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EDITOR'S PAGE

What's One More Day?

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I recently walked into a senior leadership meeting and stated that I was going to increase the length of stay for heart failure patients by 1 day to increase the health system's margin. They laughed, thinking, "What has this Dukie come up with now?" I further told them that the savings and revenue enhancement could be proven with a randomized controlled clinical trial of an additional day in the hospital versus usual care. We would use cluster randomization at the hospitals in our health system with more than 1,000 patients who are hospitalized with acute decompensated heart failure each year. I explained the reduction in 30-day readmission penalties would more than compensate for the cost of the clinical trial and provide additional advantages to our margin. The intention of the additional day of in hospital stay for the heart failure patients would be to enhance their health status before discharge.

In the United States, the average length of stay has now been reduced to 4 days in contrast to the rest of the world, which is on average of 7 days. There is little time for conversion from intravenous therapy, institution of guideline-directed therapies, medication adherence counseling, psycho-social screening, and therapists. In fact, many patients are still congested when they leave the hospital! Given all the shortcomings in providing these additional benefits to our heart failure patients, an additional day could accomplish many of these goals. In this proposed randomized controlled trial of 1 additional day above expected discharge, we would provide comprehensive education around nutrition, medication adherence, physical exercise, compliance with cardiac rehabilitation, and assurance of an early visit with the health care provider. Additionally, during this extra day, we would titrate guideline-directed therapies, initiate new therapies, and consider the patient for novel therapies and clinical trials. We would assist in purchasing the outpatient medication regimen if necessary, ensure that the patient understands this regimen and the differences from the inpatient and previous outpatient regimens. We would enroll the patient in cardiac rehabilitation and schedule the 3-day follow-up visit. The usual care group would be discharged on the anticipated day of discharge. The primary endpoint would be total days alive out of the hospital over a 30-day and 90-day period, and the cost incurred over this 30-day and 90-day period, including penalties paid for excessive readmission rates.

For some time now, the evidence has clearly shown that length of stay is inversely related to readmission rates. The rest of the world has learned that spending additional time with patients who are hospitalized with heart failure on education, ambulation, physical therapy, and medication titration can afford advantages in the transition and post-discharge stay. The ability to enhance decongestive therapies, and allow the patient to be in a better mind-body state before discharge, will provide additional advantages. In designing this trial, the advantage of cluster randomization is that a uniform policy could be employed by each health system without confusion or contamination of the intervention on a patient-to-patient basis.

In the end, we ask "What's one more day?" I respond could it be a better deal for our patients, and that it is what our patients deserve.

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