Reducing 30 Day All Cause Readmissions

Saunders Medical Center
Wahoo, NE

Leadership/Planning

Saunders MEDICAL CENTER Be Well.

Our Mission

To improve the health of the people of Saunders County and beyond by providing convenient and timely access to high-quality comprehensive care with exceptional service and compassion.

Our Vision

To serve as the provider of choice for the citizens of Saunders County.

To develop and maintain a reputation for innovation and leadership in rural healthcare services.

Our Values

Extraordinary Care

- Departments work together toward common goals
- Use your "voice"
- Obtain knowledge for your position

Compassionate Care

- Offer the thoughtful care we want for ourselves and our family members
- Go above and beyond when people least expect it
- Remember, patients come first

Caring Leadership

- Be a leader, show the way
- Own it, the good and the bad

Care for the Community

- Involvement in the Saunders Medical Center community and beyond

Process of Identifying Need

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- Participation with the Hospital Improvement Innovation Networks to achieve a 12 percent reduction in 30-day hospital readmissions as a population based measure from the 2014 baseline.
- Internal evaluation of 30-Day Readmission Rate
- Baseline readmission rate of 8% in 2014.
- Expansion of the Quality Department and monthly review of the HCAHPS survey results

Process Improvement Methods

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- PDSA
  - Plan: Transitional Care Team formed and formulated aim statement
  - Do: Enhance process of identifying high-risk patients and emphasize importance of patient education
  - Study: Review readmission data with team and create summary to identify areas to improve
  - Act: Implement TCM services and hospital health coach sessions with complimentary home visits after discharge as well as several other interventions done by multiple departments.

Results

Qualitative data gathered through individual interviews and HCAHPS scores.

- Patient outcomes:
  - Increased understanding of individual health and well-being as well as medication understanding and compliance
  - Improved patient involvement in health care decision making
  - Improved confidence and trust in healthcare providers
- Community Improvements:
  - Improves continuity of care between different facilities in Saunders County
  - Provides easy transition from hospital to home or hospital to other health care facility ie. Nursing Home/Assisted Living/Home Health/Hospice
- Financial Improvements:
  - TCM charges

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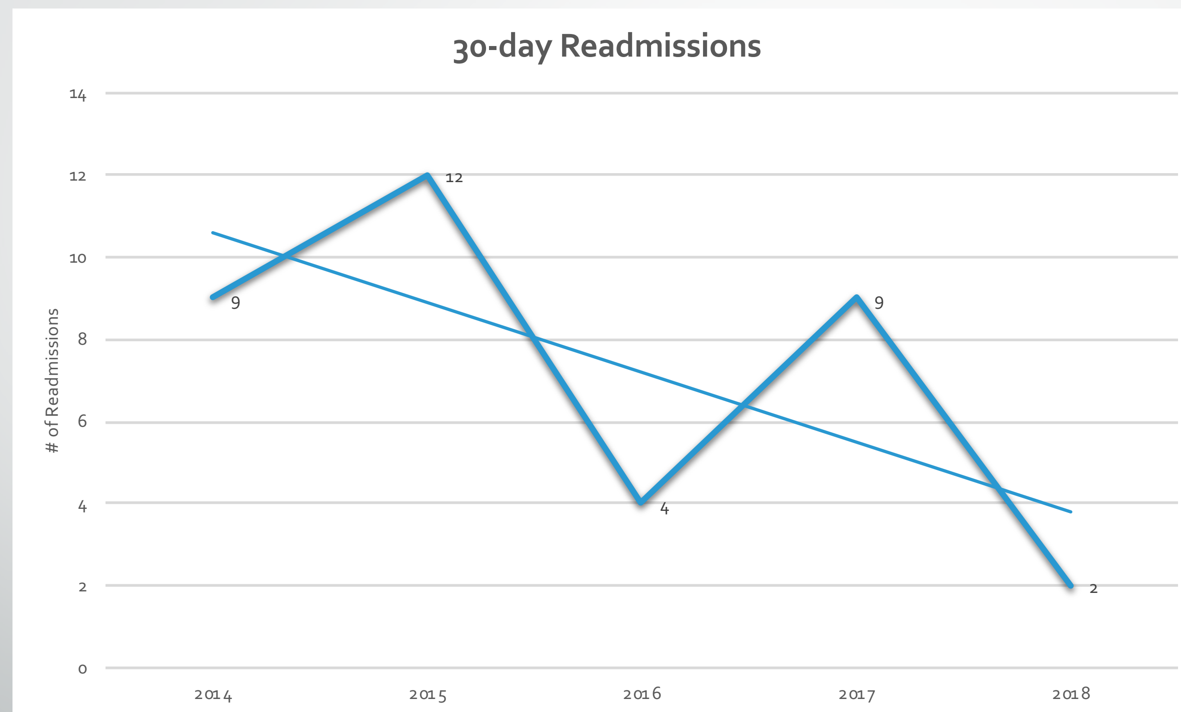
Results



Lessons Learned

- Gains
  - Inspiring healthy lives to take root at Saunders Medical Center by strengthening our model of care to promote and support active and health-focused lifestyles.
  - Creating and sustaining relationships amongst the community with our Care Transitions Collaborative
  - Utilizing community resources appropriately with our social service consult
  - Improving HCAHPS scores that reflect patient understanding of their plan of care
  - Financial gain of $15,000
- Areas for Improvement
  - Continue staff education on the Tell Me 3 and Teach Back Method
  - Expand Home Visits to involve more staff
  - Discharge Medication Reconciliation

Lessons Learned

- Sustainability
  - Continuity of care education to providers, nursing, pharmacy, and care coordinators
  - Community Outreach on transition of care through marketing
  - Use TeamSTEPPS tools and Lean Six Sigma methodology to communicate effectively and work efficiently
- Next Steps
  - Continue TCM
  - Continue and enhance complimentary home visits
  - Re-implement Patient Family Advisory Council