Medtronic Care Management Services’ Readmission Reduction Program (RE30) is designed with key drivers of readmission in mind. Through a combination of remote patient management platforms, proprietary software, patient engagement and care coordination, Medtronic Care Management Services complement patient care teams—providing clinicians important insights useful in identifying patients potentially at risk for acute events, and determining their course of care during the first 30 days post discharge.

This clinically robust program is built to:

- Help **manage unnecessary readmission risk** and improve patient satisfaction
- Deliver **actionable information** to enable timely and effective clinical intervention
- Provide patient context and education and enable **existing clinical teams** to focus their team

**EXPERIENCED CARE COORDINATION YOU CAN COUNT ON**

The heart and soul of the RE30 program are the Patient Advocacy and Support Services (PASS). PASS consists of clinical staff trained in nursing, who complement a coordinated care program. These experts follow evidenced-based clinical pathways that guide them through a dynamic assessment designed to help standardize post-acute monitoring.

In addition, Patient Advocacy and Support Service clinical staff:

- Average 15 years experience
- Operate on weekdays, weekends, and holidays
- Focus education on key drivers for:
  - Readmission
  - Condition management
  - Medication management
  - Discharge plan adherence
**HOW THE READMISSION REDUCTION PROGRAM WORKS**

**Enroll**
Patient is enrolled prior to discharge. On the day of discharge, MCMS clinical staff reviews discharge instructions with patient to promote successful transition to home. Monitoring equipment is sent to the patient’s home on day two.

**Monitor**
Patient submits biometric and symptom data during a daily health check. This data is sent securely to clinical staff where proprietary software organizes it by risk level for review.

**Assess**
The PASS team reviews and assesses incoming patient health data to facilitate patient engagement and report generation.

**Educate**
The same clinical staff member reaches out to the patient as needed to gather clarifying health information and to educate the patient on their condition in accordance with the pathway.

**Report**
Notable changes in a patient’s health status are delivered to the patient’s medical provider who determine if a change in medication or care plan is needed.

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**MINIMUM OUTREACH EXPECTATIONS**

**DAYS 1-7: DAILY OUTREACH**
Discussion topics and education include:
- Introduction to the Program
- Device Set-Up
- Adherence/Engagement Process
- Diagnosis & Symptom Education
- Dietary Education
- Lifestyle Modifications
- Medication Reconciliation
- Provider Follow-Up
- Caregiver Support
- Self-Management

**DAYS 8-21: PASS OUTREACH EVERY THREE DAYS**
Discussion and education topics include:
- Symptom Recognition
- Medication Management
- Device Adherence

**DAYS 22-30: PASS OUTREACH EVERY FOUR DAYS**
Discussion and education topics include:
- Current Symptoms
- Self-Management
- Program Adherence
As a trusted provider to hospitals, clinics, and payers, we are committed to delivering clinical and economic benefits to the health care system. That’s why for customers satisfying certain program requirements, a readmission credit may be available for patients readmitted during an enrollment period. In such a case, the customer would be credited for the 30 day period in which the readmission occurred.

Call 888-243-8881 to learn more.