Effective Health Care
Congestive Heart Failure and Preventing Readmissions Nomination Summary Document

Results of Topic Selection Process & Next Steps

- Congestive heart failure and preventing readmissions 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 questions what effective methods exist to prevent readmissions for patients with congestive heart failure (CHF) and to improve patient quality of life and possibly early or premature death due to modifiable CHF care items (such as dietary restrictions and weight monitoring).

Staff-Generated PICO
Population(s): Adults with heart failure requiring hospitalization
Intervention(s): Heart failure education (signs, symptoms, pathophysiology), self-care interventions (diet, fluid restrictions, sodium dietary restrictions, review of medications, exercise recommendations, weight monitoring), patient support (telephone support, increased clinic visits, home visits, social support, psychological support, multidisciplinary care)
Comparator(s): Usual care versus intervention, one intervention versus another intervention
Outcome(s): Readmission rates (all causes), length of hospital stay, health care utilization, mortality rates (all causes), quality of life

Key Questions from Nominator:

1. How can we prevent readmissions for patients with congestive heart failure?

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 the most common discharge diagnosis for the elderly. 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 an 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 are listed below.

  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 care is an area of research that continues to grow, and implementation research of HF programs is likely to increase significantly in the next 2 years. Therefore, an update of the previous AHRQ Technology Assessment report will help guide hospitals, health systems, and care givers in selecting and implementing interventions.