Maryland Hospital Association
Transitions: Handle with Care
Hospital – Nursing Facility Partnerships

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Barbara Hirsch, RN, JD – Charles E Smith Life Communities
Marsha J Butler, RN – Genesis HealthCare
Carol Sylvester, MS, RN – Johns Hopkins Bayview Medical Center
Johns Hopkins Medicine

- The Johns Hopkins Hospital
- Johns Hopkins Bayview Medical Center
- Howard County General Hospital
- Sibley Memorial Hospital
- Suburban Hospital
- All Children’s Hospital
- Johns Hopkins University School of Medicine
- Johns Hopkins Community Physicians
- Johns Hopkins Home Care Group
- Johns Hopkins Health Care
- Johns Hopkins Health System
- Johns Hopkins Medicine International
Johns Hopkins Bayview Medical Center

- Academic/Community hospital with 360 staffed acute beds and 60 Specialty Hospital beds
- Specialty services: Burn, NICU, Chemical Dependency, COE for Stroke and Bariatrics
- Nearly 60% of admissions are medical
- Primary service area av household income $51,710, 30% uninsured, 31% MA.
  JHH/JHBMC 38% MC, 41% MA
- Nat’l Inst Alcohol and Drug Abuse on campus
• 30 Day all Cause readmission rate 12.1% in 2011
• 22,000 discharges annually, 15% go to SNF
• **SNF readmit** rate 24% (30.2% of all readmits), some facilities as high as 57%
• 6 facilities accepted 50% of our SNF discharges
• Principal diagnosis of SNF patients:
  – Heart Failure
  – Septicemia
  – PNA
  – CVA
  – ARF
  – COPD
# JHBMC/JHH
## Top 6 SNF Volumes 2011

<table>
<thead>
<tr>
<th>Facility</th>
<th>JHBMC</th>
<th>JHH</th>
<th>TOTAL</th>
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<tbody>
<tr>
<td>JHB Care Center</td>
<td>741</td>
<td>34</td>
<td>775</td>
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<tr>
<td>Genesis Heritage</td>
<td>410</td>
<td>19</td>
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<td>Future Care North Point</td>
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<td>27</td>
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<td>Future Care Canton Harbor</td>
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<td>143</td>
<td>47</td>
<td>190</td>
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<tr>
<td>Riverside</td>
<td>177</td>
<td>0</td>
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<tr>
<td><strong>Total</strong></td>
<td>2079</td>
<td>254</td>
<td>2333</td>
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Genesis HealthCare
Chronic Disease Management Pilots
Genesis HealthCare

- Largest Provider of Skilled Nursing and Rehabilitation both locally and nationally
- Locally offer Specialty Centers to meet the market’s clinical needs
- Strong network of resources that includes Genesis Physician Services
- 24/7 day admissions process w/ a clinical focus on transitions of care
Genesis HealthCare
Chronic Disease Programs

- Partner with hospitals to implement standard protocols across the healthcare continuum for patients at high risk for 30 day readmission due to cardiac or pulmonary disease
- Create defined care paths with hospitals, post acute care and community resources
- Insure clear, clean clinical handoffs with each level of care
- Empower patients/families to be an active partner in managing their chronic disease process
Hospital Partners 10/31/13

- Franklin Square Hospital
- Anne Arundel Medical Center
- Union Memorial Hospital
- St. Joseph Medical Center
- Harbor Hospital
- Doctors Community Hospital
- Frederick Memorial Hospital
- Peninsula Regional Medical Center
- Good Samaritan Hospital
- Washington Hospital Center (LVAD/Inatrope Program)
- Shady Grove Adventist Hospital
- St Agnes Hospital
Hallmarks of Success in Chronic Disease Management Pilots

Franklin Woods Center 30-Day Readmit Rate 5/11 thru 4/12

- Percentage

- 1st Qtr.
- May'11
- June'11
- July'11
- August'11
- September'11
- October'11
- November'11
- December'11
- January'12
- February'12
- March'12
- April'12

- 27.5
- 33.3
- 18.8
- 20.3
- 20.6
- 19.7
- 19.7
- 16.4
- 18.5
- 20
- 18.5
- 16.7
Action Plan, Phase I

- Initiated partnership between JHBMC and GHC Heritage Center for chronic cardiac disease management
- Meetings between Medical Directors, Administrators and Directors of Nursing
- Executed contract for JHU- SOM Specialist
- Established referral and tracking procedures
- Develop Collaborative
  - Medical Director, Administrator, DON connections
  - Establish shared purpose
  - Development of condition management protocols
  - Data capture about handoffs
- Meet Regularly to share data and lessons learned
Action Plan, Phase II
CMS Center for Innovations Grant

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• Its contents are solely the responsibility of the authors and do not necessarily represent the official views of HHS or any of its agencies.
Action Plan, Phase II

• Initiated a Collaborative of all 6 Nursing facilities, JHBMC and JHH
  – Improve chronic disease management
  – Improve handoffs
  – Reduce 30 day readmissions

• Introductory meetings with Medical Directors, Administrators and DON’s
Action Plan, Phase II

- Pre-Intervention Survey
- Initiated protocols
  - Heart Failure
  - Planned Discharges
  - COPD
- Initiated data collection on all Hopkins admissions and discharges
- Feedback to hospitals, focused review of readmissions
Discharge Protocol

Discharge Protocol Adherence Rates

2013 Fiscal Year Qtr

- Total Discharge
- Adherence Rate
SNF Collaborative Results

30 Day All Cause Readmission Rate

Fiscal Year Qtr

2012

2013

All Discharges

30-Day Rate

Total Discharge
30-Day Rate
FY'12 Rate (19.4%)
FY'13 Rate (18.1%)
Suburban Hospital is

- 228 bed community not for profit hospital located in Bethesda MD, near NIH and Walter Reed Medical Center.

- Service Lines include: Cardiothoracic, Level II Trauma, Orthopedics, Behavioral Health, General Medical, Neurosurgery, NIH Stroke Program

- 60% of our population is Medicare
Nursing Facility Collaboration Efforts at Suburban Hospital

- Original ideas for working with NH. Provide venue for open communication
- Promote positive impressions for patients and families
- Improve transfer expectations of rehab
Suburban Hospital Nursing Home Collaborative Groups

- Multi Facility NH Collaborative Team
- Hebrew Home/Suburban Hospital Task Force
- Manor Care Tracking of RA
- Contractual agreements regarding placement
The action plan/strategies implemented

- LAB
- PAIN
- COMMUNICATION
- REGULATORY CHANGES
- READMISSIONS
- CLINICAL SHARING
DC TO HEBREW HOME/READM. FROM HEBREW HOME - JAN. - APR. 2012
(Readmission Units Only)

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<td>DC To Hebrew Home</td>
<td>19</td>
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<td>21</td>
<td>19</td>
<td>22</td>
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<tr>
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<td>2</td>
<td>1</td>
<td>3</td>
<td>2.75</td>
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<tr>
<td>% RA</td>
<td>26</td>
<td>7</td>
<td>5</td>
<td>16</td>
<td>13</td>
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Closing the Gap in Transitional Care: Medication Reconciliation between Hospital Discharge and Admission to Long Term Care (A joint project between The Hebrew Home and Suburban Hospital/Johns Hopkins Medicine)

Extent of the Problem
Preventable adverse drug events at transition points of care account for 46-76% of all medication errors.

Berwick (2006)
Gosfield (2005)
Frequency of Medication Reconciliation

- **# patients with 100% reconciliation between pharmacy and hospitalist**: 18.75%
- **# medications reconciled between pharmacy and hospitalist**: 83.15%
- **# patients with 100% reconciliation between hospitalist and admission to HHGW**: 20.83%
- **# medications reconciled between hospitalist and on admission to HHGW**: 66.30%
Relationship between length of medication list and degree of reconciliation

- **Total # of Meds on Pharmacy Reconciliation Sheet**
- **# of meds on Pharmacy Reconciliation Sheet that were NOT included on discharge summary**
Conclusion: Lessons Learned

- Medication Reconciliation is a multi-disciplinary process with important roles for both the Pharmacist and Hospitalist.

- Communication strongly affects the overall continuum of care with respect to medication reconciliation.

- Initial provider (e.g. HHGW) must provide accurate information about the patient’s medication regimen when transferred to another level of care (e.g. SH). This information must be legible and complete.

- Discharging organization must provide the discharge summary (with list of medications) to the receiving organization, timely and prior to discharge.
Suburban Hospital Nursing Home Collaborative Groups

- RA rate for NH dropped from 24% in FY12 to 11% FY 13
- Continue to engage nursing facilities regarding smooth transitions and readmission preventions
- Continue to meet with nursing facilities on an individual basis to ensure open communication
- Identify and problem solve any issues that arise