Does Peer Support Help Patients With Heart Failure? 
Finding the Perfect Match 

Kathleen Dracup, RN, PhD

Match making has been an intriguing and reoccurring theme in books, songs, plays, and movies. Parents have been doing it for generations ... tirelessly working to find the right match for their unmarried children. Close friends launch similar campaigns to help single friends find a life partner. Sometimes parents and friends hit the jackpot. Sometimes the results of the most well-intentioned matches end in an evening of painful tragedy or unintended comedy. Unfortunately, the majority of subjects of these heroic efforts know that the chances are slim that the connection will result in a match.

In this issue of Circulation: Heart Failure, Heisler et al1 designed an elegant effectiveness study to test the hypothesis that an intervention in which patients recently discharged from the hospitals with heart failure (HF) were matched with similar peers, and the pair was instructed to call each other weekly for information and support would improve all-cause hospitalization and all-cause mortality, as well as increase social support and quality of life. All the participants were recently discharged from the hospital with a diagnosis of HF and were unable or unwilling to attend an outpatient HF program. Patients were randomized to 1 of 2 groups: a peer-support intervention with weekly phone calls or an intervention that involved enhanced engagement in group sessions with nurse practitioners who were expert in the care of HF patients. Recognizing the importance of communication in the relationship between peers, the investigators tried to match patients in the peer-support arm by sex and age. The intervention group of weekly peer telephone calls was supplemented by 3 group sessions held with nurse practitioners across the 6 months of the study, based on recommendations of Riegel and Carlson2 who had disappointing results with a peer-support intervention trial for HF patients and who recommended the addition of structured support by nurses.

Unfortunately, patients randomized to the reciprocal peer-support group had a risk of rehospitalization or death that was not significantly different from patients randomized to nurse practitioner–care management in this study. Moreover, there were no significant differences between the 2 study arms in HF quality of life and social support at 6 months. The study was carefully conducted and the data appropriately analyzed, which makes the negative results all the more disappointing but illuminating.

Unlike the many methodological problems inherent in studies of medication adherence, where every measure of adherence is problematic except serum samples,3 the authors carefully measured and documented adherence to the peer-support intervention. The patients who were peer partners used an interactive voice response facilitated telephone platform that documented the frequency and duration of all calls, and attendance at group sessions was also carefully recorded for both arms. At the end of the study, the investigators had the advantage of knowing the exact adherence of the patients in the 2 groups; unfortunately, it was abysmal. Less than 30% adhered to the protocol, whereas 82% made <50% of the weekly peer calls over the 6 months of the study. Forty percent of patients assigned to the peer-support group did not speak over the phone even once.

As noted by the authors, peer-support groups have had remarkable success in improving the clinical outcomes and psychological states of some populations, such as cancer patients4 and new mothers committed to breast-feeding.5 The authors speculated on the difference between their results and those documented in other populations, particularly in patients with chronic diseases, such as diabetes mellitus where peer support has been documented as effective.6 It must be noted that the patient populations in successful trials are quite different from patients with HF. For example, cancer patients participating in peer-support groups cope with changes in health status and focus on various stages of diagnosis and aggressive treatment but do not have the same level of self-care requirements as patients with HF. With new mothers, peer support is related to a specific activity (ie, breast-feeding). In the case of a chronic population with diabetes mellitus, patients are usually younger than patients with HF and focused on a specific, easily measured outcome (ie, glycemic control). In contrast, HF patients are older, often frail, and struggling with multiple symptoms. The HF population may be more similar to patients with multiple sclerosis, who also struggle with debilitating symptoms and a negative trajectory. Trials testing peer-support interventions in this population have been disappointing.7 The intervention of a weekly phone call to a relative stranger may have seemed like an additional burden to an individual already burdened with daily weights, dietary restrictions, and a complex medication schedule. The recruitment data support this interpretation. Of the 1204 eligible patients, 68% refused to participate and another 9% agreed, signed a consent form, but then did not return to be randomized at the first group session.

The peer-support intervention tested in this study was different from that used in many lay programs, such as Alcoholics Anonymous, which has documented success.8 Although many

The opinions expressed in this article are not necessarily those of the editors or of the American Heart Association.
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Editorial

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The peer-support intervention tested in this study was different from that used in many lay programs, such as Alcoholics Anonymous, which has documented success.8 Although many
lay peer-support interventions have not been rigorously tested, most are based on the participants selecting their own peer or sponsor after multiple in-person encounters, rather than by being matched by a third person.

In healthcare today, we are grappling with the high costs of caring for patients with HF, which leads to multiple rehospitalizations and significant mortality. It is important that we discover which interventions work and which interventions do not work to keep patients with HF alive and out of the hospital. Interdisciplinary HF programs work; telemonitoring does not. We do not know whether the intervention tested by Heisler and et al did not work because the intervention is ineffective or because the patients chose not to follow the study protocol and rejected the idea of peer support. What we do know is that patients voted with their feet. The vast majority of eligible patients either refused to participate or agreed but then did not adhere to the protocol. The study, which was carefully conducted and reported, adds important information to our knowledge about how best to care for patients with HF. This report supports the principle that negative trials are as valuable as positive trials in science and should be reported.

As many parents and best friends have learned to their peril, matches often do not work.

Disclosures

None.

References


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