Most patients lack early follow-up care after heart failure hospitalization

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Early follow-up care following hospital discharge reduces readmission rates for heart failure patients, but most hospitals have no formal follow-up procedures in place, according to a new study by researchers at the Duke Clinical Research Institute.

In a study of more than 30,000 Medicare beneficiaries hospitalized at 225 hospitals nationwide between 2003 and 2007, fewer than 40% of heart failure patients saw a health care provider within seven days of discharge, says Adrian F. Hernandez, MD, a Duke cardiologist who authored the study which appears today in the Journal of the American Medical Association.

Patients who were discharged from hospitals with more consistent follow-up were 15 percent less likely to be readmitted within 30 days of hospitalization than those who weren't.

"From what we can tell, there is a lot of room for improvement," says Hernandez. "A 15- or 20-minute visit with a physician or a physician assistant can go a long way when you compare it to the costs of re-hospitalization. Many readmissions can be prevented with a simple process that hospitals and providers can put into place."

Before this study, there was talk about the need for a systematic hospital follow-up approach, but no data was available to support that need, says Eric Peterson, MD, a Duke cardiologist co-author of the paper, and associate director of the DCRI. "The evidence this study provides is crucial because we are also involved in the early development of national guidelines that will inform hospitals on how to implement a successful hospital follow-up system. This much-needed evidence supports the need for those guidelines, and will assist in the development process."

That's important for all hospitals because the recent health care reform bill calls for reducing Medicare payments to hospitals with high readmission rates for patients with heart failure conditions starting in October 2012.

Heart failure affects nearly five million people in the United States and is the leading diagnosis for readmissions, according to Medicare data published in 2009. Total hospital readmissions account for approximately 20 percent of Medicare hospital payments.

The condition occurs when a weakened heart is unable to pump enough blood to the body. It is usually complicated by other diseases like diabetes, liver or kidney disease, and lifestyle challenges such as obesity, all of which may require consistent medical management.

When heart failure patients are hospitalized, doctors may initiate new therapeutic approaches and treatments for managing the disease that need to be continued following discharge. However, in the patient's transition between leaving the hospital and returning home, there is often a communication gap between the various specialists and providers who have ongoing responsibility for optimal treatment, says Hernandez.

"It's possible during this transition period for miscommunication, or no communication, to take place among in-hospital providers, patients and their outside providers," says Hernandez. "If a system is in place to make sure those lines of communication are immediately clear upon discharge, and verified in follow-up, the potential exists to reduce readmission rates."

A hospital-led follow-up care system ensures the patient's regular health care provider is aware of changes that occurred in the hospital, and is in contact with the patient to make sure they and their caregivers are following the discharge recommendations, including medication

compliance, follow-up testing, and discussions about signs and symptoms of worsening conditions.

Patients can do their part too, Hernandez says. "Patients should ask questions, such as, 'How will my doctor in the clinic know what happened to me during hospitalization? How can I make sure I see a health care provider within seven days of discharge?' It doesn't matter what type of provider they see -- it could be their internist, cardiologist, nurse practitioner or physician assistant. The most important element is that they see someone early to make sure they are doing okay, that they are taking the right medications, and that everyone is on the same page."

Provided by Duke University Medical Center