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Monitoring hospital readmissions

SEVERAL recent studies have established that readmissions to an acute care hospital occur relatively frequently and they are responsible for a significant proportion of inpatient hospital spending. Anderson and Steinberg,¹ for example, examined readmissions in the Medicare population between 1974 and 1977 and found that 22.5% of the Medicare beneficiaries discharged from an acute care hospital were readmitted within 60 days and that 49.7% were readmitted within one year. They also found that hospital expenditures could be reduced substantially if the readmission rate could be reduced. Zook and associates² examined high-cost patients in Boston-area hospitals and found that, over one year, most of these patients incurred high costs because of multiple admissions and not because of a single catastrophic illness.

■ See Farmer et al (pp 704-708)

Since these articles were written, concern over readmissions, especially in the elderly population, has increased primarily as a result of the Medicare Prospective Payment System (PPS). PPS has created new financial incentives for hospitals to discharge patients prematurely and also to discharge and then readmit patients with multiple problems.³

Most of the initial studies of hospital readmission rates were primarily descriptive. One of their major values has been to prompt clinicians to ask a whole series of additional questions about readmissions. Two important questions that warrant further investigation are

1) why do readmissions occur and 2) what, if anything, can be done to lower the readmission rate?

In this issue Farmer and associates identify four reasons why readmissions might occur and classify a sample of patients from the Cleveland Clinic into each category. They find that 53% of the readmissions were planned, 17% were the result of complications of a previous admission, 11% were for a recurrence of the illness, and 16% involved conditions unrelated to the previous admission.

As with any good study, this paper raises several new questions that will require further analysis. The authors examine the reasons for readmissions in three services of the Cleveland Clinic Hospital: cardiology, cardiovascular surgery, and gastroenterology. The study will cause most readers to wonder whether the results are generalizable to other settings. Would the classification system work in other hospitals and other departments? Would the percentage of patients falling into each category be the same in other departments and other hospitals? These questions are certainly worth exploring.

In this study more than half of the readmissions were planned. It is unclear whether all the planned readmissions were absolutely necessary. Further analysis of these planned readmissions should investigate whether medical practice could be modified to reduce the number of planned readmissions. It might be time to reevaluate certain treatment protocols, especially in the field of oncology, where planned readmissions occur most commonly. Changes in medical practice could generate considerable cost savings, improved quality of care, and greater patient satisfaction.

Farmer and associates suggest that readmissions are

not necessarily a reliable indicator of poor quality care. They argue that since 69% of the readmissions were either planned or unrelated to the initial diagnosis that no quality of care implications can be drawn. In my opinion, this finding suggests that use of readmission rates as an indicator of quality of care should take into account the reasons for the readmission. Taking this one step further, it might be necessary to examine each department, and maybe each diagnosis and/or procedure separately and adjust for the patient's health status to be able to use readmission rates as a quality-of-care measure. Otherwise, the comparisons across hospitals and across departments might be invalid. It does not suggest, however, that readmission rates are a poor indicator of quality of care if used appropriately.

At a minimum, the results of this research suggest that careful analysis of the patients who were readmitted for complications and/or recurrence of the originally diagnosed illness is clearly warranted. A hospital or department with more complications or recurrences than its peers should investigate the reasons for the higher rate of readmissions.

For all of this information gathering to have any practical value, the focus of the research must shift to specific interventions that could lower the readmission rate. Within the hospital setting, alternative ways of treating patients, better quality of care, and more focused discharge planning will probably lower the rate of readmission. This is an area requiring further study.

Possibly more important, however, are the medical and social services the patient receives following discharge from the hospital. After receiving very expensive and excellent medical care, many patients enter a home environment that is not conducive to recovery. Many patients, especially elderly patients living in low income areas, have multiple physical, cognitive, and emotional

problems that are not treated adequately at home. Many have difficulty arranging for and then paying for appropriate medical and social services. However, it may be cost effective to provide them specific medical and social services following discharge to reduce their readmission rate. Without further research, however, it is unclear which specific services will lower the readmission rate.

A second but related issue is that once a patient is discharged from a hospital, it is unclear who is responsible for coordinating their postdischarge care. Even affluent patients have difficulty obtaining adequate nursing and social services, and without a family member who is an effective advocate for the patient, it is frequently difficult to arrange for necessary services. There are a number of possibilities for coordinating care following discharge, including the hospital, the physician, the home health agency, or a totally new entity such as the social health maintenance organization (SHMO). To reduce the readmission rate, more attention must be given to who will coordinate the care of patients who are discharged from the hospital. Because it is an unreimbursed expense, too often no one accepts responsibility, and the patient's care is fragmented.

Increasing attention is being given to the postdischarge period. The article by Farmer and associates is an important component in our understanding of how quality of care can be improved and how readmission rates can be reduced. Classification of the reasons for readmission is an important next step.

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