**Idolatry in Care Transitions**

James Lett, MD, CMD, with Wayne Saltsman, MD, PhD

In our current medical reality, movement of increasingly aged, comorbid and frail patients between sites of care is fraught with potential harm. Enhancing care transitions justifiably demands our attention. Witnessing the illnesses of my parents, I made the painful discovery of the gaps and flaws in a health care system I had spent my career believing was the best the world had to offer. More than a decade ago, I made a decision to do whatever I could to make those flaws fewer and the gaps smaller. The best method I determined was to improve systems of care during transitions; that is, to improve the efficiency, safety, and the patient/family-centered aspect of those who transit through our system of care. Acknowledging the fact that we cannot improve what we cannot measure, the 2009 study by Stephen F. Jencks, MD, Conway, MD, acting principal deputy administrator and chief medical officer, in 2016.

This state of affairs has led me to ask again the questions that have troubled me for some time:
1. What is the desired, ideal 30-day hospital readmission rate goal, so hospitals and clinicians will understand the target, and know when it is reached?
2. What are the unintended consequences of the inexorable demand to ratchet down readmission rates in an aging population with more medications and comorbidities than the health care system has ever seen? Is there potential — or real — harm looming?
3. In our race to avoid the monetary penalties of readmissions and reap the financial benefits of BPCIs and ACOs, have we lost sight of the real intention of the care transitions movement? Are we instead focused upon the false idol of 30-day readmission rates?
4. How should the quality and value of care transitions actually be measured?

**Rate Goals**

What is the desired, ideal 30-day hospital readmission rate goal, so hospitals and clinicians will understand the target, and know when it is reached? From the payer and regulatory side the answer I extrapolate is, “Start with your current rate, then reduce it. Then reduce that rate again. Then reduce it again.” Researchers respond with what I feel is the essence of the issue: An overall population readmission rate depends upon the population and the individual transition. It is impossible to apply a number that defines, or even implies, quality (finally, the word “quality” enters the discussion).

**Unintended Consequences**

What are the unintended consequences of the inexorable ratcheting down of readmission rates in an aging population with more medications and comorbidities than the health care system has ever seen? Is there potential — or real — harm looming? The core of this concept is whether a frail population becomes relegated to observation status care (which is significantly rising), emergency department care, and temporary fixes for the first 30 days after hospital discharge in order to avoid hospital readmission penalties. One could even perversely argue that a high mortality rate among patients discharged from the hospital is a trend that will reflect positively on the 30-day readmission rate — at least as long as they die outside the hospital.

An article by Allen Gupta, MD, PhD, concludes, “In fee-for-service Medicare beneficiaries discharged after heart failure hospitalizations, implementation of the HRRP was temporally associated with a reduction in 30-day and 1-year readmissions but an increase in 30-day and 1-year mortality. If further confirmed, this finding may require reconsideration of the HRRP in [heart failure].” ([JAMA Cardiol](2018;3:44–53)). In fairness, equally prominent research groups have, using essentially the same readmission data, reported results ranging from no increase in mortality to increased mortality since the advent of HRRP. From my perspective, the burden of proof of stating that no harm comes to our patients is on those who administer the HRRP.

**Proxy for Quality**

In our race to avoid monetary penalties we have lost sight of the real intention of the care transitions movement, and instead focused upon the false idol of 30-day readmission rates? From my own observation, there has been a move toward perceiving all 30-day hospital readmissions as negative, and viewing 30-day readmission rates as a proxy for quality. This despite the fact that our increasingly frail population in post-acute care/long-term care intermittently will require hospitalizations to achieve their highest practicable level of functioning. In fact, acute admissions can be considered one stage of a natural course of the disease process.

Neel Buttala, MD, and colleagues reported the readmission rates for heart failure, acute myocardial infarction and pneumonia (the first three readmissions measures in the HRRP) and concluded that “currently reported measures may not be good surrogates for overall hospital quality related to 30-day readmissions” ([Ann Intern Med. 2018;168:631–639]). In fact, the rabid pursuit of the hospital 30-day readmission rate has been fueled somewhat by an article by Andrew Ibrahim, MD, and colleagues published in [JAMA Internal Medicine](which found nearly two-thirds of the national readmission rate lowering was due to changes in coding practice (2018;178:290–292)). By excluding some patients from the denominator and adding in substantially more comorbidities, those pesky readmission rates could decline.

In a provocative article in the [JAMA Forum](2018;319:431–433), it is certain time for an accounting of HRRP’s unintended consequences.

**Measuring Quality**

Admitting quality care and financial benefits is a potentially toxic and combustible brew. Although we may agree that appropriate, high quality clinical care will produce lower costs, clear measures are necessary to ensure that profitable care is indeed quality in nature. I fear any readmission/transitions program that is fixated upon readmission rates rather than safe, efficient, patient-centered care has been worshipping an idol of brass, not gold.

How should the quality and value of care transitions actually be measured? We should ask the patient and family for that answer —not as a function of patient/family satisfaction, but through discussions of their goals and needs. We must take into account advance directives, quality of life, and social determinants. Determine those patient-centered goals, document them, then base outcomes upon whether we clinicians and facilities are actually meeting them. Why not create a true “value-based payment” on the rate that we meet patient values, and not on the artificial and false idol of 30-day readmission rates?

Dr. Lett is a Society past president, past chair of the Society’s Transitions of Care Committee and previous editor of this column. Dr. Saltsman is the section chief of geriatrics and transitional care for Lahey Health, Burlington, MA. He is the chair of the Society’s Transitions of Care Committee and this column’s editor.

**EDITOR’S NOTE**

The image of ‘false idolatry’ that Dr. Lett portrays is a powerful one. Perhaps it also serves to illustrate the blind acceptance that we all have in swinging the pendulum of health care to extremes that ultimately cannot and should not be supported. Many have come forward with the idea that readmissions are not the end game, but only as part of the game of transitions itself; we need to look much harder at the value we desire and perhaps pull the pendulum back to a place where we can coordinate quality care again for our patients, their families, and our system. We may need to “break some tablets” to force us away from the adoration of readmissions, and toward a better prayer for quality care.

—Wayne Saltsman, MD, CMD, PhD