Adding transition services does not aid heart failure outcomes

March 27 2019

(HealthDay)—Additional transitional care services do not improve

outcomes for heart failure patients discharged from the hospital, according to a study recently published in the *Journal of the American Medical Association*.

Harriette G.C. Van Spall, M.D., M.P.H., from the Population Health Research Institute in Hamilton, Ontario, Canada, and colleagues evaluated the effectiveness of the Patient-Centered Care Transitions in HF transitional care model in patients hospitalized for heart failure at 10 hospitals in Ontario from February 2015 to March 2016 (with follow-up until November 2016). Hospitals were randomly assigned to receive the transition intervention (1,104 patients) or usual care (1,390 patients). The intervention consisted of nurse-led self-care education, a structured hospital discharge summary, a family physician follow-up appointment within one week of discharge, and structured nurse home visits for high-risk patients.

The researchers observed no significant difference between the groups for the first primary composite outcome of all-cause readmission, emergency department visit, or death at three months (hazard ratio [HR], 0.99; 95 percent confidence interval [CI], 0.83 to 1.19) or the second primary composite outcome of all-cause readmission or emergency department visit at 30 days (HR, 0.93; 95 percent CI, 0.73 to 1.18). At six weeks, there were significant differences between the groups in the secondary outcomes of the mean B-PREPARED score for discharge preparedness, mean 3-Item Care Transitions Measure for quality of transition, and mean 5-level EQ-5D for quality of life.

"Health care interventions that do not improve clinical outcomes such as readmission or death may still be worthy of program funding if patients report greater satisfaction with care and quality of life," Van Spall said in a statement.

More information: Abstract/Full Text (subscription or payment may

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Citation: Adding transition services does not aid heart failure outcomes (2019, March 27) retrieved 10 May 2024 from https://medicalxpress.com/news/2019-03-adding-transition-aid-heart-failure.html

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