

Are Transitions of Care Leaving Your Patients Stranded?



The sad, but well-known fact is that with no formal patient discharge strategy, far too many heart failure patients won't "stay the course" when it comes to their own safety and well-being. As care providers, **your team can't afford to ignore discharge planning and allow the disease state to progress unchecked** - especially since so many heart failure patients often end up as readmissions requiring more invasive treatments and longer than average length-of-stay when they return to the hospital.

To improve care coordination at discharge, you need the tool that helps connect all the dots from patient education to scheduled follow-up care to clinical management plans - the tool that integrates the interventions that actually produce better outcomes. **ACC's Heart Failure Accreditation** is that tool.

Results of Accreditation

Solid evidence of progress is wide ranging and captured by the markers that track the optimization of medical treatment and therapy. In addition, HF Accreditation helps prioritize patient education about self-management and care after discharge. Other benefits include:



Early identification and rapid stabilization of HF patients which results in an overall decrease in LOS



Creation and consistent utilization of appropriate patient education tools



Improved communication with post-acute care provider(s) which may lead to increased revenue for the coordination of transitional care

Map Out New Goals with Heart Failure Accreditation

In addition to helping your facility focus on the many factors that must be considered for safe patient discharge, Accreditation gives you the tools to effectively examine variance in care and utilization of care-specific order sets. Ask us how HF Accreditation can help your team address not only these concerns, but also the early detection and referral of patients in need of advanced therapy treatment options such as LVAD or heart transplant.



ACC
ACCREDITATION
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Heart Failure Accreditation



Heart Failure Accreditation Drives Safe Hospital Discharge

As a result of achieving Heart Failure Accreditation, facilities are largely able to point to significant improvements in the transitions of care after hospitalization:



Increases clinic utilization and decreases 30-day readmissions



Employs individualized patient and family-centered approach



Provides formalized process for planning and scheduling follow-up appointments



Creates a defined care coordination team



Promotes provider collaboration and communication



Increases patient satisfaction

What Direction is Your Heart Failure Program Headed?

What happens when the patients you serve need advanced therapies or improvement in quality of life and functional status? How can your facility optimize therapies, change results, and renew your commitment to quality care?

You need the trusted advice, tools, and resources that will help you align all the essential elements associated with the treatment of heart failure.

Get Where You're Meant To Be!

While today's challenge may be establishing an enhanced discharge plan, tomorrow's could be tackling variance in care and adherence to guidelines. It's too easy for a performance improvement program to go miles off course when not guided by the best tools, best practices, and most current medical therapies.

Ask us how ACC Accreditation Services can help you create a roadmap that leads to optimal results.