

Hearing the Veteran's Voice in Congestive Heart Failure Readmissions

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ABSTRACT

Purpose/Objective: Our purpose was to examine congestive heart failure (CHF) readmissions from the veterans' perspective. The use of health care provider interventions, such as standardized education materials, home telehealth, and a CHF clinic, was able to reduce readmissions rates from 35% to 23%. Our objective was to use input from the veterans to fine-tune our efforts and achieve readmission rates for patients with CHF below the national average of 21%. We wanted to identify factors that result in CHF readmissions, including disease education, self-care management, and barriers to self-care. This study was directed toward answering two questions:

1. What is the veteran's explanation for readmission?
2. According to the veteran, what are the barriers to following their treatment regimen?

Primary Practice Setting: It was a rural 84-bed Veterans Health Administration hospital in the Western United States.

Findings: Before this study, our efforts to reduce CHF readmissions were one-sided, all from the health care professionals' viewpoint. We wanted to hear what the veteran had to say; so, we interviewed 25 veterans. Four veterans were excluded due to issues with their consents. Ninety percent ($n = 19/21$) responded that they knew their CHF was worse by a change in their breathing (shortness of breath). They identified 48 signs/symptoms that indicated worsening CHF. Weight gain was noted as an indication of worsening CHF symptoms ($n = 6/48$) in 12.5% of the responses. Twenty-five percent ($n = 12/48$) of the veterans stated they recognized the early symptoms of worsening CHF. Thirty-eight percent ($n = 8/21$) of the veterans stated they had early symptoms of worsening CHF, but only two of them contacted their doctor. It is interesting to note that only 29% ($n = 6/21$) of the veterans recognized weight gain as a sign of worsening CHF and all of these veterans listed other symptoms (such as shortness of breath) along with weight gain. Weighing on a daily basis was practiced by only 30% of the group ($n = 7/21$); all but two of the veterans had no problems with weighing themselves. More than 71% of the veterans responded that they had no problems following their diet or taking their medications. More than half of the veterans did not need help with meals, transportation, or daily grooming/dressing/toileting.

Conclusions: We were concerned about the evident delays in seeking medical care for worsening CHF. All veterans who did need help with the activities of daily living, medications, or diet had their needs met through their support systems. They did not perceive any barriers to seeking care. However, there remain many unanswered questions. Does the patient understand their discharge education and know how to use this information from daily weights or recognition of early symptoms, to indicate their need for urgent and emergency medical interventions? Or is it a problem that the education is not sufficient? Is it a question of the burden of care from multiple comorbid conditions or of taking too many medications? Do social issues drive readmissions? These questions are further explored in a second study, which is in the data analysis stage.

Implications for Case Management Practice: There are three key findings from our study.

1. Veterans think in terms of symptoms that increase the impact of CHF on their life.
2. The relationship between daily weight and controlling CHF is not clear to veterans.
3. Hospital discharge instructions should clearly associate symptoms that are associated with worsening CHF.

Key words: CHF, readmissions, veterans' perspective

Our facility is a small, rural Veterans Hospital located in the Western United States. From 2009 to 2010, our hospital had 1003 veteran admissions for congestive heart failure (CHF). Of these, 355 or 35% had readmissions; we were well above the national average of 21% for the CHF

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readmission rate. This really caught our attention. As nurses and dietitians in the inpatient area, we wanted to know why these patients were having such frequent readmissions, and, more importantly, how we could help prevent them.

BACKGROUND

Heart disease is the most expensive cause of morbidity and death in the United States. More than 5 million people have some degree of CHF, of which about 50% of these people will die within 5 years of diagnosis. CHF costs the United States about \$32 billion in health care expenditures each year (Go et al., 2013). Estimates indicate that CHF is the single most common reason for hospital admissions among older adults and results in about 6.5 million days in the hospital each year (Lopert et al., 2012). A review of the literature revealed key reasons for CHF readmissions as being the complexity of the disease and its interaction with comorbid conditions, the difficulties associated with coordination of multidisciplinary health care, and the poor outcomes patients often experience.

COMPLEXITY AND COMORBID CONDITIONS

CHF is a complex syndrome resulting from various structural or functional heart problems that impair the ventricles ability to fill with, or eject, blood. Although about 50% of the people with CHF die within 5 years after diagnosis, early diagnosis and adequate treatment can lengthen life expectancy and improve the quality of life. Treatment involves a daily regimen of medications, low-sodium diet, and physical exercise. In addition, the treatment must be tailored to the underlying cause of the condition and the heart failure stage, as well as the individual's comorbid conditions (National Clinical Guideline Centre, 2010). Most patients with CHF have other chronic health problems, as well. Reports show that more than 80% of patients with heart failure older than 65 years have four or more comorbid conditions (Van der Wel et al., 2007). The literature revealed that a universal lack of understanding related to signs of a worsening condition and when to seek appropriate health care were just as prevalent as the lack of understanding regarding the disease and its prognosis. This literature review also noted the heavy burden of self-care management on the patient and his/her condition. Dietary and fluid restrictions and daily weighing were noted as problematic in these patients who struggled with unquenchable thirst and the need to restrict fluids. In addition, with multiple comorbid conditions, these patients often dealt with medication side effects and medication interactions (Annema, Luttk, & Jaarsma, 2009).

HEALTH CARE EFFORTS

Many efforts have been made to improve the CHF patient's outcomes. These have been directed toward optimizing the patient's treatment as the disease progresses, educating the patient for self-care to improve their adherence to treatment, and close follow-up by a health professional (Gwadry-Sridhar, Flintoft, Lee, Lee, & Guyatt, 2004; Kim & Han, 2013). The Veterans Health Administration (VHA) implemented two initiatives to address the care of veterans with CHF. The first was a comprehensive CHF toolkit for providers to use when treating veterans with the condition. This toolkit focused on key parts of CHF management and included algorithms for medical management and patient discharge self-care instructions, covering medication, diet restrictions, weighing daily, and activity level (VA Quality Enhancement Research Initiative, 2010). The second initiative was the Hospital to Home (H2H) program. The H2H program was developed collaboratively with the Institute for Healthcare Improvement and the American College of Cardiology to reduce CHF readmission rates. The focus areas for the H2H program were medication management (e.g., patient is competent with their medication regimen), early follow-up after hospital discharge (e.g., scheduling follow-up appointments within a week of discharge), and symptom management (e.g., assuring that the patient knows when to call for medical attention and who to contact) (Hospital to Home, 2013).

RISING HOSPITAL READMISSIONS

Despite these efforts toward improving care for patients with CHF, hospital readmissions for CHF have continued to rise. In 2008, the National Institutes of Health sponsored a clinical trial called the Heart Failure Adherence and Retention Trial to compare deaths and CHF hospitalizations between a patient self-management skills training with a CHF education group and a CHF education alone group (Powell et al., 2008). Results from the study indicated no difference between the patient groups with regard to death rates, hospitalizations, or quality of life (Powell et al., 2010).

STUDIES OF READMISSIONS

Annema et al. (2009) conducted the first study to examine hospital readmissions of patients with CHF from different perspectives: patient, caregiver, cardiologist, and the nurse. Several reasons for readmission were identified, including worsening symptoms, comorbid health conditions, and lack of compliance with treatment (such as nonadherence to diet, fluid restrictions, or

medications). Inadequate medications for treating the disease and inadequate help from health professionals were also identified as factors that led to readmission. The findings also indicated that 23–31% of the readmissions were believed to be preventable. This study found that patients, care givers, and health professionals did not always agree regarding the reason for readmission (Granger, Sandelowski, Tahshjain, Swedberg, & Ekman, 2009). This disagreement may be the underlying factor that interferes with the patient's ability to carry out the treatment plan on a daily basis. These findings imply that patient education should focus on recognition of symptoms and appropriate actions for those symptoms to decrease hospital readmissions. Several patient factors have been identified as significantly related to hospital readmissions. Shippee, Shah, May, Mair, and Montori (2012) designed a patient-centered model for patient complexity (cumulative complexity model) that considers clinical and social factors that shape access, utilization, self-care, and health for the individual patient. The patient complexity factors were categorized into two areas: workload (demands on the patient time and energy) and capacity (personal resources, social support, and abilities and limitations). Workload and capacity interactively affect the patient's ability to access and utilize health care resources, as well as perform self-care related to their disease. Multiple health conditions compound this burden for the patient.

PATIENT EDUCATION

Strengthening patient education can improve self-care behaviors and decrease readmissions to the hospital. One VHA medical center formed an interdisciplinary team to develop and implement an outpatient heart failure education program in an effort to improve patient compliance with treatment. A study compared the usual education provided for discharged patients with the education provided by an interdisciplinary team in a group setting. Their findings supported interdisciplinary education decreasing the 30-day readmission rate, but at 60 and 180 days, there was a gradual increase in their reported readmission rates (Gerdes & Lorenz, 2013).

Other studies identified various reasons patients with CHF do not comply with their treatment.

Reasons for not complying with the medications include expense, attitudes about medications, effects on sexual function, and not being convinced that the medication helps their condition. Other reasons for not complying with treatment include having other chronic conditions that require self-care, poor health care literacy, depression, and personal cultural factors.

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FACILITY-SPECIFIC INTERVENTIONS

Our facility's initial knee-jerk response to reduce CHF readmissions was to improve our patients' knowledge by putting together a standardized discharge education packet. The packets included educational materials and a checklist to ensure that the education was completed before discharge. In addition, providers enrolled veterans with CHF in the Care Coordination Home Telehealth (CCHT) program and referred them to a newly opened outpatient CHF clinic. After these initiatives were put in place, the readmissions rate went to about 23%, but we wanted to do better. We went back to the drawing board, and decided we needed more information. So we decided to look at the part of the equation we had not considered, namely what

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METHODS

Design

Our study was a qualitative design in which we interviewed 25 patients readmitted for CHF during 2009–2010.

Setting

We are a small, rural VHA medical center that is the main source of medical treatment for about 94,000 veterans living in our service area. Some of those veterans are from larger urban areas, but most come from small towns and outlying farms and ranches, and finally some of these veterans are homeless. The local VHA leadership, the institutional review board, and the Boise Research and Development Committee approved the study.

Procedure

To help us design the study, we used a report from the Institute for Healthcare Improvement and Robert Wood Johnson Foundation, *How-to Guide: Creating an Ideal Transition Home for Patient With Heart Failure*. This report was part of the Transforming Care at the Bedside national program “to improve the quality and safety of patient care on medical and surgical units, to increase the vitality and retention of nurses, and to improve the effectiveness of the entire care team” (Nielsen et al., 2008, pg. 1). Because our goal was to find out what our veterans, with CHF, thought contributed to their readmission to the hospital, we developed a short questionnaire (based on the *How-to Guide*) that asked about the patient’s recognition of symptoms, perceived barriers to care, and what they perceived caused the readmission. Then, we interviewed patients readmitted from January through May 2011. All patients had CHF as a primary or secondary diagnosis. The patients signed a consent form at the time of the interview.

RESULTS

We interviewed 25 veterans in their hospital rooms. We had to exclude four interviews because of problems with the consents. Of the 21 veterans whose information we could use, only four were readmitted with a primary diagnosis of CHF. The rest of the veterans had secondary diagnoses of CHF. The veteran interview questionnaire contained seven questions. We have presented the information gathered from each question individually.

TABLE 1
Veteran Responses to Question 1: Reason for Readmission ($n = 21$)

“It’s probably nothing that I ate or drank, probably more worrying about going belly up”
“Loss of breath”
“3 months ago when they switched my medication I could feel my breathing getting worse”
“My doctor cut my Lasix back. My swelling increased in my legs. It kept getting worse and I got short of breath”
“I had coughing and trouble breathing, I think it started with my lungs, I gained fluid weight”
“I had a PA, change my medication, and take my water pill out of the meds.”
“Ongoing heart problem, there is nothing they can do to fix it”
“My oxygen count was low, they found at today’s doctor’s appointment”
“Smoking I guess, my lung overtaxed my heart, maybe exertion”
“I had chest pain and shortness of breath”
“I was having coughing, shortness of breath, and wheezing”
“I couldn’t breathe, my lungs were filling up with fluid”
“I smoked too many cigarettes”
“They did not take off as much fluid during dialysis for a month or so. I was getting short of breath”
“This time I was coughing and I passed out. I was driving my car and I passed out”
“I let it go until I was too uncomfortable to go any longer”
“Infection to left foot, atrial fibrillation caused my heart to get stressed”
“My legs swelled”
“Had a heart attack”
“My breathing was worse”
“I went blank, I passed out”

Question One: How Do You Think You Became Sick Enough to Be Readmitted to the Hospital?

Some veterans identified more than one cause for their readmission. Their answers revealed that they viewed the readmission in terms of their symptoms, with shortness of breath or breathing difficulty being the primary symptom reported (9 of the 21 responses). Table 1 contains the veteran responses to question 1.

Question 2: Was There a Doctor Office Visit Scheduled Before This Admission to the Hospital?

It was interesting to note that over half of the veterans ($n = 12$ or 57%) had a scheduled office visit before this admission. Conversely, nine patients (43%) did not have a prior scheduled office visit.

The second half of question 2 pertained to whether the veteran perceived problems with scheduling or getting to the clinic appointment. One veteran responded that he was confused about the appointment date. Another stated he had had several

appointments during that month for the same problem. A third stated that he had gone to the emergency department and a fourth stated that he had difficulty walking. The responses revealed no common difficulties with either scheduling an appointment or being able to get to the appointment.

Questions 3: How Often Have You Weighed Yourself Since Your Last Admission to the Hospital?

For this question, only 17 interviews were completed because four of the veterans received a prior approved questionnaire that did not contain this question. Six of the 17 veterans (35%) weighed themselves daily, four (24%) weighed weekly, two (12%) weighed two to three times per week, and three (18%) weighed four to five times per week. Only one veteran did not weigh himself at all. Table 2 presents the responses for frequency of weighing among the veterans.

The second half of question 3 asked whether the veteran had problems weighing himself. Only two responded that they had problems, and each of those stated that someone in their assisted living home weighed them.

Questions 4: Have Any of the Following Interfered With Your Ability to Follow the Diet Your Doctor Prescribed for You?

Fifteen veterans (71%) responded that they had no problems following the prescribed diet. Three responded that the assisted living home handled their diet and two responded that transportation interfered with their following the diet. One responded that money and being “too sick to get out” interfered with them following the diet. Table 3 contains the veteran responses to question 4.

Question 5: Have Any of the Following Prevented You From Taking Your Medications as Prescribed?

Seventeen of the veterans (81%) responded that they had no problems taking their medications as

TABLE 3
Responses to Question 4: Factors Interfering With Following Diet

Factor	n (%)
None	15 (71)
Money/too sick to get out	1 (5)
Transportation	2 (10)
Other (living in assisted living = 2; drinking too much fluid = 1)	3 (14)
Food prepared/no diet prescribed	0 (0)

prescribed. One veteran mentioned money as a factor preventing him/her from taking his/her medications as prescribed. Three veterans responded “other” to this question; their reasons included “mobility,” “not given the proper medication,” and “get the medication from the nurse at assisted living.”

Question 6: Did You Need Help With Any of the Following Since Your Last Hospitalization?

The subquestions dealt with preparing meals, transportation, grooming, dressing, toileting, and medications. More than half of the veterans responded that they did not need help with any of these areas of their care. Nine veterans (43%) answered that they needed help with transportation. In relation to these areas where veterans needed help, there were persons or mechanisms in place to meet the veteran’s needs, including assistance from a family member, a friend, or another health care professional. Table 4 has responses for this question.

Question 7: How Do You Know When Your Heart Failure Is Getting Worse?

The veterans responded with more than one symptom, totaling 48 individual symptoms. However, of the 21 veterans, 90% responded that they knew their heart failure was worse by a change in their breathing, mainly shortness of breath. Weight gain—the

TABLE 2
Veteran Responses to Weighing Frequency (n = 17)

Weighing Frequency	n (%)
Never	1 (6)
Monthly	1 (6)
Weekly	4 (23)
Two to Three times a week	3 (18)
Four to five times a week	2 (12)
Daily	6 (35)

TABLE 4
Veterans’ Need for Help

Responses (Need Help With)	Yes	No
	n (%)	n (%)
Meals	8 (38)	13 (62)
Transportation	9 (43)	12 (57)
Daily grooming	7 (33)	13 (62)
Daily dressing/toileting	5 (24)	16 (76)
Medication	3 (14)	18 (86)
Other	0	0

standard self-care activity for monitoring CHF—was noted as an indication of worsening heart failure symptoms in six of the 48 responses. Table 5 displays the responses to Question 7.

DISCUSSION

Our facility was able to reduce our readmission rate for veterans with CHF from 35% to 23% by the use of a standardized discharge education packet and a discharge checklist, consult for patients to the CCHT program, or the CHF clinic. But we wanted to do better. So we asked our veterans for their input on why they felt they had been readmitted to the hospital.

We identified three questions that concerned us most:

1. “Did the veterans perceive barriers to their care?”
2. “How did the veterans recognize worsening CHF?”
3. “Did the veterans practice daily weighing and follow up with their doctor?”

Barriers

For the first question, the veterans did not identify any barriers to following their disease management plan. This let us know that our social work and case managers were doing a great job in removing any barriers to care.

Symptom Recognition

On the other hand, in terms of recognizing worsening symptoms, almost half (nine of the 21) veterans reported that shortness of breath and breathing difficulties were the signals to seek help. These are late symptoms and require emergency care according to the clinical practice guidelines for CHF (National Clinical Guideline Centre, 2010). Two veterans said that swelling, another late sign of worsening CHF, was what brought them back into the hospital. Two

What was concerning to us was that none of the veterans reported recognizing the early signs of CHF, such as weight gain or fatigue.... All of our veterans answered that they had no perceived barriers to carrying out this activity (daily weights), but only a third were doing daily weights and less than that recognized weight gain as a sign of worsening CHF.

other veterans reported either weight gain or just delayed too long coming in as what led their readmission. What was concerning to us was that none of the veterans reported recognizing the early signs of CHF, such as weight gain or fatigue.

Of note, 57% of our veterans had a doctor’s visit before their readmission; however, the timing of that visit was not collected for this study. Therefore, it is not known whether the visit was for early signs of worsening condition (which may have been appropriate behavior) or for another issue. But the fact remains that 43% or a little under a half of our veterans delayed seeking medical care until they were experiencing late signs of CHF. This has been recognized as a prevalent problem in patients with CHF (Goldberg et al., 2008).

Weighing Practices

The final issue concerns the use of daily weights as the cornerstone of patient self-management of CHF at home. We found that only 35% of our veterans responded that they weighed themselves daily and only six (13%) responded that weight gain was a sign of worsening heart failure. Our standard education packet contains daily weighing instructions and to contact the provider for a gain of 2 lb in 1 day. All of our veterans answered that they had no perceived barriers to carrying out this activity (daily weights), but only a third were doing daily weights and less than that recognized weight gain as a sign of worsening CHF.

IMPLICATIONS FOR CASE MANAGEMENT

When I was in the Air Force, there was a plane called the AWACS-Airborne Early Warning and Control. Their job was to fly around the area and provide a bird’s eye view of what was going on the ground. They could generally catch movement on their radar

TABLE 5
Responses to Question 7: Recognition of Worsening Condition (n = 48)

Response	n (%)
Shortness of breath	19 (40)
Other—fatigue, chest pain, nausea	13 (27)
Swelling	7 (13)
Weight gain	6 (13)
Increased need for oxygen	2 (4)
Heavy legs	1 (2)
Increased blood pressure/decreased urine	0

that folks on the ground could not see. This is how I see the role of case managers in health care. They can catch things on their radar way before the veteran gets admitted or after discharge that the doctors and nurses in the clinics or inpatient units just are not in the position to see. So if there are patients being readmitted who we know are getting the education and follow-up, yet are still coming back time and time again, maybe it is because we are not using terms they see as important and meaningful to their situation. That said our study brought out three points we feel can help case managers as they assess their patients with CHF.

1. Our veterans think in terms of signs or symptoms that increase the impact of CHF on their life.
2. Daily weights are not as important to the veteran as the impact of symptoms of CHF on their life.
3. Discharge instructions should match how the veteran sees worsening CHF.

Veterans think in terms of signs or symptoms that increase the impact of CHF on their life.

Patients have better outcomes when plans of care are put in terms, and conditions they feel are important, and have the most impact on their quality of life. This belief was strongly pointed out to us by the fact that more than 70% of those we interviewed said the symptom of shortness of breath, fatigue, or chest pain was what brought them back into the hospital. All of these symptoms impact on how a person lives her or his life. A study conducted at two medical centers in the Pacific Northwest ($n = 14$) looked at the impact of living with someone with CHF. They stated the following: "Planning for the future was difficult because of frequently cancelled or changed plans due to the patient's symptoms. Lack of energy, fatigue and difficulty breathing were the symptoms most frequently discussed by partners. These symptoms reduced or eliminated the patient's ability to work, walk, travel, and engage in social events" (Imes, Dougherty, Pyper, & Sullivan, 2011, pg. 213).

Case managers can use this knowledge to couch health care conversations and health care goals in terms that the patient will better understand and are the most meaningful to the veteran. The benefits of this approach are demonstrated by a study conducted at the University of Michigan Medical Center CHF clinics with patients with CHF and their spouses ($n = 169$) by Rohrbaugh, Shoham, and Coyne (2006). They reported that only useful discussions (Wald = 12.64; relative risk = 1.70; 95% confidence interval = 1.27 to 2.88; $p = 0.001$) and observed positivity (Wald = 6.15; relative risk = 1.55; 95% confidence interval = 1.10 to 2.19; $p = 0.013$) predicted the 8-year survival functions after controlling for CHF

severity (Rohrbaugh et al., 2006, pg. 1071). We discuss the meaningfulness of daily weights to our veterans in the next section.

Daily weights are not as important to the veteran as the impact of symptoms of CHF on their life. What we know is that out of the 21 veterans only one stated gaining weight was a factor in his readmission. Only six of the 21 veterans or 35% practiced daily weights. And the most interesting is that of the 48 responses about how our veterans perceived their CHF getting worse, 31 or 65% identified symptoms such as shortness of breath, fatigue, or chest pain, all of which are symptoms that would impact the most on quality of life, which matches the results from Imes et al. (2011). This is opposed to six of the 21, or 13%, who used weight gain to monitor for worsening CHF. If only one of the 21 veterans saw a correlation between weight gain and their admission, only a third of the 21 people weighed daily, and 2/3 of the 21 veterans identified the symptoms that have the worst impact on folks with CHF, *then symptoms and not daily weights are what is most important to this population*. How this applies to case managers is discussed in the following point.

Discharge instructions should match how the veteran sees worsening CHF. The patient perspective can sometimes slip under the "radar screens" when assessing a patient for education needs at discharge. In an article by Birmingham (2009), the author gives key advice on the case manager's role in this regard. "Case Managers have the ability to objectively form an opinion about a patient's readiness for discharge, and what the potential post-acute level of care would best meet the continuing care needs of the patient. Case managers need to express those opinions based on assessment of the patient, and knowing the levels and types of post-acute levels of care to which patients can be discharged and the mitigating factors that can be determined by clinical judgment" (Birmingham, 2009, pg. 298). The patient perspective should be part of these mitigating factors. Another article by Auricchio, Brugada, Ellenbogen, Gold, and Francisco Leyva (2010) stated that CHF "symptoms vary from person to person, and not everyone experiences CHF in the same way." "It is clinically recognized that acute decompensation of CHF is frequently preceded (days or weeks) by one or more symptoms including weight change, leg edema, increase in mean heart rate, reduction in exercise capacity, or cough. Each of these symptoms has a different, mostly unknown time dynamic in a specific patient. So their personal history and perspective of the impact of the signs and symptoms of worsening CHF should be used as a gauge for their condition" (Auricchio et al., 2010, pg. 1364; Tzanis, Stavros Dimopoulos, Agapitou, & Nanas, 2014).

A final point about daily weights is that some articles say that daily weights are the cornerstone of monitoring for worsening CHF (Lindenfeld et al., 2010). Yet another article mentions the importance of monitoring weight loss because of the relationship between weight loss and increased morbidity (Pocock et al., 2008).

Folks might ask—where can we find this information? An article by Hunter, Nelson, and Birmingham (2013) gives some helpful information. They said that “face-to-face meetings” and another really nifty idea was the introduction of a “readmission box” added to nursing admission assessments that would alert the nurse to ask the patient or family member for an explanation of the readmission to gather this data.

Who should we listen to when we teach our patients about the role of daily weights? We believe it is time to listen to our patients. We recommend that discharge instructions for our veterans with CHF should include the symptoms they understand as being signs or symptoms of worsening CHF. Research has shown daily weights, whether weight gain or loss, have an important role in helping our veterans manage their disease and should be used to indicate when they should call their doctor for further instructions.

CONCLUSIONS

This is a small, unique sample of veterans with heart failure, which is a significant limitation for this study. However, the findings do agree with findings from other studies related to patient perspectives (Annema et al., 2009). The data collection tool was very basic and provided limited information. The findings may have been more useful if the basic questions had been expanded to identify underlying factors, such as detailed information about the provider visit before readmission. Further study surrounding personal factors and the burden of treatment for heart failure is warranted. In addition, further study surrounding the role of depression and personal motivation for self-care is needed. Last, further study related to the effects of comorbid conditions, burden of self-care, and realistic expectations for heart failure patients is needed.

The finding that 65% of the veterans in this study were not following the clinical practice guidelines regarding daily weight is concerning and needs further investigation. The researchers examined our printed discharge instructions and found that although daily weighing is mentioned, the instructions need to be more prominent. The facility's discharge instruction sheet needs to be expanded to include a list of symptoms that indicate worsening heart failure, how to monitor symptoms, daily weight instructions, and when to contact the provider. Home monitoring through telehealth may be the answer for some veterans.

Health literacy may influence a patient's ability to perform self-care so substantially that the Institute of Medicine included the improvement of health literacy as one of the 20 priority areas that could transform health care. Although there have been few investigations of the impact of health literacy on heart failure patients' self-care behaviors, research does suggest that low health literacy is a fundamental barrier to effective self-care (Riegel et al., 2009).

But for us, we feel the most important issue our study found was that we need to listen to the veteran's voice.

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