Community Medical Center
Barnabas Health

Life is better healthy.

DSRIP PROJECT #6

Care Transitions Intervention Model to reduce 30-Day Readmissions for Chronic Cardiac Conditions

COMMUNITY MEDICAL CENTER

Community Medical Center (CMC)

- 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).

COLEMAN MODEL

- 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

THE CMC PROGRAM

- 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

THE CMC PROGRAM (CONT'D)

- 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)

SUCCESSES

- 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?