## Abstract

**Background:** Hospital readmissions impact both patients and the healthcare system. Avoidable reasons for readmissions include medication prescription confusion, miscommunication between providers, and inadequate discharge instructions.
**Local problem:** The 2018 30-day readmission rate for Virginia was14.8%. The community hospital's readmission rate in which this project was implemented was 14.5%.
**Methodology:** This quality improvement project was to identify, implement, and evaluate the transition of care of high-risk readmission patients. Identified patients met the inclusion criteria of 55 years and older, English speaking, diagnosed with heart failure and or sepsis, discharged to home with or without home health, and or consults received from case management and social services. A comprehensive discharge plan was developed along with pharmacy collaboration to aid in the transition of care.
**Interventions:** The interventions for consented participants included 30-60 minute educational sessions with a post discharge phone call within 24-48 hours. Each session incorporated education, support, and resources for day to day disease management at home.
**Results:** The heart failure readmission rates during the project implementation were as follows: January 24.05%, February 20%, March 19.75%, and April 11.11%. After the project completion the readmission rates were May 22.97% and for June 26.03% respectively. The potential cost avoidance with sustained gain from the project is $405,316.00.
**Implications:** This project demonstrated that a discharge navigator had an effect on 30-day readmissions as evident by a steady decline in overall heart failure readmission rate during project implementation. Further research is warranted for a longer time frame with focus on sepsis populations.