Abstract

Inadequate discharge planning may cause a difficult transition from hospital to home for heart failure (HF) patients, resulting in a hospital readmission. One intervention shown to reduce the number of 30-day hospital readmissions is a HF nurse navigator program. The purpose of this project was to implement a HF Nurse Navigator program at a 266-bed community hospital and evaluate its effectiveness at reducing the hospital’s readmission rate. The HF nurse navigator provided extensive HF education, coordinated discharge care, organized post-discharge physician appointments, and conducted weekly structured telephone support (STS) calls. The nurse navigator collected deidentified data from a convenience sample of HF patients discharged from the hospital for three months following the formal start of the program. Of the 186 HF patients discharged home during this project, only 27 (14.5%) were readmitted to the hospital. This finding is well below the national average of 21-22%. Also, a significant correlation was found by Week 4 between the nurse navigator’s weekly STS calls and 30-day hospital readmissions ($r = -.522, p = .0001$). This finding suggests that having a nurse talk with a patient on a weekly basis after they were discharged home reduced their likelihood of being readmitted to the hospital. These results suggest that the HF Nurse Navigator program improved the discharge transition care for HF patients while reducing hospital healthcare costs.

Keywords: heart failure, hospital readmission, quality outcome, nurse navigator, transition care

Virginia Hawkins – Effect of Nurse Navigator Program