Where people live before hospitalization important for discharge planning, reducing readmissions

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Forty per cent of older adults who leave hospital are discharged to home care or a long-term care facility, which, combined with where they lived

before hospitalization, affects their risk of readmission, found a study published in *CMAJ* (*Canadian Medical Association Journal*).

These data are important for both health care professionals and policy-makers to improve discharge planning for patients and to reduce readmissions.

"The information from this study will contribute to a better understanding of the extent to which complicated transitions to and from hospital influence readmission among older adults, which is essential for system planning, performance measurement, and the targeting and testing of interventions to improve transitions and reduce readmissions," writes Dr. Andrea Gruneir, Department of Family Medicine, University of Alberta and ICES, with coauthors.

While most research on readmissions focuses on people who are admitted to hospital from the community and who return to the community, this study considers the large number of older adults with more complex pathways across the system.

The large study of 701,527 hospitalized adults over age 65 in Ontario found that 31.5% of people were discharged to home care and 9.5% to long-term care, with 3% newly admitted to long-term care. More than half (53.5%) were women and 40% had five or more chronic conditions. Almost every patient (98%) had visited a doctor at least once during the year before hospital admission, 331,168 (47%) had visited the emergency department and 72,536 (10%) had been admitted.

The authors state that the study "shows that fundamental shortcomings in the health system's ability to meet older adults' needs, particularly those with dementia, manifest as frequent use of acute care, including readmissions, prolonged hospital stays with extended alternate levels of care periods and 'non-acute' reasons for hospital admission."

People who were discharged with home care were the most likely to be readmitted, and when readmitted, 19% were there for two or more weeks and nearly 20% were designated as alternate level of care (ALC), the longest of any group in the study. Conversely, people who were discharged to long-term care (as a new admission) were the least likely to be readmitted, but their first hospital stay was most often for dementia. More than 80% were in hospital for two or more weeks and were designated as ALC, which means they no longer need acute hospital care but can't be discharged as the appropriate level of care required is not available in another setting.

"By contextualizing hospitalization within these care settings, our findings suggest an approach to understanding readmissions as a signal of the health system's preparedness for the ageing population," the authors conclude.

More information: Andrea Gruneir et al, Care setting and 30-day hospital readmissions among older adults: a population-based cohort study, *Canadian Medical Association Journal* (2018). DOI: 10.1503/cmaj.180290

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