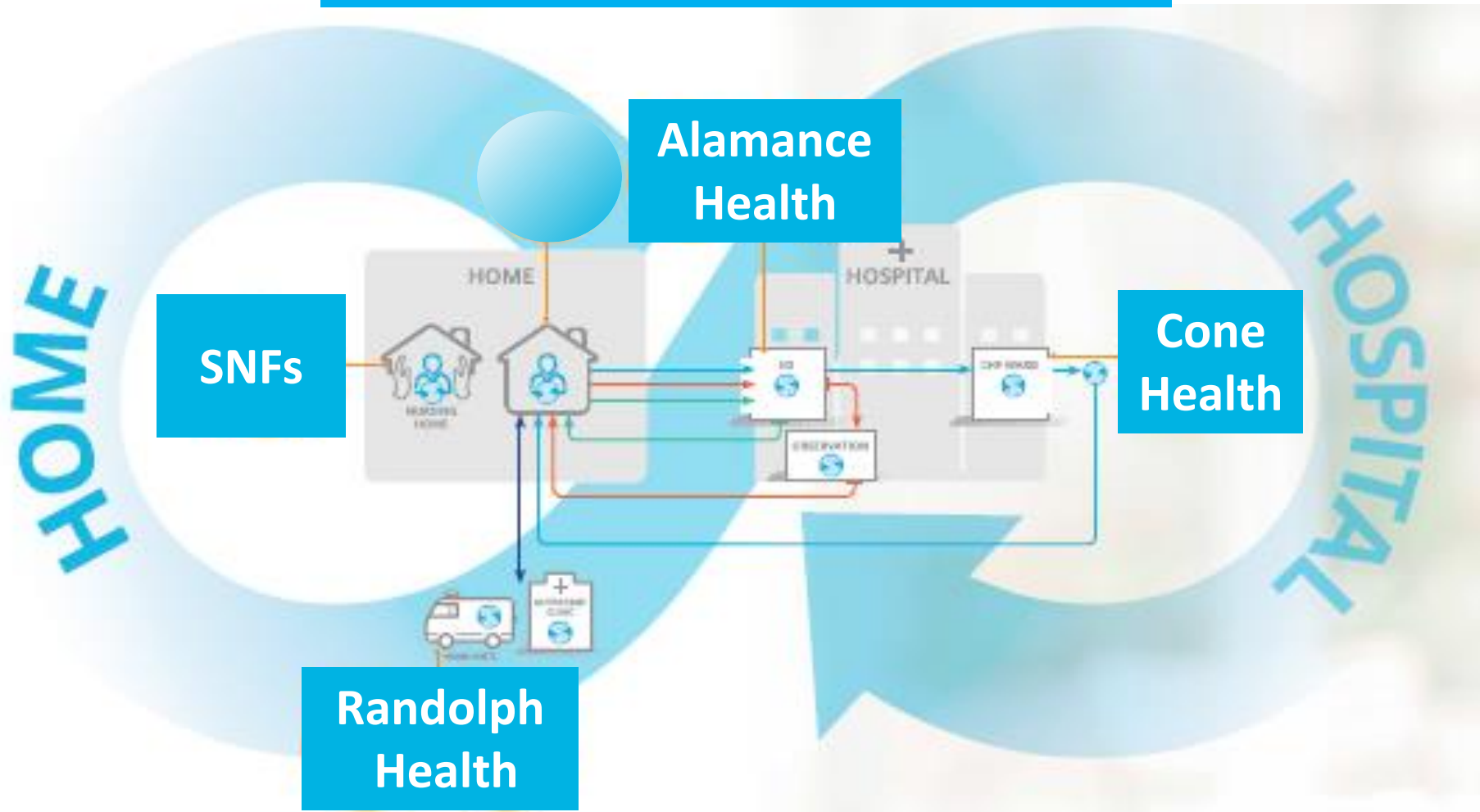


ReDS across the Continuum of Care How to initiate your Heart Failure Program?

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ReDS Across the Continuum of Care

Triad Healthcare Network (90K+ pts)



- 100-bed hospital in central NC with no HF program
- High priority pilot site based on its high readmission rates and CMS penalties
 - For four consecutive years, the hospital received penalties from Medicare for excessive 30-day HF readmissions rates (> 25%)
- Goal: Reducing 30 days HF Readmissions Rate and save costs by utilizing ReDS System post HF discharge
- Setting: Nurse-led Care Transition Program
 - RN visits patients 1-3 days post-discharge & any time patient calls with increased symptoms
 - ReDS reading \geq 35% led to specifically-designed diuretic protocol
 - Renal function and electrolytes were monitored and replaced following pre-specified protocol

Care Transition Program – Results

The Problem:

25% Medicare reported 30-day readmission rate

The Method:

Care Transition Program



105



patients were enrolled in 18 months

52%



of patients had elevated ReDS reading (>35%) led to a ReDS Guided protocol

2.5



Visits on average to obtain goal of ReDS reading < 35%

The Result:

3% readmission rate and **15%** Medicare reported 30-day readmission rate

Dramatic reduction in 30-day HF readmission rate: 25% → 15% **40%**

Dramatic reduction in cost



~ \$800,000

in penalty savings not included readmissions cost savings

> Conclusions

- > A nurse-led care transitions program employing ReDS technology and a specifically-designed diuretic protocol to assess and treat HF patients
 - > is successful in reducing 30-day HF readmissions
 - > is successful in reducing costs and avoiding Medicare penalty
 - > is safe - no adverse events
- > ReDS guided treatment is effective
- > Can be a solution for a community hospital without a dedicated HF program