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Hospitalist Update

Hospital Readmissions

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Hospital readmissions are under scrutiny in the context of health care delivery and payment reform. Hospital readmission rates for Medicare (CMS) patients with principal diagnoses of heart attack, heart failure and pneumonia are published to the consumer-focused Hospital Compare site as an “outcome of care” for hospitals participating in the Inpatient Quality Reporting program [1]. The CMS Hospital Readmissions Reduction Program will first affect Medicare payment in federal fiscal year 2013. In year one, the focus is 30-day readmissions of patients with heart attack, heart failure and pneumonia. Hospitals with higher-than-predicted readmission rates between July 1, 2008, and June 30, 2011, will be subject to as much as a 1% payment reduction (1% reduction in base operating DRG payment amount for Medicare Fee for Service patients aged 65 or older) in October, 2012. In subsequent years, more diagnoses will be added and the payment reductions increase (up to 2% in 2014 and 3% in 2015). Hospital readmissions also appear as a quality performance standard in the Medicare Shared Savings Program final rule on Accountable Care Organizations. Additionally, in some bundled payment models outlined by the Center for Medicare & Medicaid Innovation, participating hospitals would not receive payment beyond the predetermined “bundled payment” for patients with related readmissions within 30 days.

What is the evidence that hospital readmissions are preventable or that readmission rates reflect the quality of a hospital’s care? In an analysis of 2005 Medicare data, 76% of 30-day readmissions were deemed to be potentially preventable. The greatest variation amongst hospitals in readmission rates was for patients with heart failure, COPD and pneumonia [2]. Some of this variability is accounted for by patient characteristics used to calculate the hospital’s “risk standardized readmissions measure” but the assumption is that variability outside of patient characteristics reflects the quality of care provided by that hospital. In a systemic review by van Walraven et al., the median proportion of potentially avoidable hospital readmissions was 27% [3].



Precisely what the hospital must do to optimize quality and thereby influence readmission rates is unclear, however. In a review by Hansen et al., no single intervention during hospitalization clearly reduced 30-day readmissions [4]. All elective “bundles” of interventions included patient-centered discharge instructions and post-discharge telephone calls. Interestingly, a recent article by Epstein et al., demonstrated regional variations in hospital readmission rates as having the single largest impact on hospital readmission rates (larger than case mix or discharge planning). [5]

Variability in readmission rates may reflect how well the hospital manages the continuum of the patient’s care rather than the quality of care provided in the inpatient setting. In a study by Misky et al., patients with the same medical condition who had follow-up with a primary care provider within 4 weeks of discharge had a 30-day readmission rate of 3.1% compared to 21.3% for those who did not receive such follow-up. [6] A similar relationship was demonstrated by Hernandez et al. in patients with heart failure; this study evaluated the impact of a follow-up within 7 days on all-cause readmissions within 30 days. [7].

Patient characteristics do influence readmission rates. A number of studies have examined patient characteristics which correlate with readmission rates, demonstrating positive relationships between readmission and low socioeconomic status, increasing age, prior hospitalization and a higher burden of comorbidities, including depression [8]. Another approach to reducing readmission rates would be to use these characteristics to stratify interventions at the individual patient level.

What is a hospitalist to do with this information? At the patient level, we must recognize those who are at an increased risk for readmission. We must then look for ways to mitigate this risk by ensuring timely post-hospital appointments and by providing patient-centered discharge information (especially regarding their discharge medications). Hospitalists engaged in performance improvement for their organization should be aware that hospital readmissions are an area of focus in a number of health care reform programs. Finally, we must stay abreast of literature defining key patient characteristics and key hospital interventions that influence potentially preventable readmission risk.

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