Redefining Care Across the Continuum - Keep it Simple

Saunders Medical Center
Wahoo, NE
Process of Identifying Need

• Participation with the Hospital Improvement Innovation Network 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.

• Review of readmission reports provided by external data analytics.

• Baseline readmission rate of 8% in 2014.
Process Improvement Methods

• **PDSA**

• **Multi-Disciplinary Team:**
  - Quality, Clinic Health Coaches, Hospital DON, ED Manager, Pharmacy

• **Aim Statement:** Reduce inpatient 30-day readmissions by 50% by December 2018 and sustain a readmission rate of <4%
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 health care 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
## Results

### TCM Revenue

<table>
<thead>
<tr>
<th></th>
<th>FY2018</th>
<th>FY2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dollars</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>10,333</td>
<td>25,635</td>
</tr>
</tbody>
</table>

### Harm Measure

<table>
<thead>
<tr>
<th>Harm Measure</th>
<th>Monthly Baseline Numerator</th>
<th>Monthly Baseline Discharges</th>
<th>Baseline Rate per 1000</th>
<th>Target Rate</th>
<th>Project To Date Numerator</th>
<th>Project To Date Discharges</th>
<th>Project To Date Rate per 1000</th>
<th>Harms Prevented</th>
<th>Cost Per Harm</th>
<th>Costs Avoided</th>
</tr>
</thead>
<tbody>
<tr>
<td>Readmission Rate 30-Day All Cause</td>
<td>1</td>
<td>10</td>
<td>54.95</td>
<td>48.35</td>
<td>10</td>
<td>321</td>
<td>31.15</td>
<td>8</td>
<td>$15,477</td>
<td>$118,203</td>
</tr>
</tbody>
</table>
Results

30-day Readmissions

Data as of August 1, 2019
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

• 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
  • Expand project to include 30-day ED Readmissions and Multi-Visit Patients (MVP)
  • Modify Hospital Health Coach responsibilities to a Discharge Planner