The Role of Early Follow Up in Reducing Readmissions of HF and AMI Patients

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Purpose

The purpose of this presentation is to explain the important role of early follow up in reducing readmissions of HF and AMI patients and provide an overview of the H2H See You in 7 Challenge project.
Why focus on early follow-up?

• Trends in care with greater segmentation of providers into inpatient vs. outpatient.
• Days immediately following discharge are a vulnerable period.
• Care is often complicated and coordination is important in preventing readmission.¹
• Often there are additions or changes in therapies that may have unknown effects or even worsen a patient’s clinical status or other co-morbid conditions.²

Decreasing Continuity of Care

From 1996 to 2006, continuity of care from inpatient to outpatient settings has steadily decreased.

Lack of Outpatient Physician Visit between Discharge and Rehospitalization

Patients without early follow up are at higher risk of being readmitted within 30 days of discharge. The highest percentage of readmission occurs for patients within 10 days of discharge.
Timely follow-up and Readmission: Care Transitions Intervention- A Randomized Control Trial

- Intervention
  - Medication self-management,
  - Patient-centered record,
  - Timely follow-up with primary or specialty care,
  - List of "red flags" indicative of a worsening condition and instructions on how to respond to them.
- Intervention patients had a lower rehospitalization rate at 30 days (8.3% vs. 11.9; \( p=0.048 \))


Relationship Between Early Follow-up and 30 Day Readmission

Objectives
- To characterize hospitals’ patterns of physician follow-up after hospital discharge.
- To determine the association of early follow-up with readmission after hospitalization for heart failure.

Methods
- Study Population:
  - 225 hospitals in Get With The Guidelines –Heart Failure
  - Linked with Medicare Claims for follow-up
  - 65 years and older admitted with heart failure
- Early Follow-up: Any visit within 7 days after discharge from index hospitalization

Hernandez AF et al. JAMA; 2010; 303(17): 1716-1722
Hospital Variation in Early Follow-up

Median Follow-up Visit within 7 days = 37.5%

225 GWTG-HF Hospitals

Rates of physician follow-up within 1 week of discharge were low and varied substantially across hospitals.

Hernandez AF et al. JAMA. 2010; 303(17): 1716-1722

Follow-up by Physician Type

Patient follow-up after discharge is important to continuity of care however fewer outpatient visits occur within seven days of discharge for cardiologists than all physicians.

Hernandez AF et al. JAMA. 2010; 303(17): 1716-1722
Follow-up outpatient visits with the same physician and/or same cardiologist strengthens the continuity of care provided to the patient; however, less than 20% of patients receive a follow-up visit with the same cardiologist within a month of discharge.

**Early Follow-up Unadjusted HR 95% CI P Value Adjusted HR 95% CI P Value**

| Quartile 1 | 1.0 (REF) | 1.0 (REF) |
| Quartile 2 | 0.86 | 0.78-0.94 | <.01 | 0.85 | 0.78-0.93 | <.01 |
| Quartile 3 | 0.85 | 0.76-0.94 | <.01 | 0.87 | 0.78-0.96 | <.01 |
| Quartile 4 | 0.87 | 0.79-0.95 | <.01 | 0.91 | 0.83-1.0 | .05 |

Covariates: age, sex, race, anemia, atrial arrhythmia, COPD, CKD, CAD, depression, diabetes, hyperlipidemia, hypertension, PVD, prior CVA/TIA, smoker, creatinine, systolic blood pressure, serum sodium, hemoglobin, LVSD, discharge process, LOS>7 days, year of admission.
Study Conclusions

• Rates of physician follow-up within 1 week of discharge were low and varied substantially across hospitals.

• Patients discharged from hospitals with more consistent early follow-up with 7 days have lower risk of 30-day readmission.

• Enhanced transition planning and ensuring that patients are evaluated within a week of discharge represents an achievable target for hospital quality improvement.

Hernandez AF et al. JAMA. 2010; 303(17): 1716-1722

Important Elements for Early Follow-up

• Establishing communication between sending and receiving clinicians
• Natural opportunity for reconciliation of medications at follow up visit
• Review outstanding tests and follow-up plans from recent tests
• Discussions about monitoring signs and symptoms of worsening conditions

Other Opportunities for Follow-up: Cardiac Rehabilitation

GWTG-CAD Hospitals
- Cardiac Rehabilitation Referral Rates
  After acute myocardial infarction, PCI, or CABG
- Median referral rate by hospital was 43%


H2H Early Follow-Up Challenge: “See You in 7”

Goal
All patients discharged with a diagnosis of HF or MI have a follow-up appointment/cardiac rehab referral scheduled within 7 days of discharge
- HF patients have an appointment to see any healthcare professional within 7 days
- MI patients have a referral to go to cardiac rehab within 7 days
“See You in 7” Success

The hospital discharge process is successful if:

• HF and MI patients are identified prior to discharge.

• Clinic or cardiac rehab appointment within 7 days is scheduled and documented in the medical record.

• Patient is provided with documentation of the scheduled appointment (e.g., appointment card).
  – Date, time, location, provider contact information

• Possible barriers to keeping the appointment are identified in advance, addressed, and documented in the medical record.

“See You in 7” Success

The follow-up clinic or cardiac rehab appointment is successful if:

• Patient arrives at appointment within 7 days of discharge from hospital.

• Discharge summary (including summary of hospitalization, updated medication list) available to follow-up provider.

• Patient brings his/her medications or a medication list to clinic visit.

• Reason for referral available to cardiac rehab center and patient brings referral letter or provider prescription.
Thank You

H2H
HOSPITAL-TO-HOME

Helping Cardiovascular Professionals