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Authors

Pfeffer, Michael A.
Lazarus, Michael

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CLINICAL VIGNETTE

The Spotlight on Readmissions -- Communication at the Transition of Care

Michael A. Pfeffer, MD, FACP, Michael Lazarus, MD, FACP

Readmissions are currently in the healthcare spotlight with the recent financial implications of the *Hospital Readmissions Reduction Program*. While the focus is initially directed at congestive heart failure, pneumonia, and acute myocardial infarction, this list will soon be expanded. Communication between physicians at the transition of care will be critical to ensure patients receive proper post-discharge care, and may help reduce preventable readmissions. We will discuss the evolution of the *Hospital Readmissions Reduction Program* and focus on communication between providers, specifically on the discharge summary.

The Medicare Payment Advisory Commission (MEDPAC), an independent federal body commissioned under the Balanced Budget Act of 1997 to advise Congress on issues affecting the Medicare program, produced a report entitled *Promoting Greater Efficiency in Medicine* and presented this to congress in June 2007[1]. The report recommended policies to promote efficiency in the Medicare program. One area was payment policy for inpatient readmissions. The report found that readmissions are frequent, expensive, variable, avoidable, and fixable [Box 1].

Box 1: Issues with Readmissions[1]	
Frequent:	17.6% readmission rate in 30 days
Expensive:	$15 billion
Variable:	readmission rates vary considerably by hospital, even when adjusted for
Avoidable:	DRG and severity class
Fixable:	a large number of readmissions are preventable
	enacting quality initiatives aimed at inpatient and transitional care

MEDPAC recommended selecting three diagnosis-related groups (DRGs) to have hospitals report publically on their 30-day readmission rate. Based on this data, low performers would be financially penalized while high performers would be rewarded.

In 2009, Jencks et. al. published a landmark paper confirming the findings in the MEDPAC report[2]. One-fifth of Medicare fee-for-service patients were rehospitalized within 30 days, with a cost to the system of $17.4 billion in 2004. Heart failure and pneumonia topped the medical conditions for readmission. Looking at those patients that were rehospitalized, 50% did not see an outpatient physician, 71% of patients readmitted after a surgical discharge were rehospitalized for a medical diagnosis, and, not surprisingly, readmissions were more likely to stay greater than two times the expected DRG.

A modification of the MEDPAC recommendation was put into law on March 23, 2010 under the Patient Protection and Affordable Care Act (PPACA)[3]. The *Hospital Readmissions Reduction Program* would evaluate readmission data starting October 1, 2011 (which is fiscal year 2012) and enact penalties beginning in fiscal year 2013. The initial version of the law focused on congestive heart failure (CHF), pneumonia, and acute myocardial infarction (AMI) as the diagnoses, and eliminated the reward while keeping the penalty. Hospitals in the lowest quartile of risk-adjusted 30-day readmission performance would see up to a 1% reduction in their total Medicare payments, to increase to 3% for fiscal year 2015. In addition, readmissions were defined as "all cause," meaning that even unrelated readmissions would count (e.g. hip fracture after being discharged 20 days prior for pneumonia). In August of 2012 after a new report from MEDPAC[4], the final version of this law was published with some notable changes[1]: readmission rates would be based on the National Quality Forum's (NQF) 30-day risk-adjusted measure (which is the same result one would find on hospitalcompare.hhs.gov)[2]; three years of data would be used instead of one to determine the penalties[3]; hospitals needed a minimum of 25 index admissions to be counted in the measure); and[4] all hospitals with an excess readmission ratio greater than one would be penalized up to 1%, which would be deducted from fiscal year 2013's Medicare inpatient prospective payment system (IPPS) [5].

The *Hospital Readmission Reduction Program* will have a significant financial impact on hospitals that are determined to have an excess readmission ratio compared with their peers. Therefore, it is critical to

look for ways to reduce readmissions thereby reducing one's financial penalty, but more importantly, improve patient care. While there are a lot of potential areas to improve, we will focus on discharge documentation and communication.

Approximately two-thirds of adverse events (AEs) a patient experiences during transition from the hospital to home involve medications[6]. Up to one-third of those AEs are ameliorable, and could have been recognized early and tended to with appropriate follow-up[7]. One study looking at patients discharged from a large academic medical center found that 11% of all culture results returned postdischarge, with 4% requiring an intervention[8]. Another study found that 41% of inpatients are discharged with test results pending, with 9% requiring clinical intervention.[9] 25% of discharged patients require additional outpatient workup[10]. These findings represent the tip of the iceberg in terms of reasons for why communication between the discharging physician and outpatient physician, or primary care provider, is essential.

So how do we do in terms of communication? Of the 41% of patients with test results pending, only one-third of primary care providers were aware[9]. Of the 25% of patients requiring additional outpatient workup, greater than one-third were not completed[10]. In addition, courts have found physicians liable for not making a good faith effort to notify patients of test results that return postdischarge, with approximately one-fourth of all diagnosis-related malpractice cases related to a failure to follow-up on test results after discharge[11].

Discharge summaries are typically the way communication between the inpatient and outpatient physicians occur. A call to the outpatient provider to discuss the case would be ideal, but this is often not done due to logistical reasons. Kripalani et. al. found that the discharge summary was available at the first postdischarge visit only 12-34% of the time, with only 51-77% availability after four weeks. When the discharge summary is received, it is often lacking key components, such as pending test results and discharge medications [Box 2][12].

Box 2: Important Categories Missing for Discharge Summaries[12]
Diagnostic test results: 33-63%
Treatment/Hospital course: 7-22%
Discharge medications: 2-40%
Pending test results: 65%
Patient/family counseling: 90-92%
Follow-up plans: 2-43%

However, when the discharge summary is present at the first follow-up visit documenting the needed workup, patients are greater than two times more likely to get it[10].

While there are no studies that show a direct reduction in readmission rate due to improved communications during the transition of care from inpatient to outpatient, it makes logical sense that this would improve care for patients. There are substantial data illustrating that physicians can do better, simply by ensuring that discharge summaries contain the appropriate information needed *and* get to the outpatient providers in a reasonable amount of time.

In conclusion, the readmission penalties associated with the Affordable Care Act are just the first step in a national push toward higher quality and safer care for vulnerable hospitalized patients. The improvements in discharge communication, medication reconciliation and documentation are "low hanging fruit" solutions that most hospitals are implementing right now. As we look ahead to a healthcare landscape of even greater oversight and a push towards increased value, the more challenging issues of access to care and individual health literacy will come to the fore.[13] This is a timely opportunity for health care organizations to consolidate their efforts on improving care for socioeconomically vulnerable patients.

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