Introduction
In terms of preventing unplanned readmission, there is some evidence that the rate of readmission can be reduced by attention to pre-discharge planning and transition to the next setting of care. Therefore, the transitional care intervention was developed to target patients who are hospitalized for congestive Heart Failure (CHF) and uses trained senior nurses to administer the intervention.

Objectives
The transition care program is effective at reducing hospital readmission and improves the quality of life for elderly patients with heart failure.

Methodology
- Trained senior nurses assess the patients in hospital and according the patients need to make a comprehensive post discharge care plan and arrange adequate social support. - The transitional care support was a four -week interventions after discharged that focus on improving care transitions by fostering improved patients self -management skills for community-dwelling aged over 65. The four main components of intervention: 1.Handoff education on medications management, body weight and BP measurement and heart failure symptoms identification. 2.Comprehensive risk assessment and problem solving, such as diet control and life-style changing. 3.Facilitate early and regular medical follow up for heart failure disease monitor. 4.Conducts a regular phone and nurse clinic FU for patients heart failure symptoms early detected and response.
There were 62 elderly were recruited from Sep 2014 to Jan 2015. Total 84 episodes early medical FU and phone consult completed for the elderly with early detection of worsen heart failure symptom. 78% elderly without unplanned admission within 28 days after discharged. Also, elderly has significant improvement in functional mobility (p<0.001) and performance in activities of daily living (p<0.001) after completion of program. Transitional care support was key areas to reduced avoidable readmission for elderly with heart failure. The results have shown that the interventions included close coordination of care in the post-acute period along early post discharge follow-up care has lowered readmission rate.