Nurse home visits after hospitalization for heart failure improve patient outcomes at a reasonable cost

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Compared to usual care, transitional care services, such as nurse home visits, can improve health outcomes and reduce readmissions for a reasonable cost after hospitalization for heart failure. The authors suggest that transitional care services should become the standard of care for post-discharge management of patients with heart failure. Findings from a microsimulation study are published in *Annals of Internal Medicine*.

Heart failure affects 26 million people globally and is a leading cause of hospitalization and rehospitalization among older adults. Yet despite dozens of studies on methods for reducing rehospitalizations in older patients with heart failure, the great majority of patients still receive usual care, which is careful medication reconciliation, a close outpatient follow-up appointment, and some education. Transitional care service interventions could be a way to reduce rehospitalizations and improve patient outcomes.

Researchers from Stanford University created a microsimulation model using clinical trial, registry, and hospital data to assess the cost-effectiveness of three types of post-discharge heart failure transitional care services and standard care. The interventions assessed included disease management clinics, nurse home visits, and nurse case management, and the patients studied were those with heart failure who were aged 75 at the time of hospital discharge. The researchers found

that all three transitional care interventions examined were more costly but also more effective than standard care, with nurse home visits dominating the other two interventions. Compared with standard care, nurse home visits increased quality adjusted life years (QALYs) and costs, resulting in an ICER of $19,570 per QALY gained. Of note according to the researchers, each of the transitional care interventions studied resulted in important improvements in health outcomes, and the differences among them were modest. The authors suggest that it is highly unlikely that standard care post-discharge management is more cost-effective than any of the transitional care services they studied.

An accompanying editorial from New York University School of Medicine and New York University Langone Health says that transitional care services are not standard care yet because initiating them can be complicated and include upfront costs that must be shouldered by health care providers and may not be subsequently reimbursed by payers.

More information: Study: http://annals.org/aim/article/doi/10.7326/M19-1980

Editorial: http://annals.org/aim/article/doi/10.7326/M19-3872

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