BRINGING MEDICINE HOME

Demonstrated Impact of the VNSNY Heart Failure Transitions Program on Rehospitalization Rates

A retrospective, observational study shows that heart failure patients most at risk of rehospitalization who received VNSNY transitional care services were ***43% less likely to be readmitted within 30 days.***

THE NEED

Congestive heart failure (CHF) is the leading cause of hospitalization in the United States among adults 65 or older.[1] Congestive heart failure patients tend to have one of the highest – if not the highest – rehospitalization rates.[2]

However, many of these rehospitalizations are believed to be preventable.[3] Comprehensive transitional care focused on coordination between healthcare providers, patient education, and self-care management may address some of these issues and reduce rates of rehospitalization in this population.[4, 5]

THE PROGRAM

To help address the needs of CHF patients, the Heart Failure Transitions Program was designed and implemented through a collaboration between VNSNY's Certified Home Healthcare Agency and a major New York City hospital. Its goal was to maximize coordination and integration among the hospital, the home care agency, the community physician and the patient during the first 30 days after discharge.

Key components of the VNSNY Heart Failure Transitions Program include:

- Integration of caregivers into the discharge process and the plan of care
- Educational, self-management and coaching support including a self-care guidebook
- Scheduling a medical appointment within seven days of discharge
- Ongoing collaboration with primary care provider and specialists
- Nursing assessment of the home environment, community resources, caregiver support and psychosocial condition
- Medication reconciliation
- Frequent contacts through home visits and phone calls during first two weeks after discharge
- Potential for periodic reports to the hospital on patient clinical characteristics, service utilization and outcomes (hospitalization and emergent care)

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THE STUDY

To better understand the impact of its Heart Failure Transitions Program on rehospitalization rates, VNSNY initiated a retrospective observational study. The study analyzed an intervention group compared to a control group of heart failure patients. The intervention group consisted of 223 HF patients who participated in the VNSNY Heart Failure Transitions Program during the first nine months of 2010. The control group consisted of 224 HF patients who received standard home care services (e.g., skilled nursing, physical therapy, home health aide) during 2009.

Patients in both groups averaged 79 years of age and were clinically complex, as demonstrated by their high average number of comorbidities (mean = 5.4 comorbidities). Patients selected to be included in this study also had a high likelihood of rehospitalization, as determined by VNSNY's validated, proprietary predictive risk model that takes into account demographic, financial, clinical and health status factors.

The primary endpoint of this study was rehospitalization within 30 days from the start of home care. A regression analysis shows that in the intervention group, the adjusted odds ratio for 30-day rehospitalization was 0.57 ($p<.01$) – meaning that the patients who received transitional care services were 43% less likely to be readmitted within 30 days than patients in the control group.

THE OUTCOMES

These results suggest that patients who received transitional care services are significantly less likely to be readmitted to the hospital. This study also highlights the potential for positive outcomes among heart failure patients when hospitals and home healthcare organizations work together to implement transitional care practices.

As this analysis was based on a preliminary retrospective observational study, further research is needed to replicate the findings using a randomized prospective design.

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