Redefining Care Across the Continuum- Keep it Simple

Saunders Medical Center
Wahoo, NE

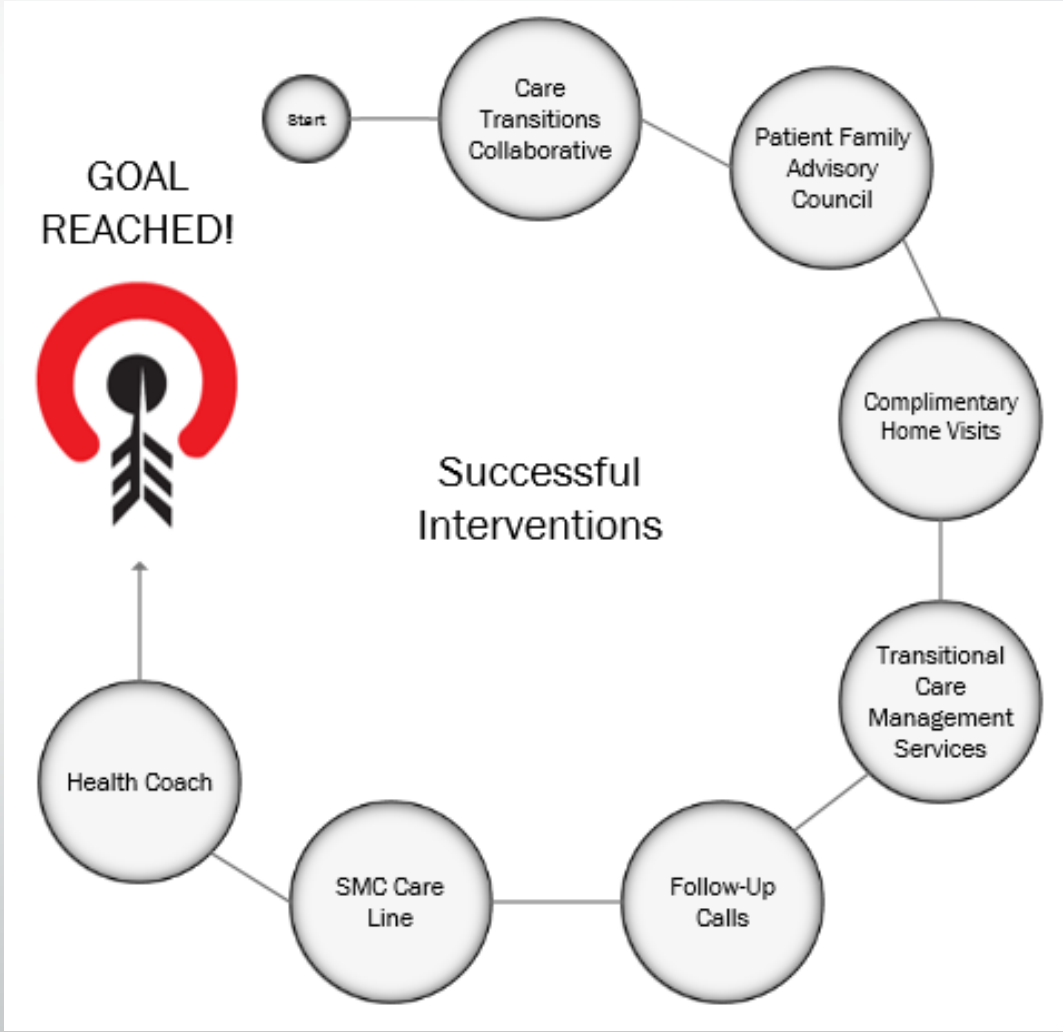
Saunders MEDICAL CENTER
Be Well.

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%

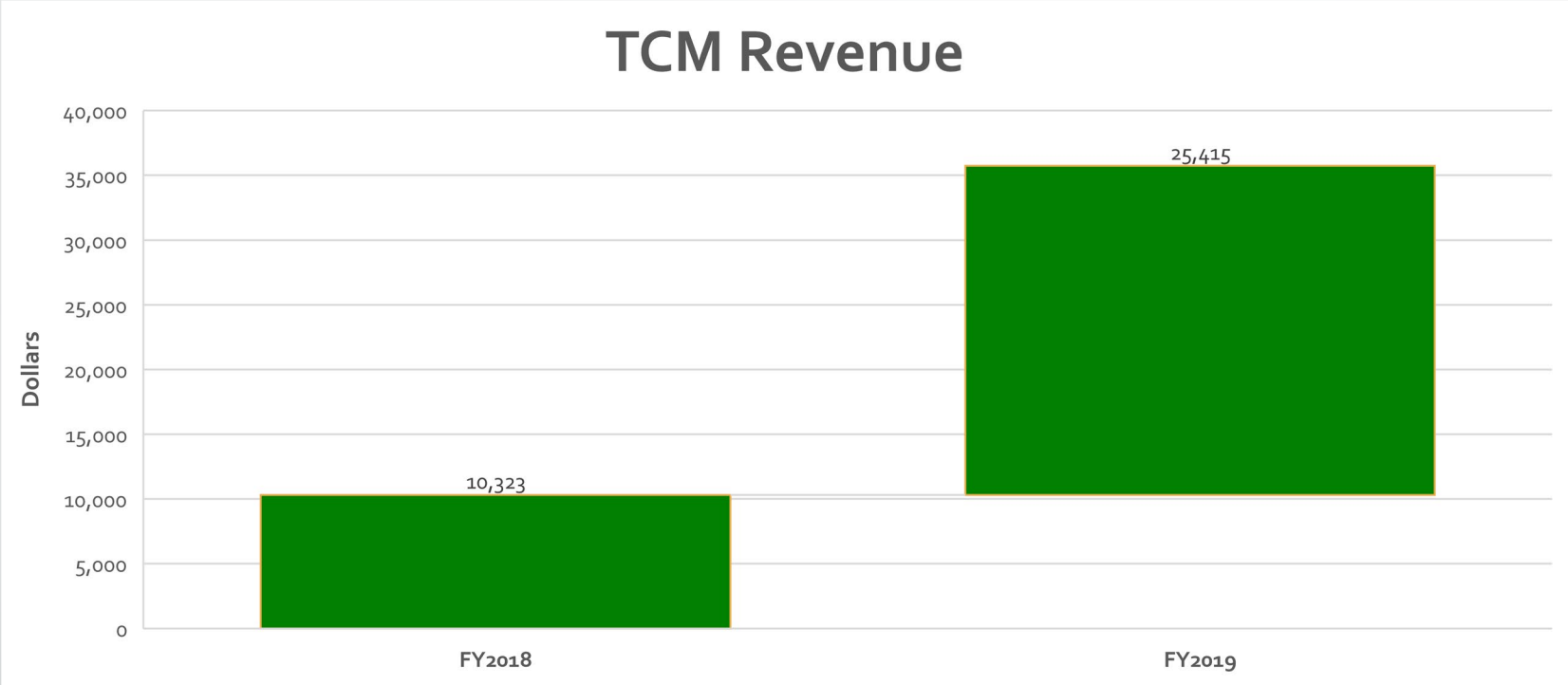


Results

Qualitative data gathered through individual interviews and HCAHPS scores.

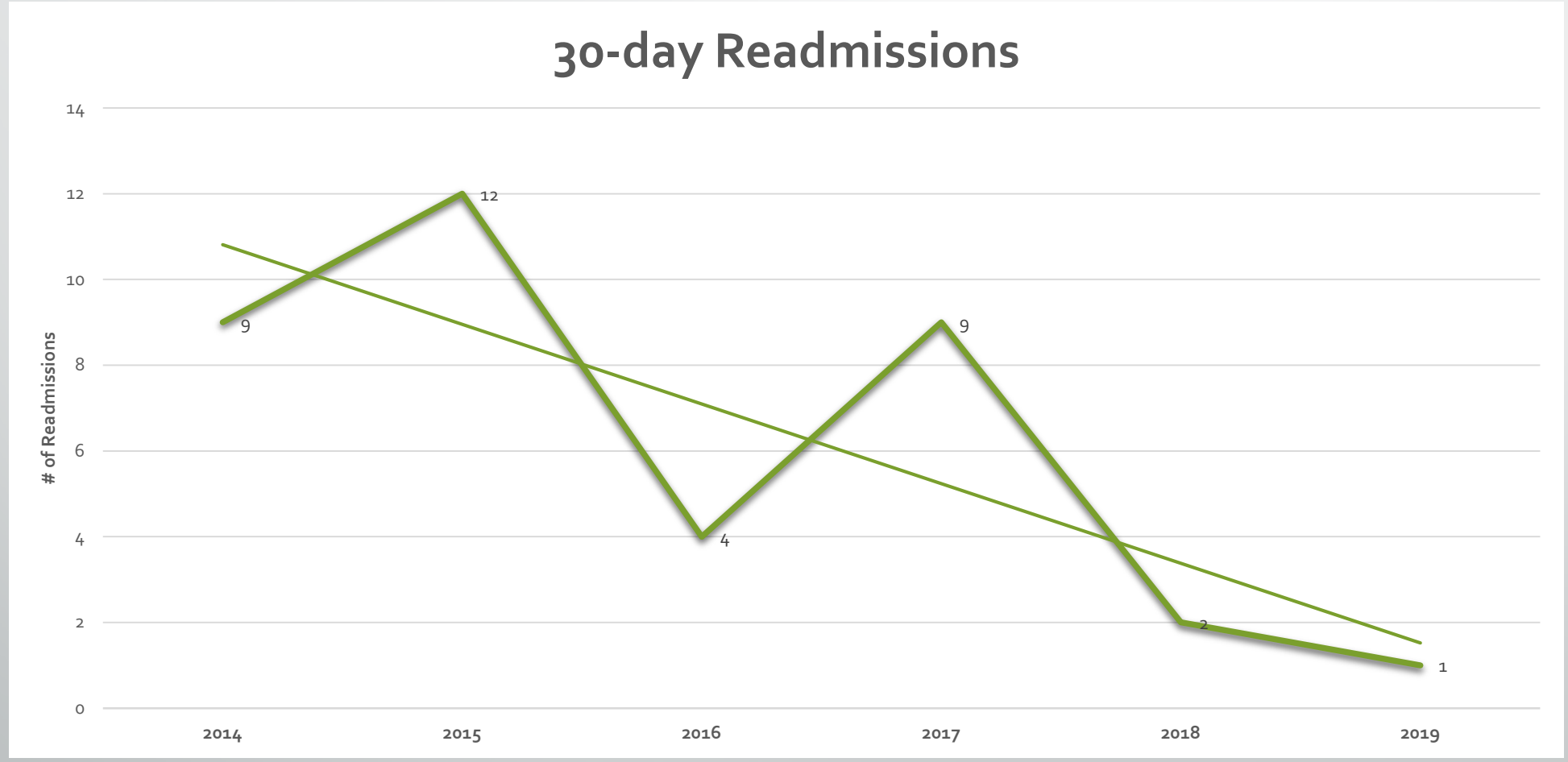
- Patient outcomes:
  - Increased understanding of individual health and well-being as well as medication understanding and compliance
  - Improved patient involvement in health care decision making
  - Improved confidence and trust in health care providers
- Community Improvements:
  - Improves continuity 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



Harm Measure	Monthly Baseline Numerator	Monthly Baseline Discharges	Baseline Rate per 1000	Target Rate	Project To Date Numerator	Project To Date Discharges	Project To Date Rate per 1000	Harms Prevented	Cost Per Harm	Costs Avoided
Readmission Rate 30-Day All Cause	1	10	54.95	48.35	10	321	31.15	8	$15,477	$118,203

Results



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