In Reply We thank Lin and Li for their interest in our article.1 With respect to their first point, we agree that younger Canadian patients are healthier than younger US Medicare patients (who are only eligible for Medicare if receiving Social Security Disability Insurance benefits), which is why we reported sensitivity analyses by age (as well as length of stay) in Table 3.1 We also reported that, like older American patients, length of stay for Canadian patients older than 65 years changed little (from 7.6 days to 7.4 days) between 2005 and 2015. The readmission rates for Canadians older than 65 years closely mirrored those reported for the full cohort in all time quarters, with no statistically significant changes on segmented regression analyses after April 2010 or October 2012, consistent with our overall results.

With regard to their second question about in-hospital mortality rates in the United States, we would like to point out that these cannot be calculated from the study flowchart, as the numbers would have been different at each step if we reported inhospital death as the first exclusion criterion rather than the last in figure 1B in the Supplement.1 Thus, the 1% Lin and Li cite using the flowchart is incorrect, and the 3.8% reported in the text of our article (based on deaths in hospitalized patients before application of the other eligibility criteria) is the correct inhospital mortality rate in the US cohort. While Lin and Li reference a study that reported a 30-day mortality rate of 8% in Medicare fee-for-service patients,2 that analysis appeared to be based on all heart failure (HF) hospitalizations, rather than just first-time hospitalizations, as in our analysis. It is well known that mortality rates are higher for patients with recurrent hospitalizations,3,4 and thus we are not surprised that an analysis combining incident and recurrent hospitalizations reported a higher mortality rate than our study of first-time hospitalizations.

Third, they asked for clarification about our rationale for restricting the segmented regression analyses to the period from 2006 to 2015. As our analysis focused on patients discharged alive after their first hospitalization with a primary diagnosis of HF, we used a 1-year washout to exclude any patients with prior HF hospitalizations, and thus, we used a requirement for patients to have at least 1 year of data prior to their index HF hospitalization, as described in our Methods section.4 As we only had 1 year of prior data for all patients hospitalized after January 1, 2006, we used that as the start date for the segmented regression analyses to minimize the risk of erroneously including prevalent HF cases in our analysis (as pointed out in the prior paragraph, prevalent patients have different prognoses).

Finally, Lin and Li have correctly drawn attention to an error in the Figure for our article.1 While our original figure included the readmission rates out to the fourth quarter of 2015, we did not notice it had been truncated at 2013 in the galley proofs. This has been published as a correction.5

Finlay A. McAlister, MD, MSc
Erik Youngson, MMath

CORRECTION

Error in Figure: The Original Investigation "Trends in Readmissions and Length of Stay for Patients Hospitalized With Heart Failure in Canada and the United States," published online April 10, 2019, and in print in May 2019, contained an error in the Figure. The Figure was truncated, omitting data from 2014 and 2015. It has been corrected to include the data for this period.


Error in Figure 1: In the Original Investigation titled “Assessment of the German and Italian Stress Cardiomyopathy Score for Risk Stratification for In-hospital Complications in Patients With Takotsubo Syndrome,” published online August 7, 2019, the key in Figure 1 was mislabeled. GEIST should be dark blue and RETAKO should be light blue. This article has been corrected online.


Error in Strengths/Limitations Section: In the Original Investigation titled “Association of Low-Density Lipoprotein Cholesterol With Risk of Aortic Valve Stenosis in Familial Hypercholesterolemia,” published online October 16, 2019, there was an error in the final paragraph of the Strengths/Limitations section. The second sentence of the paragraph should read “Participants in the present study account for almost one-third of the total number of patients with FH in Norway, given a prevalence of 1:300.” This article has been corrected online.