2013 Quality Excellence Achievement Awards

Recognizing Illinois Hospitals and Health Systems Leading in Quality, Innovative and Transformative Health Care
Overview

The Illinois Hospital Association (IHA) Institute for Innovations in Care and Quality’s (The Institute) third annual Quality Excellence Achievement Awards—Delivering Quality with Distinction—celebrates Illinois hospitals and health systems’ transformational achievements utilizing the Institute for Healthcare Improvement’s Triple Aim philosophy:

- Enhancing the patient experience;
- Improving population health; and
- Reducing health care costs.

Building upon previous years, 104 projects from 57 hospitals and health systems were submitted this year. IHA appreciates the expertise and commitment demonstrated by our members as well as our judging panel of 29 nationally-recognized quality improvement leaders, who carefully reviewed and scored each application. This year, three awards were presented, one in each of the following categories: Health Care System, Rural/Critical Access Hospital, and Urban Hospital.

To share these initiatives among members, The Institute has published this compendium that provides a synopsis of all project entries along with contact information for additional details. The compendium receives national exposure by being featured annually on the Hospitals in Pursuit of Excellence (HPOE), an AHA affiliate, website.
CALL FOR ENTRIES
Opens Spring 2014

Be sure to watch for this opportunity to be recognized and celebrated for your hospital’s achievements in advancing patient care.

AWARD CATEGORIES

- Health Care System
- Rural/Critical Access
- Urban

New in 2014: The Tim Philipp Award

A passionate advocate for quality improvement and patient-centered care, Tim Philipp, who died in May 2013 after a long battle with cancer, spearheaded the work of IHA’s Quality Awards. His work was greatly influenced by his unique perspective as a nurse, teacher and cancer patient. The Tim Philipp Award for Excellence in Palliative Care will honor excellence and innovation in palliative care.
Care Coordination: Readmissions

Project Title: Readmission Rate Reduction Through Team Collaboration and Patient Partnership

Hospital/System: Pekin Hospital, Pekin

Summary: The hospital’s multidisciplinary team utilized Plan-Do-Study-Act (PSDA) with evidence-based practice research, Centers for Medicare & Medicaid Services Hospital Engagement Network guideline recommendations, and patient feedback to create a Care Transition Program to reduce all cause 30-day readmissions by 20%. The program provides individualized multi-faceted support to the patient from admission and extends beyond discharge to improve the patients' self-managed care and outcomes.

The Care Transition Coordinator, with the assistance of the physicians, case managers, social workers, pharmacy staff and outside agencies, assists the patient with follow-up appointments and medication management, weight and blood pressure monitoring, and improved education. Through the team collaboration and patient partnership, the hospital reduced their all cause 30-day readmissions rate by approximately 55% in nearly one year.

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