Thirty-Day Readmissions — Truth and Consequences

Karen E. Joynt, M.D., M.P.H., and Ashish K. Jha, M.D., M.P.H.

Reducing hospital readmission rates has captured the imagination of U.S. policymakers because readmissions are common and costly and their rates vary — and at least in theory, a reasonable fraction of readmissions should be preventable. Policymakers therefore believe that reducing readmission rates represents a unique opportunity to simultaneously improve care and reduce costs. As part of the Affordable Care Act (ACA), Congress directed the Centers for Medicare and Medicaid Services (CMS) to penalize hospitals with “worse than expected” 30-day readmission rates. This part of the law has stimulated hospitals, professional societies, and independent organizations to invest substantial resources in finding and implementing solutions for the “readmissions problem.”

Although a focus on readmissions may have good face validity, we believe that policymakers’ emphasis on 30-day readmissions is misguided, for three reasons. First, the metric itself is problematic: only a small proportion of readmissions at 30 days after initial discharge are probably preventable, and much of what drives hospital readmission rates are patient- and community-level factors that are well outside the hospital’s control. Furthermore, it is unclear whether readmissions always reflect poor quality; high readmission rates can be the result of low mortality rates or good access to hospital care. Second, although improving discharge...

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From the Urban Institute, Washington, DC (R.A.B.); and Mission Health System, Asheville (R.A.P.), and the Fuqua School of Business, Duke University, Durham (N.S.K.) — both in North Carolina.

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Planning and care coordination is a laudable goal, there are better, more targeted policies that are more likely to be effective in achieving it. Finally, because hospitals are expending so much energy on reducing readmissions, they have probably forgone quality-improvement efforts related to more urgent issues, such as patient safety. An evidence-based, holistic approach to quality improvement is far more likely to achieve what policymakers, clinicians, and the public all want: better care at lower cost.

With regard to the first problem, preventability, a recent systematic review reported that on average, just 27% of readmissions were preventable (moreover, only 12% were deemed preventable in studies that used clinical data, as compared with 59% in those that used administrative data only). In a recent study of Ontario hospitals that involved careful chart review, van Walraven and colleagues found that less than a fifth of urgent rehospitalizations were preventable, an estimate in keeping with the proportion of total hospital admissions in the United States generally deemed to be preventable. Perhaps even more important, the van Walraven study showed that although the total number of readmissions varied substantially among hospitals, the rate of preventable readmissions did not—a finding suggesting that readmissions may be a poor measure of hospital performance.

The growing body of evidence suggests that the primary drivers of variability in 30-day readmission rates are the composition of a hospital's patient population and the resources of the community in which it is located—factors that are difficult for hospitals to change. We know that some of the most important drivers of readmissions are mental illness, poor social support, and poverty, which are often deeply ingrained. Therefore, readmission rates have weak signaling value for identifying high-quality hospitals. The current scheme to penalize hospitals with high readmission rates is likely to disproportionately affect institutions that care for poor or minority populations or those with a high burden of mental illness.

Given that readmissions result from a complex interplay among patients, hospitals, and communities, asking hospitals to focus their effort on this measure will lead them to expend substantial energy yet have little effect. We suspect this is the reason that, despite the tremendous focus on readmissions, we have seen little improvement over the past decade (see graph).

In fact, there are several factors influencing readmission rates that we would not want hospitals to change. For example, hospitals with a low mortality rate among patients with heart failure have higher readmission rates, presumably because they keep their sickest patients alive, and those patients are subsequently more likely to be readmitted. Similarly, given the close relationship between overall community-level hospitalization rates and readmission rates, communities that invest resources in outpatient care and thus are able to keep their healthiest patients from being hospitalized may see their readmission rates rise. Finally, whereas some studies have shown that sustained efforts can reduce readmission rates somewhat, others have shown that interventions aimed at improving care coordination and access to follow-up care actually increased the rate of readmissions, presumably because of improved access to needed care, with commensurate improvement in patient satisfaction. These interventions should hardly be seen as failures.

All of which is not to say that the core values of improved coor-
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the hospital soon after discharge because we failed to recognize the challenges they faced at home or failed to make an effective handoff to their primary care provider. However, there are many ways to target better coordination of care at the time of discharge. Hospitals could be held responsible for ensuring that the patient’s medication list is reconciled at discharge or even that every patient is scheduled for a follow-up visit with an ambulatory care provider or a visiting nurse, unless the patient opts out.

Should policymakers remain convinced that hospital readmissions are a necessary metric, they could consider limiting the time window. The causes of readmissions occurring within 3 days after discharge or even 7 days after discharge are much more under the hospital’s control, and these near-term readmissions are preventable far more often than later ones.\(^2\) Focusing on near-term readmissions would motivate clinicians, who generally feel more responsible for these types of events. CMS could provide hospitals with timely data on their near-term readmission rates, which hospitals could use for internal quality-improvement efforts. CMS could even go so far as to require a “warrantee” and deny hospitals reimbursement for any near-term readmissions. Each of these policies is more likely to improve effective discharge planning than our current approach.

Finally, the focus on readmissions for acute myocardial infarction, congestive heart failure, and pneumonia means forgone opportunities to invest in other quality-improvement efforts that are potentially more feasible and are of higher value. For example, over the past decade, we have seen very little improvement in patient safety, and although mortality rates have declined for a few conditions, they remain high for most others. Many of these deaths are preventable. Yet we are focusing tremendous resources on preventing rehospitalizations for three conditions that account for approximately 10% of all hospital admissions in the Medicare population. Even if CMS expands its readmission penalties to include more conditions, the policy will fail to address what patients care about most: we suspect that many patients would happily trade a slightly higher likelihood of being re-admitted to the hospital for a greater chance of surviving their hospitalization without being injured.

The metrics that policymakers choose to use in rewarding and penalizing hospitals have a profound effect not just on what hospitals do but on what they choose not to do. The financial penalties for high readmission rates dwarf the penalties for poorer care, including those for high mortality rates and unsafe care. The current policy sends a clear signal about where hospitals should focus their efforts. We are asking U.S. hospitals to spend their limited resources on ensuring that patients are not re-admitted as many as 4 weeks after discharge — events that are largely outside the hospitals’ control. But the most important consequence of this policy is the improvements in quality and safety that hospitals will forgo, and those will be far more difficult to measure.

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From the Department of Health Policy and Management, Harvard School of Public Health (K.E.J., A.K.J.); the Divisions of Cardiovascular Medicine (K.E.J.) and General Internal Medicine (A.K.J.), Brigham and Women’s Hospital; and the Veterans Affairs Boston Healthcare System (A.K.J.) — all in Boston.
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