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EDITORIAL COMMENT

So Nice to See You Again

Physician Continuity and Outcomes for Heart Failure*

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In this issue of *JACC: Heart Failure*, Sidhu et al. (1) set out to determine whether physician continuity improves outcomes for patients with heart failure (HF) treated and released from the emergency department (ED). They report that, indeed, HF patients who are seen by a familiar physician in the first month after an ED visit are significantly less likely to die or to be hospitalized than those patients who see no outpatient physician in the same time frame or those who have visits only with unfamiliar physicians. The size of the associations was impressive, with a 21% lower hazard of repeat ED visit or death for patients with a follow-up visit with a familiar physician compared with an unfamiliar physician.

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These are interesting and important findings, but determining the mechanism underlying these relationships is equally important as we, as members of a research and clinical community, try to determine how this report should change practice. The crux of the matter is the following: are patients who see a familiar physician better off simply because of the familiarity, or is there something different about patients who see a familiar physician compared with patients who do not? The former suggests that a guideline or policy change should be made to encourage early follow-up with a familiar physician; the latter suggests that there may be a group of patients who are inadequately plugged in to the system who may need extra attention. This study does not definitively differentiate between these 2 possibilities, but suggests ample opportunity for future work in this area.

If we assume for a moment that the phenomenon underlying the results of this study is that continuity has a causal effect on outcomes, then this study provides strong support for the increasing movement toward improving continuity of care through the patient-centered medical home (PCMH) model. The concept of the PCMH is simple: patients should have a medical "home" where their health needs are consolidated and coordinated under the purview of a single entity. For practices to be certified as PCMHs for primary care, they must demonstrate that they can provide 5 key functions: comprehensive care, patient-centered care, coordinated care, accessible services, and high-quality, safe care (2).

One question relevant to the HF community is the degree to which the traditional PCMH model, which is typically centered around a primary care physician, may be relevant to patients with HF. These patients often require specialized management and treatment, and some have argued that specialty care by a cardiologist (ideally one with a particular specialty in HF) is likely to be associated with better outcomes in this population. On the inpatient side, the data seem to bear this out; multiple previous studies have suggested an association between care by a cardiologist and lower in-hospital and 30-day mortality for HF patients (3,4), and there are emerging data that this finding may be true in the outpatient setting as well (5). We also know that disease management programs, which can in many ways mirror PCMH programs, can have positive effects for HF patients if implemented correctly, although data are mixed on their overall impact (6). However, data are lacking on the optimal coordinated outpatient management strategy for this complex population that includes both primary care

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and specialty care. This is an important area in which cardiologists and primary care physicians may need to work together to determine how we can best care for HF patients as a team.

The results of this study could also imply, however, that there is a group of patients with HF who are fundamentally disconnected from the healthcare system. One possibility is that this is driven predominantly by patient factors, such as medical comorbidities, mental health issues, or socioeconomics, which are associated with both low engagement with care and worse health outcomes in HF (7). This may in some ways be analogous to medication adherence: although it seems self-evident that nonadherence with evidence-based medications would be associated with higher morbidity and mortality, research actually suggests that even nonadherence to placebo is associated with worse health outcomes (8). Disengagement from the health care system may be a similarly poor prognosticator.

The common factor underlying both lack of follow-up with a known clinician and worse health outcomes could also be access to the healthcare system. If an HF patient cannot access outpatient care consistently enough to have a usual source of care, it is likely that he or she will be less well managed in the outpatient setting and have higher levels of morbidity and mortality as a result. It is worth noting, however, that this study was conducted in Alberta, Canada, a setting with universal health care. Therefore, a set of very specific barriers that we might assume were present in the United States, such as a lack of health insurance and a consequent inability to pay for follow-up visits, are not likely driving the differences seen here, suggesting that the results may be more about the particular challenges facing the patients themselves rather than system-level barriers to care. It will be important to replicate these findings in other countries and other care settings as we try to tease apart the degree to which the authors' findings are related to systems versus patient factors.

How should we, as clinicians, proceed? First, it seems reasonable, given the accumulating evidence that continuity is associated with better outcomes, to move toward new and perhaps more flexible scheduling systems to ensure that patients with HF can be seen by a known clinician after discharge from the ED or from the hospital. This may require blocking a certain number of slots in cardiologists' already busy schedules for urgent visits, but in the era of shared savings contracts and accountable care organizations, this option may pay off for providers and health systems in the future by preventing expensive rehospitalizations. The more clearly aligned the payment models are with the clinical goals, the more likely we will see these changes take hold.

Second, as specialists, we should reach out to engage with PCMHs and other primary care innovations, to determine how our sickest and most complex patients can be comanaged. Even the most well-run PCMHs are likely to benefit from cardiology consultation for their particularly fragile HF patients, and cardiologists should be involved in determining how we can operationalize this important goal. There is increasing attention to the concept of a "medical neighborhood," and this will work best if specialists from all groups are represented in their planning.

Third, we should redouble our efforts to identify patients who are at high risk of "falling through the cracks." Patients who have had trouble with follow-up appointments previously, or who may be managing difficult social and economic situations, might need additional support and resources to adequately manage their medical illness. To the degree that a visit to the ED facilitates identification of these patients, taking that opportunity to connect these vulnerable patients with social workers and other essential resources may have the potential to make a real difference in their outcomes.

It is one of the particular joys of outpatient medicine to see a familiar face in the office; this study suggests that it may also be of significant benefit to the patient in terms of hard medical outcomes. It really is so nice to see you again.

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REFERENCES

1. Sidhu RS, Youngson E, McAlister FA. Physician continuity improves outcomes for heart failure patients treated and released from the emergency department. J Am Coll Cardiol HF 2014;2:368–76.

2. National Committee for Quality Assurance. Start to Finish: Patient-Centered Medical Home (PCMH) Recognition. Available at: http://www.ncqa.org/Programs/Recognition/Practices/PatientCenteredMedicalHomePCMH.aspx. Accessed June 2014.

3. Boom NK, Lee DS, Tu JV. Comparison of processes of care and clinical outcomes for patients newly hospitalized for heart failure attended by different physician specialists. Am Heart J 2012;163:252–9.

4. Joynt KE, Orav EJ, Jha AK. The association between hospital volume and processes, outcomes, and costs of care for congestive heart failure. Ann Intern Med 2011;154:94–102.

5. Chou CY, Chen TJ, Chiang SC, et al. Disparity of physician specialties in the management of chronic heart failure: trend analysis in Taiwan, 2000-2010. Int J Clin Pharmacol Ther 2013;51:678–87.

6. Takeda A, Taylor SJ, Taylor RS, Khan F, Krum H, Underwood M. Clinical service organisation for heart failure. Cochrane Database Syst Rev 2012;9:CD002752.

7. Joynt KE, Whellan DJ, O'Connor CM. Why is depression bad for the failing heart? A review of the mechanistic relationship between depression and heart failure. J Card Fail 2004;10:258–71.

8. Avins AL, Pressman A, Ackerson L, Rudd P, Neuhaus J, Vittinghoff E. Placebo adherence and its association with morbidity and mortality in the studies of left ventricular dysfunction. J Gen Intern Med 2010;25:1275–81.

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