Catholic Health Association
Strategy Summit: Integrating Services for Seniors

Provider Strategies:

Transitional Care in Skilled Nursing Facilities

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Continuing Care

Catholic Health

Transitional Care

Catholic Health

HeartSTRONG

Introduction

- **History: How we got here!!**
  - **Launched in 2005**
    - **NYSHFA 2005 Innovative Practice Award**
    - **IHA Quality Award 2005, 2006 & 2007**
  - **Re-launched in 2009**
- **HeartSTRONG is**
  - **Specialized subacute program**
  - **Medical cardiac conditions (CHF, MI, etc.,)**
  - **Post cardiac surgery patients**
- **HeartSTRONG provides**
  - **Continuity in care**
  - **Support and education for patients & families**
  - **Assists in management of cardiac related diseases**

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Goals

- **Direct admission of appropriate, stabilized patients from the ER**
- **Direct admission of patients from physician's office**
- **Improve hospital performance against DRG guidelines (length of stay)**
- **Improve in system referrals (capture) for subacute and homecare**

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Goals Continued

- **Clinical integration into Catholic Health's Cardiac Service Line - ACO**
- **Improve patient quality of life**
- **Decrease rehospitalizations**

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Program Components

- **Medical Director and Nurse Practitioner of HeartSTRONG**
- **Policies, Procedures & Protocols**
  - **Admission Orders**
  - **Pathways (Cardiac Dx, CHF, MI)**
  - **Discharge Summary/Physician Communication Tool**

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Program Components

- **Clinical competencies; staffing ratios-RN's**
- **Physician and associate education**
- **Capital equipment (EKG, Pulse Ox, Dopplers, Striker Treatment chairs, Diamap, portable peddlers, O2 concentrators)**
- **Outcomes (enrollment, compliance with program, patient satisfaction)**
- **Marketing plan and capability material**

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Admission Criteria

- **Cardiac event with active co-morbidity and functional limitation**
- **Appropriate level of care – transitional care medical treatment and/or rehab (InterQual)**
- **Clinically stable**
- **Discharge plan to "home"**

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Outcome Metrics

1. **Admissions to Transitional Care - Market Share Increase**

2. **Readmissions to Acute Hospitals Decreased**

3. **Patient Satisfaction**

4. **Improved *Quality of Life – 4th Quarter 2010***
   Minnesota "LIVING WITH HEART FAILURE®"

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Metric – 2009 Admission to Transitional Care

	1Q09	2Q09	3Q09	4Q09	YTD
2009 Heart Failure Admissions	94	113	107	128	442
Father Baker Manor	44	58	48	53	203
McAuley Residence	19	34	42	45	140
St. Francis of Williamsville	18	12	15	25	70
St. Francis of Buffalo	13	9	2	5	29

30 Day Readmission Rate 2009 Year End = 13%

Average Age – 81 Years Young
Average Length of Stay – 16 Days

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Metric – 2010 Admission to Transitional Care

	1Q10	2Q10	3Q10	4Q10	YTD
2010 Heart Failure Admission	73	95			168
Father Baker Manor	41	59			100
McAuley Residence	21	25			46
St. Francis of Williamsville	11	11			22

30 Day Home to Hospital Readmission Rate = 15%

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Admissions - CH Hospitals to Transitional Care

2009 Cardiac Surgical Patients

	1Q09	2Q09	3Q09	4Q09	YTD
2009 Cardiac Surgery Admissions	11	13	16	8	48
Father Baker Manor	7	11	12	5	35
McAuley Residence	3	1	3	3	10
St. Francis of Williamsville	1	1	0	0	2
St. Francis of Buffalo	0	0	1	0	1

30 Day readmission Rate 2009 Year end = 17%

Average Age – 76 Years Young

Average Length of Stay – 17 Days

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Admissions - CH Hospitals to Transitional Care

Cardiac Surgical Patients 2010

	1Q10	2Q10	3Q10	4Q10	YTD
2010 Cardiac Surgery Admissions	11	14			25
Father Baker Manor	7	7			14
McAuley Residence	4	7			11
St. Francis of Williamsville	0	0			0

30 Day Home to Hospital Readmission rate = 9%

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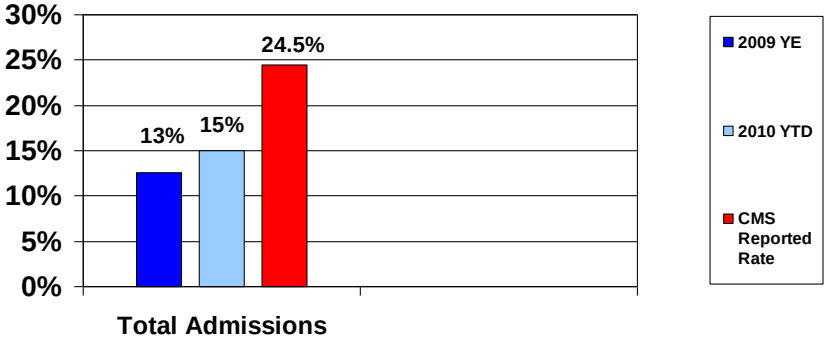
HeartSTRONG

Heart Failure and Related Cardiac DRGs



US National Readmission Rate from Home to Hospital – 24.5%

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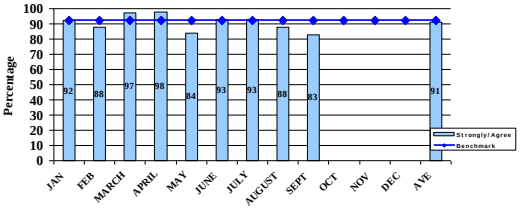
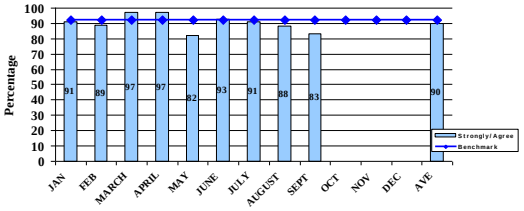
Patient Satisfaction

- Would You Recommend?



- Overall Satisfaction?



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Thank You

Questions?

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