Heart Failure (HF) has increased in prevalence, incidence, and mortality over the past 25 years, with an annual economic impact of $34.4 billion annually. Patients discharged to a skilled nursing facility have higher readmission rates than those admitted home.

American Heart Association Heart Failure Guidelines

**Project Goal**
Implement evidence based practices for the treatment of patients with the diagnosis of chronic systolic heart failure in the post-acute setting to reduce hospital readmission rates.

**Change in Practice**
- Diagnosis of Systolic Heart Failure
- Echocardiogram results
- LV Ejection Fraction less than 40% should be on a beta-blocker and ACE-I or ARB as BP tolerates
- Individual patient education
- Address and document EOL discussion
- Improve discharge communication
- Nursing: Accurate daily weights

**Results**
- 30-Day Readmission Rate
  - August
  - September
  - October

**Implications**
- Diagnosis of HF is frequently missed
- EF to diagnose and follow treatment
- Reconciliation of diagnosis and medications
- Beta-blockers and ACE-I
- Individual patient education
- Patient-centered care
- Discuss end-of-life wishes in advance of refractory disease
- Improved communication during transitions
- Visit summary given to resident at d/c