HEALTHPRO® HERITAGE

Safe Transitions Framework

SIGNATURE CLINICAL PROGRAM

Our Safe Transitions clinical framework improves patient experience, minimizes the risk of rehospitalization, optimizes length of stay, and accelerates relationships with downstream providers. Embracing the philosophy *discharge planning begins on admission*, our patient-driven model offers:

- Clinical programs that support patients' needs and goals for discharge
- Processes to define collaboration and timelines to meet LOS expectations (defined by network partners, conveners, ACOs)
- Use of home assessments to ensure meaningful outcomes (safety, functional abilities)
- Comprehensive patient/caregiver education throughout plan of care and beyond

SPOTLIGHT ON

DEMONSTRATES EFFECTIVE CARE PLANNING; PROVIDES EVIDENCE

Proactively manages timely & safe transitions to next level of care. Implemented for ~25,000 Medicare Part A patients in our client communities nationwide.

	Safe Transitions*	National Average
Average Length of Stay	20.81 days (rehab)	28.8** 24.81***
Discharged to Acute Care Hospital	17.5%	21.2% §
Discharged to Community	80.1%	56.4% §§
Discharged to Community with Home Health or Outpatient	72.7%	

*Q1-Q218 – HealthMAX®, HealthPRO® Heritage's BI
**FY17 – PDPM Provider Impact File
***CY17 – Medicare FFS Claims from AB National data
§ CY17 – Medicare FFS Claims patients
§§ Nursing Home Compare (short-term residents)

Prior Level Of Function	Upon Admission	At Discharge
4.73	2.25	3.5

CARE Tool item set is 1-6 utilized in HealthMAX®

FACILITATES CROSS-CONTINUUM CARE COORDINATION

Enhances coordination of services by promoting best practices and optimizing outcomes, fortifying partnerships with regional referral sources.

HealthPRO® Heritage is a full service therapy partner and consultant on clinical initiatives at Holy Family Manor, a CCRC (208 SNF, 52 AL, 115 IL) in Bethlehem, PA. The Safe Transitions framework helped support Holy Family's top-ranked status among referring hospitals and conveners by facilitating:

- Multidisciplinary admission process to ensure immediate review and evaluation of patient conditions, needs, and discharge plans
- Risk Assessment Process to identify risk factors for readmission
- Weekly Utilization Review on all BPCI patients
- Post-discharge communication to ensure safety, services, and mitigate transitions to SNF vs. acute care

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