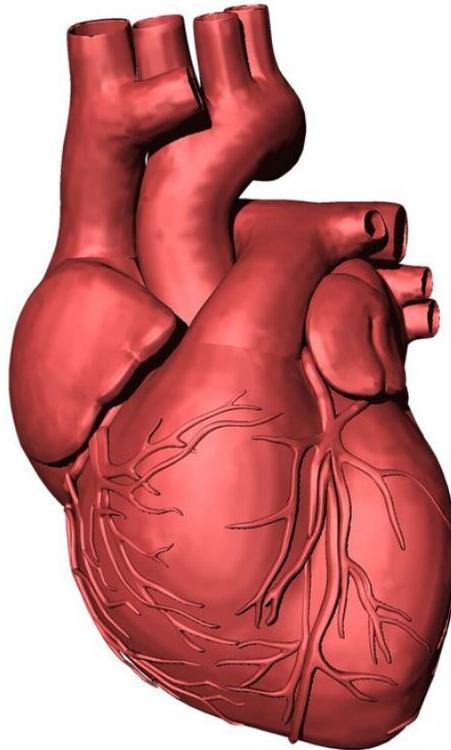


Alabama study finds lack of timely follow-up after heart failure hospitalization for most adults with diabetes

June 7 2023



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More than half of Medicaid-covered adults in Alabama with type 2 diabetes did not receive follow-up health care within the recommended

two-week period following hospitalization for newly-diagnosed heart failure, according to new research. The analysis, published today in the *Journal of the American Heart Association*, found worse follow up for African American and Hispanic adults.

The large, racially diverse study also found that African American adults and Hispanic adults were less likely to see a primary care doctor after leaving the hospital compared to similar white adults. When African American adults and Hispanic adults had a follow-up visit, it was about two to three days later than their white peers.

People with type 2 diabetes are at increased risk of developing [heart failure](#) requiring hospitalization. The [American Heart Association's guidelines](#) recommend patients hospitalized with heart failure have outpatient follow-up 7-14 days after leaving the hospital.

Alabama, the sixth poorest state in the U.S., is also home to the third-highest number of people diagnosed with type 2 diabetes. The state also has the highest rates of heart failure hospitalizations and cardiovascular death in the country. Obesity and type 2 diabetes are among the [risk factors](#) for heart failure and disproportionately affect people with [low socioeconomic status](#), which increases the risk for heart failure, according to previous studies.

The study's findings "likely demonstrates system-related factors, such as problems in the transitions of care between hospitals and clinics, and also structural racism that exists in the health care system," said lead study author Yulia Khodneva, M.D, Ph.D., an assistant professor of medicine and primary care physician at the University of Alabama School of Medicine in Birmingham.

"The study underscores a necessity to develop interventions that will facilitate guideline-directed treatment and care for patients with type 2

diabetes and heart failure, especially for those with Medicaid or people of underrepresented races and ethnicities," she said.

The analysis found most follow-up visits were well beyond the guideline-stated standard of care:

- 31% had a medical visit between the third week and up to two months after hospital discharge;
- almost 27% did not see a doctor during the 60 days of the study observation period; and
- individuals who had no health care clinic visits within 60 days of hospital discharge were more likely, in general, to be men, African American adults, or Hispanic or other adults.

"Hopefully, this study will trigger additional, more in-depth studies that may help to explain the reasons for these observed [racial disparities](#) and help in the development of interventions to promote prompt follow-up for these patients," Khodneva said.

Because the study was conducted in Alabama, the results may not be applicable to other U.S. states. Additionally, the research did not include people without Medicaid coverage or commercial insurance plans for comparison.

Study design:

- Researchers reviewed data on more than 9,800 adults (average age 53 years; 65% women; 35% men) with type 2 diabetes and first-time hospitalizations for [heart](#) failure covered by Alabama Medicaid between 2010 and 2019.
- More than 47% of the people in the analysis were African American adults; about 42% were Non-Hispanic white adults; and 11% were categorized as Hispanic or Asian, Native

American or Pacific Islander adults or other. Racial identification was based on self-reported information from patients to Medicaid.

- Nearly 20% of the participants lived in a [rural area](#), and more than 80% lived in an urban city or small town. Disability was the reason for Medicaid eligibility in 92% of cases.
- Researchers analyzed Medicaid claims for clinic visits after hospital release for follow-up in primary care and specialty care, such as cardiology or endocrinology, within 60 days of hospital discharge.

More information: Disparities in Postdischarge Ambulatory Care Follow-Up Among Medicaid Beneficiaries With Diabetes, Hospitalized for Heart Failure, *Journal of the American Heart Association* (2023). [DOI: 10.1161/JAHA.122.029094](https://doi.org/10.1161/JAHA.122.029094)

Provided by American Heart Association

Citation: Alabama study finds lack of timely follow-up after heart failure hospitalization for most adults with diabetes (2023, June 7) retrieved 24 April 2024 from <https://medicalxpress.com/news/2023-06-alabama-lack-follow-up-heart-failure.html>

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