Can Hospital Readmission Rates Be Trusted?

When hospital patients have to be readmitted soon after discharge, hospitals look bad.

A high readmission rate also can result in reduced Medicare reimbursements. But a study of spine surgery patients has found that the standard method used to calculate readmission rates is a misleading indicator of hospital quality. Loyola University Medical Center neurosurgeon Beejal Amin, MD, and his colleagues found that 25 percent of the readmissions of spine surgery patients were not due to true quality-of-care issues.

Results are reported in a featured article in the February 2013 issue of the Journal of Neurosurgery.

"We have identified potential pitfalls in the current calculation of readmission rates," Amin said. "We are working on modifying the algorithm to make it more clinically relevant."

Medicare is trying to improve patient care by penalizing hospitals with poor outcomes. One key outcome measure is the readmission rate. Medicare may begin to withhold reimbursements to hospitals with excessively high readmission rates.

In spine surgery, a high readmission rate can indeed reflect poorly on a hospital's quality of care if the readmissions are due to reasons such as infections, surgical complications, blood clots and failures of surgical hardware, Amin said.

But some types of readmissions are not a true indication of quality of care, Amin said. Such cases include:

Planned readmission for a staged procedure. For example, a procedure to straighten a curved spine in a scoliosis patient requires two surgeries performed in different stages.

Readmission unrelated to spine surgery. Occasionally, patients who undergo spine surgery will be readmitted within 30 days for surgery for an unrelated condition, such as a hip replacement.

Operation canceled or rescheduled for unpreventable reasons. For example, a patient is admitted to the hospital, but the spinal surgery is postponed due to an irregular heart rate. The patient is readmitted a couple of weeks later for elective surgery, after the heart rhythm is under control.

Amin and his colleagues examined the records of 5,780 spine surgery patients treated at the University of California San Francisco Medical Center between October 2007 and June 2011. (Before joining Loyola, Amin did a clinical fellowship in

complex spine surgery at UCSF under Dr. Praveen Mummaneni. Currently, Amin is an assistant professor in the Department of Neurological Surgery at Loyola University Chicago Stritch School of Medicine. His clinical expertise is in minimally invasive and complex spine surgery.)

The study found that under the standard readmission formula 281 patients were readmitted within 30 days of discharge. But 69 of these readmissions (25 percent) should not have been counted against the hospital. These included 39 cases that were planned readmissions for staged procedures, 16 cases that were unrelated to spine surgery and 14 cases that were canceled or rescheduled due to unpreventable reasons.

“From the clinician’s point of view, this 25 percent of readmission cases was appropriate and unavoidable,” the authors wrote. “Efforts to curtail such readmissions would be unnecessary and potentially use resources that could be directed elsewhere."

Amin and his colleagues concluded that their findings identify the potential pitfalls in the calculation of readmission rates from administrative data sets. “Current algorithms overestimate clinically relevant readmission rates and cost,” Amin and his colleagues wrote. “This overestimated rate may then be used by payers (that is, Medicare) to deny payment for clinically unavoidable readmissions. Developing more sophisticated algorithms with spine surgeons’ input will increase the reporting accuracy. Surgeons can play a vital role to help improve benchmarking and improve the value of health care provided."

Amin previously presented these findings at the 2012 meeting of the Congress of Neurological Surgeons and the 2012 meeting of the American Association of Neurological Surgeons.

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