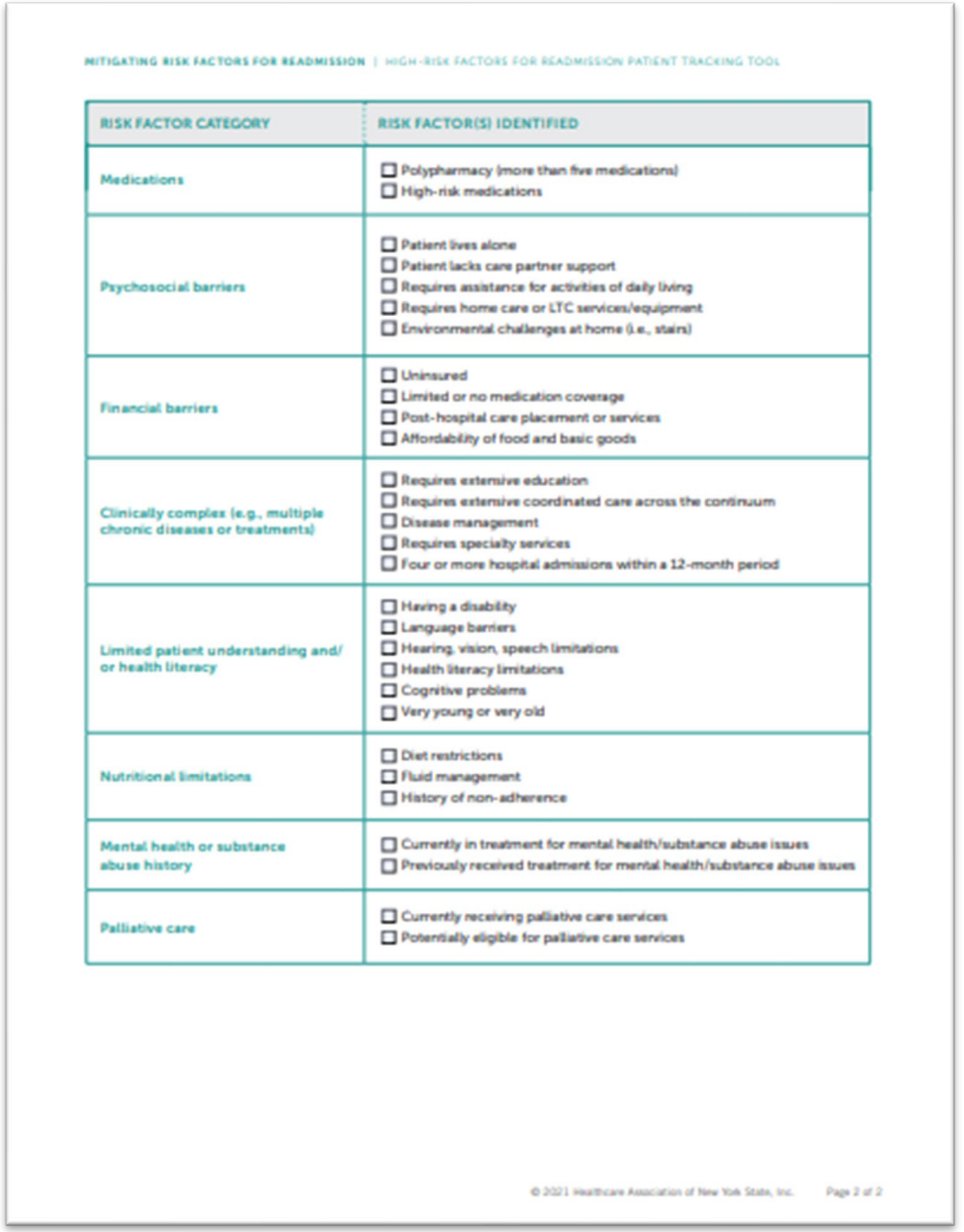

RISK FACTOR CATEGORY	RISK FACTOR(S) IDENTIFIED
Medications	☐ Polypharmacy (more than five medications) ☐ High-risk medications
Psychosocial barriers	☐ Patient lives alone ☐ Patient lacks care partner support ☐ Requires assistance for activities of daily living ☐ Requires home care or LTC services/equipment ☐ Environmental challenges at home (i.e., stairs)
Financial barriers	☐ Uninsured ☐ Limited or no medication coverage ☐ Post-hospital care placement or services ☐ Affordability of food and basic goods
Clinically complex (e.g., multiple chronic diseases or treatments)	☐ Requires extensive education ☐ Requires extensive coordinated care across the continuum ☐ Disease management ☐ Requires specialty services ☐ Four or more hospital admissions within a 12-month period
Limited patient understanding and/or health literacy	☐ Having a disability ☐ Language barriers ☐ Hearing, vision, speech limitations ☐ Health literacy limitations ☐ Cognitive problems ☐ Very young or very old
Nutritional limitations	☐ Diet restrictions ☐ Fluid management ☐ History of non-adherence
Mental health or substance abuse history	☐ Currently in treatment for mental health/substance abuse issues ☐ Previously received treatment for mental health/substance abuse issues
Palliative care	☐ Currently receiving palliative care services ☐ Potentially eligible for palliative care services

EQIC High-risk Factors for Readmission Tracking Tool

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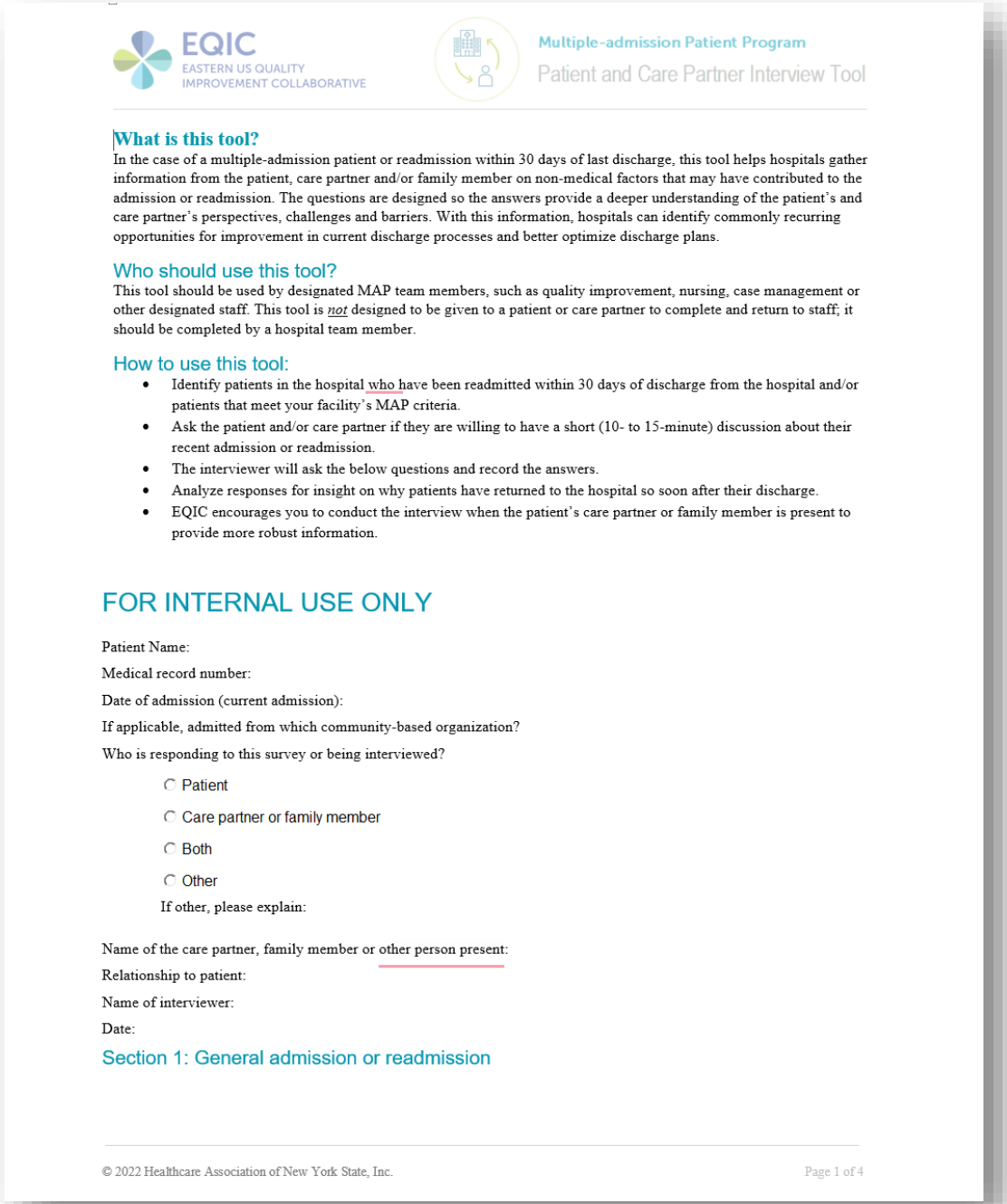
https://qualityimprovementcollaborative.org/focus_areas/readmissions/docs/mitigating_risk_factors_for_readmission.pdf

Gather information from patient and care partner

- Interview patient and care partner as part of readmission risk assessment at each admission.
- Build into the routine workflow a discussion focused on patient and care partner reasons for each hospital admission.
- Evaluate, adapt or adopt the EQIC Patient and Care Partner Interview Tool.

EQIC Patient and Care Partner Interview Tool



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Multiple-admission Patient Program

Patient and Care Partner Interview Tool

What is this tool?

In the case of a multiple-admission patient or readmission within 30 days of last discharge, this tool helps hospitals gather information from the patient, care partner and/or family member on non-medical factors that may have contributed to the admission or readmission. The questions are designed so the answers provide a deeper understanding of the patient's and care partner's perspectives, challenges and barriers. With this information, hospitals can identify commonly recurring opportunities for improvement in current discharge processes and better optimize discharge plans.

Who should use this tool?

This tool should be used by designated MAP team members, such as quality improvement, nursing, case management or other designated staff. This tool is *not* designed to be given to a patient or care partner to complete and return to staff; it should be completed by a hospital team member.

How to use this tool:

- Identify patients in the hospital who have been readmitted within 30 days of discharge from the hospital and/or patients that meet your facility's MAP criteria.
- Ask the patient and/or care partner if they are willing to have a short (10- to 15-minute) discussion about their recent admission or readmission.
- The interviewer will ask the below questions and record the answers.
- Analyze responses for insight on why patients have returned to the hospital so soon after their discharge.
- EQIC encourages you to conduct the interview when the patient's care partner or family member is present to provide more robust information.

FOR INTERNAL USE ONLY

Patient Name:

Medical record number:

Date of admission (current admission):

If applicable, admitted from which community-based organization?

Who is responding to this survey or being interviewed?

- ○ Patient
- ○ Care partner or family member
- ○ Both
- ○ Other

If other, please explain:

Name of the care partner, family member or other person present:

Relationship to patient:

Name of interviewer:

Date:

Section 1: General admission or readmission

https://qualityimprovementcollaborative.org/focus_areas/readmissions/docs/2022-06-13_patient_and_care_partner_interview_tool.docx

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Regularly review risk data to identify and mitigate risk trends

- Collect, stratify and review available data from both the readmission risk assessment and patient and care partner interviews.
- Identify trends and/or high-leverage opportunities revealed in the data.
- Utilize the EQIC Readmission Discovery Tool.

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Discovery Tool: Readmissions

n the section below, please enter an "y" or "n" for each patient being tracked to indicate if the following elements were completed. Note: All fields must be filled in.

)ates being tracked:	Please enter the current period being tracked here:															
Element	**Best Practice**	**Patient Sample**														
		1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**
Patient ID# (optional)		ID# HERE	ID# HERE	ID# HERE	ID# HERE	ID# HERE	ID# HERE	ID# HERE	ID# HERE	ID# HERE	ID# HERE	ID# HERE	ID# HERE	ID# HERE	ID# HERE	ID# HERE
Patient identified as a readmission	Patient readmitted within 30 days															
	Readmitted from SNF															
	Multi-visit patient: Four or more inpatient admission in 12 months (or hospital criteria)															
	If the answer is yes to any of the above three questions, patient and care partner interview to be completed															
Care partner	Care partner identified in EMR															
	Preferred contact method for care partner documented															

EQIC Readmissions Discovery Tool

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https://qualityimprovementcollaborative.org/focus_areas/readmissions/docs/readmissions_discovery_tool.xlsm

Identify and address any health equity and social determinants of health concerns for the patient

- Use readmission risk assessment tool findings and additional screening tools to identify health equity and social determinants of health opportunities.
- Address these opportunities in coordination with CBOs that support these needs.

Identify risk… now which CBO should I consider?

- Coordinate MAP program team interventions and transition plan
- Identify which CBO would be “key” to assist in addressing each risk
- Examples of how MAP program team may address identified risks:
  - Food insecurity risk: Meals on Wheels, Nutritional support and education
  - Behavioral Health risk: CBO provider ;behavioral health treatment/support-telehealth
  - Financial risk: Social services
  - Medication risk: Pharmacist consult/PCP/specialist/payer –Home health nurse
  - Functional limitations: PT/OT/Speech therapy
  - Medical equipment risks: Educational needs-home DME vendor/inpatient enhanced education
  - Language barriers: translation services, refugee/ethnic-focused centers

Health equity tools and resources

- EQIC Health Equity tools and resources
- AHC Health-Related Social Needs Screening Tool and PRAPARE
- Hospital Guide to Reducing Medicaid Readmissions | AHRQ *(See Tool 10, pg. 24 Whole-Person Assessment)*
- Community Partnerships: Strategies to Accelerate Health Equity | IFDHE

https://qualityimprovementcollaborative.org/focus_areas/health_equity/tools_resources/

Emergency department

- Include the emergency department in the MAP program
- Adopt similar or same tools used by MAP program for patient and care partner assessment of risks and reasons for admission
- Consider AHRQ ED Care Plan

Questions

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Next steps

- Assess MAP patients risk for readmission
  - Utilize a standardize risk assessment screening tool
- Engage the patient and care partner in the risk assessment
  - Include the patient and care partner in the risk assessment
- Evaluate EQIC tools and resources - adapt or adopt
- Review risk data to identify trends
- Identify health equity and social determinants of health concerns

MAP program curriculum

Upcoming webinars

September 15: The impact of health disparities and social determinants of health on readmission

October 20: Interventions for the MAP program

November 17: Role of the emergency department - 15 years of ED case management: Lessons learned and benefits realized

December 15: Capstone

Complete the survey

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Thank you.

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