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National Trends in Recurrent AMI Hospitalizations 1 Year After Acute Myocardial Infarction in Medicare Beneficiaries: 1999–2010

Sarwat I. Chaudhry, MD; Rabeea F. Khan, BA; Jersey Chen, MD, MPH; Kumar Dharmarajan, MD, MBA; John A. Dodson, MD; Frederick A. Masoudi, MD, MPH; Yun Wang, PhD; Harlan M. Krumholz, MD, SM

Background—There are few data characterizing temporal changes in hospitalization for recurrent acute myocardial infarction (AMI) after AMI.

Methods and Results—Using a national sample of 2,305,441 Medicare beneficiaries hospitalized for AMI from 1999 to 2010, we evaluated changes in the incidence of 1-year recurrent AMI hospitalization and mortality using Cox proportional hazards models. The observed recurrent AMI hospitalization rate declined from 12.1% (95% CI 11.9 to 12.2) in 1999 to 8.9% (95% CI 8.8 to 9.1) in 2010, a relative decline of 26.4%. The observed recurrent AMI hospitalization rate declined by a relative 27.7% in whites, from 11.9% (95% CI 11.8 to 12.1) to 8.6% (95% CI 8.5 to 8.8) versus a relative decline in blacks of 13.6% (95% CI 12.6 to 13.8) to 11.4% (95% CI 10.9 to 12.0). The risk-adjusted rate of annual decline in recurrent AMI hospitalizations was 4.1% (HR 0.959; 95% CI 0.958 to 0.961), and whites experienced a higher rate of decline (HR 0.957, 95% CI 0.956 to 0.959) than blacks (HR 0.974, 95% CI 0.970 to 0.979). The overall, observed 1-year mortality rate after hospitalization for recurrent AMI declined from 32.4% in 1999 to 29.7% in 2010, a relative decline of 8.3% (P<0.05). In adjusted analyses, 1-year mortality after recurrent AMI hospitalization declined 1.8% per year (HR, 0.982; 95% CI 0.980 to 0.985).

Conclusions—In a national sample of Medicare beneficiaries hospitalized for AMI from 1999 to 2010, hospitalization for recurrent AMI decreased, as did subsequent mortality, albeit to a lesser extent. The risk of recurrent AMI hospitalization declined less in black patients than in whites, increasing observed racial disparities by the end of the study period. (J Am Heart Assoc. 2014;3:e001197 doi: 10.1161/JAHA.114.001197)

Key Words: epidemiology • mortality • myocardial infarction
In addition, previous work evaluating recent temporal trends in AMI hospitalization rates has shown that black men and women experienced a lower decline in AMI hospitalization rate than their white counterparts, but it is unknown whether such differences also exist in recurrent AMI hospitalization rates. These analyses can provide insight about whether contemporary management strategies for AMI have resulted in decreasing rates of recurrent AMI hospitalization, and whether these gains have been shared equally across demographic subgroups.

Methods

Data Source
We used Medicare Provider Analysis and Review inpatient data from the Centers for Medicare and Medicaid Services to identify a complete sample of fee-for-service Medicare beneficiaries who were hospitalized for AMI between January 1, 1999 and December 31, 2011. These administrative billing claims data include information on patient demographics (age, sex, and race), admission and discharge dates, and principal and secondary diagnosis codes as coded by the International Classification of Diseases, Ninth Revision, Clinical Modification. Medicare denominator files were used to ascertain beneficiary eligibility, and enrollment in fee-for-service Medicare. Institutional Review Board review and approval was obtained through the Yale University Human Investigation Committee. Medicare claims data were provided through a data use agreement with Centers for Medicare and Medicaid Services.

Study Sample
Subjects were included if they were aged 65 years or older and discharged alive from an acute care hospital with a principal discharge diagnosis of AMI (International Classification of Diseases, Ninth Revision, Clinical Modification code: 410.xx) between January 1, 1999 and December 31, 2010. We identified the first admission for AMI during the study period as the “index AMI” hospitalization and the first subsequent AMI admission as the “recurrent AMI hospitalization.” We excluded patients with principal discharge diagnosis International Classification of Diseases, Ninth Revision, Clinical Modification codes 410.x2, as these represent subsequent episodes of care related to the index AMI. Patients with a total length of stay of ≤1 day were excluded, as those hospitalizations are unlikely to represent true AMI. We also excluded (1) beneficiaries aged <65 years; (2) beneficiaries without ≥1 year of Medicare fee-for-service enrollment before and after their index AMI hospitalization, as data would be limited to assess comorbidity (see “Patient Characteristics” section below) and outcomes; (3) beneficiaries with conflicting dates of death and hospitalization; and (4) patients who were subsequently transferred to another acute care hospital for continuing care after an initial AMI. Patients who died during the 1-year follow up period without experiencing hospitalization for recurrent AMI were censored at the time of death; all others were censored at the end of the follow-up period.

Patient Characteristics
We used the Medicare Provider Analysis and Review data set to collect information on patient characteristics, including age, sex, race, and comorbidities. Race was determined from the Medicare denominator files, which use patient-reported data from the Social Security Administration. Coexisting illnesses were classified according to the categorization used by Centers for Medicare and Medicaid Services for the AMI 30-day mortality measure. We identified comorbidities from both primary and secondary diagnosis codes of all patient hospitalizations up to 1 year before the initial hospitalization for AMI. For example, the inpatient data from 1998 were used to obtain comorbidity information on patients who were hospitalized for AMI in 1999.

Outcomes
Our first study outcome was recurrent AMI within 1 year of (admission for) the index AMI. Our second outcome was 1-year all-cause mortality rates among patients who were hospitalized for recurrent AMI.

Statistical Analysis
Baseline characteristics of patients hospitalized for AMI during the study period were collapsed into 3-year intervals to simplify presentation, and we used the Cochran–Armitage trend test to examine the significance of trends. We used Cox proportional hazards regression models to assess annual trends in recurrent AMI hospitalization rates, adjusting for age, sex, race, and all comorbidities shown in Table. We fitted separate Cox models to analyze trends in recurrent AMI hospitalization rates among subgroups (ie, age, sex, and race). All Cox models included an ordinal time variable, ranging from 0 to 11, corresponding to years 1999 (time=0) through 2010 (time=11) to represent the risk-adjusted annual trend in 1-year recurrent AMI hospitalizations. Similarly, Cox proportional hazards regression models were used to analyze 1-year mortality among patients who experienced recurrent AMI hospitalization.

Y.W. conducted all analyses using SAS 9.3 64-bit version (SAS Institute Inc, Cary, NC), and takes responsibility for the accuracy of the results. Hazard ratios are reported with 95% CI. Statistical tests were 2-sided at a significance level of 0.05. The Yale University Human Investigation Committee.
approved the study and waived the requirement for participant informed consent.

Results

Patient Characteristics

During the 12-year study period, 3,067,263 patients experienced an index AMI hospitalization. The number of patients who experienced an index AMI hospitalization decreased from 1283 (95% CI 1278 to 1287) per 100,000 person-years in 1999 to 830 (95% CI 827 to 833) per 100,000 person-years in 2010. Among patients who experienced an index AMI hospitalization, 2,305,441 were enrolled continuously in the Medicare fee-for-service program for at least 12 months before and 12 months following (in the absence of death) the index AMI hospitalization, were discharged alive after at least 1 day, and were not transferred to another short-term acute-care hospital.

Table. Patient Characteristics

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<tbody>
<tr>
<td>Total</td>
<td>592,255</td>
<td>631,114</td>
<td>565,082</td>
<td>516,990</td>
<td>2,305,441</td>
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<td>Age in years, mean (SD)</td>
<td>78.8 (7.8)</td>
<td>78.8 (8.1)</td>
<td>78.9 (8.3)</td>
<td>78.9 (8.5)</td>
<td>78.8 (8.2)</td>
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<tr>
<td>Female, n (%)</td>
<td>303,715 (51.3)</td>
<td>321,297 (50.9)</td>
<td>282,310 (50.0)</td>
<td>254,543 (49.2)</td>
<td>1,161,865 (50.4)</td>
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<tr>
<td>White, n (%)</td>
<td>525,818 (88.8)</td>
<td>555,212 (88.0)</td>
<td>496,067 (87.8)</td>
<td>452,153 (87.5)</td>
<td>2,029,250 (88.0)</td>
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<tr>
<td>Black, n (%)</td>
<td>42,645 (7.2)</td>
<td>47,188 (7.5)</td>
<td>43,024 (7.6)</td>
<td>40,325 (7.8)</td>
<td>173,182 (7.5)</td>
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<tr>
<td>Other race, n (%)</td>
<td>23,792 (4.0)</td>
<td>28,714 (4.5)</td>
<td>25,991 (4.6)</td>
<td>24,512 (4.7)</td>
<td>103,009 (4.5)</td>
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<tr>
<td>Comorbidity, n (%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Coronary artery disease</td>
<td>413,276 (69.8)</td>
<td>459,239 (72.8)</td>
<td>415,081 (73.5)</td>
<td>383,472 (74.2)</td>
<td>1,671,068 (72.5)</td>
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<td>Hypertension</td>
<td>326,468 (55.1)</td>
<td>373,051 (59.1)</td>
<td>344,592 (61.0)</td>
<td>343,818 (66.5)</td>
<td>1,387,929 (60.2)</td>
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<td>Diabetes</td>
<td>182,534 (30.8)</td>
<td>199,071 (31.5)</td>
<td>177,807 (31.5)</td>
<td>164,339 (31.8)</td>
<td>723,751 (31.4)</td>
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<tr>
<td>COPD</td>
<td>135,963 (23.0)</td>
<td>152,168 (24.1)</td>
<td>139,223 (24.6)</td>
<td>106,540 (20.6)</td>
<td>533,894 (23.2)</td>
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<td>Congestive heart failure</td>
<td>95,656 (16.1)</td>
<td>102,466 (16.2)</td>
<td>90,212 (16.0)</td>
<td>79,159 (15.3)</td>
<td>367,493 (15.9)</td>
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<td>Pneumonia</td>
<td>73,783 (12.5)</td>
<td>87,483 (13.9)</td>
<td>81,442 (14.4)</td>
<td>79,956 (15.5)</td>
<td>322,664 (14.0)</td>
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<td>Dementia</td>
<td>56,303 (9.5)</td>
<td>66,764 (10.6)</td>
<td>60,434 (10.7)</td>
<td>58,597 (11.3)</td>
<td>242,098 (10.5)</td>
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<td>Renal failure</td>
<td>27,923 (4.7)</td>
<td>38,572 (6.1)</td>
<td>54,477 (9.6)</td>
<td>66,316 (12.8)</td>
<td>187,288 (8.1)</td>
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<tr>
<td>Peripheral vascular disease</td>
<td>38,715 (6.5)</td>
<td>44,107 (7.0)</td>
<td>39,733 (7.0)</td>
<td>35,977 (7.0)</td>
<td>158,532 (6.9)</td>
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<tr>
<td>Cancer</td>
<td>37,070 (6.3)</td>
<td>40,736 (6.5)</td>
<td>37,047 (6.6)</td>
<td>34,393 (6.7)</td>
<td>149,254 (6.5)</td>
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<td>Trauma</td>
<td>31,268 (5.3)</td>
<td>38,071 (6.0)</td>
<td>36,030 (6.4)</td>
<td>32,167 (6.2)</td>
<td>137,536 (6.0)</td>
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<tr>
<td>Depression</td>
<td>27,372 (4.6)</td>
<td>34,267 (5.4)</td>
<td>30,676 (5.4)</td>
<td>28,552 (5.5)</td>
<td>120,867 (5.2)</td>
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<tr>
<td>History of MI</td>
<td>29,546 (5.0)</td>
<td>32,848 (5.2)</td>
<td>27,353 (4.8)</td>
<td>26,107 (5.0)</td>
<td>115,854 (5.0)</td>
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<td>Cerebrovascular disease</td>
<td>33,581 (5.7)</td>
<td>32,471 (5.1)</td>
<td>25,257 (4.5)</td>
<td>22,256 (4.3)</td>
<td>113,565 (4.9)</td>
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<td>Unstable angina</td>
<td>36,748 (6.2)</td>
<td>31,937 (5.1)</td>
<td>22,021 (3.9)</td>
<td>17,102 (3.3)</td>
<td>107,808 (4.7)</td>
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<td>Respiratory failure</td>
<td>15,475 (2.6)</td>
<td>17,774 (2.8)</td>
<td>20,445 (3.6)</td>
<td>25,121 (4.9)</td>
<td>78,815 (3.4)</td>
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<tr>
<td>Malnutrition</td>
<td>13,212 (2.2)</td>
<td>16,266 (2.6)</td>
<td>17,528 (3.1)</td>
<td>23,703 (4.6)</td>
<td>70,709 (3.1)</td>
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<tr>
<td>Functional disability</td>
<td>15,897 (2.7)</td>
<td>16,246 (2.6)</td>
<td>12,807 (2.3)</td>
<td>13,409 (2.6)</td>
<td>58,359 (2.5)</td>
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<td>Stroke</td>
<td>12,731 (2.1)</td>
<td>12,653 (2.0)</td>
<td>10,802 (1.9)</td>
<td>9,649 (1.9)</td>
<td>45,835 (2.0)</td>
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<tr>
<td>Psychiatric disease</td>
<td>11,536 (1.9)</td>
<td>12,202 (1.9)</td>
<td>10,029 (1.8)</td>
<td>10,877 (2.1)</td>
<td>44,644 (1.9)</td>
</tr>
<tr>
<td>Liver disease</td>
<td>2980 (0.5)</td>
<td>3730 (0.6)</td>
<td>3566 (0.6)</td>
<td>3291 (0.6)</td>
<td>13,567 (0.6)</td>
</tr>
<tr>
<td>Length of stay, mean (SD)</td>
<td>7.1 (6.2)</td>
<td>6.8 (6.2)</td>
<td>6.4 (5.9)</td>
<td>5.9 (5.4)</td>
<td>6.5 (5.4)</td>
</tr>
<tr>
<td>Discharged to home, n (%)</td>
<td>367,198 (62.0)</td>
<td>365,415 (57.9)</td>
<td>314,186 (55.6)</td>
<td>286,929 (55.5)</td>
<td>1,332,545 (57.8)</td>
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<tr>
<td>Discharged to ICF/SNF, n (%)</td>
<td>114,897 (19.4)</td>
<td>126,223 (20.0)</td>
<td>115,842 (20.5)</td>
<td>102,881 (19.9)</td>
<td>461,088 (20.0)</td>
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<td>Discharged to home care, n (%)</td>
<td>76,993 (13.0)</td>
<td>89,618 (14.2)</td>
<td>89,283 (15.8)</td>
<td>81,684 (15.8)</td>
<td>336,594 (14.6)</td>
</tr>
<tr>
<td>Discharged to hospice, n (%)</td>
<td>148,064 (0.25)</td>
<td>8836 (1.4)</td>
<td>14,692 (2.6)</td>
<td>17,061 (3.3)</td>
<td>41,498 (1.8)</td>
</tr>
</tbody>
</table>

COPD indicates chronic obstructive pulmonary disease; MI, myocardial infarction; ICF, intermediate care facility; SNF, skilled nursing facility.
The characteristics of the patients in the final study sample are presented in Table. The mean age was 78.8 years (SD 8.2 years), 50.4% were women, and 12.0% were of nonwhite race. The most common comorbidities were coronary artery disease (72.5%), hypertension (60.2%), diabetes (31.4%), chronic obstructive pulmonary disease (COPD) (23.2%), and heart failure (15.9%).

There were several notable (and statistically significant, \( P<0.05 \)) changes in the characteristics of patients hospitalized for AMI during the 12-year study period. The percentage of females decreased from 51.1% in 1999 to 48.8% in 2010, and the percentage of nonwhites increased from 11.0% to 12.7%. The prevalence of a diagnosis of coronary artery disease prior to the index MI and hypertension both increased over the study period, from 68.3% to 74.1% and 53.1% to 66.9%, respectively. The prevalence of renal failure also increased notably from 4.2% to 13.5%. The mean length of stay decreased from 7.2 days (SD 6.2 days) in 1999 to 5.6 days (SD 5.3 days) in 2010. The percentage of patients discharged to home decreased over the study period (62.6% to 56.0%), while the percentage of patients discharged to home care increased (13.4% to 15.9%). Among participants who did not experience a recurrent AMI hospitalization during the year following an initial AMI hospitalization, the 1-year mortality declined from 21.7% (95% CI, 21.6 to 21.9) in 1999 to 21.1% (95% CI, 20.9 to 21.3) in 2010.

One-Year Recurrent AMI Hospitalization Rate

The overall (during the entire study period) 1-year recurrent AMI hospitalization rate was 10.1% (95% CI 10.0 to 10.1). The mean number of days until readmission for recurrent AMI increased from 108 in 1999 to 117 in 2010 (\( P<0.05 \)).

The observed (ie, unadjusted) annual recurrent AMI hospitalization rate declined from 12.1% (95% CI 11.9 to 12.2) in 1999 to 8.9% (95% CI 8.8 to 9.1) in 2010, a relative decline of 26.4% (Figure 1). The mean, relative annual decline was 2.4%. The decline in recurrent AMI hospitalization rate was observed among all demographic subgroups (Figure 1). Throughout the study period, the lowest recurrent AMI hospitalization rate was observed in those 65 to 74 years old (9.5%, 95% CI 9.2 to 9.7). Although a decline in recurrent AMI hospitalization rate was observed in both males and females, females consistently had a higher rate of recurrent AMI hospitalization than males over the course of the study period. The recurrent AMI hospitalization rate declined by a relative 27.0% in females, from 12.6% (95% CI 12.4 to 12.9) in 1999 to 9.2% (95% CI 9.0 to 9.5) in 2010, and by 25.2% in males, from 11.5% (95% CI 11.3 to 11.7) in 1999 to 8.6% (95% CI 8.4 to 8.8) in 2010. When compared by race, the reduction in recurrent AMI hospitalization rate was larger in whites than blacks. The recurrent AMI hospitalization rate declined by a relative 27.7% in whites, from 11.9% (95% CI

Figure 1. Observed 1-year rates of recurrent acute myocardial infarction (AMI) hospitalization.
annual decline in recurrent AMI hospitalizations was 4.1%,
corresponding to a HR of 0.959 (95% CI 0.958 to 0.961).
The rate of annual decline was highest among those 75 to 84 years of age, HR 0.953 (95% CI 0.951 to 0.955). While
males and females had similar adjusted rates of decline in recurrent AMI hospitalization, whites experienced a statistically significantly higher rate of decline (HR 0.957, 95% CI 0.956 to 0.959) than black patients (HR 0.974, 95% CI 0.970 to 0.979).

1-Year All-Cause Mortality After Recurrent AMI Hospitalization

The overall, observed 1-year mortality rate after hospitalization for recurrent AMI declined from 32.4% in 1999 to 29.7% in 2010, a relative decline of 8.3% (P<0.05) (Figure 3). Within age subgroups, the decline in 1-year mortality was greatest among those 75 to 84 years of age, declining relatively 16.4%, from 31.7% in 1999 to 26.5% in 2010 (P<0.05). Declines in 1-year mortality were observed across both sexes and all races. Consistently higher 1-year mortality rates were observed in females compared with males: 30.8% versus 28.5% by 2010 (P<0.0001).

In adjusted analyses, (Figure 4) the 1-year mortality declined 1.8% per year (HR 0.982 [95% CI 0.980 to 0.985]). Among the age subgroups, the lowest rate of decline was observed in those over 85 years of age (HR 0.988 [95% CI 0.984 to 0.993]). Adjusted rates of mortality decline were similar in both sexes and in all racial groups.
National Trends in Recurrent AMI Hospitalizations  Chaudhry et al

Discussion

In a national sample of Medicare fee-for-service beneficiaries, we found that the incidence of recurrent AMI hospitalization declined substantially from 1999 to 2010. The overall risk-adjusted rate of annual decline in recurrent AMI hospitalizations was 4.1%. Declines were seen in all demographic groups, but blacks had less decline in recurrent AMI hospitalizations as compared with whites. Females and those in the oldest age group (85 years and older) remained at higher risk for recurrent AMI hospitalization throughout the study period, compared with males and younger persons, respectively. When considering risk-adjusted mortality after hospitalization for recurrent AMI, there was an annual decline of 1.8%, and females again had persistently higher mortality than males.

Our analysis extends prior work examining temporal trends in recurrent AMI hospitalization rates. A Swedish study found an adjusted decrease in average risk of 2.5% per calendar year for women and 3.1% for men for recurrent AMI from 1972 to 2001. A decline of 5.9% per year in the rate of recurrent AMI was observed in the Danish MONICA population from 1982 to 1991, and similar decreases in the rate of recurrent AMI were observed during this time period in Iceland and Finland. In the United States, a decline in annual rate of recurrent AMI in men (2.6% per year) and women (1.9% per year) was reported between 1987 and 1994 in 4 different United States communities in the ARIC study. Notably, these previous studies do not include contemporary data from a racially diverse population. To our knowledge, our study is the first to examine changes in the rate of hospitalization for recurrent AMI after AMI over the last decade using US-based national data.

Although we cannot identify the specific reasons for the decline in recurrent AMI hospitalizations and 1-year mortality rates, several theories might explain these observations. One possible explanation is that the improvements may reflect the implementation of secondary prevention as recommended by the American College of Cardiology and American Heart Association, including increasing use of aspirin, β-blockers, angiotensin converting enzyme inhibitors, thienopyridines, and statins. A study based on the Global Registry of Acute Coronary Events, which includes data from 113 hospitals across 14 countries, reported that use of these medications increased in AMI patients from 23% in 2000 to 58% in 2005, findings similar to the increases reported in the Worcester, Mass study from 1995 to 2005. Furthermore, the use of percutaneous coronary intervention has increased substantially over the last decade, which may also have contributed to improved outcomes. A recent study based on the United States Nationwide Inpatient Sample database, an all-payer inpatient care database from 1000 hospitals, reported that percutaneous coronary intervention for ST-segment elevation myocardial infarction increased by 33.5% among patients aged 65 to 79 and 22% in patients >80 years of age in the United States from 2001 to 2010. Of note, the observed decrease in recurrent AMI hospitalizations occurred despite the increasing use of high-sensitivity troponin assays to diagnose AMI over the study period. It is possible that the observed decrease would have been even greater if laboratory assays for AMI diagnosis had not changed.

While the overall declines in recurrent AMI hospitalization and subsequent mortality rates over the past decade are encouraging, not all groups benefitted equally from improvements in recurrent AMI hospitalizations. When compared by race, the reduction in observed, recurrent AMI hospitalization rate in whites was double that seen in blacks, with a relative decline of 27.7% versus 13.6% from 1999 to 2010 (P<0.05). Racial disparities in recurrent AMI hospitalization rates thereby actually widened over the study period. The explanation for the attenuated decline observed in black patients is likely multifactorial. A higher prevalence of cardiac risk factors (hypertension, diabetes, smoking, obesity), as well as socioeconomic factors (ie, healthcare access, insurance) leading to differences in quality of care have been linked to worse outcomes in blacks as compared to whites. As multivariable models were constructed separately for each demographic subgroup, it is possible that differences in cardiac risk factors contributed to the differences observed between blacks and whites in recurrent AMI hospitalization rates. Furthermore, some evidence suggests that nonwhite race is a risk factor for nonadherence to recommended American College of Cardiology/American Heart Association guidelines for treatment of AMI.

A study of AMI patients in the 1992–2003 Medicare Current Beneficiary Survey reported...
that while overall combination drug therapy increased over the study period, nonwhite race was independently associated with suboptimal treatment. Notably, mortality rates were similar in blacks and whites, making differential censoring an unlikely explanation for the differences in recurrent AMI hospitalization.

There are several potential limitations in our study. Our data are based on the Medicare fee-for-service population, and trends in recurrent AMI hospitalizations may differ in younger patients or those with different health insurance. Because we relied on administrative data, we were also not able to obtain detailed clinical information about risk factor profiles (eg, cigarette smoking), mechanism of recurrent MI (eg, stent thrombosis), and cause of death. Comorbidities were ascertained from administrative codes and not clinically confirmed, and hospitals may have changed patterns of medical coding over time. Finally, we used a linear model to examine changes in recurrent AMI rates. The decline in recurrent AMI appears to diminish in the final years of the study period, and future studies are needed to determine whether there is continuing decline in recent years.

Conclusions

In a national cohort of Medicare patients, the risk-adjusted rate of annual decline in recurrent AMI hospitalizations was 4.1% from 1999 to 2010. The risk-adjusted rate of annual decline in mortality within 1 year after recurrent AMI hospitalization was 1.8% during this period. Improvements in recurrent AMI hospitalization rates were significantly attenuated in black patients, resulting in widened racial disparities by the end of the study period. Future work should examine strategies to ensure that gains realized in post-AMI outcomes can be shared equally among all patients, regardless of race.

Sources of Funding

This study was supported by grant 1 U01 HL105270-04 (Center for Cardiovascular Outcomes Research at Yale University) from the National Heart, Lung, and Blood Institute (NHBLI). In addition, Dr Chaudhry is supported by the National Institutes of Health (NIH) NHBLI grant R01HL115295 (Risk Stratification in Older Persons with Acute Myocardial Infarction: SILVER-AMI) and a Beeson Career Development Award from the NIH/ National Institute of Aging (NIA) (K23 AG030986); Dr Chen is supported by the Agency for Healthcare and Quality Career Development Award (1K08HS018781-01); Dr Dodson is also supported by the NIH NHLBI grant R01HL115295 (Risk Stratification in Older Persons with Acute Myocardial Infarction: SILVER-AMI) and the NIH NIA grant R03AG045067, a T. Franklin Williams Scholarship Award (funded by: Atlantic Philanthropies, Inc, the John A. Hartford Foundation, the Alliance for Academic Internal Medicine-Association of Specialty Professors, and the American College of Cardiology), and is the recipient of a Clinical Research Loan Repayment award from the NHLBI; Dr Dharmarajan is supported by a NIH T32 training grant in cardiovascular disease (2T32HL007854-16A1) from Columbia University; and Dr Krumholz is supported by grant U01 HL105270-02 (Center for Cardiovascular Outcomes Research at Yale University) from the NHBLI.

Disclosures

Dr Krumholz works under contract with the Centers for Medicare & Medicaid Services to develop and maintain performance measures; he is also a recipient of research grants from Medtronic and from Johnson & Johnson, through the American College of Cardiology, to develop methods of clinical data sharing. Dr Krumholz is the chair of a cardiac scientific advisory board for UnitedHealth. Dr Masoudi has contracts with the Oklahoma Foundation for Medical Quality and the American College of Cardiology Foundation. All other authors (Chaudhry, Khan, Dharmarajan, Wang, and Dodson)—none.

References


