Navigating Congestive Heart Failure

Complex, costly and confusing … patients diagnosed with congestive heart failure must carefully monitor and manage a long list of items to ensure the best possible health. However, data from the Centers for Medicare and Medicaid Services finds that approximately one in every five patients admitted with heart failure returns to the hospital within 30 days of discharge.

To improve outcomes for patients and lower hospital readmission rates, Bristol Regional Medical Center and Holston Valley Medical Center, both part of the Wellmont Health System and participants with the Tennessee Hospital Association HIIN program, have adopted a successful nurse navigator initiative that emphasizes education and evidence-based guidelines. The two community teaching hospitals serving Northeast Tennessee and Southwest Virginia have seen dramatic differences in their CHF patient population since the launch of the program.

Matthew Bledsoe, PharmD, BCPS, clinical pharmacy coordinator for Bristol Regional Medical Center, noted, "There's more to managing heart failure than just medication therapy, and the navigator helps the patient and family understand the full spectrum of heart failure management."

Bledsoe said the program was launched at BRMC in November 2014 after pinpointing the heart failure population as one with high readmission rates. While the reasons were multifactorial, Bledsoe said the team recognized the importance of standardizing information and introducing education early and often throughout a patient's stay, as well as following up after discharge.

The CHF team at Wellmont Bristol and Holston Valley includes (L-R) Amber Murdock, Christina Goodman, and Matthew Bledsoe. Not pictured: navigators Rachel Garrard and Kelly Reed.

"There is a huge patient education component, and I'd say that's really the primary focus of the nurse navigator to ensure the patient understands their diagnosis and how to self-manage their condition at home," he explained.

Amber Murdock, MBA, CPHQ, director of quality for Holston Valley Medical Center, added, "We felt strongly that any patient with heart failure could benefit from having access to this approach."

Beginning at Bristol and expanding to Holston Valley, Murdock said the hospitals tracked patients in a non-randomized observational trial from November 2014 through December 2016. Exclusionary criteria included patients who were pregnant, being discharged to a post-acute care facility, or who were already enrolled in another heart failure clinic. For the remainder of adult patients admitted to either facility, a nurse navigator was rapidly notified when a patient was identified as having congestive heart failure, diastolic heart dysfunction, cardiomyopathy, decreased ejection fraction, or a history of CHF with no prior education documentation. Rachel Garrard, BSN-RN, and Kelly Reed, BSN-RN, serve as the cardiac nurse navigators for the CHF program at Bristol, and Christina Goodman, BSN-RN, is the navigator at Holston Valley.

Bledsoe said once alerted, nurse navigators begin having conversations with patients and their caregivers from day one. "The purpose of that is to provide information throughout the entire admission instead of trying to fit it all in on the last day." He added, "Various studies have shown repetition is key."

Garrard agreed, "I love having the chance to spend that much needed time to educate and answer questions about following a plan to help patients better manage their disease and prevent a return trip to the hospital."

Goodman, who previously worked as a cardiac nurse on the floor at Holston Valley, said the navigator position is a very different approach from simply dispensing bedside care. "We want to education patients about preventative measures like monitoring diet, weight and symptoms of congestive heart failure on a daily basis," she outlined. "We want people to take ownership of their disease management."

However, Goodman continued, it's also critical to involve family members and caregivers. "Determining what is the safest discharge scenario is so important," she said. "The family may not be aware of how much help the patient is going to need." Before the navigator program, when most discharge education was dispensed near the end of a hospital stay, families were sometimes left scrambling to find home health or a skilled nursing facility as it became apparent the care needed was more than could be provided by family. Now, Goodman said, everyone involved has a better idea on the front end what is required to ensure the patient achieves optimal outcomes.

The nurse navigator's role doesn't end at discharge. Instead, the nurses continue to check in on patients through a series of phone calls to assess adherence to evidence-based protocols and answer any questions. Typically, those calls are made at days 2, 7, 16 and 23 post-discharge.

"I truly feel at the end of the day I have made a difference," said Reed. "Our patients seem to appreciate the extra one-on-one time and the post-hospital follow up." Garrard and Goodman agreed, adding patients and families have provided a lot of positive feedback about both the inpatient education and follow-up calls. "Many of my patients are thrilled to get a call from me either because they have a question or problem they need help with, or they want to tell me how much better they are doing," said Garrard. "They often thank me for calling again to check on them."

Murdock said the results have been impressive. "We know that of the patients that were enrolled in this – all 1,438 – only 35 were readmitted in 30 days." She added that equals a 2.4 percent readmission rate over the observational study for those who had access to the cardiac nurse navigator. That number is significantly less than the national average 30-day readmission rate of 21.9 percent for heart failure.

"Because of the success of this program, we've actually expanded this role of nurse navigator to other disease groups," Murdock continued. She noted both Bristol and Holston Valley now have a similar program for COPD and pneumonia and that a sister Wellmont hospital recently launched a general nurse navigator program.

For all involved, the bottom line measure of success is what the program has meant to patients working hard to manage a complex condition. "I love seeing the navigator program success reflected in the decreased readmission rates," Reed concluded.

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