## AHA/HRET HEN 2.0 STORYBOARDS

### ORGANIZATION AND TEAM

**SANFORD ABERDEEN MEDICAL CENTER: ABERDEEN, SOUTH DAKOTA**

- Sanford Aberdeen Medical Center is a full-service 48-bed regional hospital located in northeastern South Dakota. Services include:
  - Adult and pediatric care
  - Emergency/tissue, labor and delivery
  - Critical care
  - Cardiovascular lab
  - Inpatient and outpatient surgical and procedural areas
  - Inpatient and outpatient therapies
  - Laboratory and imaging services
  - Connected to the medical center is Sanford Aberdeen Clinic that serves the health care needs of Aberdeen and the surrounding area with a medical staff consisting of more than 50 providers ranging from family medicine to advanced specialty providers for both children and adults.

### IMPROVEMENT STRATEGIES

- The care transition program followed patients for 30 days post discharge:
  - Increased access to follow-up appointments
    - Prior to implementation, 60 percent of readmitted patients did not attend a follow-up appointment and 11 days was the average time for a follow-up appointment with PCP
    - Readmission risk analysis of readmitted patients determined program criteria
    - Pharmacist completed medication reconciliation at first post-discharge visit
    - Nursing health coach held disease management visits to provide patients with one-point of contact for questions
    - Rounded with an interdisciplinary team at the bedside and held weekly meetings to discuss high-risk patients
    - Involved inpatient and outpatient representatives including advanced practice provider to assist with transition to post-acute care setting, long term care facilities and care transition appointments

### LESSONS LEARNED

- Start small, keep it simple.
- Complete multiple plan-do-study-act cycles.
- Engage patients—it’s a must.
- Listen to the patient—What matters to you not what’s the matter with you?
- Standardize processes and monitor completion of key processes.
- Follow up early post discharge. It was helpful to follow up 48-72 hours with medication reconciliation.
- Increased health care visits post discharge equals lower readmission rate.
- Define role expectations of team members to minimize negative affects of staff turnover.
- Home health or home visit alternatives would be beneficial.
- It takes a village.

### PROJECT GOALS

**READMISSIONS**

- Many hospital readmissions are considered preventable and missed opportunities.
- Hospitalizations are costly and readmissions contribute significantly to the cost with one-in-five Medicare patients being readmitted.
- Readmissions are the subject of many health care improvements initiatives, such as the Readmission Reduction Program which penalizes hospitals with excess readmission rates acute myocardial infarction, chronic obstructive pulmonary disease, pneumonia, heart failure, total knee arthroplasty and total hip arthroplasty.
- Sanford Aberdeen’s readmission rate continued to increase after opening the facility; therefore, a project team was formed.
- The project team reviewed hospital readmissions to identify trends and missed opportunities in discharge planning and transitions of care.
- The goal was set to reduce non-elective all cause 30 day readmission rate to < 7.0 percent.
- We created a driver diagram to drive plan-do-study-act cycle for improvement interventions.

### RESULTS

- After implementing the care transition program, non-elective all cause 30 day readmission rates decreased below the goal for five consecutive quarters.
- Increased weekly health care visit attendance decreased our readmission rate.
- We observed improvement in follow-up phone call completion and follow-up appointment attendance.
- Leadership support and staff passion were key to success.
- Multiple good catches occurred during care transition visits that led to prevented readmissions.
  - For example, teaching patients about re-timing their medications at the wrong time.
- Process measures, outcome measures, and qualitative data from patients and staff defined success.
- Turnover with key team members affected sustainability.

### SUSTAINABILITY AND SPREAD

- Automation of readmission risk scores allowed staff to incorporate risk in daily interdisciplinary rounds.
- Reports containing readmission risk scores are emailed on a daily basis by decision support.
- We continually face challenges with staff resources and with expansion of care transition program.
- Re-evaluate program criteria to determine eligibility based on allocated resources.
- Although annual rate increased in 2015, readmission rate is still within identified goal.

### IMPROVEMENT STRATEGIES

- Reconciled medications on admission and discharge.
- Provided heart failure teaching:
  - Medication reminders
  - Scales
  - Daily weight booklets
- Used teach-backs for discharge education and included caregiver.
- Completed follow-up phone calls within 48-72 hour post discharge.
- Reviewed each readmission chart and interview patients to determine system opportunities.
- Analyzed monthly data for trends on key processes.
- We identified poly pharmacy, prior hospitalizations and multiple comorbidities as common risk factors.
- Engaged leadership with data and readmission reduction penalty programs to allocate resources.

### TOOLS, RESOURCES, POLICIES, TIPS

- Medication reminders
- Scales
- Daily weight booklets
- Teach-backs for discharge education
- Follow-up phone calls
- Review of each readmission chart
- Interviews with patients to determine system opportunities
- Monthly data analysis for trends
- Poly pharmacy identification
- Prior hospitalizations identification
- Multiple comorbidities identification as common risk factors
- Leadership engagement with data and readmission reduction penalty programs

## Sanford Aberdeen Medical Center: A Full-service 48-bed Regional Hospital Located in Northeastern South Dakota

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- Sanford Aberdeen Clinic that serves the health care needs of Aberdeen and the surrounding area with a medical staff consisting of more than 50 providers ranging from family medicine to advanced specialty providers for both children and adults.

- Members of the HEN project team, pictured with the Golden HEN, which was awarded for the Sanford HEN hospital that has the most applicable measures requiring submission.

- "It takes a village."