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# Letters

## TO THE EDITOR

### Telehealth: The Future of Consultations?



We read with interest the paper by Sammour et al,<sup>1</sup> in which a similarity was found in the outcomes of patients with heart failure seen in person compared with those seen via telehealth. Their results support telemedicine, as it enables sufficient continuity of care for patients amid a climate antagonistic to in-person consultation.

The efficacy of telehealth is further demonstrated by Yun et al.<sup>2</sup> In their study, clusters of patients were identified presenting distinct susceptibility to adverse outcomes. Their findings, consistent among all clusters, show a reduction in the occurrence of nonfatal heart failure events in patients receiving telemedicine over usual care. These data, considering psychosocial factors when defining clusters, suggest that diversity in frailty will not reduce the quality of care patients receive should telehealth be adopted.

On the other hand, a key factor affecting outcomes is the patient experience. Sammour et al<sup>1</sup> suggest that, because of patient frailty, telehealth may be preferred. However, in an analysis of patient-reported experiences, Raman and Vyselaar<sup>3</sup> found that 69% preferred in-person consultations. Their questionnaire results relay some dissatisfaction with perceived quality of care. Perception can have a significant impact on compliance, and further research should address public concerns.

Yuan et al<sup>4</sup> expand upon patient outcomes by discriminating between telephone and video visits, finding an increase in 90-day mortality associated with telephone but not video consultations. The authors attribute this to a decrease in testing and prescription by clinicians associated with telephone consultations. Differing clinical-care practices between telephone and video consultations should be resolved before integrating telehealth.

One way forward may be the AMULET model as proposed by Krzeński et al.<sup>5</sup> The authors found that nurse-led noninvasive measurements alongside telecare resulted in a reduction in cardiovascular

deaths and hospitalizations in the 12 months following acute heart failure. Overall, there is potential for telehealth to be adopted into the primary care of patients with heart failure; however, the model used should be standardized to ensure effective care.

**\*Maaroothen Ganeshalingham, BSc (Hons)  
Mahmood Ahmad, MBBS**

\*University College London  
Flat 2, Kingston House, 24 Fortess Road  
London NW5 2EX, United Kingdom  
E-mail: [zchamg0@ucl.ac.uk](mailto:zchamg0@ucl.ac.uk)

<https://doi.org/10.1016/j.jchf.2022.01.015>

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The authors have reported that they have no relationships relevant to the contents of this paper to disclose.

The authors attest they are in compliance with human studies committees and animal welfare regulations of the authors' institutions and Food and Drug Administration guidelines, including patient consent where appropriate. For more information, visit the [Author Center](#).

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## REPLY: Telehealth: The Future of Consultations?



We thank Drs Ganeshalingham and Ahmad for their interest in our recent study exploring the role of telehealth in the management of outpatients with heart failure at our health system during the early phase of the COVID-19 pandemic.<sup>1</sup> Our findings showed that the use of telehealth was not associated with increased subsequent emergency department visits, hospitalizations, or mortality in comparison with in-person visits. Now 2 years into the pandemic, telehealth has continued to provide a safe, reliable

method to maintain continuity of care, especially as providers and patients became more experienced and comfortable using telehealth.<sup>1</sup>

We agree that patient preference is one of the key factors to improve the telehealth experience. Although some patients prefer—and some chief complaints require—in-person consultation, there remains general satisfaction with telehealth visits. An abstract by Cho et al<sup>2</sup> reported favorable levels of satisfaction in 1,038 patients who were surveyed on their experience during the COVID-19 pandemic. Higher satisfaction scores were noted among patients with longer travel time or need to arrange child care and those who were younger, female, of non-White ethnicity, and who had familiarity with technology.

We also agree with the authors that video visits should be the preferred mode of virtual visit. Our group has reported that socioeconomic disparities were present among patients with heart failure that resulted in less access to video telehealth visits including patients who were older, Black, without spouses or significant others, lacking college education, and those with lower median household incomes.<sup>3</sup> Further, we found that telephone visits were associated with higher rates of subsequent acute care hospital encounters after the index visits, which is consistent with the data presented by Yuan et al;<sup>4</sup> however, we did not find differences in mortality between the 2 telehealth modes.

We believe that telehealth is here to stay, particularly with the continued pressure for remote medical care given the emergence of novel COVID-19 variants. Our data suggest that in-person visits can be supplemented safely with telehealth visits in a hybrid model. We concur that further studies are needed to identify best practices for future implementation of telehealth to improve outcomes and experience for patients.

Yasser Sammour, MD

John A. Spertus, MD, MPH

Islam Shatla, MD

Michael L. Main, MD

\*Brett W. Sperry, MD

\*Department of Cardiovascular Medicine  
Saint Luke's Mid America Heart Institute  
4401 Wornall Road

Kansas City, Missouri 64111, USA

E-mail: [bsperry@saintlukeskc.org](mailto:bsperry@saintlukeskc.org)

Twitter: [@BrettSperryMD](https://twitter.com/BrettSperryMD)

<https://doi.org/10.1016/j.jchf.2022.01.013>

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## A Systematic Review and Network Meta-Analysis of Pharmacological Treatment of HFrEF



In their network meta-analysis (NMA), Tromp et al<sup>1</sup> compared various pharmacologic treatments for heart failure with reduced ejection fraction (HFrEF). The authors used the surface under the cumulative ranking (SUCRA) method to rank the agents. Based on the SUCRA scores, the study found that a combination of angiotensin receptor-neprilysin inhibitors (ARNi), beta-blockers (BB), mineralocorticoid receptor antagonists (MRAs), and sodium glucose cotransporter-2 inhibitors (SGLT2i) was most effective in reducing all-cause death (HR: 0.39; 95% CI: 0.31-0.49), followed by ARNi, BB, MRA, and vericiguat (HR: 0.41; 95% CI: 0.32-0.53) and ARNi, BB, and MRA (HR: 0.44; 95% CI: 0.36-0.54).<sup>1</sup> However, when considering the limitations of SUCRA, this conclusion might be inappropriate.

It could be very misleading to draw conclusions about the effectiveness or harmfulness of treatments by relying only on the SUCRA score but ignoring the certainty of evidence, because the SUCRA approach focuses only on point estimates of effect and ignores the possibility that chance can explain differences between SUCRA scores (precision of estimates); the magnitude of absolute difference between rankings; and, most importantly, the certainty of the evidence.<sup>2</sup> For example, Busse et al<sup>3</sup> reported both the SUCRA and certainty of evidence in their NMA of non-low-back pain; fentanyl ranked as the highest effect for pain relief (<2 h after treatment) but proved to have low- or very-low-certainty evidence. This means that it is very unsure that the high effect of fentanyl is true.<sup>4</sup>