Readmission rates: Haven't I seen you somewhere before?

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Central Message

Hospital readmission rates are a commonly reviewed quality metric. There remains not only confusion regarding accurate reporting of such rates but the relevance of readmission as a quality metric.

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Hospital readmission rates are a commonly reviewed quality metric in most hospitals today. There remains, however, significant discrepancy in the reporting of such rates, particularly in postoperative cardiac surgery patients, with relevant differences noted between what is reported to the Society of Thoracic Surgeons (STS) National Adult Cardiac Surgery Database and what is reported to the individual institutions from the Centers for Medicare & Medicaid Services. In this issue of the *Journal*, this discrepancy and the opportunities and challenges to resolve such differences are well described by Edgerton and colleagues¹ in their article “Can Use of an Administrative Database Improve Accuracy of Hospital Reported Readmission Rates?”

Their manuscript reviews the analysis of 45,539 STS records from January 2008 to December 2016 from 28 hospitals performing cardiac surgery (from 5 different hospital systems) collected in their regional quality consortium (Texas Quality Initiative) compared with shared administrative claims data from 81 area hospitals. The authors noted that the reported STS readmission rate of 10.5% underreported the readmission rate by 2.5 actual percentage points, stating “The true rate should have been 13.0%. Actual readmission rate was 23.8% higher than reported by the clinical database. Approximately 36% of readmissions were to a hospital that was a part of a different hospital system.”

This challenge to accurately collect and evaluate readmission rates in postoperative cardiac surgery patients is certainly not a new issue and has been the focus of numerous studies that have sought to define risk factors for hospital readmission after cardiac operations.²⁻⁶ Shahian and colleagues⁷ evaluated the readmission rates after isolated coronary artery bypass grafting between 2008 and 2010 and demonstrated the rate obtained from the STS database was 10% compared with 16.8% obtained from the Medicare data. Moreover, not only is the accurate measurement of such rates often in question, but the relevance of readmission as a measure of hospital quality continues to remain controversial and confusing. Shih and Dimick⁸ clearly documented that “readmission rates are

not a reliable measure of hospital quality in cardiac surgery” and “the proposed financial penalties will largely be determined by chance and not by true differences in hospital quality.”

Although it is enticing for cardiac and thoracic surgeons to discount the importance of readmission rates based on these limitations, it is still incumbent on us to be a part of the solutions to improve postdischarge care coordination and limit readmission. Contacting the patients directly within 2 days postdischarge, patient office visits within 3 to 4 days from discharge, and active collaboration with the visiting nurses and/or staff in postacute care facilities with standardization of expectations and order sets are only several of the options available to reduce readmissions. Regardless of the cancellation of the Centers for Medicare & Medicaid Services Episode Payment Model and Cardiac Rehabilitation Incentive program for bundled payment care incentive for isolated coronary artery bypass grafting, cardiothoracic surgeons may still lead such quality initiatives that will only benefit our patient outcomes and continue to reduce the costs of care delivery for this patient population.

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