Care Transition Team Reduces Heart Failure Readmissions

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BACKGROUND

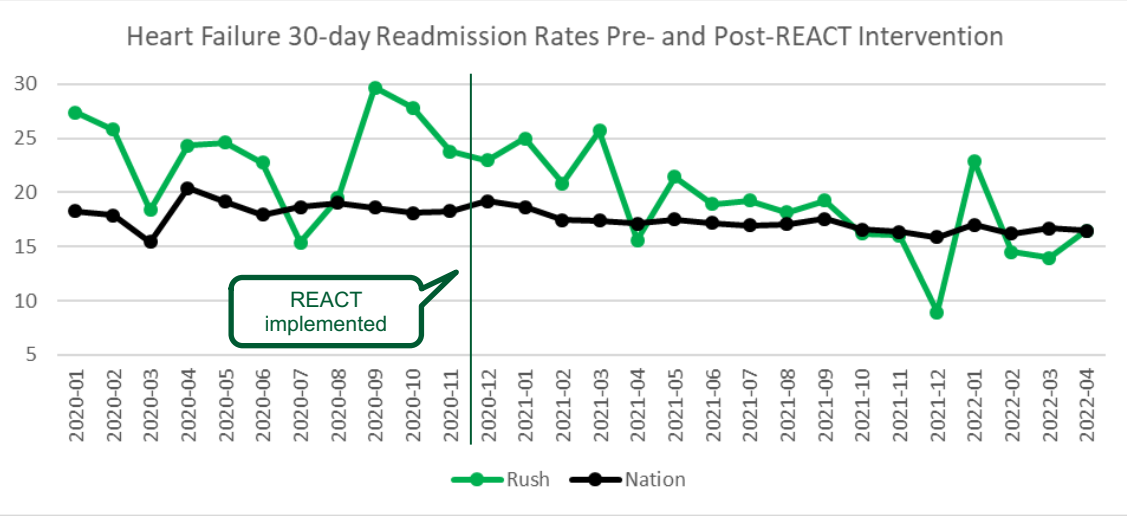
- Nationally, up to 18.2% of heart failure (HF) patients hospitalized are readmitted within 30 days [(1)].
- RUSH HF 30-day readmissions were 24.07%
- RUSH implemented the **REACT team (Readmission Engagement and Care Transition)** to reduce HF readmissions and enhance safe transition from the hospital to home.

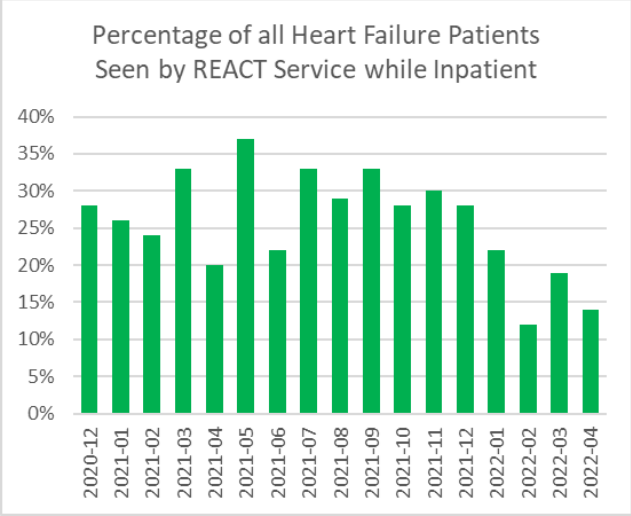
METHODOLOGY

1. Formed a multidisciplinary committee to study how to reduce HF readmissions.
2. Developed a Heart Failure Risk Score (HFRS) to provide a real-time calculated score for all hospitalized patients.
3. Implemented REACT team consisting of a cardiologist, advanced practice providers, HF Registered Nurse (RN) case manager, pharmacist, and social worker.
4. Focused on inpatient and post-hospital care including care transition calls, heart failure education, medication reconciliation, & confirmation for appointments within 7 days.
5. Analyzed 30-day readmission rates pre- and post-REACT intervention.

VALUE PROPOSITION

Our HF care transition team brings value to patients by reducing their need for hospitalization, improving optimization of GDMT for HF, and providing consistent follow up. It brings value to providers, the healthcare system and payers by reducing the burden and costs associated with HF readmission





RESULTS

Heart Failure 30-day Median Annual Readmission Rates

Group	2019	2020	2021	2022 YTD
Rush	19.9%	24.1%	19.1%	15.5%
Nation	18.6%	18.4%	17.2%	16.6%

Since REACT implementation, the average monthly 30-day readmission rate decreased from: Median 24.07% in 2020 (IQR: 20.29-26.98) to Median 19.08% in 2021 (IQR: 16.08-21.28), (U=32, z= -2.31, p = .02, r = .47) showing a **statistically significant difference** with a medium size effect

CONCLUSION

HF care transitional teams are invaluable to patients, providers and payers. Their contribution leads to improving safe transition from the hospital to the home along with reducing HF readmissions.

LESSONS LEARNED

- Engaging with patients upon admission & identifying issues proactively supports better patient outcomes.
- Multi-disciplinary approach is required for successful patient care (including across the emergency department, hospital, & outpatient clinic).
- A system should be implemented to allocated limited resources to the highest need patients.
- Need to revalidate the HFRS to ensure appropriate patient population is still being captured

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References: [(1)]Khan MS, Sreenivasan J, Lateef N, et al. Trends in 30- and 90-Day Readmission Rates for Heart Failure. *Circ Heart Fail*. 2021;14(4):e008335. doi:10.1161/CIRCHEARTFAILURE.121.008335

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