Redefining Care Across the Continuum - Keep it Simple

Saunders Medical Center
Wahoo, NE
Presenters

Amber Kavan
Performance Improvement Coordinator

Ansley Roth
Clinic Health Coach

Denise Sabatka
Director of Quality Services

Stacie Sabatka
Director of Clinics
Saunders Medical Center

- 16 bed CAH
- Clinic
- LTC
- Lab
- Surgery
- Radiology
- Therapy
- Specialty Clinic
Objectives

- Identify areas for improving care transitions
- Defining and forming effective multidisciplinary teams to meet each patient's needs
- Design and develop actions and interventions that help patients move through the health system
- Assess quantifiable data and evidence that demonstrates how care coordination contributes to better outcomes and lower costs
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, Providers, Therapy, Front-line Nursing Staff, Social Work

• **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
## HCAHPS Results

<table>
<thead>
<tr>
<th>Survey Question</th>
<th>Baseline: 2014</th>
<th>3Q18</th>
<th>4Q18</th>
<th>1Q19</th>
<th>2Q19</th>
<th>3Q19</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of pts who stated nurses treated them with courtesy and respect</td>
<td>66%</td>
<td>83%</td>
<td>78%</td>
<td>100%</td>
<td>100%</td>
<td>83%</td>
</tr>
<tr>
<td>% of pts who stated doctors treated them with courtesy and respect</td>
<td>87%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>% of pts who stated staff talked about the help you would need</td>
<td>81%</td>
<td>100%</td>
<td>100%</td>
<td>86%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>% of pts who stated they were told what medicines were for</td>
<td>84%</td>
<td>100%</td>
<td>80%</td>
<td>100%</td>
<td>100%</td>
<td>67%</td>
</tr>
<tr>
<td>% of pts who stated they had confidence and trust in their nurses</td>
<td>71%</td>
<td>50%</td>
<td>89%</td>
<td>100%</td>
<td>89%</td>
<td>83%</td>
</tr>
</tbody>
</table>

### Patient Comments

- "I have been in 30+ hospitals overtime and SMC is one of the best as far as I'm concerned."
- "I had excellent care. Happy and kind staff. Everything went fine with my stay."
- "Nurses took really good care of me."
- "My experience was pleasant and professional."
- "I couldn't ask for better care, everyone on your staff was excellent."
- "Excellent care! Caring staff!"
Results

TCM Revenue

<table>
<thead>
<tr>
<th></th>
<th>FY2018</th>
<th>FY2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dollars</td>
<td>10,323</td>
<td>25,435</td>
</tr>
</tbody>
</table>

Dollars
## Results

<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><strong>$118,203</strong></td>
</tr>
</tbody>
</table>

![Efficiency, Quality, Costs Diagram](image)
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
  • Discharge Medication Reconciliation
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

<table>
<thead>
<tr>
<th>Situation</th>
<th>Identified opportunities for improvement to reduce inpatient 30-day readmissions.</th>
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<tbody>
<tr>
<td>Background</td>
<td>Baseline readmission rate of 8% in 2014.</td>
</tr>
<tr>
<td>Assessment</td>
<td>Over 50% of inpatient readmission were from long term care facilities and also patients that needed more support at home.</td>
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<tr>
<td>Recommendation</td>
<td>Implement TCM Services, hospital health coach, complimentary home visits, follow-up calls, follow-up appointments, and institute a Care Transitions Collaborative.</td>
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</table>
Next Steps

• Expand TCM Services to include other hospitals
• Expand project to include 30-day ED Readmissions and Multi-Visit Patients (MVP)
• Assigning Discharge Planning responsibility to existing staff
• Participation in Transitions of Care Collaborative and Serious Illness Projects with HHA
• Age-Friendly Collaborative with NHA