



Improving Quality of Life, Reducing Readmissions in HF Patients



Results of new study, published in the journal *Heart & Lung*, support improved quality of life and decreased readmission rates following a multidisciplinary transition-to-care programme for heart failure (HF) patients. This team-based, patient-specific and collaborative approach is an effective practice-based strategy to improve HF outcomes, according to researchers.

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The incidence and prevalence of heart failure has increased dramatically in the past three decades. It has been estimated that HF affects 10 per 1000 individuals after 65 years of age, and 1 in 5 will develop it after 40 years of age. The most common risk factor of HF is coronary heart disease, which is also considered the most costly medical condition in the U.S. Common symptoms of HF are: shortness of breath during daily activities; trouble breathing when lying down; weight gain with swelling in the legs, ankles, or lower back; and general fatigue and weakness.

Approximately, 20% of patients hospitalised nationally with HF are readmitted within 30 days. HF patients often lack support from healthcare teams especially when transitioning from hospital to home. To address this problem, a variety of outpatient HF management and transitional care programmes of varying lengths have been implemented nationally. These programmes help to ensure continuity of care, reducing the risk of poor outcomes. The goal is to complement, not to replace primary care, disease management, discharge planning or case management, by educating patients with chronic disease and their caregivers.

Transitional care programmes have generally focused exclusively on hospital readmission. However, little research has examined the impact of these programmes on managing the physical and emotional symptoms of patients with HF or on their quality of life. The current study aimed to examine the feasibility and effects of a four-week transition-to-care programme on quality of life in patients with HF. A pre- and post-test design was used. Quality of life, as measured by the Minnesota Living with Heart Failure Questionnaire, and hospital readmissions were the outcomes. A convenience sample of 50 patients with HF was recruited for the study.

The patients attended weekly sessions for four weeks. Each visit consisted of a physical assessment and evaluation which included vital signs, weight, assessment of volume overload by checking for lower leg oedema, abdominal distension, and jugular venous distension, and assessment of heart and lung sounds by a nurse practitioner.

Thirty-six (72% of participants) completed the study. There was a significant improvement in quality of

life. Men reported greater improvement in physical symptoms and less emotional distress when compared to women. Only two participants were readmitted within 30 days.

"Prevalence of depression in patients with HF has been reported as ranging from 15 to 36%, which is above the lifetime prevalence of 13% for major depression in the general population," the authors write. "In addition to a four-week transition-to-care programme for patients with HF, individuals may benefit from continued monthly support group meetings to ensure adequate emotional support, protocol modification to include a depression screening to identify the patients earlier and in a future study consider ongoing assessment of emotional status."

Source: [Heart & Lung](#)

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