Care Transitions Intervention Model to reduce 30-Day Readmissions for Chronic Cardiac Conditions
Our fully accredited acute care hospital opened in 1961

We offer a comprehensive array of services including:

- Advanced cancer care
- Sophisticated neurology/neurosurgery services including a neuro-interventional lab with a bi-plane and Level 3 Epilepsy Program
- Cardiac care featuring 3 cardiac catheterization labs
- Surgical Services including the daVinci Si robotic surgical platform
- A sophisticated linear accelerators for radiation therapy
- A CyberKnife for treating inoperable tumors

CMC also offers maternal and children’s services through:

- Superior obstetrical care
- Level 2 special care nursery with 24/7 on-site neonatologists
- Dedicated pediatric unit
- Pediatrician in our Emergency Department
SELECTED PROJECT

- CMC has selected:
  - #6: Care Transitions Intervention Model to reduce 30-day Readmissions for Chronic Cardiac Conditions

  - Create evidence-based care for low-income chronic cardiac patients (AMI and CHF) across the continuum

  - Development of a Patient Navigation system using the Coleman Model to educate facility-based Transition Coaches

  - Transition Coaches will educate our patient population on self-management skills around medication management, red flags, importance of medical care and follow up with physician/clinical providers and use of the Personal Health Record (PHR).
CMC has selected the Coleman Model to structure our patient-centered 30-day transitions project.

The Coleman Model focuses on improving quality and safety during times of transition and hand-off of care.

The 30-day program will include enrollment of patient, 1 home visit, follow up phone calls and use of Coleman Model forms including:

- Personal Health Record
- Activation Assessment
- Medication Discrepancy data collection tool
Identification of newly diagnosed or readmitted AMI or CHF patient
Referral from Case Management / Unit
Transition Coach meets with patient and/or significant other to review the Transitions Program
Declination or Acceptance by patient into the program
Review of Personal Health Record
Advise of 1 Home Visit within the first 2-3 days post discharge
Scripted telephone calls by Transition Coaches to follow up on Medication management, Red flags, Medical care/follow up and PHR

Data collection over time related to project requirements, including but not limited to reduction in 30-day cardiac care readmissions and improved patient satisfaction (through CMC developed Patient Satisfaction survey)
Training of transition staff on Coleman model
Electronic medical record capable of producing patient list, readmission report
Primary Care and Cardiology partnerships
Home Health partnership
Multi-disciplinary approach to transition of care (Case Management, Nursing, Quality, Pharmacy, Home Health)
Senior Leadership support
**BARRIERS**

- Low volume Medicaid/Charity care patients

- Low number of physicians in CMC area that accept Medicaid resulting in low number of providers engaged in partnership

- Lack of clinics
Thank you for your time

ARE THERE ANY QUESTIONS?