Effective Health Care

Management of Heart Failure Patients Transitioning from Acute to Home Health Care Setting Nomination Summary Document

Results of Topic Selection Process & Next Steps

- Collaborative management of heart failure patients transitioning from an acute care setting to home health care was found to be addressed by three existing products: a 2008 AHRQ Technology Assessment titled *Non-Pharmacological Interventions for Post-Discharge Care in Heart Failure;* ACCF/AHA guidelines titled *2009 Focused Update Incorporated into the ACC/AHA 2005 Guidelines for the Diagnosis and Management of Heart Failure in Adults*; and a 2009 AHA statement titled *State of the Science Promoting Self-Care in Persons With Heart Failure.* Given that these products cover this nomination, no further activity will be undertaken on this topic.
  - Lau J, DeVine D, Raman G. Technology Assessment Report: Non-Pharmacological Interventions for Post-Discharge Care in Heart Failure. Prepared by the Tufts-NEMC Evidence-based Practice Center. (EPC) under contract to the Agency for Healthcare Research and Quality (AHRQ), Rockville, MD (Contract No. 290-02-0022). February 2008. http://www.ahrq.gov/clinic/ta/hospdischrg/hospdischg.pdf
  - Hunt SA, Abraham WT, Chin MH, Feldman AM, Francis GS, Ganiats TG, Jessup M, Konstam MA, Mancini DM, Michl K, Oates JA, Rahko PS, Silver MA, Stevenson LW, Yancy CW. 2009 focused update incorporated into the ACC/AHA 2005 Guidelines for the Diagnosis and Management of Heart Failure in Adults: a report of the American College of Cardiology Foundation/American Heart Association Task Force on Practice Guidelines: developed in collaboration with the International Society for Heart and Lung Transplantation. Circulation. 2009;119(14):e391-479. http://content.onlinejacc.org/cgi/reprint/53/15/1343.pdf
  - American Heart Association. State of the Science Promoting Self-Care in Persons with Heart Failure. A Scientific Statement from the American Heart Association. Circulation. 2009;120 (12):1141. http://circ.ahajournals.org/cgi/reprint/CIRCULATIONAHA.109.192628v1

Topic Description

Nominator: Individual

Nomination Summary: The nominator is interested in knowing the most recent, evidence-based approach for managing the transition of care for heart failure patients moving from an acute care setting to home health care.

Population(s): Heart failure patients
Intervention(s): Management of care transition including treatment, patient education, the use of electronic medical records, and various approaches (e.g., holistic, single-

minded)
Comparator(s): See above interventions
Outcome(s): Improved appropriate management of heart failure, early identification of symptoms, early intervention, decreased hospitalization and complications, and empowerment of patients to self-management with medical guidance.

Key Questions from Nominator:

1. For clients diagnosed with heart failure, what is the latest evidence-based care protocol for collaborative management of heart failure clients transitioning from an acute care setting to home health care?

Considerations

- The topic meets EHC Program appropriateness and importance criteria. (For more information, see http://effectivehealthcare.ahrq.gov/index.cfm/submit-a-suggestion-for-research/how-are-research-topics-chosen/.)

- The incidence of heart failure (HF) is high, and it is one of the most common reasons for hospitalization and rehospitalization. There is an increasing interest in multidisciplinary care for heart failure patients due to a variety of factors including research showing that frequent visits by patients to primary care physicians alone do not appear to reduce readmissions or improve quality of life. However, some recent trials of disease management programs for heart failure patients have not been shown to be of benefit compared to usual care and follow-up. There is debate within the literature about what comprises evidence-based components of such programs, as there remains variation in the content, intensity, and duration of the components, the setting, and the personnel involved. Considerable uncertainty remains with the topic of multidisciplinary and collaborative care of heart failure patients. Much of this has been addressed in recent work by AHRQ and others.

- The topic was found to be addressed by a 2008 AHRQ TA titled *Non-Pharmacological Interventions for Post-Discharge Care in Heart Failure.* The TA addresses a number of interventions including education on symptoms and disease management, instruction on self management behaviors, and instruction to increase self-care behavior in patients. It includes assessment of self-care ability, diet advice, sodium restriction, medication review, education reinforcement, exercise recommendations, weight monitoring, telephone support, home visits, social and psychological support, and multidisciplinary care. Outcomes include mortality, length of hospital stay, quality of life, readmission, costs, and combined endpoints of mortality and hospitalization. Key questions from this report include:

  1. In HF patients 50 years and older, what is the effectiveness of interventions to support post-discharge care compared with the usual care to prevent readmission?
     a. What is the relationship of the following parameters to the outcome readmission?
        - Internal and external validity of the studies (includes inclusion and exclusion criteria of the studies).
        - Length of followup.
        - Concurrent discharge planning in disease management programs.
        - Place of delivery of discharge planning (home, inpatient, outpatient).
        - Components of discharge planning and whether components were individually tailored or generalized.

- Intensity of discharge planning, number and frequency of interventions.
- Patient characteristics.
- Other study characteristics that may affect outcomes.

- The topic was also found to be addressed by two sets of guidelines. The first is a joint effort by the American College of Cardiology Foundation (ACCF) and American Heart Association (AHA). In 2009, the ACCF/AHA updated their 2005 guidelines on the diagnosis and management of heart failure in adults. The guideline developers felt it was necessary to address the increasingly recognized problem of the patient with acute decompensated heart failure, as opposed to the patient with chronic heart failure, as heart failure is now the single most common reason why patients over 65 years are admitted to the hospital. The updated guidelines review important management principles for this population including recommendations for diagnosis, assessment, treatment, and monitoring. The second set of guidelines is a 2009 state-of-the-science document by the AHA on promoting self-care in patients with heart failure. Specifically, the document describes what is known about (1) the self-care behaviors required of HF patients, (2) factors that make self-care challenging for patients, (3) interventions that promote self-care, and (4) the effect of self-care on HF outcomes. The review includes evidence-based recommendations for clinicians and future research suggestions.