Gradual Increases in Scheduled and Actual Early Follow-Up After Heart Failure Hospitalization
Two Steps Forward or One Step Forward?

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Since roll out of the Hospital Readmission Reduction Program in 2012, which penalizes hospitals ≤3% of their total Medicare payments if 30-day readmission rates for selected chronic conditions are in excess of the national average, heart failure (HF) readmission reduction has been center stage for hospital administrators, clinicians, and health-policy researchers.\(^1\) Although the goal of improving care around the time of hospitalization is laudable, specific actions for reducing excess HF readmissions are not offered by the Hospital Readmission Reduction Program. Furthermore, the majority of high-quality randomized trials of varied HF transitional care interventions have failed to reduce readmission rates. Instead, hospitals have needed to rely on locally implemented solutions often using care processes with face validity.\(^2\)

The reasons for the gap between scheduled and actual follow-up are not explained by the study, but anyone who has spent significant time arranging and providing clinic follow-up can guess at some of the barriers. As this study points out, predicting patients with scheduled early follow-up include demographics and comorbidities associated with higher risk, such as older age, diabetes mellitus, chronic kidney disease, and anticoagulant use. Despite the frequent tendency in medicine to observe a risk-treatment paradox, encouragingly in the case of follow-up providers seem to be matching follow-up scheduling to perceived risk.

However, these findings also demonstrate how implementation of care delivery interventions typically requires executing multiple steps to achieve the intended goal. Although documented scheduling of appointments went up (the measure on which hospitals are benchmarked in Get With The Guidelines), the rate of actual early physician follow-up among this cohort was much lower. The rate of actual follow-up was also lower than reported in the original article by Hernandez et al,\(^3\) where the median rate of hospital-level follow-up at the time of hospital discharge increased from 51% to 65%, and patients at higher risk for postdischarge adverse events—those older, anemic, diabetic, or on warfarin—were more likely to be scheduled for early physician follow-up. In the subgroup analysis of Medicare fee-for-service beneficiaries who were linked to Medicare part B claims, of whom 59.2% were scheduled for early physician follow-up, actual early physician follow-up went from 26.7% to 30.4%. There are both many encouraging and troubling issues raised by these findings.

DeVore et al\(^5\) demonstrate that high-quality, observational research can leverage large data sets to influence clinical practice. Now incorporated into clinical guidelines, individual hospital policies, transitional care models, and even transitional care management payments, scheduling early follow-up (although not necessarily as stringent as the 7-day cutoff) has become a standard of care. A 14% absolute increase in scheduling for ambulatory follow-up when applied to the ≈1 million US HF hospitalizations annually represents a major change in clinical practice.

Furthermore, predictors of patients with scheduled early follow-up include demographics and comorbidities associated with higher risk, such as older age, diabetes mellitus, chronic kidney disease, and anticoagulant use. Despite the frequent tendency in medicine to observe a risk-treatment paradox, encouragingly in the case of follow-up providers seem to be matching follow-up scheduling to perceived risk.

However, these findings also demonstrate how implementation of care delivery interventions typically requires executing multiple steps to achieve the intended goal. Although documented scheduling of appointments went up (the measure on which hospitals are benchmarked in Get With The Guidelines), the rate of actual early physician follow-up among this cohort was much lower. The rate of actual follow-up was also lower than reported in the original article by Hernandez et al,\(^3\) where the median rate of hospital-level actual early follow-up from 2003 to 2006 was 38.3%.

The reasons for the gap between scheduled and actual follow-up are not explained by the study, but anyone who has spent significant time arranging and providing clinic follow-up can guess at some of the barriers. As this study points out, predictors of patients with scheduled early follow-up include demographics and comorbidities associated with higher risk. Yet these may be the same patients with significant barriers to keeping outpatient appointments, especially early after discharge from an HF hospitalization as they may be weakened, homebound, or lack the financial or caregiver support to get them to appointments. Hence, this gap between scheduled and
actual follow-up suggests the need for a better understanding of patient’s resources, support, and home environment to identify barriers to outpatient provider appointments. Solutions may include appointment reminders, removing impediments such as copays and lack of transportation. Alternatively, other follow-up methods, such as phone calls or home visits and benchmarking hospitals on actual (rather than scheduled) follow-up, may be preferable to simply scheduling early provider follow-up appointments at the time of discharge. If the goal is to have patients seen in the early follow-up, the data provided here suggest that it is going to take more than writing an appointment on the discharge paperwork to get patients into the clinic within 7 days.

As we continue to work to make early follow-up a reality, the lingering question is whether early discharge follow-up, and in what form, actually improves outcomes for patients with HF. Intuitively, it makes sense that patients with HF—at high risk for postdischarge morbidity and mortality by virtue of illness severity, comorbidities, and complex medicine regimens—would benefit from a clinic visit during the vulnerable period directly after discharge. However, increased contact with the medical system does not necessarily translate to less hospitalization. Recent telemonitoring trials have been resoundingly negative.6-8 The Diagnostic Outcome Trial in Heart Failure (DOT-HF) study showed that thoracic impedance alerts markedly increased hospitalization.9 Clinic visits could help catch errors in management … or they could lead people to send patients to the emergency department who may otherwise have gotten by at home.

When one critically reviews the evidence for early follow-up, major questions remain. The findings by Hernandez et al1 demonstrated a hospital-level association between early follow-up and reduced 30-day readmission rates among hospitals in the 3 higher quartiles of early follow-up versus the lowest quartile of early follow-up. However, among hospitals in the 3 higher quartiles of early follow-up, there was no significant difference in readmission rates. If early physician follow-up was a key variable in reducing readmission rates, one would expect a dose-related step-wise reduction in the odds of readmission moving from lowest to highest quartiles hospital-level early follow-up. This raises the obvious question given the study’s retrospective design of whether hospital-level low rates of early physician follow-up is truly a causal variable associated with increased readmissions or rather a marker of other confounding variables or lack of a robust transitional care process. Indeed, another study looking at the relationship between early follow-up and readmission rates have not found such an association.10

Perhaps one of the explanations as to why less than one third of Medicare beneficiaries receive 7-day follow-up is that healthcare providers lack reasonable assurance that such efforts will have the intended effect. Ambulatory follow-up, such as readmission, is resource intensive. If hospital systems are going to invest the resources needed to actually get these patients to the clinic within a week of discharge, then we should have further prospective evidence that this intervention truly improves the targeted outcome of reducing 30-day readmissions.

Perhaps most disturbing is that with all of the resources going into early follow-up, there are no ongoing large randomized trials to ascertain its true effectiveness. Although the efforts of the Get With The Guidelines investigators help us understand the landscape of HF transitional care and ambulatory follow-up with what drives current care patterns, its ability to tell us what we should be doing is limited. These efforts must be combined with randomized interventional trials of care delivery. Pragmatic clinical trials across health systems are technically feasible, but to date have been limited. That culture must change if the United States is to make significant strides on reducing HF readmission, specifically, and getting more value for its healthcare dollar, generally.

The authors of the present study convincingly demonstrate the ability of well-designed observational research to change clinical practice. This is particularly important in an era of decreased federal funding for randomized clinical trials and increased focus on patient-centered outcomes. Yet, their findings also demonstrate the challenges of translating desired interventions into clinical practice and the need to identify barriers and facilitators of transitional care delivery. As for most clinical questions, observational data will never provide a clear answer to what works best. It has been said, “Until you spread your wings, you’ll have no idea how far you can walk.” Since 2009, we have made important but incremental progress on transitional care and readmissions for HF. It seems unlikely that we will take flight until we commit to a series of high-quality randomized data that elucidate causal relationships between various transitional care interventions and patient-centered outcomes.

Disclosures

Both Drs Kociol and Allen have volunteered in various capacities with the American Heart Association (AHA) Get With The Guidelines (GWTG) program. Dr Kociol received past AHA grant support to perform research utilizing the AHA-GWTG registry and has received honoraria for speaking engagements about readmission reduction. Dr Allen received research grants from the National Institutes of Health (K23HL105896) and the American Heart Association, and has served as a consultant to Janssen and Novartis.

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