Hospital-to-home transition care may not help patients with heart failure

26 February 2019

Harriette Van Spall, first author and principal investigator of the study, a researcher at the Population Health Research Institute of McMaster University and Hamilton Health Sciences. Credit: McMaster University

Providing additional health-care services for heart failure patients to help them transition from hospital to home does not improve their outcome, according to research led by the Population Health Research Institute (PHRI) of McMaster University and Hamilton Health Sciences (HHS).

The conclusion comes from a trial that followed the health status of almost 2,500 adults hospitalized for heart failure in hospitals across Ontario, Canada.

The results were published today in the *Journal of the American Medical Association* (*JAMA*).

"Heart failure is a leading cause of hospitalization in older adults," said Harriette Van Spall, who is first author and principal investigator of the study, a researcher at PHRI, associate professor in the Department of Medicine at McMaster, and a cardiologist at HHS.

"We know that approximately 40 per cent of early readmissions after heart failure hospitalizations are related to suboptimal care as patients transfer between health-care settings.

"Transitional care services can improve outcomes in select patients, but have not been systematically implemented. We wanted to test the effectiveness of this health intervention after implementing it in hospitals in our health-care system."

The research team ran a randomized trial that included 2,494 adults hospitalized for heart failure at 10 hospitals in Ontario between February 2015 and March 2016, with follow-up until November 2016.

Hospitals were randomized to receive the hospital-to-home transition care intervention. This intervention, delivered to 1,104 patients, included nurse-led self-care education, a structured hospital discharge summary, and a family physician follow-up appointment less than one week after discharge and, for high-risk patients, structured nurse home visits and heart function clinic care.

The remainder of the patients received usual care in which transitional care was left to the discretion of clinicians.

The study tested the effect of the intervention on the outcome of hospital readmission or emergency department visit for any cause at 30 days, and readmission, emergency department visit, or death at three months.

"We found the patient-centred transitional care service model did not improve clinical outcomes in patients hospitalized for heart failure in our health-care system," said Van Spall.

"There were no significant differences in death, readmissions, or emergency department visits between the patients who received the transitional care intervention and those who received usual

care.

"However, patients receiving the intervention reported improvements in discharge preparedness, quality of transitional care, and quality of life."

Van Spall said the study's outcome may impact health-care policy.

"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," she said.

"However, if the goal is to improve clinical outcomes, then stronger evidence of the effectiveness of this intervention may be needed to support its funding."

She added that further research could help determine whether this type of intervention could be effective in other health-care systems or locations.

Provided by McMaster University