

## Postdischarge Emergency Department Visits: Good, Bad, or Ugly?

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Once upon a time, discharges were easy to categorize: *good*, *bad*, or *ugly*. Good discharges allowed the patient to leave before noon, while bad discharges allowed the patient to leave without follow-up appointments. The worst discharges were defined by the two ugly cousins of acute care re-escalation: return emergency department (ED) visits and readmissions. Recently, however, much of this conventional wisdom has been turned on its head. For example, pre-noon discharges and provider-scheduled follow-up appointments may lead to unintended negative consequences and futility.<sup>1,2</sup> In contrast, weekend discharges, which were often viewed to be unsafe, may reduce lengths of stay without compromising care even in high-risk patients.<sup>3</sup>

Having obfuscated the line between good and bad, we can now turn our attention to the ugly. Comparing return ED visits with readmissions, hospitalists may be forgiven for judging the latter cousin as uglier – and not just for reimbursement reasons. Readmitted patients are sicker, more vulnerable, and have poorer outcomes. In our healthcare system's resultant quest to eliminate readmissions, return ED visits that do not end in readmission are generally either ignored or grouped with readmissions. Ignoring these treat-and-discharge ED visits is problematic because of their incidence, which rivals that of ED visits ending in readmission.<sup>4</sup> On the other hand, grouping these visits with readmissions only makes sense if the two are considered to be equally ugly outcomes. Is this a valid assumption to make?

In this issue of the *Journal of Hospital Medicine*, Venkatesh et al<sup>5</sup> tackle that question by studying Medicare beneficiaries hospitalized for acute myocardial infarction, heart failure, or pneumonia over a 1-year period. The authors differentiate 30-day treat-and-discharge ED visit rates from 30-day readmission rates before risk-standardizing these rates based on visit codes and hospital characteristics. Similar to the results of prior studies, the authors observe an 8%–9% overall incidence of treat-and-discharge ED visits within 30 days of hospital discharge.<sup>6</sup> Mapping treat-and-discharge ED visit rates versus readmission rates for each hospital, the authors detect modest but noticeable inverse correlations between the two. Among hospitals

discharging heart failure patients, for example, every 10% increase in postdischarge ED visit rates corresponds to a roughly 2% decrease in readmission rates.

The authors are correct to tread cautiously with their interpretation of this correlation. Dispositions for ED patients exist on a continuum, so hospitals with higher propensities to discharge patients from EDs (whether directly or from observation units) will inherently have lower admission rates. The authors hint at a causal relationship nonetheless, suggesting that ED providers may be able to intervene on high-risk patients earlier before Readmission Road becomes a one-way street. Proving this hypothesis will require careful research that controls for patient, disease, and ED factors as well as their complex interactions in the postdischarge timeline. That being said, most analyses of outpatient follow-up visits (except for heart failure patients) have failed to find any anti-readmission correlation analogous to that identified by Venkatesh et al. What powers do ED providers have that outpatient providers lack? Many, admittedly: stat phlebotomy services, on-demand consultations, and observation units. Additionally, while ED visits invariably require a patient's presence in person, 25% of provider-scheduled posthospitalization outpatient visits end in no-shows.<sup>2</sup> Whether patient-triggered follow-up through rapid access clinics or even urgent care centers can replicate ED functionality in recently discharged patients is unknown and warrants further study.

Venkatesh et al<sup>5</sup> also find that reasons for postdischarge ED visits bear only a slight resemblance to reasons for index hospitalizations. For example, of all ED visits by patients recovering from hospitalizations for pneumonia, only 20% involve respiratory or pulmonary complaints. What explains the other 80%? Some variability may be attributable to the study's use of visit codes instead of chart reviews or stakeholder interviews; in surveys of patients and ED physicians during these postdischarge visits, the two groups may have very different perceptions of why the encounter is occurring and whether it is preventable.<sup>7</sup> Regardless of who is "right," the heterogeneity of reasons that prompt care re-escalation lends further credence to the existence of a distinct posthospitalization syndrome:<sup>8</sup> in the immediate postdischarge interval, patients experience many transient but real physiological risks for which they may identify the ED as their best recourse.

Whether the ED actually provides secondary prophylaxis against the posthospitalization syndrome is highly debatable, and Venkatesh et al wisely refrain from assigning a positive or negative valence to treat-and-discharge ED visits. Ultimately, postdischarge ED visits are neither inherently good nor bad (nor ugly, for that matter). Their unique nature is attracting

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Published online first March 15, 2018.

Received: February 2, 2018; Accepted: February 7, 2018

© 2018 Society of Hospital Medicine DOI 10.12788/jhm.2971

newfound appreciation, and their potential ability to prevent readmission merits further research. If hospitals with high post-discharge ED visit rates can deliver high-quality care while truly arresting or reversing readmission-bound trajectories, then the strategies employed by these hospitals should inspire emulation, innovation, and dissemination.

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Disclosures: The authors have nothing to disclose.

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