Interventions for the MAP Program

October 20, 2022

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HQIC Hospital Quality Improvement Contractors
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Agenda

- MAP framework step 4: Customize interventions
- Arnot Ogden Hospital presentation
- Next steps

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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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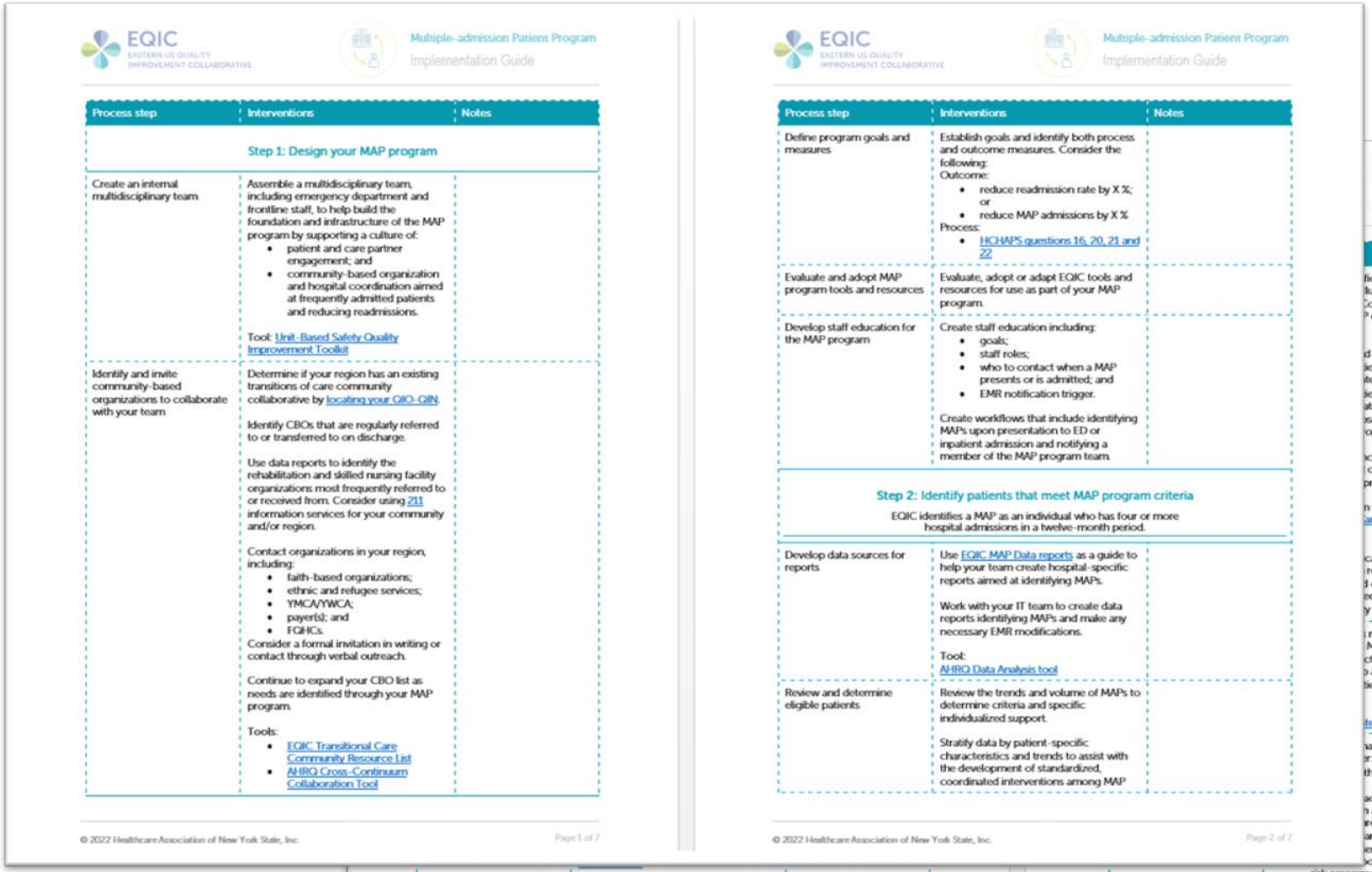
MAP Program Implementation Guide



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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	

Multiple-admission Patient Program
Implementation Guide

	Notes
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Multiple-admission Patient Program
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Engage emergency department staff in the MAP program	Use MAP program notifications/flags created by IT.	

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Step 4: Customize interventions

- Create an individualized 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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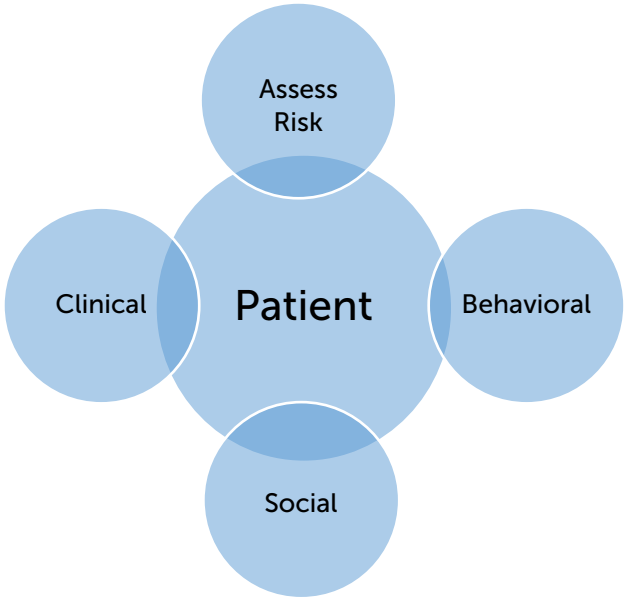
Create an individualized plan for each patient

- Create a patient-centered individualized transition plan for each MAP.
- Review and continue to customize patient-specific interventions post discharge at MAP program team meetings.

Coordinate a discharge plan with the MAP program team

- The discharge or transition plan should include input from the patient and care partner.
- Review and address each of the risk factors for readmission and reasons for admission identified in the risk assessment and patient and care partner interview.
- Any unexpected, patient-specific challenges may require additional research and outreach to a new type of CBO.



Link the patient to services and resources

Link patient to outpatient and community services:

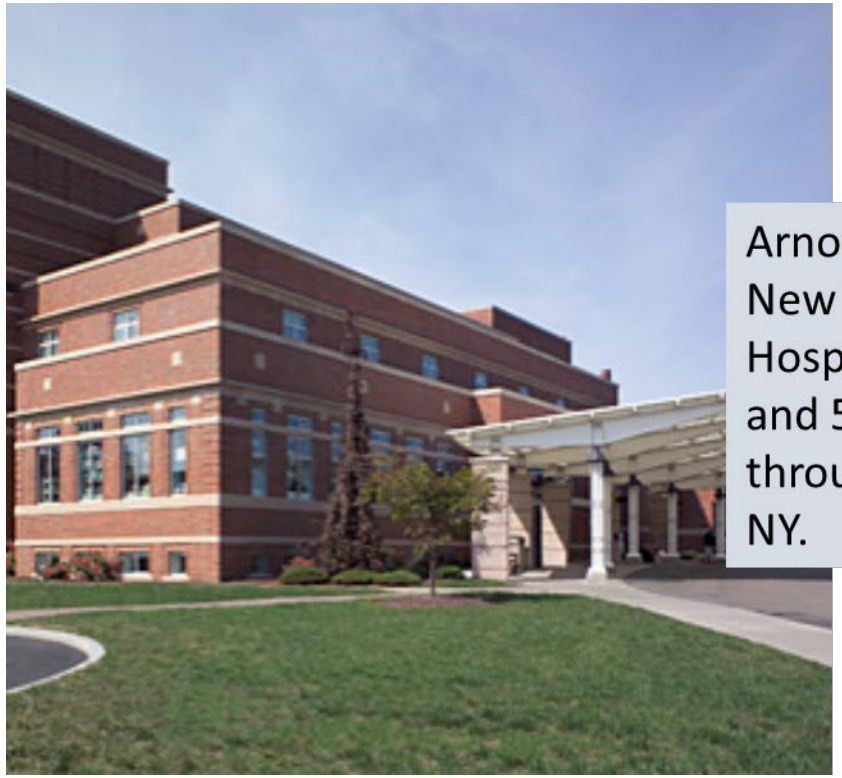
- Wound Care, IV therapy, ADLs: Home care services
- Oxygen therapy: DME
- Food insecurity: Food banks, Office of the Aging
- Financial barriers, transportation: Social services
- Disease-specific programs: CHF, COPD, behavioral health and substance abuse

Provide warm handoffs

- In-person at bedside
- Bedside medication delivery
- Delivery of glucometers

ArnotHealth

About Us



Arnot Health is located in Elmira, New York. Our system consists of 3 Hospitals, a provider group of 230, and 52 clinic locations located throughout the Southern Tier of NY.

The Challenges

HOSPITAL READMISSIONS

Patients with chronic health conditions and co-morbidities frequented our Emergency Department, and discharged inpatients were readmitted, often under 30 days.

PATIENT COMPLIANCE

Lack of follow up at time of discharge often enabled patient non-compliance in their care.

COMMUNICATION

Planning and communication between inpatient and outpatient PCPs at time of discharge needed improvement.

FREQUENT ED VISITS

Due to a lack of support planning and community continuity, patients with high needs were frequenting our ED, at times twice in one day.

DISJOINTED PLANNING

While community resources existed, opportunities for creating a cohesive plan for high utilizer patients wasn't consistently occurring.

Frequent ED Visits

Arnot*Health*

ED Solutions

GOAL

Identification of patient needs/high utilizer automated alerts.

MEASURABLE OBJECTIVE

Identify who is the key community resources, needs and support. Engaging in an action plan of care for the patient to remain successful in the discharge plan.

GOAL

Presenting problem and barriers identified, leading to a collaborative community partnership.

MEASURABLE OBJECTIVE

Goals of care established: Acute inpatient vs. Discharge planning from ED. Provider meeting initiated to advocate, educate, guide and support the patient in their crisis.

ED Outcomes

IDENTIFY

PCP office/case manager care coordination adding key resources/services for the patient.

ORGANIZE

Establish community partnerships with needed support.

IMPLEMENT

Initiate all resources/services. Educate on next steps in the event another crisis/emergency occurs.

MAINTAIN

- Follow up
- Empowerment
- Self-determination
- Advocacy

ED Success Stories

This takes time, but does work

- 13 year old patient with history of seizures and psych/social challenges
- 70 year old female non-compliant medical patient (outside of our system)

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Readmissions

Arnot Health

Our Objectives

REDUCE READMISSIONS

- Developed robust analytics reporting
- Developed a standardized and systematic process for scheduling of hospital follow-up visits with PCPs
- Development of a Palliative Care program
- Utilized home visits through residency program

DEVELOP BETTER PLANS

- With higher post-hospital visit compliance, PCPs were able to have realistic plans

INVOLVE COMMUNITY

- Improved efforts to better align and utilize community resources

ArnotHealth

Outcomes

0.82 %

Readmission Rate

- 30 Day readmissions in focused populations

655

Palliative Care Visits

- Part Time Palliative Care Physician
- Referrals from PCPs & Hospitalists
- Dedicated social worker

Community Collaborations

- Meds to Beds
- CCHD
- Home to Health
- Office of the Aging

Success Stories

83 year old with history of COPD, CHF, Pulmonary HTN

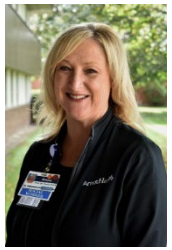
61 year old female with a history of frequent admissions for evaluation of chest pain

ArnotHealth

The Presenters

TINA BURT, NP
Director, Outpatient
Quality& Population Health

CARY MARBLE, MS
Chief Administrative Officer,
Outpatient



STACEY MCMAIL-JERZAK, LMSW
System Director, Social Work & Behavioral Health Team

ArnotHealth

Summary

Through enhanced communication with internal stakeholders & collaboration with external community partners, health care systems can:

- Successfully influence patient outcomes
- Prevent readmissions
- Positively affect the health of patients

ArnotHealth

Thank you

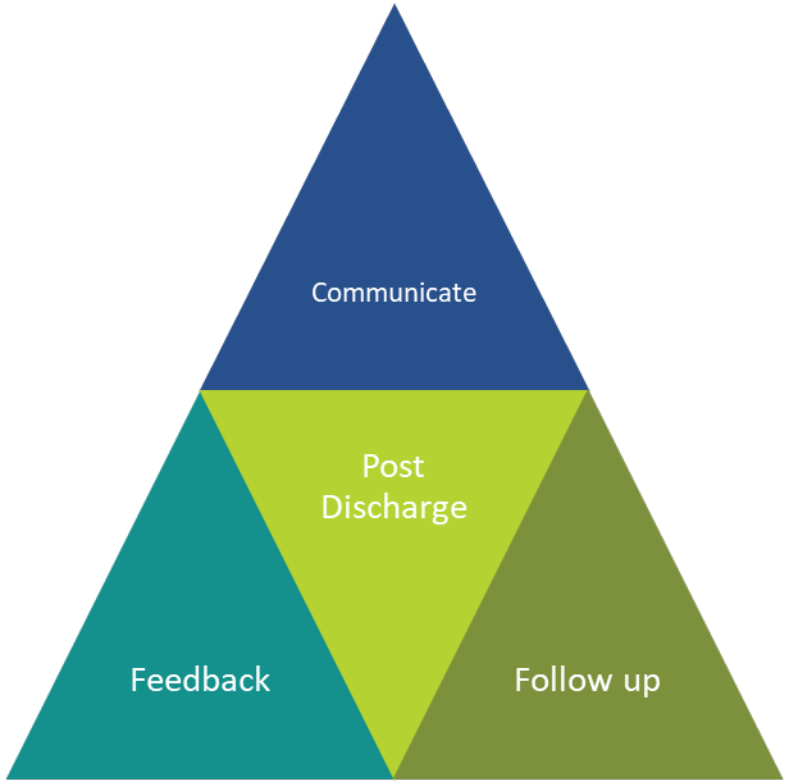
Engage ED staff in the MAP program

- Use MAP program notifications/flags created by IT
- Share patient-specific MAP program discharge plans
- Educate ED staff and providers on alternatives to inpatient admission where medically appropriate
- Create workflows including notifications/consultations on MAP program contact upon MAP presentation
- Continue communication between the MAP program team regarding patient-specific support and continued or additional patient needs
- Develop a feedback mechanism between CBOs and inpatient MAP team staff

Ensure follow-up communication with post-discharge provider(s)

Develop a feedback mechanism between CBOs and inpatient MAP team staff

- Consider data collection based on post-discharge follow up aimed at identifying trends in opportunities for improvement



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

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Provide post-discharge support and follow up

- Conduct post-discharge follow-up calls to patients. Consider:
  - a call to both patient and care partner;
  - review of each patient-specific intervention and support arranged through the MAP program team; and
  - using a patient and care partner interview tool or standardized risk assessment tool as a guide for these discussions.
- Determine a feasible and appropriate post-discharge timeframe for follow up.

Tools and resources

- EQIC Transitional Care Community Resource List
- EQIC Circle Back Interview Tool.

Questions

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Next steps

- Assess MAP patients' risk for admission or readmission
  - Create customized care transition plans and include identified risks
- Engage the patient and care partner in the care plan
- Continue to build MAP team and CBO resources
- Evaluate EQIC tools and resources - adapt or adopt
- Engage the ED in the MAP program
  - Develop readmission alerts for ED EMR
  - Educate ED staff of alternatives to inpatient admission
- Provide post-discharge follow up and support
  - Develop communication feedback between hospital and CBO
  - Provide post-discharge call to patient and care partner

MAP program curriculum

Upcoming webinars

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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