The Heart Success Program
&
Delivery System Reform Incentive Payment (DSRIP) Program
The Heart Success Program

• **Who:** Heart failure patients

• **What:** Education, communication, monitoring, and support

• **Where:** The Heart Success Clinic

• **When:** 24/7

• **Why:** Controlled symptoms leads to decreased readmission

• **How:** Multidisciplinary team of providers
**DSRIP:** Significantly enhance an already existing program to reduce readmission within a specific population

- **Who:** Charity Care, Medicaid, self pay, and dual eligible patients with a primary diagnosis of heart failure

- **What:** Patients are managed through a medical home model based system to reduce readmission

- **Where:** Atlantic Health System

- **When:** 2012-2017

- **Why:** Improved care for the underserved population

- **How:** Transitional care using DocView and a multidisciplinary team of providers
**DSRIP: Opportunities**

**HCAHPS**
- Communication with patients
- Responsiveness of hospital staff
- Pain management

**DSRIP**
- Education - patient understanding
- Medical Home Model based communication
- Decreased readmission
DSRIP: In Line with the Vision of Atlantic Health System

IHI Triple Aim

- Population Health
- Experience of Care
- Per Capita Cost
DSRIP Is: Using a New Risk Stratification Tool

Length of stay

Acuity of the admission

Co-morbidities

Emergency Department visits in the previous 6 months

<p>| LACE Index for the quantification of risk of death or unplanned readmission within 30 days of discharge* |</p>
<table>
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<th>Attribute</th>
<th>Value</th>
<th>Points*</th>
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DSRIP Is: Making Improvements in Patient Management

All identified DSRIP inpatients will be entered into the DocView Web-based Portal
- Patient demographics
- Patient education tracking
- Stage 3 & 4 measures
- LACE score

Patients with a LACE score of 14-19 will be given the DocView Mobile Application
- Live symptom management post discharge
- Provide appropriate interventions
HF Patients with LACE 14-19

DocView Mobile Application

Monitoring by Nurse Navigator

*When necessary:* Intervention by Nurse Practitioner
DSRIP Is: Enhancing Relationships with Clinics

The Joint Commission’s
Medical Home Model
DSRIP: Moving Forward

- Develop patient centered lines of communication
- Enhance patient education methods
- Staff education
- Develop an enhanced model for a multidisciplinary approach to care
- Trend and track program progress to eliminate gaps in care
- Evaluation of DSRIP patient population outcomes

Consistency throughout The Heart Success Program across all AHS sites

Improved population health
Challenges to Date: Operationalizing Deliverables

- Resource and labor intensive
  - Lack of resources

- Buy in from all interested parties

- Greatly enhancing an already existing program
DSRIP: Organization Chart

Atlantic Health System

Executive Committee

Operations Team

DSRIP Nurse Navigator and Social Worker

Morristown Medical Center
Nurse Practitioner

Overlook Medical Center
Nurse Practitioner

Newton Medical Center
Nurse Practitioner

Chilton Medical Center
Nurse Practitioner