| **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](https://qualityimprovementcollaborative.org/focus_areas/ubs/docs/NYSPFP_PatientSafety_Toolkit.pdf) |  |
| 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](https://qioprogram.org/locate-your-qin-qio).  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](https://www.211.org/) 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 * federally qualified health centers.   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](https://qualityimprovementcollaborative.org/focus_areas/readmissions/docs/2022-06-13_transitional_care_community_resource_list.docx" \o "EQIC Transitional Care Community Resource List) * [AHRQ Cross-Continuum Collaboration Tool](https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/systems/hospital/medicaidreadmitguide/mcaidread_tool12_collaboration.docx) |  |
| 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](https://hcahpsonline.org/globalassets/hcahps/quality-assurance/2022_survey-instruments_english_mail.pdf) |  |
| 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 12-month period. | | |
| Develop data sources for reports | Use [EQIC MAP Data reports](https://qualityimprovementcollaborative.org/data/) 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](https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/systems/hospital/medicaidreadmitguide/mcaidread_tool1_data_analysis_final.xlsx) |  |
| 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 team organizations. Teams should consider:   * Is the volume of patients that met recommended MAP criteria an amount our team can handle? * Stratification of data elements to arrive at a manageable number of MAPs. * Should our team focus on specific criteria for MAPs that we feel our program is best prepared to support? |  |
| Develop EMR notifications | Work with hospital IT to create flags or notifications upon presentation for MAPs in the inpatient and ED EMRs. Consider having an individualized MAP care and treatment plan, including information on involved CBOs, incorporated into the ED EMR.  Develop and educate inpatient staff on how to identify MAPs. |  |
| Create a plan for healthcare team communication | Encourage MAP program discussion among care teams, including involvement of the patient and care partner as part of the healthcare team.  Identify MAPs in the shift report and rounding tool and consider adding this information to the whiteboard.  Notify MAP program team of admission and/or ED presentation, including any CBOs involved in each patient’s care and support. |  |
| Step 3: Assess readmission risk | | |
| Evaluate readmission risk using a standard assessment tool | Review and modify existing readmission risk tool to ensure targets align with the MAP program or adapt or adopt the [EQIC High-risk Factors for Readmission Tracking Tool](https://qualityimprovementcollaborative.org/focus_areas/readmissions/docs/mitigating_risk_factors_for_readmission.pdf).  Include the patient and care partner in the readmission risk assessment.  **Tool:**  [AHRQ ED Care Plan](https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/systems/hospital/medicaidreadmitguide/mcaidread_tool13_ed_care_plan.docx) |  |
| 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.](https://qualityimprovementcollaborative.org/focus_areas/readmissions/docs/2022-06-13_patient_and_care_partner_interview_tool.docx) |  |
| 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 to identify trends and/or high-leverage opportunities revealed in the data.  **Tool:**  [EQIC Readmission Discovery Tool.](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.  **Tools:**   * [EQIC Health Equity tools and resources](https://qualityimprovementcollaborative.org/focus_areas/health_equity/tools_resources/) * [AHC Health-Related Social Needs Screening Tool](https://innovation.cms.gov/files/worksheets/ahcm-screeningtool.pdf) and [PRAPARE](https://prapare.org/) * [Hospital Guide to Reducing Medicaid Readmissions | AHRQ](https://www.ahrq.gov/sites/default/files/publications/files/medread-tools.pdf) *(See Tool 10, pg. 24 Whole-Person Assessment)* * [Community Partnerships: Strategies to Accelerate Health Equity | IFDHE](https://ifdhe.aha.org/health-equity-resources) |  |
| Step 4: Customize interventions | | |
| 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.  **Tools:**   * [AHRQ Whole-Person Transitional Care Planning](https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/systems/hospital/medicaidreadmitguide/mcaidread_tool9_trans_care.docx) * [AHRQ IDEAL Discharge Process](https://www.ahrq.gov/patient-safety/patients-families/engagingfamilies/strategy4/index.html) |  |
| Engage ED staff in the MAP program | Use MAP program notifications/flags created by IT.  Share patient-specific MAP program discharge plans, including information on all involved CBOs. Consider modifying ED EMR to include MAP discharge instructions/plans.  Educate ED staff and providers on alternatives to inpatient admission where medically appropriate:   * holding patient pending communication with CBO; or * leverage observation status where appropriate.   Create workflows including notification/consult of MAP program contact upon MAP presentation.  Provide the ED team with a completed [EQIC Transitional Care Community Resource List.](https://qualityimprovementcollaborative.org/focus_areas/readmissions/docs/2022-06-13_transitional_care_community_resource_list.docx)  Continue communication between the MAP program team regarding patient-specific support and continued or additional patient needs. Consider MAP team staff availability 24/7. |  |
| 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.  **Tool:**  [EQIC Circle Back Interview Tool](https://qualityimprovementcollaborative.org/focus_areas/readmissions/docs/2022-06-13_circle_back_interview_tool.docx) |  |
| 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.  **Tool:**  [AHRQ RED toolkit: How to conduct a post-discharge follow-up call.](https://www.ahrq.gov/patient-safety/settings/hospital/red/toolkit/redtool5.html) |  |

# References

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