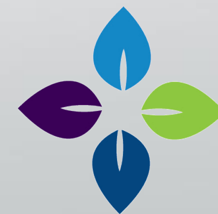
Redefining Care Across the Continuum- Keep it Simple

Saunders Medical Center
Wahoo, NE



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Presenters

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Performance Improvement Coordinator

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Clinic Health Coach

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Director of Quality Services

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Director of Clinics

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Saunders Medical Center

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

Objectives

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- Identify areas for improving care transitions
- Defining and forming effective multidisciplinary teams to meet each patients 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

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- 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

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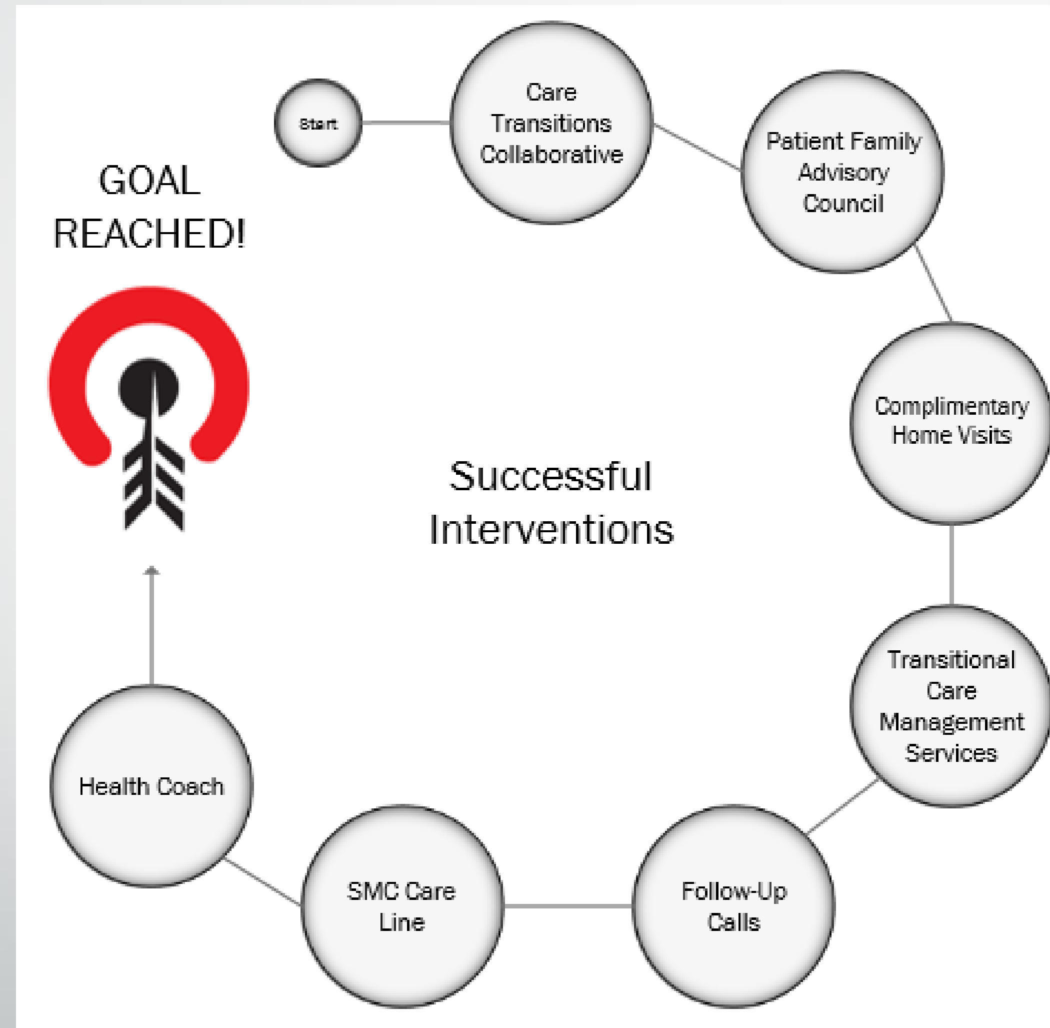
- **PDSA**
- **Multi-Disciplinary Team:**
  - Quality, Clinic Health Coaches, Hospital DON, ED Manager, Pharmacy, Providers, Therapy, Front-line Nursing Staff, Social Work
- **Aim Statement:** Reduce inpatient 30-day readmissions by 50% by December 2018 and sustain a readmission rate of <4%

Interventions



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

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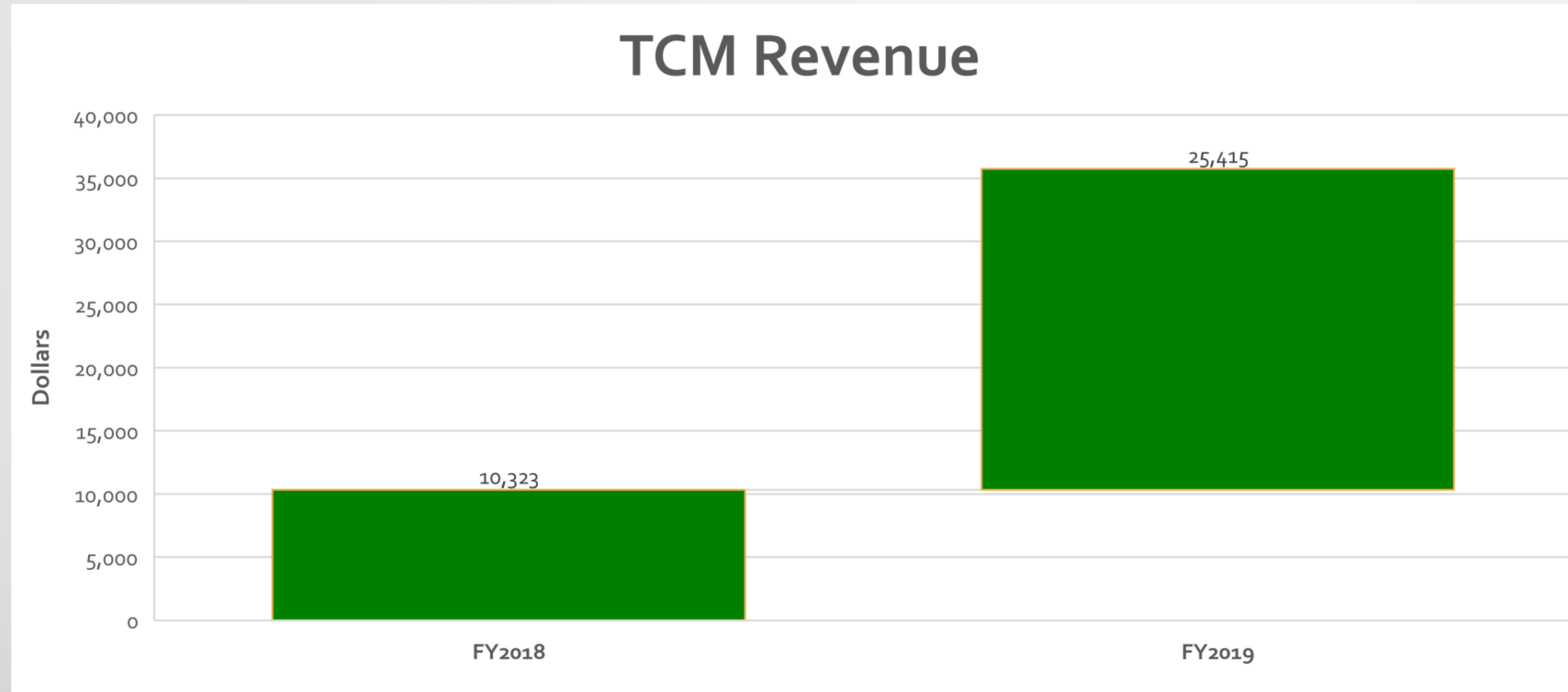
HCAHPS Results

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

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



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

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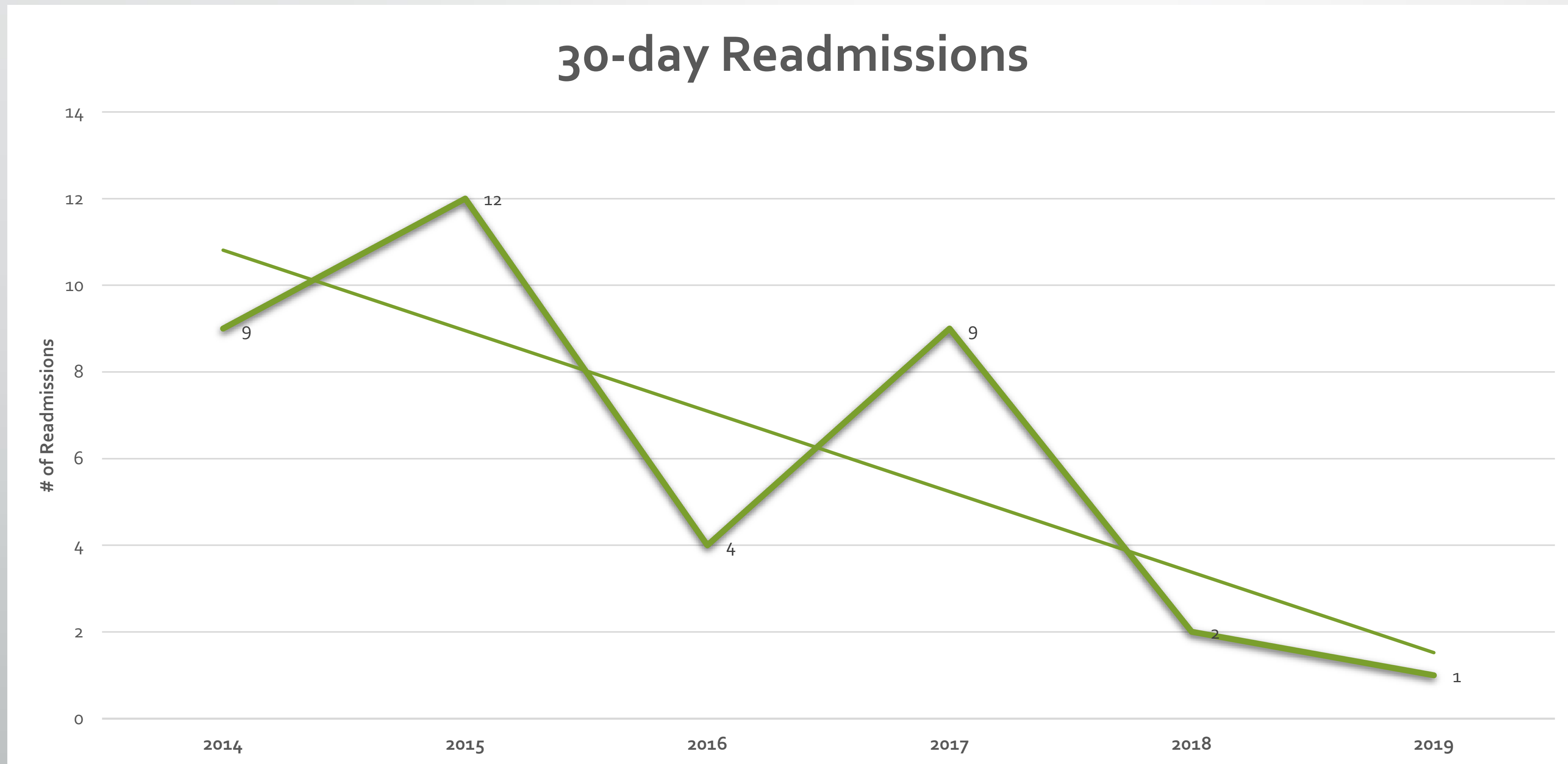
Results



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
  - 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

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

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

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Health Coach
ANSLEY ZALOUDEK, BSN, RN

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