Journal of Clinical Gerontology & Geriatrics 1 (2010) 27–28

Contents lists available at ScienceDirect

Journal of Clinical Gerontology & Geriatrics

journal homepage: www.e-jcgg.com

Editorial

Social admissions of the elderly: More medical attention should be paid

Population aging is a global phenomenon and has caused various challenges to the health care system, and Taiwan is no exception. Taiwan is the fastest aging country in the world, and the percentage of people aged 65 years and older is estimated to reach 20% of the total population between 2010 and 2025.[1,2] Unlike most Western countries, the demographic transition of Taiwan is faster than ever, and the challenges to health and social care systems are far beyond government's assumptions.[3]

Admission because of social reasons (i.e., "social admission" in previous literature) may pose a special challenge to the health care system in Taiwan. In particular, Taiwan has well-established acute care services, but no developed post-acute care and long-term care services are self-funded. The aforementioned conditions may largely shift the unmet social care needs to the acute care settings. "Social admission" is usually defined as an acute hospital admission that is mainly because of unfulfilled social care needs, that is, the patient (family or caregivers) cannot cope with current societal setting.[4] Sometimes, it may be labeled as "acopia," "dyscopia," or "bed blocker," which are considered prejudicial descriptions.[5] Apart from these unfriendly descriptions, eventually, the mortality of social admission patients was significantly higher than that of the elderly patients admitted because of specific acute illnesses (34.9% *vs.* 8.9%).[6,7] Therefore, "social admission" may be more than a "social-only" admission, and more medical attentions should be paid to avoid potential ignorance of health hazards among these patients with complex care needs.

Currently, most acute medical units have abandoned the concept of age-related admission criteria. This is partly because of an intension to make the admission process fairer to all patients to obtain highest quality of care without age concern. Moreover, promoting the efficiency of health care facility management is another important reason. However, in fact, the pure social admission (i.e., the patient has no active medical issues, and his or her home circumstance has broken down) is rare, and patients usually suffer from multiple chronic conditions and the lack of appropriate care resources. Often, there are certain medical issues in the social admissions but are just not recognized properly by the health care professionals. For example, a frail elderly patient repeatedly falling at home may make him or her no longer suitable for the current level of home care. However, under such a circumstance, nursing home is not a satisfactory solution. By correcting the home environment, the "social factor" may be solved and the patient may return home with appropriate support of social care. On the contrary, frail older patients with atypical presentation of a medical condition (e.g., pneumonia without respiratory symptoms or silent myocardial infarction) may be misinterpreted as "social admission" patients, which may lead to unfavorable clinical outcomes and may partly explain the higher mortality of social admission elderly. The complex interaction among social (personal, family, carer); financial; and medical issues of elderly patients may make it easier for health care professionals to refer these conditions to "pure social" and "more social" admissions. However, labeling a "more social" admission as a "social-only" admission may overlook hidden medical issues and atypical presentations of diseases. Therefore, the terms "social admission," "acopia," "dyscopia," or "bed blockers" are not helpful at all, and patients' conditions may be misinterpreted and delayed.

Achieving optimal use of hospital beds is challenging because of the potential conflicts between actual medical needs and patients' preferences. Several methods have been developed to evaluate the appropriateness of hospital admissions, including (1) intensity-severity-discharge,[8] (2) appropriateness evaluation protocol,[9] (3) pediatric appropriateness evaluation protocol,[10] (4) Oxford Bed Study Instrument,[11] (5) Medical Patient Assessment Protocol,[12] and others. Generally speaking, the rate of inappropriate use of acute beds is higher in geriatric patients, and the principal reason is mostly the lack of availability of care at the long-term care system.[13]

The "social admission" is usually defined as a hospital admission that is mainly because of social reasons, that is, patient (family or caregivers) cannot cope with current societal setting. Although it is generally agreed that admissions because of social reasons should be avoided, social admissions are necessary when there is no solution. Among older people with insufficient social support, admission to acute hospitals sometimes saves lives, and health care professionals should take this opportunity to evaluate their health and social care needs. A qualitative study has indicated that patients admitted because of social factors usually felt isolated, lonely, and sometimes afraid,[14] which implies the possibilities of hidden mood disorders. Moreover, a Welsh cohort study has disclosed that patients admitted because of social reasons were very elderly, female, and severely disabled, whereas most of the admissions were planned to relieve their carers.[15] Although the admissions because of social factors seem to be benign clinically, mortality and readmission rates at 3 months and 12 months after the index admissions were very high, and their disabilities were not improved by hospital admissions.[15] The aforementioned unfavorable clinical outcomes of social admissions imply an underestimation of clinical significance. Therefore, more medical attention should be paid to these patients, and a comprehensive geriatric assessment should be of great benefits.

In the literature, the concept of "social admission" may be overlapped with the description of "medically inappropriate admission,"

doi:10.1016/j.jcgg.2010.11.001

because major causes of medically inappropriate admissions are social factors. A cross-sectional study of a systematic sample of 500 admissions showed that the prevalence of medically inappropriate admission was 15.2%, and risk factors of medically inappropriate admissions were as follows: better physical functioning before admission, lower mental health status of the spouse, recipient of informal support from family or friends, and hospitalization by personal physician.[16] However, the appropriateness of hospital admissions perceived by patients and evaluated by hospitals is very different. It has been reported that 88% of patients within 48 hours of admission and 85% of patients at 14th day of admission felt that their hospital use was justified, but the appropriateness determined by the appropriateness evaluating protocol was only 37%.[17] Medically inappropriate use of hospital beds can be presented in another form by delaying the discharge instead of increasing admissions.[18] Interestingly, inappropriate medical admission rate was not increased although the acute hospital admission rate was increased,[19] but the medically inappropriate admission was very common among elderly patients with a hospital stay longer than 30 days.[20]

In this cost-containing era, the reduction of acute hospital beds and shortening of hospital stay may reduce the possibility of social admissions. To reduce the medically inappropriate admissions can be achieved by administrative methods, such as intensive hospital admission audit, more outpatient observation instead of inpatient admission, or to change the reimbursement into that on outpatient basis.[21] However, these administrative interventions may improve the efficiency of health care system administration but may aggravate the underpinning unmet social care needs of older people. A more comprehensive strategy has been reported to reduce emergency-department calls and acute hospital admissions by community-based preventive visits and integrated health–social care services.[22] To discover hidden medical issues, correct home environment and care resources and performing a full geriatric assessment and investigations are all important goals to treat patients admitted because of social factors. More importantly, health care professionals should take this opportunity to review all medications for patients because polypharmacy is a major problem in the frail elderly and may be the contributing factor for this "social admission."

Often, older people with mild health care conditions may be admitted to acute hospitals because of various social factors. The social–health care problems behind the social admission have not been well recognized. On the one hand, health care professionals do not properly identify the potentially unfavorable clinical outcomes of these patients. On the other hand, social admission is often considered as a medically inappropriate admission by the administrative staff. Under such circumstances, older people may encounter even more difficulties to manage their problems, and chances of their occult health care needs may be higher. However, the mortality and readmission rates of so-called "social admission" patients are significantly higher than the rates of those who were admitted with clear acute illnesses. It is agreed that social admissions should be avoided, but it is necessary when no alternative solution is available. All health care professionals should be aware of the unfavorable clinical outcomes of these patients, and performing comprehensive geriatric assessment for them is of great importance to evaluate occult health problems. To systemically prevent unnecessary hospital admissions, community-based preventive visits with integrated health and social care interventions should be considered superior to simple administrative interventions to reduce reimbursement of acute beds. Most social admissions are "more social" instead of "social only"; hence, there are usually some undiscovered health care needs. Health care professionals should avoid using inappropriate terms to label these patients, because it may overlook their health care problems and lead to poorer health care outcomes.

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