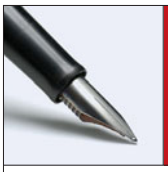


LETTER FROM THE EDITOR-IN-CHIEF

The Role of Urgent Care in Reducing Hospital Readmissions

Early outpatient follow-up after hospital admission has been documented to be an important factor in reducing hospital readmission rates. Readmissions are also well known to cost billions of dollars annually. The problem with readmissions spans all socioeconomic classes and impacts all payors, public and private. As of 2013, the CMS began penalizing hospitals for readmissions, thus efforts are being made to limit these rates as much as possible. Numerous studies have evaluated the impact of early outpatient follow-up and all have demonstrated significant benefits, especially with regard to medication management and adherence, early identification of adverse reactions, decompensation and, of course, readmission.

So, we know that early outpatient follow-up is impactful. But what are the obstacles? Studies have shown that a full 90% of patients with an admission to a hospital report having a "usual source of care".[1] However, having a usual source of care is no guarantee of access or follow up. In fact, only 66% of all adults with a hospital admission saw a doctor for follow up within 30 days of discharge. In this same study, only about one-third of these patients stated that their regular source of care was available on nights and weekends. And one in 10 said that office was difficult to get to.

It is clear that limited access to care impacts post-discharge follow-up. That has been known for some time. Yet, until recently, not one study had attempted to evaluate whether there was a true connection between "access to care" and readmission rates. In April of this year, researchers from the Health Research and Educational Trust did just that, examining readmission rates over a 3-year period at over 4,000 hospitals. The results are dramatic and actionable. Of all the independently associated community characteristics identified, measures of "access to care" were the most strongly associated with readmission rates. Less access, independent of demographics, independent of payor type and insurance status, was reproducibly associated with higher readmission rates.

Our dependence on primary care for post-discharge follow-up is a major factor. Consider these problems:

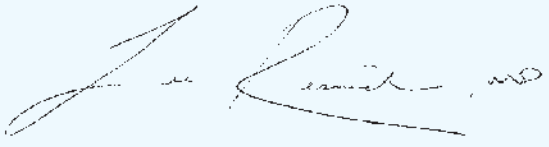
1. Transportation and logistics
   a. Primary care physicians often have one physical office, limiting choice of location.
   b. Primary care offices are often buried in medical office buildings, creating both real and perceived physical obstacles to access. These obstacles are further exaggerated by the limited mobility common during the first few days after discharge.
2. Scheduling
   a. Primary care physicians most often require scheduling, an access barrier that is also amplified in the post-discharge time period. Dependency on caregivers for transportation complicates this even more.
   b. Limited hours and no weekend coverage are well-known access issues, made even more problematic for those who are still convalescing from illness.
3. Lab and x-ray
   a. The availability of lab and x-ray at the point of care is imperative for evaluation of the recently hospitalized patient.

Urgent care has been the most consistent access solution for the last 20 years and its rapid growth has led to broad urgent care coverage in most major markets. So, why not look to urgent care to remove the access barrier to early post-discharge follow-up? The following steps are necessary, but eminently achievable: 1) hospital records access (perhaps through a read-only agreement); 2) hospitalist consultation availability; 3) clinical protocols to drive decision-making; and 4) primary care collaboration.

A pilot study could easily be done and, if successful, would be a tremendous opportunity for urgent care to demonstrate value on a major national health policy initiative. ■

Reference

1. Medical Expenditure Panel Survey 2000-2008



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