EQIC
EASTERN US QUALITY IMPROVEMENT COLLABORATIVE

Multiple-admission Patient Program Syllabus

EQIC is pleased to offer our Multiple-admission Patient program, which allows hospitals to identify patients and engage community-based organizations to reduce unnecessary hospital admissions and readmissions. This program supports hospitals and systems in operationalizing patient-centered care and engaging community-based organizations during the hospital stay and beyond to improve outcomes.

The MAP program provides the hospital, patients and care partners with best-practice tools and interventions for patients at risk for frequent admission or readmission. The goal of the program is to develop relationships with community-based organizations, which can assist the patient and care partner with needs outside of the hospital. The ultimate goal and measure of achievement is a successful discharge and transition to home or the next level of care for each patient. All of these interventions help EQIC hospitals reach the CMS readmission reduction goal of 5%.

The sprint begins in June with the release of the MAP program materials and includes a series of webinars outlined below. The first webinar features an overview of EQIC's MAP program curriculum and data reports. During the sprint, we will hear from various subject matter experts in implementing the four-step MAP framework of design, identify, assess and customize.

To register for webinars, visit the EQIC Events page. For questions related to this content or to join the readmissions listserv, please contact Brenda Chapman.

Calendar	MAP program objectives	Hospital follow up and tools
Introduction: What is the MAP program?		

MAP program announcement
 	
Thursday, June 16
	After reading the *EQIC Update* announcing the MAP program and reviewing the materials, participants will be able to:
	
	• understand what the MAP program is;
	• identify benefits of implementing the program; and
	• identify your team and tools and resources for implementation.
		Upon receipt and review of the MAP program announcement and materials, hospitals will:
		
		• work with the executive leadership to garner support;
		• identify multidisciplinary hospital team members;
		• strategize on how to identify MAPs:
		  ○ review data and report resources; and
		  ○ engage with IT/EMR team;
		• identify and invite community-based organizations to collaborate;
		• evaluate existing readmission or community collaborative programs or initiatives;
		• identify admission and readmission reduction goals;
		• evaluate EQIC MAP program tools and resources for adoption or adaptation;
		• evaluate current communication methods and tools with community-based organizations; consider MAP team redesign or develop tools and resources specific to the MAP program; and
		• evaluate the current patient and care partner communication methods and tools; modify or develop new communication tools.
		
		Tools and resources:
		
		• ECIQ High-risk Factors for Readmission Patient Tracking Tool
		• EQIC data reports
		• AHRQ data tool
		• EQIC Transitional Care Community Resource List

Calendar	MAP program objectives	Hospital follow up and tools
Design your program and identify MAPs Subject matter experts: *Brenda Chapman, BS, RNC, Project Manager, EQIC; Maria Sacco, RRT, CPHQ, Director, Quality Advocacy, Research and Innovation, HANYS; and Melissa Bauer, Principal Healthcare Informatics Analyst, DataGen*		
Webinar 1 **Thursday, July 21** **1 - 2 p.m.**	**By the end of this session, participants will be able to:** • describe the MAP program; • understand data identifying trends and risk factors associated with patients meeting the MAP program criteria; and • identify MAPs.	**Following this webinar, participants will:** • understand the value of the EQIC MAP program and begin implementation; ○ use data to identify and evaluate meaningful opportunities; • identify the top characteristics of patients that would benefit from patient-specific and enhanced transitional care support; • build EMR notification for MAPs; • develop internal education to build awareness and engagement with leaders, staff, physicians, nursing and case management; • plan MAP program team communication; • schedule routine MAP program team meetings; and • develop a mechanism for patient-specific communication among engaged MAP program organizations. **Tools and resources:** • EQIC High-risk Factors for Readmission Patient Tracking Tool • EQIC data reports • AHRQ data tool • EQIC Transitional Care Community Resource List
Assess patients at risk for multiple admissions and readmission Subject matter experts: *Brenda Chapman and Maria Sacco*		

Webinar 2
Thursday, Aug. 18
1 - 2 p.m.
	By the end of this session, participants will be able to:
	• determine the causes of readmission and identify MAPs:
	  ○ use a standardized readmission risk assessment tool, and
	  ○ determine the reason for admission or readmission from the patient and care partner's perspective; and
	• engage MAP program team members to mitigate risks.
		Following this webinar, participants will:
		• gather information from patient and care partners through interviews;
		• deploy a standardized readmission risk assessment; and
		• evaluate results of interviews and readmission risk assessments to identify trends.
		
		Tools and resources:
		• EQIC Patient and Care Partner Interview Tool
		• ECIQ High-risk Factors for Readmission Patient Tracking Tool
		• EQIC Transitional Care Community Resource List

Calendar	MAP program objectives	Hospital follow up and tools
The impact of health disparities and social determinants of health on readmission Subject matter expert: *TBD*		
Webinar 3 **Thursday, Sept. 15** **1 - 2 p.m.**	**By the end of this session, participants will:** • understand how health equity and SDoH contribute to MAPs; • identify community services to support health equity; and • collaborate with community-based organizations to address SDOH	**Following this webinar, participants will:** • understand the influence of health equity and SDoH on the MAP population and readmission; • use data to identify the SDoH most commonly found in your patient population; • consider additional products, community support services and tools to address health equity; and • link patients to community services. **Tools and resources:** • EQIC Transitional Care Community Resource List
Interventions for the MAP program Subject matter experts: *Brenda Chapman and Maria Sacco*		

Webinar 4
 	
Thursday, Oct. 20
1 - 2 p.m.
	By the end of this session, participants will be able to:
	• describe interventions to use with MAPs;
	• enhance communication and handoffs with community-based organizations; and
	• describe strategies to improve transitions across the continuum of care.
		Following this webinar, participants will:
		• schedule regular communication with MAP program patients, care partners and team members;
		• engage with patients and care partners to identify:
		  ○ patient-specific goals for care (What matters to the patient and care partner?),
		  ○ the necessity for alternative level of care or support and
		  ○ services for high-risk patients;
		• identify strategies to implement MAP program interventions;
		• enhance communication between hospital and community-based organizations and providers to:
		  ○ improve quality of patient handoffs
		  ○ create relationships, not just provide referrals; and
		• engage the patient and care partner in the post-discharge follow-up call.
		
		Tools and Resources:
		• EQIC Transitional Care Community Resource List

Calendar	MAP program objectives	Hospital follow up and tools
Role of the emergency department — 15 years of ED case management: Lessons learned and benefits realized Subject matter expert: *Casey Grover MD, FACEP, Chair, Division of Emergency Medicine; and Vice Chief of Staff, Community Hospital of the Monterey Peninsula, Monterey, CA*		
Webinar 5 **Thursday, Nov. 17** **1 - 2 p.m.**	**By the end of this session, participants will be able to:** • understand strategies to engage ED case management for services and support for high-risk patients; • educate ED physicians, providers and staff on the MAP program; and • identify strategies for the ED to reduce readmissions.	**Following this webinar, participants will:** • make the ED staff aware of the MAP program; • identify patients that frequently utilize the ED and develop a notification alert in the ED EMR; • understand the role of case management in the ED; • utilize observation status when appropriate to avoid admission and readmission; and • utilize care plans for the multi-admission patient; engage the patient and care partner in post-hospital follow-up calls. **Tools and Resources:** • EQIC Transitional Care Community Resource List • EQIC Patient and Care Partner Interview Tool
Capstone Subject matter experts: *Brenda Chapman and Maria Sacco*		
Webinar 6 **Thursday, Dec. 15** **1 - 2 p.m.**	**In this webinar, we will:** • celebrate program implementation and success stories; and • consider promoting the MAP program in your hospital.	**Following this webinar, participants will:** • continue implementation and determine the sustainability of the MAP program; and • describe various ways of continuing collaboration with community-based organizations on the MAP program.

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