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Length of stay, quality of care and elderly patients

I read with interest the article "Discharging patients earlier from Winnipeg hospitals: Does it adversely affect quality of care?" (*Can Med Assoc J* 1995; 153: 745–751), by Ms. Marion L. Harrison and Drs. Lesley A. Graff, Noralou P. Roos and Marni D. Brownell. The conclusions surprised me, and, on reflection, I believe that the authors should look at their data again.

The report makes no mention of the age characteristics of the patients studied. As a geriatrician, I suspect that there may be a significant difference in outcomes between subjects over 75 years of age (and particularly over 80) and their younger counterparts.

Such a re-organization and reanalysis of the data would likely show as well that grouping patients by diagnostic category is somewhat simplistic. I do not believe that the use of Refined Diagnosis Related Groups overcomes the complexities of dealing with coexisting illnesses among the very elderly patients usually seen by specialists in geriatric medicine.

Postdischarge visits to physicians may not be a good indicator of the need for subsequent care among elderly patients, who may be frail, disabled or socially isolated. They may lack the motivation or mobility to visit their physician.

Therefore, the conclusion that "improving hospital efficiency by shortening length of stay does not appear to result in increased rates of readmission or numbers of physician visits within 30 days after discharge" may apply only to younger patients or to those with "simpler" conditions.

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[The authors respond:]

Dr. Gryfe's hypothesis that there are significant differences in outcomes between elderly patients and their younger counterparts is correct. We have explored this concern in research on the effect of changes in the acute care hospital sector on patient care.[1] We examined readmission rates for several patient categories, including the four mentioned in our article, and found that, in many cases, patients 75 years of age and older have significantly higher readmission rates than younger patients. Although this finding is important, the principal interest in our study was whether readmission rates had changed as lengths of stay had decreased. Reassuringly, the readmission rates among the elderly patients showed no change during 4 years, despite decreasing lengths of stay.

Although lengths of stay among patients in all age groups have decreased significantly for the last several years, for each year studied the stays were significantly longer among patients 75 years of age and older than among younger patients. In fact, we found that the mean length of stay for elderly patients (11.5 days) in 1993–94 was still longer than the mean length of stay for younger patients in 1989–90 (11.0 days). Clearly, the length of stay has not been determined arbitrarily but has taken patient needs into consideration.

The Refined Diagnosis Related Groups system was designed to identify comorbidities and complications expected to increase length of stay and resource use, regardless of age. Because the sample used to develop the RDRGs included many elderly

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