Transitions Between Hospital and Home

Early in the Hospital Admission: Assess Patient Risk of Readmission

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Patients who have multiple conditions and complex needs may require care across different health care settings (e.g., hospitals, family physicians, specialists etc.), which could potentially pose serious risks to their safety and quality of their care. Incomplete or inaccurate transfer of information, lack of comprehensive follow up care, and/or medication errors at the time of transition could be very dangerous and cause serious, preventable harm to patients. Furthermore, the impact of these risks may be intensified by patients and families who feel unprepared for self-management, and are unsure of how to access appropriate health care providers for follow-up.

Figure 1 is an outline of **innovative practices and evidence-informed best practices** that are designed to improve transitions between hospital and home.

The use of these practices varies significantly across the province. Teams are encouraged to prioritize the implementation of evidence-informed best practices before adoption of the innovative practices.

EARLY IN THE HOSPITAL ADMISSION

- Perform medication reconciliation on admission
- Assess patient risk of readmission
- Assess health literacy
- Notify community providers of patient admission to hospital
  Aspire to use e-notification
- Collaborate with community providers to begin/update the coordinated care plan

THROUGHOUT THE HOSPITAL STAY AND TRANSITION PROCESS

- Use teach back when building caregiver and patient capacity
- Enhance patient and caregiver communications with the use of visual tools

CLOSE TO TIME OF DISCHARGE

- Ensure personal clinician to clinician information transfer
- Perform medication reconciliation at discharge
- Schedule primary care visit before leaving hospital

IN THE COMMUNITY AFTER A HOSPITAL STAY

- Identify one lead to perform medication reconciliation in community
- Ensure discharge summary available to primary care within 48 hours
- Follow-up with patient within 48 hours of transition home
- Designate a person in the community to support non-clinical needs in the immediate post-hospital period

Evidence-informed best practices | Innovative practices

*Figure 1: **Practices to Improve Transitions Between Hospital and Home***

The material for Transitions Between Hospital and Home was developed in collaboration with Health Links and the Clinical Reference Group.

Description of this Evidence-Informed Best Practice

Patients with multiple conditions and complex needs should be assessed for their risk of readmission using an evidence-based risk assessment tool as early as possible in the hospital admission period to address issues prior to transition and/or arrange post transition supports. The following section outlines existing screening tools that can be used for this assessment.

Tools and Resources

In an environmental scan and literature review, the following tools were found to be highly effective and commonly used assess patient risk for readmission. The decision to implement or administer one of these tools must be considered alongside other locally contextually relevant information.

Assess Patient Risk for Readmission		
Name of Tool	**Overview**	**Considerations/Links**
LACE ***(Length of Stay, Acuity of Admission, Comorbidities, Emergency Room Visits)***	**LACE** is a validated tool used within the **hospital sector** to assess risk of readmission. The **LACE** considers factors such as length of stay, acuity, co-morbidities, involvement in programs with community care access centres (CCACs) or primary care. It takes less than 5 minutes to administer the **LACE**, and is typically completed by a health care professional.	• **LACE** was developed using Ontario-derived data and has been shown to be accurate in predicting acute care re-admissions (notably 30-day readmissions). • **LACE** tool is available online at the ***Health System Performance Research Network*** website: http://www.hsprn.ca/?p=33 • Medically focused and may not address other factors such as health literacy, social isolation and other social determinants that impact risk for readmission.
PRA **(Predictive Repetitive Admission)**	**PRA** is used to help family physicians within the **primary care sector** to support decision making regarding whether or not a patient would benefit from Health Links/Coordinated Care Management approach. Typically, patients with a **PRA** score of 50% or higher are considered likely to benefit from a Health Links/Coordinated Care Management approach. It takes less than 5 minutes to complete the PRA, and may be self-administered by the patient, or with support from the health care professional, as needed.	• The ***North York Central Health Link*** has this tool posted on their website: https://www.nygh.on.ca/HealthLink/
DIVERT Scale **(Detection of Indicators and Vulnerabilities for Emergency Room Trips Scale)**	**DIVERT** (Detection of Indicators and Vulnerabilities for Emergency Room Trips) Scale is used to help Providers in the **home and community care sector** to predict unplanned emergency services use among home and community care clients. Typically, patients with a **DIVERT** score of 6 or more are considered likely to benefit from Health Links/Coordinated Care Management.	• **DIVERT** Brief Guide posted on ***Health Quality Ontario***'s in Health Quality Ontario's Tools and Resources Section, with permissions, at: http://hqontario.ca/Quality-Improvement/Tools-and-Resources

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	DIVERT is typically completed by the Care Coordinator, and can be derived from the InterRAI Home and Community Care Instruments at no additional cost. A screening Model is also available for those not running the interRAI platform.	

Additional Resources

For additional information on Quality Improvement, please visit: http://qualitycompass.hqontario.ca/portal/getting-started.

References

1. Costas AP, Hirdes JP, Bell CM, Bronskill SE, Heckman GE, Mitchell L, Poss JW, Sinha SK, Stolee P. Derivation and Validation of the Detection of Indicators and Vulnerabilities for Emergency Room Trips Scale for Classifying the Risk of Emergency Department Use in Frail Community-Dwelling Older Adults. J Am Geriatr Soc. 2015;63(4):763-9.

2. Madi N, Zhao H, Li JF. Hospital Readmissions for Patients with Mental Illness in Canada. Healthc Q. 2007;10(2):30-32.

3. Pacala JT, Boult C, Boult L. Predictive Validity of a Questionnaire that Identifies Older Persons at Risk for Hospital Admission. J Am Geriatr Soc. 1995;43(4):374-377.

4. van Walraven C, Dhalla IA, Bell C, Etchells E, Stiell IG, Zaruke K, Austin PC, Forster AJ. Derivation and Validation of an Index to Predict Early Death or Unplanned Readmissions after Discharge from Hospital to the Community. CMAJ. 2010;182(6):551-557.