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CORR Insights®: What Are the 30-day Readmission Rates Across Orthopaedic Subspecialties?

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Where Are We Now?

Healthcare quality can be difficult to measure and assess in ways that respect the

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expertise of individual physicians, while simultaneously applying objective standards. Hospital readmission during the first 30 days after orthopaedic surgery is discrete and quantifiable, yet different definitions of what constitutes planned and unplanned readmission can result in different estimates of rates. Evaluating the reasons for readmission may elucidate areas of need and identify opportunities for improvement.

The authors of the current study reviewed hospital readmissions after orthopaedic operations at their institution. Their analysis—which encompasses all orthopaedic subspecialties during a 2-year period and includes both surgical and medical readmissions—adds to our knowledge. Not surprisingly, a patient’s baseline health

status and the length of stay during the index hospitalization are each associated with an increased risk of readmission. However, other risk factors, such as receiving treatment on the orthopaedic trauma service or being discharged to a skilled nursing facility, are not as obvious. Even if risk factors cannot be modified, their presence can alert clinicians to the elevated risk of readmission and prompt closer followup, such as an outpatient appointment within 48 hours of discharge. Moreover, poor agreement among clinical institutions, hospitals, and Medicare regarding the definition of planned readmission reveals important differences in the way that patient services are classified and prioritized.

Where Do We Need To Go?

A policy aimed at merely reducing readmissions—without understanding the reasons and risk factors—could compromise patient safety. Financial penalties, such as denial of payment for a readmission that an insurer deems unnecessary, and administrative

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penalties, such as inclusion on a list of providers who have above-average rates of readmission—might lead some physicians to try to manage complications on an outpatient basis, even when clinical judgment indicates that the patient needs to be admitted. Some surgeons might hesitate to operate on patients with complex orthopaedic conditions and those with multiple medical comorbidities. Therefore, while the reduction of readmissions is important, it is equally crucial to ensure that the question is approached sensibly and appropriately. Furthermore, the discrepancies among clinical, hospital, and Medicare definitions of planned readmission suggest that physicians, administrators, and insurers need to evaluate key components of postoperative management and identify areas of disagreement. By unifying their efforts, these stakeholders can collaborate in order to attain a common objective: improving patient care while containing costs.

How Do We Get There?

This topic deserves further research, and additional risk factors should be examined. First, as the authors acknowledge, admissions to other facilities were not captured. If a substantial percentage of patients reside more than an hour from the index hospital and seek emergency care at a different facility, then the number of unplanned admissions may be underestimated. Second, the total operative time might have predictive value in terms of surgical factors, such as the complexity of the procedure and the severity of the underlying condition, as well as medical factors, such as possible effects of prolonged anesthesia on pulmonary and hemodynamic function during the early postoperative period. Third, the involvement of attending physicians should be assessed. At the institution of Bernatz et al., all patients are seen by an attending physician every day during the entire hospitalization. However, at some teaching

facilities, orthopaedic inpatients have no contact with any attending physician and are managed by unsupervised junior residents. Ensuring that faculty physicians are physically present and personally involved in patient management might reduce the risk of readmission and other poor outcomes. Fourth, for the more challenging subpopulations—such as trauma patients and individuals who will be discharged to skilled nursing facilities—additional analyses should focus on the range and intensity of services that they need.

Treating numbers is easy; treating people requires thought and planning. Simply reducing readmissions could be literally fatal. Understanding the reasons for rehospitalization is an important first step. The different perspectives of clinicians, policymakers, and insurers could be an asset: with their combined experience and complementary strengths, these stakeholders can together develop an integrated approach to improve healthcare quality and patient safety.