• **Objective:** The aims of this evidence-based quality improvement (QI) project is to investigate the use of a Healthy Community Plan Framework (HCPF) to decrease 30-day rehospitalizations in older adults (≥ 65 y/o) who are diagnosed with heart failure (HF) by 20% through the implementation and dissemination of comprehensive discharge interventions by the transitional care team within 6 months at Mease Countryside Hospital (MCH) in Pinellas County, Florida.

• **Sample:** 26 members of the Transitional Care Team.

• **Setting:** The current transitional care program, Enterprise Care Management Operations, at Mease Countryside Hospital (MCH) located in Safety Harbor, Florida, a hospital within the Baycare Health System: a non-for-profit healthcare organization in the Tampa Bay area whose value is to achieve healthcare excellence for the community.

• **Theoretical Framework:** PDSA Cycle

• **Conceptual Model:** IOWA was used to guide this practice change

- **Adoption assessment:** Identify the need for change in practice
- **Limit problem identification and resolution:** Analyze the problem
- **Synthesize best evidence:** Research evidence
- **Design practice changes:** Design and implement changes
- **Implement and evaluate change in practice:** Measure impact
- **Integrate and maintain change in practice:** Sustain change

- **PLANNING:** Establish Stakeholder Buy-in
- **DOING:** Collect Data & Pre & Post Survey
- **STUDY:** Analyze Translational Care Performance, HF Readmission rates, & Patient Satisfaction Scores
- **ACT:** Practice Changes & Oil Initiative

• **Methods:** The innovation of this practice improvement project utilized a quasi-experimental pre-test post-test design that targets modifying interventions that fill gaps at Baycare Health Systems through the implementation and dissemination of process improvement objectives within their transitional care program.

- **Results:**
  - A knowledge-focused trigger was identified at MCH with regards to current transitional care practices.
  - Implementation of an educational in-service illustrated an increase in the staff’s knowledge and confidence level on the transitioning of heart failure patients.

- **Discussion:**
  - A limited sample size of N = 26 members of the transitional care team posed a challenge.
  - Limitations were offset by many strengths structured within the IOWA model, which can be used to effectively implement practice change at the unit or organizational level.

- **Implications for Practice:**
  - The implementation of interventions has a cost associated with the careful regard for disseminating a comprehensive plan.
  - This intervention, however can effectively be integrated into the workflow of the transitional care team which allows it to be put into practice without added clinical resources or hiring.

- **Recommendations:**
  - Proposals for future studies include the exact length of stay expense, transitional care fees, and savings for transitioning HF patient’s home.

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- **References:**
  - Available on Request