Transitions in Care from Acute Care to Home

Lisa Jensen, RD, MBA[1];Lesley Charles, MBChB[2]; Claire Johnson, RN, BScN[1]
[1] Integrated Access, Covenant Health; [2] Division of Care of the Elderly, University of Alberta
Corresponding Author: Dr. Lesley Charles (Lcharles@ualberta.ca)

BACKGROUND

- Transitions from hospital to home are facilitated by identifying patients at high risk for readmission and coordinating discharge with community supports.
- A coordinated provider approach prevents patient morbidity, Emergency Department (ED) visits, and rehospitalization.

OBJECTIVE

To facilitate smoother discharge from the medicine units at the Grey Nuns Community Hospital (GNCH) for high-risk discharges and prevent hospital readmission.

METHOD

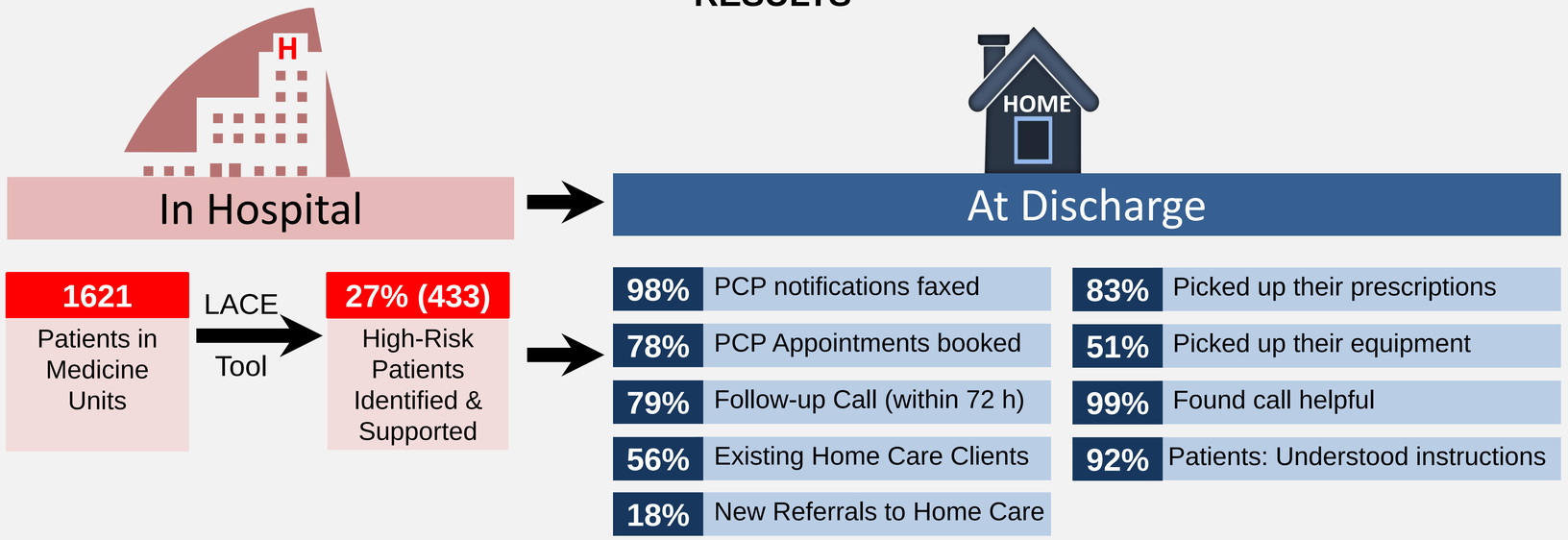
Phase 1: Preparations (Jan 2016 – Aug 2016)

- Expert consensus from the Covenant Transition Steering and Working Groups to design: a risk assessment tool, components of a scripted telephone call, and a comprehensive evaluation framework.
- Literature review
- Guidance from the experience of Providence Health, GNCH geriatrics pilot, and South East Edmonton Primary Care Network (PCN) transitions work.
- Validation of the risk assessment tool using a modified LACE tool. We decided to use the LACE tool but with a cut off of 13 to obtain roughly a third of patients as high risk.

Phase 2: Implementation (Sep 2016-May 2017)

- Use of LACE tool to identify high-risk patients.
- Follow-up telephone calls 48 hours after discharge :
  - Support , as needed, for medications, home care, physician appointments, equipment.
  - An appointment was made with their primary care physician (PCP) by the hospital prior to discharge.
  - A copy of the telephone call documentation was faxed to their PCP and homecare where involved.

RESULTS



Outcome Measures	With the Intervention (n=433)	Without the Intervention (n=231)
Average Length of Stay	12.7 days	16.6 days
ED Visits within 7-days after discharge	10.6 %	10.8%
ED visits within 30 days after discharge	30.5%	33.3%
7-day Inpatient Readmissions	7.6%	5.2%
30-day Inpatient Readmission	22.7%	20.8%
90-day Inpatient Readmission	39.3%	44.6%
6-month Inpatient Readmission	50.9%	58.4%

DISCUSSION

- Phase 1 helped inform the risk assessment tool and telephone call/supports needed to facilitate smooth discharge home for high risk patients.
- Phase 2 has identified where coordinated discharge planning within the acute care setting is being done well for high risk patients. The early identification of risk has proven valuable to the care team activities around discharge planning. However, it has also identified gaps in the system in supporting high risk patients post discharge. Support across the continuum is required for seamless transition planning.

CONCLUSION

- Having LACE on chart highlights complexity of patients to interdisciplinary team and has decreased length of stay by an average of 4 days.
- Despite the decrease length of stay, short term ED revisits and readmissions were not increased.
- In the short term the phone call did not seem to have an impact on readmission, but in the long term the phone call may have.
- The phone call identified problems with patients picking up equipment that wouldn't have been identified otherwise.
- Patients overall were satisfied with the interventions and it was clearly highlighted that patients understood their discharge instructions.

This study was funded by the Covenant Health Network of Excellence in Seniors' Health and Wellness – Innovation Fund.