MBQIP 2 OUTCOMES (M2O)
IMPROVING CARE TRANSITIONS PROJECT

Summer 2020

1. Project Background and Description

Discharge planning and patient communication are frequently targeted in improvement projects, but most hospitals continue to struggle to show measurable or sustained improvement.

The MT Flex Program will provide an interactive approach for improving aspects of care transitions as well as development of a hospital and community services capabilities and resources list to aid the discharging hospital in meeting patient needs identified during the discharge process.

Project goals include: reducing readmissions, improving HCAHPS care transitions scores, improving patient outcomes, and meeting discharge planning conditions of participation (§485.642)

2. Objectives

- Hospitals share current discharge practices and identify gaps in practices using CMS's conditions of participation & other identified best practices
- Ensure all hospitals collect and communicate with the patient and/or patient representative the findings of the patient discharge evaluation including: the discharge plan, treatment preferences, post-discharge goals and post-acute care provider
- Compile a list of services and capabilities for each facility and resources available in their surrounding communities by identifying treatment options available that aid in the post-acute care of the patient (meets new discharge planning condition of participation)
- Reduce readmissions through better discharge practices and improved patient communication

3. Facility Obligations & Expectations

- Bring together team members who commit to and are willing and excited to share discharge practices with CAH peers
- Complete data collection on:
    - Readmissions & discharge processes
    - HCAHPS
    - Hospital & Community Services, Resources & Capabilities
- Attend and participate in virtual workshop(s) to analyze current discharge processes and discuss hospital and community services available regionally and through state partners
- Complete simple project outline, including: Current state analysis, issue identification, root-cause analysis, implement improvements & track results.
- Share findings and experience during project webinars.

This project is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of an award totaling $806,474 with 0% financed with non-governmental sources. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by MT DPHHS, Montana Health Research & Education Foundation (MHREF), HRSA, HHS, or the U.S. Government.

4. Program Obligations & Expectations

MT Flex will facilitate the project and provide the resources necessary for project completion; included, but not limited to:

- Provide evidence based data collection tool to be used for gap analysis in discharge practices
- Compile data & report back to the facilities
- Provide instructor/facilitator for virtual workshops to ensure the best possible communication and collaboration throughout the project
- Share results with Montana hospitals
- Use outcomes to develop future projects
- Collect, compile and create a Hospital Service + Community Health Resources web page for easy reference and to assist in meeting new CMS conditions of participation in care transitions

5. Reporting

Participating Facilities will provide the following data for measuring the impact of the project and to identify gaps in current processes:

- Readmissions and Discharge Process Data Collection for Q4 2019 (TBD)
- HCAHPS report for Q4 2019
- Readmission data for Q4 2019 (available from HIIN, if applicable)
- Hospital & Community Capabilities List

Facilities will provide the following tools and practices for sharing at virtual workshops.

- Patient Discharge Evaluation
- Discharge Plan
- Discharge Policies or Procedures
- Process for reviewing discharge plans and readmissions
- However you collect post-discharge goals of care and treatment preferences
- Hospital and Community Services, Capabilities and Resources

6. High-Level Timeline/Schedule

June 8	Critical Access Hospital Applications Distributed
TBD	Informational video/webinar distributed
June 24	Applications Due
July 8	Data Collection Due
Aug 1	Virtual Workshops Begin
TBD - 2 months	Implement improvement activities
TD - 1 month after final webinar	Project Summary Due- format will be provided
TBD	Remeasurement timeframe

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7. Registration agreement & expectations

Facility Name & City: _____

CEO: _____

Main Facility Lead for this project:

Name: _____ Role/position: _____

Email: _____ Phone number: _____

Facility responsibilities and expectations. ***All must be initialed by both the CEO and the Main Project Lead before application will be considered***

CEO	Lead	
		CEO, Project Leader, Quality Improvement Coordinator (QIC) and additional Project Team Members must agree to support the program from assessment/data collection, through testing & providing feedback of tools & processes and by sharing findings and project outcomes with MT CAHs.
		CEO and leadership will support the project by allocating time and resources necessary at least one project team member to successfully participate in virtual workshops.
		Baseline data collection must be completed and submitted using the data collection tool by due date.
		Share facility tools & processes during virtual workshops.
		Complete remeasure data collection after the completion of the project
		The department affected by the improvement project will be informed of project goals and expectations and will actively participate in any analysis and implementation efforts

Project Contact:
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Registration must be received by June 24, 2020!

Email or fax this page to: *jennifer.wagner@mtha.org* fax: (406)443-3894 ATTN: Jen

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