Sample Employee Newsletter Article

For use in your hospital’s internal communication channels to communicate participation in the ACC Patient Navigator Program to your staff



**New Patient Navigator Program Will Help Heart Patients Transition From Hospital to Home**

Nearly 1 in 5 patients hospitalized with a heart attack and 1 in 4 patients hospitalized with heart failure is readmitted within 30 days of discharge. These readmissions are often for conditions seemingly unrelated to the original diagnosis and may be due to stresses within the hospital, fragility on discharge, lack of understanding of discharge instructions, or an inability to carry out discharge instructions.

Data suggest that many heart patients could use additional support and guidance during their stay in the hospital and for a period of time after their discharge. For that reason [Your Hospital’s name] is participating in the American College of Cardiology (ACC) Patient Navigator program, a ground-breaking program that the ACC, with support from founding sponsor AstraZeneca, has launched to help hospitals enhance care for patients hospitalized with a heart attack, heart failure or acute coronary syndrome.

The concept for the ACC Patient Navigator Program is built on increasing evidence that personalized support can be effective in helping a patient make a smooth and effective transition from hospital to home. The program’s goal is to reduce avoidable readmissions by making hospitalizations less stressful and the recovery period more supportive. As a part of this program, the members of our Navigator team help patients understand their condition, care plan, medications and how to utilize community resources. Navigator teams work with patients so that after discharge, individuals will be able to better manage their healthcare to avoid returning to the hospital. The navigator team will also continue working with the patient post-discharge.

[Your Hospital’s Name] was selected from nearly 300 eligible hospitals from across the country. Our participation in the NCDR® ACTION Registry®-GWTGTM and the Hospital to Home (H2H) Initiative qualified us to participate. By participating in the ACC Patient Navigator Program, we will help develop quality improvement strategies and best practices that will be applied not only locally, but nationwide to reduce readmissions and improve patient care.

**What Our Participation Will Mean**

The ACC will provide resources and consultative services to support qualified staff as they enhance patient care, but most importantly—

* Patients will receive personalized support as they become more involved in their cardiac care.
* Cardiologists and hospital care teams will experience greater coordination of care within the hospital and across all disciplines.
* We, along with other hospitals, will have the potential to reduce unnecessary readmissions for acute coronary syndrome, heart attack and heart failure patients.

For more information and to see the complete list of participating hospitals, visit *cvquality.acc.org/patientnavigator*.