HCAHPS Composite Measure 7: Care Transitions
Summer 2016

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NEEDS:
- Manage multiple performance improvement projects
- Decrease project length
- Engage active participation
- Identify targeted outcomes
- Leverage available resources
- Maximize opportunities
- Move from collecting data to using data
GOAL: Data To Doing

Provide a statewide, hands-on, standardized rapid-cycle performance improvement project format, including tools, education and coaching support to improve MBQIP (Medicare Beneficiary Quality Improvement Project) scores, positively impact patient outcomes at both the individual facility and state level, and provide ongoing education for CAH (Critical Access Hospital) Quality Improvement Coordinators.
M2O was born!
M2O Overview

M2O: MBQIP To Outcomes

- Targeted MBQIP measure
- Establish Agreements with Project Cohort
- Facilitated/Coached by Lean Consultant
- Utilize Current, Available MBQIP Data
- Actively Engage Participants
- Share successes
M2O Development

1. Partnered with Lean Consultant (March)

2. Developed Project Framework & Timeline (April)

3. Recruited Project Cohort (May)

4. Project Kick-Off (June)
4 Sessions & 1 Workshop:

- **June 7** – Session 1: Transitioning from Data To Doing: Defining the Project Scope
- **June 21** – Session 2: Transitioning from Data To Doing: Analyzing the Current State
- **July 11-14** – M2O Workshops: Regional In-person Meetings
  - July 11 – Western Region: Hosted by Deer Lodge
  - July 12 – Central Region: Hosted by Columbus
  - July 13 – North Eastern Region: Hosted by Scobey
  - July 14 – North Central Region: Hosted by Choteau
- **July 19** – Session 3: Solution Time: Right Side of the A3
- **August 9** – Session 4: Report Out: Share Successes with PIN
- **Next Steps**
  - September - Poster Presentation at Montana Hospital Association (MHA) Convention
  - HCAHP Re-measure: Q4 2016
  - Spring 2017 – Results shared at MHA Summit
Flex Program Commitment

1. Identify & partner with qualified consultant(s)
2. Work collaboratively with consultant(s) to develop framework to meet CAH needs
3. Identify opportunities for improvement from MBQIP data
4. Serve as project communication and cohort hub
5. Catalog, store and share project materials & resources
6. Share lessons learned/best practices with PIN (Policy Information Notice)
7. Host project webinars and coordinate workshops with host facilities
Participant Commitment

1. Attend Every Session
   (Each session builds on the previous)
2. Complete Homework
3. Participate in Regional In-person Meetings
4. Implement Solutions & Share Successes
5. Submit Q4 HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems)
Signed Participant Agreement

Facility responsibilities and expectations.

All must be initialed by both the administrator and the Main Project Contact (MPC) before application will be considered

• Q4 2015 HCAHPS Reports must be sent to the Flex Grant Office by _______ to establish baseline measures
• Administration, Quality Improvement (QI) Coordinator and additional Project Team Leads must agree to support the M2O program from project scoping through project implementation
• Administration and Management will support M2O by allocating time and resources necessary for QI Project Team (at least one participant) to successfully participate in/travel to Regional M2O Workshop
• QI Coordinator and Project Team Lead will identify M2O Project Team
• QI Coordinator/Project Team Leads will attend and participate in ALL M2O Webinars and In-Person Workshops
• QI Coordinator/Project Team Leads will submit completed M2O Project Tasks to Facilitator as scheduled
• QI Team to implement, test and report solutions by M2O Project Completion Date
• QI Team to share successes as a poster presentation at 2016 MHA Convention
• 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
• The main project contact and the administrator (if available) will participate in a follow-up webinar which will be scheduled approximately four weeks after project
Participant Expectations

You will...
• Network with Peers
• Identify & Implement Improvement(s)
• Utilize Standardized PIN Project Methodology & Sharing Platform

You will NOT...
• Be a Green, Black, or Polka-dot Belt
• Be a Sensei
• Be a Guru
M2O PI Methodology

M2O Tool Box

Utilize similar language and format to increase collaboration & improve outcomes statewide

• Project Scoping
• Current State Value Stream Mapping/Flowchart
• A3 Problem Solving
HCAHPS Composite Measure 7: Care Transitions

Cohort Participation: 13 Critical Access Hospitals

Project Resources: PIN Website
Defining the Project Scope:

1. Virtual Network Intro
2. Network Technology Overview
3. M2O Overview & Expectations
   - Process Improvement Methodology
   - Project Scoping- Process Identification & Team Development
   - Observation (Walk the Work)
M2O Pilot Project: Session 1 Materials A

PROJECT SCOPE

Project Aim: (What are we trying to accomplish?)
Project Goal: (SMART goal)

Project Constraints: (What are the boundaries for this project?)
Budget:
Schedule:
Quality:
Other: (Policies, Regulations, Senior Management requirements)

Evaluation Measure (use standardized data, easily obtainable if possible - examples include PQRS, NQF, CMS, IQR and or UDS measures)

<table>
<thead>
<tr>
<th>Measure Identifier/Number</th>
<th>Description</th>
<th>Data Source</th>
<th>Target Performance</th>
<th>Current Performance</th>
<th>Current Performance Date</th>
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Project Team Leads

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<thead>
<tr>
<th>Name</th>
<th>Title/Department</th>
<th>Role</th>
<th>Responsibilities</th>
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Process Prioritization

<table>
<thead>
<tr>
<th>Potential Processes</th>
<th>Priority ranking (low, medium, high)</th>
<th>Estimated Completion Date</th>
<th>Notes</th>
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M2O Pilot Project: Session 1 Sample A

PROJECT SCOPE

Project Aim: (What are we trying to accomplish?) Improve patients understanding purpose of taking medication when leaving hospital as being measured by HCAHPs 40%

Project Goal: (SMART goal)

Project Constraints: (What are the boundaries for this project?)

Budget: $1040
Schedule: Project Implementation 6/7/16 – 9/30/16; Re-measure Q4
Quality: Re-measure Q4; Increase Measure 7/Q25 performance to 75%
Other: (Policies, Regulations, Senior Management requirements) 2016 Care Transition Pilot; Grant XYZ; Policy 23.4; HCAHPS;

Evaluation Measure (use standardized data, easily obtainable if possible - examples include PQRS, NQF, CMS, IQR and or UDS measures)

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<tr>
<th>Measure Identifier/Number</th>
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<th>Current Performance</th>
<th>Current Performance Date</th>
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<tr>
<td>Care Transition #7/Q25</td>
<td>When leaving hospital, Patient clearly understands purpose for taking each medication</td>
<td>HCAHPS</td>
<td>75%</td>
<td>38.7%</td>
<td>Q4 2015</td>
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Project Team Leads

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<th>Name</th>
<th>Title/Department</th>
<th>Role</th>
<th>Responsibilities</th>
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<tr>
<td>Bob Smith</td>
<td>DON/</td>
<td>Nursing Lead</td>
<td>Evaluate &amp; improve nursing functions</td>
</tr>
<tr>
<td>Jane Johnson</td>
<td>Care Coordinator/</td>
<td>Care Coordination Lead</td>
<td>Patient liaison, Evaluation and improve Care coordination functions</td>
</tr>
<tr>
<td>Sue Squires</td>
<td>QC/Quality</td>
<td>Lean Facilitator</td>
<td>Lean Facilitator; Documentation &amp; notes</td>
</tr>
<tr>
<td>Kelly Jones</td>
<td>Pharmacist/Pharmacy</td>
<td>Pharmacy Lead</td>
<td>Evaluate &amp; improve pharmacy functions</td>
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Process Prioritization

<table>
<thead>
<tr>
<th>Potential Processes</th>
<th>Priority ranking (low, medium, high)</th>
<th>Estimated Completion Date</th>
<th>Notes</th>
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<tbody>
<tr>
<td>Medication Review Process</td>
<td>High</td>
<td>9/24/16</td>
<td>Manager Joan on vacation until 7/6/16 – unable to begin until returns (small monument) Larger process – from admission to discharge</td>
</tr>
<tr>
<td>Medication Ordering Process</td>
<td>Low</td>
<td>8/16/16</td>
<td>Held rapid cycle improvement project Q1 2016; will evaluate again after test period</td>
</tr>
<tr>
<td>Patient Medication Education at Discharge Process</td>
<td>High</td>
<td>8/5/16</td>
<td>Very low score, minimal cost/time to improve</td>
</tr>
<tr>
<td>Med Pass Process</td>
<td>Medium</td>
<td>9/4/16</td>
<td>Reviewing Med Errors, time study needed for further evaluation</td>
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### Process Scope

<table>
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<tr>
<th>Process Improvement Project Team</th>
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<tbody>
<tr>
<td>Name</td>
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1. Process to be analyzed:

2. Why is this process being chosen to analyze?

3. Improvement SMART goal/target for chosen process:
   (Specific, Measurable, Action oriented, Realistic and Time based)

4. Scope of process to be analyzed (clearly define start point and end point):

5. EHR/Documentation system, module and/or applications involved:

6. Items/equipment/devices involved in process:

7. Physical locations involved in process:

8. Staff/people involved in process:

9. How will the process be mapped (value stream map, flowchart, etc.) using what method (direct observation, video recording, etc.)?

10. Who will own the map once completed?

11. Planned start date/target end date (of mapping exercise)
## Process Scope

<p>| | |</p>
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<tr>
<td>1.</td>
<td>Process to be analyzed: &lt;br&gt; <strong>Patient Medication Education at Discharge Process</strong></td>
</tr>
<tr>
<td>2.</td>
<td>Why is this process being chosen to analyze? &lt;br&gt; Low HCAHPS Measure 7/Q25 score (38.7); when process observed – determined process not clearly defined, staff not educated on process. Patients interviewed expressed confusion between education and understanding paperwork sent home at discharge</td>
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<td>3.</td>
<td>Improvement SMART goal/target for chosen process: &lt;br&gt; (Specific, Measurable, Action oriented, Realistic and Time based) &lt;br&gt; To improve patient understanding of taking medication at discharge as Measure 7/Q25 score to 75% or greater in Q4 2016 through lean rapid cycle project and patient panel review to be implemented by 8.9.16.</td>
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<tr>
<td>4.</td>
<td>Scope of process to be analyzed (clearly define start point and end point): &lt;br&gt; Request for patient medication education at discharge triggered by discharge orders in EMR to care coordinator follow-up with patient one week following discharge.</td>
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<td>5.</td>
<td>EHR/Documentation system, module and/or applications involved: &lt;br&gt; Epic; Patient Discharge Forms XYZ; etc.</td>
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<td>6.</td>
<td>Items/equipment/devices involved in process: &lt;br&gt; Laptop; Patient Pill Organizer Box; Video...etc.</td>
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<td>7.</td>
<td>Physical locations involved in process: &lt;br&gt; Inpatient Rooms Floor 2, Wing 1</td>
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<td>8.</td>
<td>Staff/people involved in process: &lt;br&gt; Joe E. Pharmacy; Ellen Q. Nursing; Gail S. Social Services; Rob T. IT; Julie K., Liz F., Bill R – Care Coordinators; Rita W. Long Term Care; etc.</td>
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<td>9.</td>
<td>How will the process be mapped (value stream map, flowchart, etc.) using what method (direct observation, video recording, etc.)? &lt;br&gt; Value Stream Map</td>
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<td>10.</td>
<td>Who will own the map once completed? &lt;br&gt; Quality Department – will be available on H: Drive for all staff</td>
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<td>11.</td>
<td>Planned start date/target end date (of mapping exercise) &lt;br&gt; 6.22.16 / 7.1.16</td>
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M2O Pilot Project: Session 2 AGENDA

Analyzing the Current State:
1. Homework Review
2. Patient Perspective
3. Rules of Engagement
4. Current State: What, why & how to obtain it?
   - Observation
   - Process Visualization: Flow Chart/Swim Lane Chart/Value Stream Map
   --Data Collection
   -- Validation
### Observation Record

**Activity:**

**Person Observed:**

**Location:**

**Date:**

**Observer:**

- [Sketch of physical location/work area]

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>Observation</th>
<th>Preparation</th>
<th>Loading/Access</th>
<th>Confirmation</th>
<th>Working</th>
<th>Innovation</th>
<th>Learning</th>
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**Notes:**

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M2O Pilot Project: Session 2 Materials A
Swim-lane chart: “process for making certain that patient/patient family/caregiver preferences are taken into account in deciding what the patient health care needs will be when they leave”

- Pharmacist
  - Verifies med orders & provides medication summary sheets to nursing staff with clearly defined potential side effects & purpose of medication

- Nurse
  - Patient admitted to acute care
  - Establish Clinical Pathway
  - Patient Admit & Assessment: patient & family members on patient status board, establish who will be involved in the patient care plan & how

- Physician
  - Informed of new admit & care plan by charge nurse

- Care Coordinator
  - How is the care coordinator alerted to the new patient?

Daily Multidisciplinary Bedside Rounds:
- Patient & family members are provided medication sheets & taught about side effects & purpose of meds & learn about their roles in the patient care plan

Discharge Planning Rounds with patient & family:
- Patient discharges are provided discharge medication sheets & provide teach-back about side effects & purpose of meds. Discuss patient needs at home or LTC & patient expectations (need of health provider, etc.)

- Discharge Orders
  - Discharge Plans relayed to Care Coordinator

- Schedules Discharge Planning Rounds

Discharge Med Rec

If you don't do Discharge Planning Rounds, when is the patient/family asked about their post-hospital needs & expectations?

If you don't have a care coordinator, who helps schedule follow-up tests and appointments?

Contacts patient at home to check on status & make sure they have all of their needs met
M2O Pilot Project: Session 2 Materials C

Session 2 Materials C

Discharge Med Rec
- MD logs on to EMR
- MD compares patient meds with PAMM

Discharge Med Order
- MD orders discharge meds using inpatient med list and PAMM

Discharge Summary
- MD incorporates PAMM & discharge meds into final discharge summary
- RN reviews discharge meds with patient and/or caregiver
- RN generates EMR post hospital care plan
  - including discharge meds list
- RN signs off electronically that PAMM has been reviewed at discharge

Patient Education
- For patients referred to SNF or rehab facility
  - RN generates patient care referral form containing both PAMM and discharge med list
  - home referral to appropriate SNF/ rehab

Patient Care Referral & Discharge
- Pre-discharge: patient record updates
- Care Coordinator schedules follow-up appts.

Patient Discharged
- Care Coordinator calls SNF patient to review care plan and medication post discharge
- Care Coordinator updates patient record to

Total Time: 10,380 mins
Value Quotient: FT/FT
1st = 61/10480

Hi: 540 min
Lo: 2 min
Ave: 8 min

Hi: 25 min
Lo: 2 min
Ave: 8 min

Hi: 162 min
Lo: 5 min
Ave: 18 min

Hi: 45 min
Lo: 9 min
Ave: 10 min

Hi: 25 min
Lo: 2 min
Ave: 8 min

Hi: 28 min
Lo: 2 min
Ave: 4 min

Hi: 28 min
Lo: 2 min
Ave: 4 min

Hi: 14 min
Lo: 1 min
Ave: 5 min

Hi: 25 min
Lo: 2 min
Ave: 8 min

Hi: 48 min
Lo: 6 min
Ave: 14 min

Hi: 20160 min
Lo: 4210 min
Ave: 10080 min
All Participants actively engaged & completing activities

4 Regional In-Person Workshops

(1150 miles)
M2O Future State

- Evaluate pilot project following completion

- Cyclical calendar

- Integrate In-Person Meeting with current statewide meetings

- Replicate framework in other PI (performance improvement) activities
Thank you to Tawnie Sabin, JD, BSIE of Abundant Solutions for the use of M2O materials for this presentation.

tawnie@abundantsolution.com
Thank You!

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Lhowe@mt.gov