636 **COMMUNITY COLLABORATION IMPROVES CARE AND REDUCES REHOSPITALIZATIONS FOR HEART FAILURE PATIENTS**

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Background HF is a leading cause of hospitalization for adults, with highest readmission rates occurring 30 days post-discharge. Hospitals are instituting evidence-based strategies to improve patient transitions from hospital to home and reduce 30-day all-cause readmissions. Impacting 90-day readmissions poses a greater challenge. Incorporating community partners into care transitions is critical for successful outcomes, particularly considering new bundled payment models. Patients discharging to skilled nursing facilities (SNFs) or with home health agency (HHA) services are often more vulnerable and at heightened risk.
Objectives Create a collaborative partnership between one medical center and local SNFs and home health agencies (HHA) to improve sustained HF patient outcomes and reduce hospital readmissions.
Methods Monthly multidisciplinary meetings were held with local SNF and HHA participants. Collaborative goals included identifying gaps in patient transitions between care settings and creating an evidence-based community standard for HF patient care. Corollary aims were to align quality care practices, share outcomes data and create solutions for identified barriers to optimal care transitions.

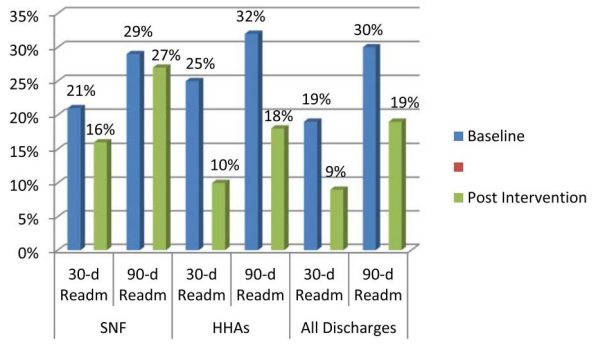

Figure 1 Primary Diagnosis HF Patient Readmissions by Index Disposition (pre/post interventions).

Results Comparing baseline data (476 HF discharges) to a year post-implementation of our intervention bundle (412 discharges), overall 30-day readmissions reduced from 19% to 9% while 90-day readmissions improved from 31% to 19%. 30-day rehospitalizations for SNF patients declined from and were decreased for patients who discharged with home health services by 26%.

Conclusions Building relationships fostering communication and collaboration among community partners is a key strategy to reduce avoidable rehospitalizations and sustain improved patient outcomes.