

Following hospitalization for heart failure, home care lessens re-admission risk

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Older adults who are recovering from heart failure often leave the hospital to stay at rehabilitation facilities (also called skilled nursing facilities) before they return home. However, healthcare practitioners

know that the stress of the transitioning from hospital to skilled nursing facility and back to a person's home can result in an older adult's readmission to the hospital within 30 days after their discharge.

For that reason, [older adults](#) who have heart failure may do better when they get [home health care](#) once they return home after their discharges from the hospital and skilled nursing facility.

To learn more, a team of researchers studied the association between hospital readmission risk and receiving home health care after leaving skilled nursing facilities. To do so, they examined the records of Medicare patients, aged 65 and older, who had returned home from skilled nursing facilities following hospitalization for heart failure. Their study was published in the *Journal of the American Geriatrics Society*.

The researchers examined the records of 67,585 older adults who had been hospitalized for heart failure, were released to a skilled nursing facility, and then were sent home.

Of those patients, almost 20 percent received home health care once they returned home.

The researchers learned that people who received home health care had lower rates of readmission to the hospital within 30 days than those who didn't receive home health care.

"It's surprising that only about 20 percent of people received home health care after discharge from skilled nursing facilities," said Himali Weerahandi, MD, lead author of the study. "Recovery from a hospitalization can sometimes take longer than expected and the support provided by the skilled nursing facility and then home health care may be what vulnerable patients need to get better."

The researchers said their findings were unexpected, because older adults who receive home health care after leaving a skilled nurse facility are more likely to have trouble getting around and other difficulties. They were also likely to have shorter stays in the skilled nursing facility, which means they had less time to recover from their illness.

The researchers concluded that for older adults who have been hospitalized with [heart failure](#), having home [health care](#) services following their stay at a [skilled nursing facility](#) may help reduce their risk of readmission to the [hospital](#).

More information: Himali Weerahandi et al, Home Health Care After Skilled Nursing Facility Discharge Following Heart Failure Hospitalization, *Journal of the American Geriatrics Society* (2019). [DOI: 10.1111/jgs.16179](#)

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