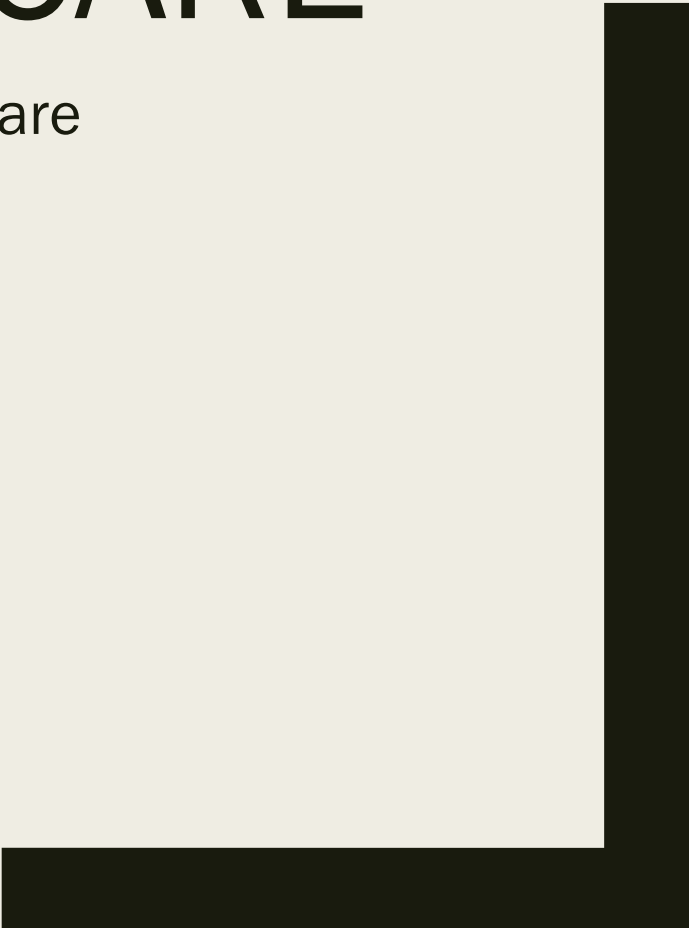




TRANSITIONS OF CARE

A Critical Component of Heart Failure Care

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Disclosure

- I have nothing to disclose

- According to The Joint Commission, one in four Medicare patients hospitalized for acute medical illness is discharged to a skilled nursing facility ¹
- 23% of these are readmitted to the hospital within 30 days ¹
- Patients admitted with HF have a 20-30% risk of death within a year ⁹

2019 ACC Expert Consensus Decision Pathway on Risk Assessment, Management, and Clinical Trajectory of Patients Hospitalized with Heart Failure

- “Actionable knowledge”⁹

- Practical guidance for point of care

Focused Discharge Handoff

- Communication tool to improve continuity of care during transition phase
- Designed to travel with the patient and provide most important information for continuing care clinicians in multiple disciplines 9

From SNF to Home

- 24.2% of patients discharged from SNF to home were readmitted to a hospital within 30 days of SNF discharge
- The risk of readmission was highest in the first two days after SNF discharge
- Readmission risk declined with longer SNF length of stay ²

How do adults learn?

- Adults need to know why they need to learn something
- Adults need to learn experientially
- Adults approach learning as problem-solving
- Adults learn best when the topic is of immediate value.

ACCF/AHA Recommendations for Hospital Discharge

- Multidisciplinary HF disease-management programs for patients at high risk for hospital readmission are recommended (Class of Recommendation I, Level of Evidence B)
- A follow-up visit within 7-14 days and/or a telephone follow-up within 3 days of hospital discharge are reasonable (Class of Recommendation IIa Level of Evidence B)

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