

Transcript: Get With The Guidelines® - 360°: 7 Day Follow-Up

- Speaker 1: [00:06](#) Welcome. You're listening to a Get With The Guidelines - 360 podcast, brought to you by the American Heart Association.
- Robin Kiser: [00:15](#) Hi everyone. My name is Robin Kiser and I'm the Program Manager for the Get With The Guidelines - 360 initiative in the St. Louis market. Get With The Guidelines - 360 is an American Heart Association initiative focused on improving the quality of care of the heart failure patient population. We're doing this through educating healthcare providers on evidence-based guidelines and transitions of care. I have the pleasure of introducing today's podcast guest. Dr. Georges Chahoud is the Assistant Professor of Medicine, Director of Cardiology Services at SSM Saint Joseph Hospital at Lake St. Louis. Dr. Chahoud, welcome to the podcast.
- Dr. Chahoud: [00:57](#) Thanks Robin.
- Robin Kiser: [00:59](#) Today's topic is a discussion on the measure, follow up within seven days post-discharge for the heart failure patient. Dr. Chahoud, the guidelines state that comprehensive written discharge instructions for all patients hospitalized with heart failure is strongly recommended with special emphasis on six aspects of care, one of which is the follow-up appointment. Can you tell me why we should focus on early follow-up visit after the hospital discharge for decompensated heart failure?
- Dr. Chahoud: [01:30](#) Absolutely, and again, thanks Robin for having me here. As we know, there has been a lot of changes in how we care with our patients with congestive heart failure. There's apparently a trend in care with more greater segmentation of providers between inpatient versus outpatient, and that's causing a gap in how we manage those patient and transition their care after they leave the hospital. The days immediately after discharge are actually the most vulnerable period because these patients are at higher risk of readmission during that first five days post-discharge. And in general, the care is often quite complicated for these patients, and that's why coordination of care is important in preventing readmission. Often that all our additions and changes in therapies that may have unknown

effects, or even worsening of the patient's clinical status or other comorbid conditions that will make it a bit more difficult for managing those patients.

Dr. Chahoud: [02:32](#)

And that's why it's important at least to follow those patients early on after discharge to make sure that they have a better understanding about their disease condition and the expectations on when and where and who to call if they have any problems. If you can let me elaborate a bit more, we have several studies that have examined the effect of providing more intensive delivery of discharge instructions, which is coupled tightly with subsequent well-coordinated followup care for those patients hospitalized with heart failure, many with positive results. Comprehensive discharge planning plus post-discharge support for older patients, for example, who have heart failure can significantly reduced readmission rates and also may improve their health outcome such as survival, as well as quality of life without increasing the cost, which is a big burden on our healthcare expenditure.

Dr. Chahoud: [03:32](#)

It's known fact that there are types of post-discharge support that can vary by studies, but almost nearly all of these studies resulted in significantly fewer readmission compared with the usual care. Among patients who are hospitalized for heart failure, there is substantial variation in hospital level rate of early outpatient follow-up after discharge. And actually, a recently published study found that early outpatient follow-up within seven days after discharge from heart failure hospitalization is truly associated with a lower risk of 30-day readmission.

Robin Kiser: [04:12](#)

Great. Are there any data on the impact of early physician follow-up and 30-day readmission?

Dr. Chahoud: [04:19](#)

Yes, and I'll try to elaborate on that by a citing two important studies. The first one is actually a study of over 30,000 patients, Medicare patients, who were hospitalized for heart failure in 225 hospitals participating in the Get With The Guidelines Heart Failure, which found that the rates of readmission within 30 days were actually highest among hospitals whose patients were least likely to have a follow-up visit within seven days. And that basically translated into about 3% higher 30-day readmission rate compared to the other 75% of the hospitals included in the study.

- Dr. Chahoud: [04:58](#) And if we go to another observational study, which included close to about 39,000 patients who were hospitalized or at least seen in the emergency department for heart failure over 12 years period of time in Alberta, Canada, found also that those patients who had early follow up with a physician they had seen before had significantly lower readmission rate than those who had no follow-up. But the interesting part as well that was noted in this study, that there was no benefit for seeing an unfamiliar physician versus no follow-up. But in general, we still kind of go to the fact that an early follow-up visit with a physician that the patient has seen before does impact their outcome and has been shown to reduce their 30 day readmission rate.
- Robin Kiser: [05:46](#) So an early follow-up appointment may be necessary, but is it sufficient to reduce risk of readmission?
- Dr. Chahoud: [05:54](#) Actually, no, it is not sufficient. The value of an early appointment may depend on the quality of care at that visit and not just merely by having an appointment scheduled for that patient and having the patients show up for that appointment. So it's very important to try to focus on the type of care that is delivered during those early follow-up visits.
- Robin Kiser: [06:17](#) Great. So what are some of the things that should take place during that follow-up visit?
- Dr. Chahoud: [06:23](#) So ideally what we have to focus on, especially with this early follow-up visit after discharge, and we've been saying this seven-day, five- to seven-day follow up period. What we usually focus on foremost is the assessment of the volume status and the presence of orthostatic hypotension, especially with adjustments of heart failure therapies that we do in those patients. But also to make sure that these patients are initiated on the guideline-directed medical therapy if this has not been started already and if there is no contraindication for it.
- Dr. Chahoud: [06:58](#) And then the plan of titration and optimization of those guideline-directed medical therapy that has been shown in several trials not just to reduced readmission rate but actually also to reduce mortality in those patients. And also, we tried to touch base on what could be precipitating cause for the heart failure readmission, and discuss the management of comorbid

conditions that are quite common in patients with chronic diseases including heart failure. So the other thing that we have paid more attention to is that with the therapies that are instituted in those patients, we have to pay close attention to their renal function and electrolytes, not just their blood pressure measurements. And we have to discuss with the patient as well about monitoring signs and symptoms of worsening condition, and when to call and who to call if they have problems. And then from there, plan for their follow-up visits as well.

Robin Kiser: [07:58](#) So what would be some perceived barriers to accomplish this measure?

Dr. Chahoud: [08:03](#) It's a great question. And actually since this strategy of trying to accomplish an early follow-up visit may not be feasible for all of the many patients hospitalized for heart failure. So particular focus for early follow-up visits should be targeted to those patients who are considered to be at increased risk for early readmission.

Dr. Chahoud: [08:23](#) So these patients include anybody with have persistent symptoms of heart failure class III or IV usually, or who had a repetitive hospitalization, two or more hospitalizations or ED visits in the preceding six months are considered to be at high risk for readmission. Coupled with that, multiple comorbid conditions, including stage three or four renal failure, diabetes, or COPD. And not to go far, but also we have to pay attention to those patients who have active major depression, cognitive impairment, minimal support for self or spouse, or even partial or total vision loss. These patients are considered to be at a high risk for readmission and we have to pay more attention to them. And along with that, a history of non-adherence to diet, medications, and/or scheduled follow-up visit appointments also constitute a patient that could be at a higher risk for readmission rates.

Dr. Chahoud: [09:24](#) So in summary, if you want to say, and try to sum it up in two short sentences, we know that the prognosis for patients hospitalized with heart failure, especially those with serial readmissions, is suboptimal. And we know for a fact from several studies that hospitalization for heart failure is actually a marker of poor outcome and high mortality rate.

- Dr. Chahoud: [09:47](#) So it is very important to try to reduce hospital readmission at any cost. And we have several measures that have been studied and one of the most important measures in my opinion and based on the trials that I've shared with you, which has been shown to reduce the 30-day readmission, is an early follow-up visit after discharge. And as I alluded to earlier, it's not just making that follow-up appointment. Actually, we'll have to make sure that the quality of care delivered during that follow-up appointment carries away the message and enhances and increases the education for the disease state that the patient will need. And that emphasizes the point that sticking with the guideline-directed medical therapy is important in order to achieve better outcome in reducing readmission, as well as improving patient quality of life and reducing mortality.
- Robin Kiser: [10:39](#) Well, thank you so much for your time and your insight, Dr. Chahoud. This has been really great, and hopefully this will help others in understanding the importance and the impact of the early follow-up visit for that heart failure patient. For those listening to the podcast, in case you missed any of what we discussed on the podcast, you can please contact your Get With The Guidelines - 360 program team at getwiththeguidelines360@heart.org. Again, thank you very much.
- Speaker 1: [11:11](#) The American Heart Association would like to thank Novartis for support of the Quality Improvement Platform, Get With The Guidelines - 360. Views expressed in this podcast do not necessarily reflect the official policy or position of the American Heart Association. For transcripts of this podcast, and more information about Get With The Guidelines - 360, please visit www.heart.org/getwiththeguidelines360. Thanks for listening.