Effective Health Care

Heart Failure Hospital Readmission Nomination Summary Document

Results of Topic Selection Process & Next Steps

- Heart failure hospital readmission prevention will go forward for refinement as an update to or expansion of an existing comparative effectiveness or effectiveness review. The scope of this topic, including populations, interventions, comparators, and outcomes, will be further developed in the refinement stage.
  - When key questions have been drafted, they will be posted on the AHRQ Web site and open for public comment. To sign up for notification when this and other Effective Health Care (EHC) Program topics are posted for public comment, please go to http://effectivehealthcare.ahrq.gov/index.cfm/join-the-email-list1/.

Topic Description

Nominator: Organization

Nomination Summary: The nominator is interested in the evidence for interventions that are effective in decreasing hospital readmissions related to heart failure.

Staff-Generated PICO
Population(s): Patients with heart failure requiring hospitalization, including subgroups based on age, symptom severity, and ejection fraction status
Intervention(s): Interventions to decrease hospital readmissions, including increased length of inpatient stay, earlier outpatient follow up, disease management strategies (e.g., medication reconciliation, home health visits, remote monitoring)
Comparator(s): See above interventions for comparisons among interventions and usual care
Outcome(s): Hospital readmission (both heart failure admissions and all-cause admissions), quality of life as measured by the Kansas City Cardiomyopathy Questionnaire or Minnesota Living with Heart Failure Questionnaire, and patient-related harms including mortality

Key Questions from Nominator:
1. Which interventions are effective in decreasing heart failure readmissions?

Considerations

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

- Heart failure (HF) is a common discharge diagnosis for the elderly. In the United States, heart failure rates are increasing as ischemic heart disease survival improves. Interventions aimed at preventing rehospitalization are often referred to as transitional care programs. HF readmissions that are associated with modifiable factors that are conducive to transitional care interventions may be prevented.

- This topic will move forward as a systematic review to update to the existing AHRQ Technology Assessment published in 2008 titled *Non-pharmacological interventions for post-discharge care in heart failure.* Key questions from the 2008 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?

        1a. 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

    - A significant body of literature was identified since the publication of the 2008 Technology Assessment. Transitional and post-discharge care of heart failure patients is an area of research that continues to grow, and implementation research of HF programs is likely to increase significantly in the coming years. Therefore, a systematic review to update of the previous AHRQ Technology Assessment report will help guide hospitals, health systems, and care givers in selecting and implementing interventions to prevent hospital readmission.