

EDITORIAL COMMENT

Does Public Reporting Improve Care?*



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In 2009, the Center for Medicare & Medicaid Services (CMS) began public reporting on risk-standardized hospital readmission rates for specific conditions that affect significant numbers of Medicare beneficiaries: acute myocardial infarction, heart failure, and pneumonia. In this issue of the *Journal*, DeVore et al. (1) have provided an insightful epidemiological analysis of outcomes after implementation of this policy. These investigators found that although risk-standardized readmission rates fell gradually for all 3 conditions, as well as for 2 other conditions not subject to public reporting (chronic obstructive pulmonary disease and diabetes), this finding was just as consistent with an ongoing secular trend toward decreasing readmission rates as it was a consequence of public reporting of these rates because the slope of the readmission rate decrease was not discernibly different before and after public reporting began.

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What does it mean to CMS and other payers to reduce readmission rates? It means dollars saved because acute care hospital admissions, including readmissions, must be reimbursed by payers to providers. What does it mean to hospitals to reduce readmission rates? It may mean reduced revenues, but at NYU Langone Medical Center in New York, we have found that the contribution margin is considerably less favorable for readmissions than for other types of admissions (S. Chatfield, November, 2015, personal communication).

More important for hospitals are the resources increasingly allocated to put in place and maintain readmission reduction strategies, policies, and

procedures, including discharge planning, thoughtful discharge training and instruction for patients and their post-discharge caregivers, communication from hospital staff with patients and their post-discharge caregivers, and even provision of direct care after discharge through structured post-discharge clinics, telemedicine, and home visits by physicians or nurse practitioners (2,3). In a sense, hospitals are increasingly expected to ensure a higher level of medical, social, and societal support for their discharged patients than in the past. However, no specific intervention or collection of interventions has been clearly associated with reducing readmissions (2,3), and in general, hospitals choose to adopt those interventions that make sense for their patients and are feasible to implement, in part in response to public reporting of readmission rates, in part in response to looming financial penalties.

What does it mean to patients to reduce readmission rates? It is doubtful that patients check the Medicare Hospital Compare website to be sure that they are going to a hospital with a low readmission rate, particularly before admission for an acute, unplanned illness. A readmission for a complication of an index admission that is averted by optimizing adherence to complication prevention procedures (e.g., venous thromboembolism prophylaxis or infection prevention practices) is undoubtedly a welcome (if underappreciated) nonevent, but a readmission for increased attention to a severe chronic condition is an option that some patients may prefer to have available. Patients perceive that a hospital that offers this option is more caring than a hospital with “readmission avoidance” procedures in place. Some patients understand that the hospital readmission prevention interventions mentioned earlier provide an enhanced array of support for care for their chronic medical conditions as a welcome addition to their health care options as well as to our national health care capacity.

Epidemiological insights provided by this and similar national-level analyses contribute important

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information to our understanding of both the possible benefits and the potential unintended consequences of national health care policy changes. Some investigators have suggested that in response to pressure on hospitals to decrease readmission rates, use of hospital-based outpatient care including observation encounters and emergency department visits could increase (4,5). DeVore et al. (1) found the opposite. For acute myocardial infarction and pneumonia, rates of post-discharge hospital-based care (observation encounters and treat-and-release emergency department visits) did not change. By contrast, both observation encounters and emergency department visits actually decreased after index heart failure discharge after public reporting began. Unlike with acute myocardial infarction and pneumonia, an admission for heart failure generally is precipitated by an exacerbation of a chronic condition, and decreased use of post-discharge hospital-based care is likely to be related to hospitals' efforts to provide increased care support for chronic disease. For 1 condition, pneumonia, DeVore et al. (1) found that nonacute outpatient visits increased; this finding may also be an indicator of improved care coordination after public reporting of hospital readmission rates began.

Although DeVore et al. (1) found that the rate of change in mortality rates did not change significantly after public reporting began (rate down for acute myocardial infarction, flat for heart failure, up for pneumonia), when examined using "statistical process control" principles, there may be an interesting "signal" developing in the heart failure cohort regarding another concern about potential unintended consequences of pressure on hospitals to reduce readmission rates: that post-discharge mortality may increase (6). The new "common cause" that may explain the finding that the heart failure 30-day mortality rate slope may be turning slightly higher since public reporting began may not be underprovision of post-discharge care, as some investigators may fear, but it may more likely be a delay in index admission until patients are later in the clinical trajectory of their chronic heart failure condition. Patients may in fact be sicker on index admission, kept out of the hospital by the same enhanced chronic care support put in place to prevent readmissions.

Although the work of DeVore et al. (1) does not lend strong support to the hypothesis that public reporting has driven lower readmission rates, their analysis does suggest that quality of care, particularly for chronic conditions, has indeed improved. However, national health care reimbursement policy makers, including CMS and large payers, need to consider that there may be a limit to the extent to which acute-care readmission or post-discharge or hospital-based care rates can be decreased. Moreover, there is likely a tipping point beyond which the negative consequences of public reporting and financial penalties for higher-than-average readmission rates will outweigh the societal benefits, which at this time are principally measured in dollars saved to payers. Access to hospital admission when needed is an important component of a "full-thickness" national health care policy. "Potentially preventable" readmissions represent less than one-half of all readmissions (7), and "potentially preventable" rates appear to be condition specific (8-10). Stated another way, the "ideal" readmission rate is not zero.

With readmission rates falling (11,12), CMS and other payers are seeing fewer readmission reimbursement dollars leaving their coffers. It is time to review reimbursement policies to ensure that the enhancements in care that have occurred during the past few years, particularly care for serious chronic conditions, are fairly reimbursed. There is evidence that hospitals with a higher-than-average proportion of socioeconomically disadvantaged patients with serious chronic conditions, including "safety net" hospitals and academic medical centers, may be disproportionately penalized by readmission penalties (13). Hospitals caring for patients who most need care for serious chronic conditions are hampered by reimbursement policy from providing such care. National trends in readmission rates, mortality rates, and use of both hospital-based and non-hospital-based care bear careful future study, building on the insightful analysis of DeVore et al. (1).

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