“Return to sender” or “consider it done”?! The importance of reducing hospital readmission after coronary artery bypass grafting

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Hospital readmission after coronary artery bypass grafting (CABG) is still relatively common and associated with worse overall outcomes and significantly reduced patient satisfaction. However, it is a clinical event often overlooked in systemic analyses, because clinical trials focus on “hard” end points, such as death, myocardial infarction, and repeat revascularization. Therefore, the retrospective analysis of a large US patient population presented by McNeely and colleagues¹ is of major interest for the surgical community.

First, it is encouraging that 30-day readmission rates decreased significantly within the analyzed time period, especially because the readmission diagnosis with the largest magnitude of reduction was one of the main postoperative surgical issues, namely, readmission for wound infections and nonhealing wounds. Furthermore, hospital mortality during the readmission showed a significant downward trend. These improvements came despite increasing comorbidities over the analyzed time period, a fact that is at least partially explained by improved patient selection and perioperative care.

Yet, at the end of the study period in 2012, the percentage of patients who were readmitted to the hospital early after CABG seems relevant. Even if only a small amount of readmissions were related to severe even life-threatening conditions, readmissions have the potential to seriously affect patient satisfaction and to generate considerable financial impact. Therefore, a further reduction of readmission rates after CABG must remain a major therapeutic goal. One key element to reach this goal could be a significantly intensified communication and teamwork of surgeons, nonsurgeons, and outpatient physicians. This communication should exceed the sending of a discharge letter that reports the number of anastomoses and suggests the duration of the antiplatelet therapy. For example, at our center we have recently implemented

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Central Message

Further reduction of readmission rates after CABG is mandatory and might be achieved by enhanced communication among physicians on different levels of perioperative and postoperative care.

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the simple concept of a direct telephone contact of the operating surgeon and the patient's outpatient physician immediately before every hospital discharge, thereby providing firsthand information for the outpatient physician regarding the patient's medical condition and potential foreseeable posthospital problems. It seems conceivable that this kind of direct contact among the involved physicians improves early posthospital care because of a better level of individual information and opens up an uncomplicated platform for discussion in case of imminent readmission before the patient is sent back to the hospital.

The amount of teamwork among all involved physicians not only is potentially capable of reducing early readmission rates but also affects overall surgical outcome after CABG and was recently demonstrated in an analysis among Medicare beneficiaries by Hollingsworth and colleagues.² This seems especially interesting as to date. In the era of digital information exchange platforms, such a teamwork based on the prompt exchange of information should be relatively easy to establish. In regard to the care of chronic heart disease, a federally supported health care project addressing this kind of intensified digital information exchange has been recently launched in northern Germany (HerzEffekt MV).

Even if in the end, as stated by McNeely and colleagues,¹ approximately half of the readmissions are not preventable, we as surgeons should continue to work on reducing the other half by implementing posthospital communication platforms and pathways as outlined.

Reference

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