

# Early Discharge of Alberta Mothers Post-delivery and the Relationship to Potentially Preventable Newborn Readmissions

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## ABSTRACT

**Objective:** To determine whether early maternal discharge increases newborn readmission rates.

**Methods:** Singleton vaginal deliveries weighing at least 2500 grams were extracted from April 1, 1997 to March 31, 2000 Alberta hospital abstracts and linked to records of birth. Potentially preventable readmissions were for dehydration, jaundice, feeding problems, inadequate weight gain, and social reasons.

**Results:** The most common reason for readmission is jaundice (74%). In order of importance, influencing factors were: length of gestation, Aboriginal treaty status, first live birth, delivering in region of residence, number of deliveries done in the hospital, newborn sex, maternal smoking, birthweight, previous abortions, and delivering in nearest hospital. Post-delivery length of stay was associated with readmissions in the first 6 days post discharge (25% greater in those <27 hours compared to those >48 hours) but not in the first 28 days post discharge.

**Conclusion:** Early maternal discharge is a minor determinant of potentially preventable newborn readmissions.

*La traduction du résumé se trouve à la fin de l'article.*

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The Canadian Pediatric Society and the Society of Obstetrics and Gynecologists of Canada recommend that a hospital stay of 12 to 48 hours is adequate for women and their newborns in absence of medical illness and in the presence of social support.<sup>1</sup> The length of hospital stay after vaginal delivery has decreased in Canada from 4.7 days in 1984/85 to 2.6 days in 1994/95.<sup>2</sup> A recent study in one Ontario hospital suggests that the successful adoption of a clinical pathway increasing early hospital discharge worsened newborn readmission rate.<sup>3</sup> Earlier maternal discharge in Ontario has been associated with increased newborn readmissions for jaundice and dehydration in that province.<sup>4</sup> The march to progressively earlier discharge (12 to 24 hours) in the early 1990s resulted in both physicians<sup>5-7</sup> and mothers<sup>8</sup> stating that maternal and newborn well-being may be worse because of less time spent in hospital after delivery. Population-based, retrospective studies in the United States differ in their conclusions regarding the effect of early maternal discharge upon newborn readmissions.<sup>9,10</sup>

If earlier hospital discharge post-delivery is associated with increased newborn readmissions, the benefits of early discharge are lessened. The possible association of early discharge and increased newborn readmission (especially those potentially preventable such as for jaundice or dehydration) may be organization-specific varying between hospitals. Conversely, newborn readmission may be more strongly associated with maternal factors such as race, age, personal habits, socio-economic status, or social support. In this study, we assess the effect of early maternal discharge after singleton vaginal delivery of newborns weighing 2500 grams or more upon potentially preventable newborn readmissions within 28 days of maternal discharge.

## METHODS

Three Alberta administrative health service databases were used.

- Canadian Institute for Health Information's (CIHI) Inpatient Discharge Abstract Database (DAD) for 1997/98 to 1999/2000,
- Vital Statistics Birth Database for 1997-1999, and
- Health Insurance Plan Registry File for 1997 to 2000.

### Identifying the maternal delivery

Maternal deliveries were identified using CIHI DAD (Discharge Abstract Database). Over 99% of the births that occur in Alberta take place in acute care facilities. All separations with a Main Patient Service area = 51 (obstetrics delivered) were extracted. Three years of data were combined because the volume of deliveries in some hospitals was small. No stillbirths were included.

### Identifying the neonatal birth

Main patient service field = 54 (newborn) was extracted from CIHI DAD. The Alberta Health Care Insurance Plan registry file group number was used to match each newborn to each mother and to determine multiple births.

### Linking to vital statistics

Vital statistic birth records contain questions to be completed by the family physician/pediatrician within 24 hours of delivery and the mother prior to hospital discharge. Because the vital statistic database does not record patients' unique Alberta Health Insurance Registry number, a deterministic linkage to maternal records for each of the three years was done by using: neonatal birth date (365 unique values), birthweight (3,007 unique values), delivery site (87 facilities), neonatal sex, and maternal age (39 unique values). Variables unique to vital statistics include weeks of gestation, history of smoking or consumption of alcohol/street drugs during the current pregnancy, and marital status at the time of birth. Vital statistics data from January 1 to March 31, 2000 were unavailable.

### Defining potentially preventable readmissions

Potentially preventable newborn readmission was defined as re-entering any acute care hospital within 28 days post-delivery for the following most responsible diagnosis: inadequate weight gain (ICD-9 CM 783.2, 783.4); jaundice (ICD-9CM 773.1, 774.2, 774.3x, 774.6, 774.7); dehydration (ICD-9CM 276.0, 276.5, 775.5, 778.4); feeding problem (779.3, 783.3); social reasons (V20.1, V650). Only singleton vaginal deliveries weighing at least 2500 grams were analyzed. If more than one readmission occurred, only the first was analyzed.

TABLE I

Most Responsible Diagnosis and Length of Stay for Newborn Readmissions

Most Responsible Diagnosis	Number of Readmissions			Readmission Length of Stay (Days)	
	0-6 Days	7-28 Days	Total	Mean	SD
Jaundice	1961	135	2096	2.01	1.17
Dehydration	56	23	79	3.11	3.16
Feeding problems	114	85	199	2.97	3.56
Inadequate weight gain	7	34	41	3.51	2.69
Social reasons	308	117	425	2.47	3.47
All newborn readmissions	2446	394	2840	2.20	2.05

TABLE II

Length of Hospital Stay for Singleton Vaginal Deliveries of Birthweight 2500+ grams

		N	Mean	Standard Deviation
Newborn	Total length of stay (days)	81,956	1.77	1.35
	Total length of stay (days)	81,955	2.01	1.66
Mother	Post-delivery length of stay (hours)	81,951	40.33	21.49
	Pre-delivery length of stay (hours)	81,733	10.09	31.76

### Defining hospital group

Hospitals providing maternal delivery services were categorized by the average number of deliveries per year over the three-year study period: group 1 = 12 hospitals with 1 to 49 deliveries each; group 2 = 12 hospitals with 50 to 99 deliveries each; group 3 = 30 hospitals with 100 to 405 deliveries each; group 4 = 5 hospitals with 631 to 1,691 deliveries each in one of the five non-metropolitan regional hospitals; group 5 = 5 hospitals located in the metropolitan health regions of Calgary and Capital; group 6 = 2 hospitals containing a Level 3 neonatal intensive care unit (one hospital in each of Calgary and Capital health regions).

### Defining the model

A forward stepwise logistic regression (SPSS version 10) was used to determine the order of importance of the factors influencing maternal and neonatal readmission. The influencing factors are defined below. The odds ratio and 95% confidence interval were used to define significance.

### Maternal variables

#### Demographic Variables

- Maternal age (<17, 17-40, >40 years)
- Aboriginal treaty status
- Welfare
- Alberta Health Insurance premium subsidy based upon taxable income less than \$12,620.

#### Variables Related to Pregnancy

- Smoking (or quit) during current pregnancy

- Alcohol during current pregnancy
- Illicit drugs during current pregnancy
- Previous stillbirths
- Previous neonatal/infant deaths
- Previous abortions.

#### Social Support Variables

- Parents married
- First live birth.

#### Neonatal Variables

- Gestation (<37 weeks, 37-42 weeks, >42 weeks)
- Birthweight in grams (2500-3000, 3001-3500, 3501-4000, >4000)
- Sex
- Apgars (less than 7) at 1, 5, and 10 minutes.

#### Organizational Variables

- Hospital groups (as described above)
- Post-delivery length of stay in quartile hours
- Delivered in the nearest hospital defined as any hospital that performs deliveries whose distance between its postal code and the mother's residence postal code is shortest
- Mother delivered in her resident region.

## RESULTS

A total of 112,835 live births occurred in Alberta between April 1, 1997 to March 31, 2000. 73% of all live births (n=81,956) were singleton vaginal deliveries of birthweight at least 2500 grams. We matched 63,972 deliveries (85% of 75,544 singleton vaginal deliveries of birthweight at least 2500 grams) to the vital statistics

**TABLE III**  
**Influencing Factors for Singleton Vaginal Deliveries of Birthweight 2500+ grams**

Influencing Factor	Deliveries n (%)	Newborn Readmission n (%)	No Newborn Readmission n (%)
<b>Maternal variables</b>			
All	81,956	2840	79,116
Not subsidy, welfare, or Aboriginal treaty status	61,670 (75%)	2029 (71%)	59,641 (75%)
Subsidy	11,807 (14%)	390 (14%)	11,417 (14%)
Welfare	3157 (3.9%)	89 (3.1%)	3068 (3.8%)
Aboriginal treaty status	5322 (6.5%)	332 (12%)	4990 (6.3%)
Smoking during pregnancy – all	61,882	2150	59,732
No	45,905 (74%)	1637 (76%)	44,268 (74%)
Yes	14,309 (23%)	456 (21%)	13,853 (23%)
Quit	1668 (2.7%)	57 (2.7%)	1611 (2.7%)
History of abortion – all	63,972	2233	61,739
No	45,470 (71%)	1573 (70%)	43,897 (71%)
Yes	18,502 (29%)	660 (30%)	17,842 (29%)
First live birth – all	63,972	2233	61,739
No	39,088 (61%)	1115 (50%)	37,973 (62%)
Yes	24,884 (39%)	1118 (50%)	23,766 (38%)
<b>Newborn variables</b>			
Gestational age – all	63,969	2233	61,736
< 37 weeks (pre-term)	1896 (3.0%)	231 (10%)	1665 (2.7%)
37 to 42 weeks	62,034 (97%)	2000 (90%)	60,034 (97%)
> 42 weeks (post-term)	39 (0.06%)	2 (0.0%)	37 (0.3%)
Birthweight – all (grams)	79,956	2840	79,116
2500-2999 g	12,429 (15%)	625 (22%)	11,804 (15%)
3000-3499 g	31,733 (39%)	1086 (38%)	30,647 (39%)
3500-3999 g	27,571 (34%)	818 (29%)	26,753 (34%)
4000 g and over	10,223 (12%)	311 (11%)	9912 (13%)
Newborn sex – all	81,956	2840	79,116
Male	41,598 (51%)	1629 (57%)	39,969 (51%)
Female	40,358 (49%)	1211 (43%)	39,147 (49%)
<b>Organizational variables</b>			
Hospital group – all	81,955	2840	79,115
Group 1-3	16,871 (21%)	762 (27%)	16,109 (21%)
Group 4	12,601 (15%)	365 (13%)	12,236 (15%)
Group 5-6	52,483 (64%)	1713 (60%)	50,770 (64%)
Delivered in the nearest hospital – all	81,502	2826	78,676
No	15,299 (19%)	738 (26%)	14,561 (18%)
Yes	66,203 (81%)	2088 (74%)	64,115 (82%)
Delivered at home region – all	81,951	2840	79,111
No	8303 (11%)	445 (16%)	7858 (10%)
Yes	73,648 (89%)	2395 (84%)	71,253 (90%)
Post-delivery length of stay – all	81,951	2840	79,111
1st quartile: <27 hours	20,202 (25%)	685 (24%)	19,517 (25%)
2nd quartile: 27-36 hours	20,054 (24%)	639 (23%)	19,415 (25%)
3rd quartile: 37-48 hours	21,558 (26%)	764 (27%)	20,794 (26%)
4th quartile: >48 hours	20,137 (25%)	752 (26%)	19,385 (24%)

database for 1997-1999 (note absence of 6,412 deliveries from vital statistics during the time period January 1, 2000 to March 31, 2000). The largest cohort sample is used wherever possible and number stated in each table.

Potentially preventable readmissions were 3.5% of newborn deliveries (Table I). Most potentially preventable neonatal readmissions (86%) occurred within the first 6 days after hospital discharge. The average readmission length of hospital stay was approximately 2 or 3 days. This is slightly longer than the total 1- or 2-day

length of stay for the original delivery (Table II).

The influencing factors for readmissions are listed in Table III. The significant influencing factors retained in the modeling of readmission are listed in Table IV. The order of entry into the model is an estimate of relative ranking of influencing factors. All other factors entered the early readmission model prior to post-delivery length of stay. Results were similar for early (0-6 days) or all (0-28 days) readmissions except for post-delivery length of stay. Newborns of mothers with a post-

delivery length of stay of more than 48 hours were 25% less likely to be readmitted between 0 to 6 days post-delivery but not 0 to 28 days compared to those with a post-delivery length of stay of less than 27 hours.

## DISCUSSION

Potentially preventable newborn readmissions for dehydration, jaundice, feeding problems, inadequate weight gain, and social reasons are not common (3.5% of singleton vaginally delivered newborns of birthweight not less than 2500 grams). The majority (86%) of readmissions are within the first 6 days post delivery. Other modifiable organizational factors (e.g., delivering in a facility with more total deliveries, delivering in the facility closest to mother, or delivering in the mother's health residence region) exerted the most influence upon the rate of readmission. As the most common reason for readmission is jaundice (74%), the timing of discharge in relation to the peak incidence of jaundice (3 to 4 days) is more likely to influence early readmissions (0 to 6 days post discharge).<sup>11</sup> In this study, early but not late readmissions were associated with early discharge which is consistent with the natural history of newborn jaundice. As well, only the shortest maternal post-delivery length of stay (less than 27 hours compared to greater than 48 hours) was associated with increased readmissions. In these delayed maternal discharges, jaundice or other newborn problems may have been incidentally noted (or have been the reason for the delay) and treated, obviating the potential need for readmission. The maternal discharge time effect upon readmission rates is much less than that noted in a retrospective before-after cohort in one Ontario hospital.<sup>3</sup> The weak effect of post-delivery length of stay found in this study may explain the variability in its significance in other population-based cohort studies.<sup>10</sup>

The major goals of hospitalization post-delivery are to identify maternal or newborn complications, provide assistance to the mother and newborn, and ensure that the mother is sufficiently recovered after delivery to look after herself and her newborn.<sup>11</sup> Those readmissions that were defined as potentially preventable may

serve as an indicator for the quality of post-delivery care provided. This indicator is not comprehensive as, for example, breastfeeding rate or maternal depression is not captured. As well, we excluded multiple births, Cesarean sections, and birthweights less than 2500 grams in order to select those mothers with routine births. Between 1960 and 1980, discharge within 48 hours after vaginal delivery was relatively uncommon.<sup>12,13</sup> Discharge before 48 hours has not been associated with maternal morbidity,<sup>14</sup> dissatisfaction,<sup>15</sup> breastfeeding problems,<sup>16</sup> or worsened emotional state.<sup>17</sup> During the 1990s, at the peak of public concern in the United States about insurer-mandated early discharge, reports of newborn medical problems with respect to kernicterus and severe dehydration surfaced.<sup>18</sup> The historic newborn readmission rate is 2 to 4%,<sup>9,13</sup> similar to that in this study.

### Influencing factors

We have included a variety of influencing factors not previously studied in understanding newborn readmissions. Their inclusion may have affected the influence of post-discharge length of stay. We are unaware of any population-based study that specifically addresses the risk of newborn readmission for mothers who have Aboriginal treaty status or our proxy for low income (health premium subsidy/welfare). Aboriginal treaty status but not subsidy/welfare was a significant risk factor for newborn readmission. Early discharge is not associated with increased readmissions in selected low-income populations.<sup>19,20</sup> However, low socio-economic status is associated with early discharge.<sup>21</sup> Early discharge may result in some unexpected repercussions such as a resumption of smoking.<sup>22</sup> The association between early post-delivery discharge and smoking status may be related to the desire of the mother to remain at home (and not have her newborn readmitted) where smoking is not discouraged. In other population studies, short gestation, primiparity, race, and married status but not maternal age were associated with increased neonatal readmission.<sup>9,20</sup> We restricted our analysis to potentially preventable newborn readmissions and found similar results. We were also able to assess the organizational influence by measuring the frequency of total deliveries at the hospital, the location of the

**TABLE IV**

### Significant Influencing Factors for Newborn Re-admission of Singleton Vaginal Deliveries of Birthweight 2500+ grams

Influencing Factor	Odds Ratio and 95% Confidence Interval for Early Re-admissions (0 to 6 days)	Odds ratio and 95% Confidence Interval for All Re-admissions (0 to 28 days)
<b>Gestational age</b>		
< 37 weeks (pre-term)	Reference	Reference
37 to 42 weeks	0.271 (0.228 – 0.321)	0.288 (0.245 – 0.339)
> 42 weeks (post-term)	0.486 (0.115 – 2.061)	0.434 (0.103 – 1.836)
Subsidy	0.984 (0.855 – 1.133)	0.991 (0.870 – 1.130)
Welfare	0.982 (0.745 – 1.296)	1.089 (0.851 – 1.392)
Aboriginal treaty status	2.145 (1.827 – 2.517)	2.151 (1.856 – 2.494)
First live birth	1.880 (1.703 – 2.075)	1.682 (1.539 – 1.840)
Delivered in the nearest hospital	0.811 (0.688 – 0.956)	0.774 (0.665 – 0.901)
Hospital group		
Group 1-3	Reference	Reference
Group 4	0.577 (0.493 – 0.676)	0.610 (0.528 – 0.705)
Group 5-6	0.648 (0.575 – 0.730)	0.675 (0.607 – 0.751)
Newborn sex : Female	1.407 (1.279 – 1.549)	1.325 (1.212 – 1.448)
Smoking during pregnancy		
Yes	0.665 (0.587 – 0.754)	0.708 (0.632 – 0.795)
Quit	0.829 (0.622 – 1.105)	0.810 (0.617 – 1.063)
Birthweight (grams)		
2500 – 2999 g	Reference	Reference
3000 – 3499 g	0.751 (0.657 – 0.859)	0.777 (0.685 – 0.881)
3500 – 3999 g	0.681 (0.589 – 0.787)	0.702 (0.613 – 0.803)
4000 g and over	0.654 (0.543 – 0.787)	0.694 (0.585 – 0.823)
Delivered at home region	0.746 (0.652 – 0.853)	0.757 (0.668 – 0.858)
History of abortion	1.158 (1.043 – 1.284)	1.135 (1.031 – 1.250)
Post-delivery length of stay		
1st quartile: <27 hours	Reference	Variable dropped
2nd quartile: 27-36 hours	0.940 (0.820 – 1.079)	Variable dropped
3rd quartile: 37-48 hours	0.932 (0.814 – 1.066)	Variable dropped
4th quartile: >48 hours	0.798 (0.692 – 0.920)	Variable dropped

Note that influencing factor order ranks the relative importance.

hospital in relationship to the mother's residence, and finally the length of hospital stay. We found these other potentially modifiable factors to be more important than maternal post-delivery length of stay in newborn readmission. Post-delivery length of stay exerted a minor influence on re-admission and organizations should not expect that newborn readmissions will be highly related to either shorter or longer stays.

### Limitations

Cohort studies such as this one lack a randomized control group and follow-up of those not readmitted. Given the low re-admission rate and small effect of length of stay, a randomized trial would not be feasible,<sup>23,24</sup> nor would it be possible to use re-admission as a quality indicator if restricted to a single randomized trial.<sup>25</sup> We used administrative data which were collected for other purposes. We attempted to verify data

in an independent database wherever possible. However, caution in interpretation is warranted. We were unable to link all cases in our multiple databases and cannot be certain that bias in one or more variables exists between linked and not linked cases.

### REFERENCES

1. Fetus and Newborn Committee, Canadian Pediatric Society and Fetal Medicine Committee, Society of Obstetricians and Gynecologists of Canada. Facilitating discharge home following a normal term birth: A joint statement with the Society of Obstetricians and Gynecologists of Canada. *Paediatr Child Health* 1996;1:165-68.
2. Wen SW, Liu S, Marcoux S, Fowler D. Trends and variations in length of hospital stay for childbirth in Canada. *CMAJ* 1998;158:875-78.
3. Lock M, Ray JG. Higher neonatal morbidity after routine early hospital discharge: Are we sending newborns home too early? *CMAJ* 1999;161:249-53.
4. Lee KS, Perlman M, Ballantyne M, Elliot I, To T. Association between duration of neonatal hospital stay and readmission rate. *J Pediatr* 1995;127:758-66.

5. Oberer D, Aucherman L. Best practice: Clinical pathways for uncomplicated births. *Best Pract Benchmarking Health* 1996;1:43-50.
6. Eidelman AI. Early discharge-early trouble. *J Perinatol* 1992;12:101-2.
7. Coody D, Yetman R, Montgomery D, Van Eys J. Early discharge and the timing of newborn metabolic screening. *Clin Pediatr* 1993;32:463-66.
8. Parisi VM, Meyer BA. To stay or not to stay? That is the question. *N Engl J Med* 1995;333:1635-37.
9. Edmonson MB, Stoddard JJ, Owens LM. Hospital readmission with feeding-related problems after early postpartum discharge of normal newborns. *JAMA* 1997;378:299-303.
10. Liu LL, Clemens CJ, Shay DK, Davis RL, Novack AH. The safety of newborn early discharge. *JAMA* 1997;278:293-98.
11. American Academy of Pediatrics, American College of Obstetricians and Gynecologists. *Postpartum and Follow-up care. Guidelines for Perinatal Care* 4<sup>th</sup> ed. Washington, DC: American College of Obstetricians and Gynecologists, 1997;142-82.
12. Brumfield CG. Early postpartum discharge. *Clinical Obstetrics Gynecology* 1998;41:611-25.
13. Norr KF, Nacion K. Outcomes of postpartum early discharge, 1960-1986: A comparative review. *Birth* 1987;14:135-41.
14. Grullon KE, Grimes DA. The safety of early postpartum discharge: A review and critique. *Obstet Gynecol* 1997;90:860-65.
15. Carty EM, Bradley CF. A randomized controlled evaluation of early postpartum hospital discharge. *Birth* 1990;17:199-204.
16. Waldenstrom U, Sundelin C, Lindmark G. Early and late discharge after hospital birth: Breast-feeding. *Acta Paediatr Scand* 1987;76:727-32.
17. Brooten D, Roncoli M, Finkler S, Arnold L, Cohen A, Mennuti M. A randomized trial of early discharge and home follow-up of women having a cesarean birth. *Obstet Gynecol* 1994;84:832-38.
18. Catz C, Hanson JW, Simpson L, Yaffe S. Summary of workshop: Early discharge and neonatal hyperbilirubinemia. *Pediatrics* 1995;96:743-44.
19. Brumfield CG, Nelson KG, Stotser D, Yarbaugh D, Patterson P, Spaybery NK. 24-hour mother-infant discharge with a follow-up home health visit: Results in a selected Medicaid population. *Obstet Gynecol* 1996;88:544-48.
20. Kotagal UR, Atherton HD, Eshett R, Schoettker PJ, Perlstein PH. Safety of early discharge for Medicaid newborns. *JAMA* 1999;282:1150-56.
21. Margolis LH, Kotelchuck M, Chang HY. Factors associated with early maternal postpartum discharge for hospital. *Arch Pediatr Adolesc Med* 1997;151:466-72.
22. Calhoun BC, Gries D, Barfield W, Kovac C, Hume R. Cost consequences of implementation of an early obstetrical discharge programme in a military teaching hospital. *Aust N Z J Obstet Gynaecol* 1999;39:1-35.
23. Braveman P, Kessel W, Egerter S, Richmond J. Early discharge and evidence based practice. *JAMA* 1997;277:334-36.
24. Margolid LH. A critical review of studies of newborn discharge timing. *Clinical Pediatrics* 1995;34:626-34.
25. Inturrisi M, Lambert L. Length of stay for uncomplicated vaginal birth: A perinatal continuous quality improvement project. *J Perinat Neonat Nurs* 1998;12:11-22.

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## RÉSUMÉ

**Objectif :** Déterminer si le congé précoce après l'accouchement accroît le taux de réadmission des nouveau-nés.

**Méthode :** Nous avons extrait des registres d'hôpitaux albertains les dossiers d'accouchements simples par voie vaginale où le nouveau-né pesait au moins 2 500 grammes, pour la période du 1<sup>er</sup> avril 1997 au 31 mars 2000, et nous les avons couplés à l'ensemble des naissances enregistrées. Les réadmissions évitables étaient des cas de déshydratation, de jaunisse, de problèmes d'alimentation, de gain de poids insuffisant et de problèmes d'ordre social.

**Résultats :** Le motif de réadmission le plus commun était la jaunisse (74 %). Les facteurs déterminants, par ordre d'importance, étaient la durée de la grossesse, le statut d'autochtone visé par un traité, la naissance d'un premier enfant vivant, l'accouchement dans la région de résidence, le nombre d'accouchements à l'hôpital, le sexe du nouveau-né, le tabagisme maternel, le poids à la naissance, les avortements antérieurs et l'accouchement à l'hôpital le plus proche. La durée d'hospitalisation après l'accouchement était associée aux réadmissions durant les six premiers jours suivant le congé (les réadmissions après un séjour de moins de 27 heures étaient de 25 % supérieures aux réadmissions après un séjour de plus de 48 heures), mais pas aux réadmissions durant les 28 premiers jours suivant le congé.

**Conclusion :** Le congé précoce des mères après la naissance est un déterminant mineur des réadmissions évitables de nouveau-nés.

## DICTIONARY OF PUBLIC HEALTH

There are many technical dictionaries and glossaries in the health sciences, but there is no single dictionary containing definitions of the words and phrases commonly used in public health practice and the major sciences associated with public health.

Several public health specialists have begun the task of compiling a *Dictionary of Public Health* which is intended to close this gap. This dictionary will contain the headwords and brief definitions of commonly used technical words and phrases from all domains of public health science and practice.

The work will be done in two main phases:

1. Compiling a master list of headwords, expected to take until approximately October 2002.
2. Composing definitions. Experience with the *Dictionary of Epidemiology* was that interactive e-mail discussions with interested colleagues were an effective way to arrive at consensus about meanings, and this facilitated the task of composing definitions.

The same approach will be used with this project.

Public health specialists interested in taking part are encouraged to contact:

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