Readmission Reduction Program and Fall Prevention Program

Salina Regional Health Center, Salina, KS

Objective

1) Reduce Hospital and Emergency Room Visits for our Chronically Ill patients with a diagnosis of COPD/Pneumonia and/or Health Failure.

2) Develop a Fall Prevention Program to reduce Hip Fractures.

Background

1) SRHC readmission rate for our three top utilizers; for 2018 were COPD 15.9%, Pneumonia 13.5% and Heart Failure 23.1%. These high 30 day all cause readmission rates incurred financial penalties.

2) Kansas has the Highest Hip Fracture rate in the nation and all are due to falls.

Metrics

Readmission Reduction Measures: All payers.

Heart Failure
FY2018 23.1
FY2019 Jan-Mar 10.6%

COPD
FY2018 15.9%,
FY2019 Jan-Mar 9.1%

Pneumonia
FY2018 13.5%,
FY2019 Jan-Mar 14.5%

Analysis

1) Our 30 day **Readmission Reduction Program** root cause analysis identified several areas of improvement to work on
   1) Why were patients not getting their medications filled?
   2) Did the patient have a post op visit?
   3) Did the patient have a PCP?
   4) Is our Discharge paperwork easily followed and understandable to our patients?
   5) How do we determine the high risk patients?
   6) Do we have a program to monitor our patients for the 30 day readmission window in their home after discharge?
2) **Fall Prevention** – We determined the root cause of our high hip fracture rate was due to falls in the home which caused an increase in our 30 day readmission rate.

Actions Taken

1) In 2018 we recognized that we needed to address these 30 day all cause readmissions and did a root cause analysis. Monthly meetings with Pharmacy, Care Management, Quality, Clinic and hospital administration to outline what the real issues where.

2) Developed a team of Ortho Surgeons, nurses and PT staff to developed a Fall Prevention Program.

Next Steps

1) Readmission Reduction Program

1) Develop a Meds-To-Bed program that provides our patient medication to take home after dismissal.
2) Ensure every patient has a documented discharge PCP visit.
3) If a patient has no PCP the Care Manager will initiate a new visit appointment and inform the patient or care giver of the new provider assigned.
4) Develop Discharge Documentation that is clear, easily readable and understandable.
5) Develop a LACE Score Assessment Program.
6) Develop a Transitional Care Program with APRN : Visit patients in home 2-3 days after discharge.

2) **Fall Prevention Program** - Developed a PT program to educate patients/family on Fall Prevention in the home.

The Compass Practice Transformation Network is supported by Funding Opportunity Number CMS-1L1-15-003 from the U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services. The contents of this publication are solely the responsibility of the authors and do not necessarily represent the views of the U.S. Department of Health and Human Services or any of its agencies.

Salina Regional Health Center
Confidence for the Good Life