

# Reasons for readmissions from Geriatric Evaluation and Management in the Home (GITH) to an acute care setting in a regional sub-acute service of Victoria, Australia

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## Background and aims

The aim of the study was to describe nature of readmissions in a newly implemented bed-substitution program, Geriatric Evaluation and Management in the Home (GITH) to an acute care setting. GITH is a relatively new model of care, using a bed substitution program, providing 11 "inpatient beds" in patients own homes. There is a multidisciplinary team approach focused on individual goals, as seen in subacute/GEM wards, supported by nursing, medical and allied health clinicians. The program includes patients living within a 20km radius of the primary healthcare centre who are clinically stable to receive care within their own home, but still have ongoing sub-acute goals of therapy.

## Methods

Retrospective medical record audit of consecutive patients discharged from GITH after commencement in Sep 2013 to Jan 2014. All relevant patient information in the hospital electronic medical record in January 2014 to extract the key study variables. The clinical context of the readmission was gathered and a determination of whether the readmission could have been prevented was made as a consensus decision by GITH staff.

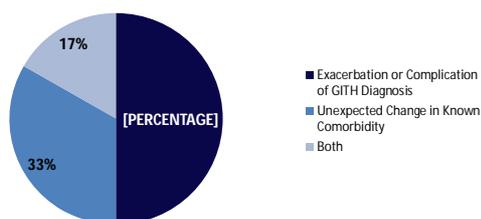
## Results

The program discharged 41 patients in the study period. In the overall study population the mean age was 81 years old, 59% were male (24/41), 59% lived alone (24/41) and had 46% cognitive impairment (including dementia and delirium). The average length of stay of the program was 27 days, with the entire range varying from 5-56 days. 11 patients (27%) were readmitted, all of the readmissions were to acute care and were unplanned. Six were due to an exacerbation or complication of their GITH admission diagnosis, four were due to an unexpected change in a known comorbidity and one due to a new event.

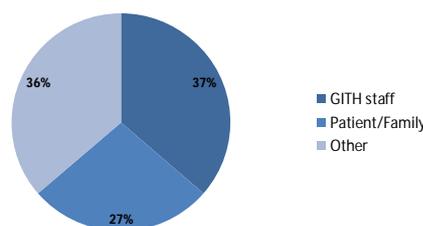
The nature of care required for readmitted patients was diagnostic (4/11, 36%), clinical management (5/11, 45%) and combined in two cases (18%). The person initiating return to an acute setting care was GITH staff (4/11, 36%), patient or family (3/11, 27%) and the other four were other sources. GITH could have provided the same elements of care as received in the acute setting for only one readmitted patient (9%). A notable factor to an unplanned readmission was the perception and response to clinical risk. There was discordance between the patient and the sub-acute inpatient clinical team about timing and/or desirability of discharge home onto GITH in 5 out of 11 patients.

Variable	Not readmitted		Readmitted to acute setting		Total	
	N	(%)	N	(%)	N	%
	30	(100%)	11	(100%)	41	(100)
Age (years)	Mean 81		Mean 78			
Gender (Male)	17	(41%)	9	(82%)	26	(63%)
Length on program (days)	Mean 29 Median 26.5		Mean 21 Median 24			
Lives alone	16	(53%)	6	(55%)	22	(54%)
Presence of cognitive impairment	16	(53%)	7	(64%)	23	(56%)

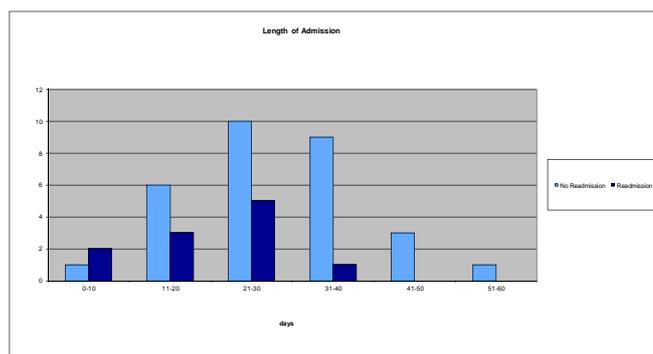
Readmission Reason



Person Initiating Readmission



Length of Admission



## Discussion

Institution of a new community program is fraught with challenges. A high readmission rate may reflect the complex nature of the patients' clinical condition and delivering care in a real world as opposed to the safe and sterile hospital environment. A major challenge is gaining an understanding of the risk tolerances of the patient, family and staff and balancing this with resource constraint in the health system. Other challenges for regional and rural centres include geographic isolation, those living on farms and limitations in accessing care. Judging the merits of GITH requires considering how the patient, family, inpatient team and GITH team perceive and respond to clinical risk.

## Conclusion

Unplanned readmissions of GITH patients to acute appear unavoidable once on the program. Patients at higher risk were those wanting to leave hospital earlier than considered desirable by the inpatient team.