EDITORIAL

Multiple readmissions: Problem or opportunity?
Múltiples readmisiones: un problema o una oportunidad?

Thirty years ago, Anderson and Steinberg demonstrated that around one fifth of Medicare beneficiaries had two or more hospitalisations over 4 years, and that they accounted for almost four fifths of inpatient expenditure.¹ This seminal analysis triggered interest in readmissions as a potential target for hospital cost containment, and led to numerous studies trying to understand the characteristics of patients who are likely to be "high cost users" in order to develop targeted lower cost outpatient care interventions. There have been a large number of cohort studies, mainly in older medical patients where unplanned admissions are the norm, examining a wide range of patient clinical, functional and social characteristics.²,³

Etxeberria-Lekuona et al's study in this issue of Rev Clin Esp⁴ applies this methodology to a Spanish general medical population, an elderly, multi-morbid and functionally impaired group typical of such services throughout the developed world. Like most previous studies, the study confirms that patients with greater chronic disease burden, functional impairment and previous admissions are at higher risk of readmission, which mostly result from exacerbation of one of their underlying chronic diseases, and that older age is not a predictor once these factors are taken into account. Male sex and rural origin are also predictors of frequent admissions. These findings are consistent with previous reports,¹,² but do they add useful information about identifying and intervening for this vulnerable patient group?

In terms of risk prediction, the resulting model had only modest predictive value, in keeping with previous studies which have not delivered useful predictive tools for clinical practice.⁵ The modest performance of models based on limited clinical data is not surprising. Recent qualitative studies with detailed collection of patient and provider data reveal the complex interplay between clinical, social and health service variables, with multiple factors contributing to the decision to represent and rehospitalise.⁶ Furthermore, it is unclear which readmissions are undesirable in achieving health care aims. While the notion of preventable readmissions seems straightforward, it has not been well defined. Most studies have been based on clinical consensus, and while reported rates of readmission are surprisingly similar between countries and across years (15–20% at 30 days and 30–35% at 3–6 months), estimation of preventable readmission varies widely between different investigator groups.⁷ A recent meta-analysis showed that less than one quarter of readmissions are preventable.⁷ Similarly, a small study which adopted the patient perspective reported that only one quarter of readmitted patients thought their readmissions might have been prevented, and agreement about preventability between patients and providers was poor.⁸

These estimates are consistent with intervention studies which show that complex and intensive multi-component interventions commencing in hospital and enhancing transition to community care by improving discharge preparation, communication and post-discharge support may reduce readmissions by up to 20% in a highly supported trial settings, usually enrolling selected high risk groups.⁷,¹⁰ Unfortunately there remains limited evidence that such interventions can be applied at scale in order to realise sufficient hospital use reduction to justify the additional expense, partly because of the many barriers to uptake and implementation of complex cross-sectoral interventions.¹¹

Importantly, Etxeberria-Lekuona et al.⁴ confirms that frequently readmitted patients have high mortality, with almost half the cohort dying within the study follow up period of 12 months, usually associated with a hospital readmission. In fact, one third of recorded hospital readmissions resulted in patient death. Despite this poor prognosis, patients were on a large number of medicines, and one in six hospitalisations was associated with adverse treatment effects. No mention was made of advance care planning in this setting, but it is likely that uptake remains poor as in other health care systems.

Perhaps it is time to re-imagine the "problem" of readmissions: to stop seeing them as a failure of our health system (or our patients), and instead recognise that they are the natural consequence of a health care system that deals very effectively with acute illness, shepherding the majority of the population to a life stage where chronic illness and functional disability accumulate as the person

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nears end of life. Rather than continuing to focus on predicting or even preventing hospital readmissions, we could recognise that accelerating hospital admissions are a predictable part of the late chronic disease trajectory, and should signal to health care providers that goals of care need to be re-evaluated. Instead of a failure, this then frames multiple readmissions as an opportunity for the health care team to connect, understand goals, and individualise care to optimise symptoms and the quality of remaining life in a vulnerable patient group.

References


A. Mudge

University of Queensland, School of Medical, School of Medicine, Brisbane, Australia

E-mail address: Alison_Mudge@health.qld.gov.au