IDENTIFYING AND TRANSFERRING PATIENTS FROM HOSPITAL TO HOME BASED CARE

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Please find following a summary of a literature search and relevant results. All articles can be provided in full - email library@monashhealth.org for a list of the articles you require.

QUESTION

Identifying and transferring patients from hospital to home based care.

RESULTS

ONLINE RESOURCES (GREY LITERATURE)

GUIDELINES

United States Department of Health and Human Services (2021). **Acute Care Delivery at Home.** Link.

- Features of Acute Care Delivery - Start with a limited number of conditions and a clear pathway for patient selection. How many patients will the program see at one time, what is the target population and patient group, what is the shift pattern.

Welsh Government Delivery Unit (2021)**. Delivering Home First**. Link.

- Discharge to Recover then Assess: the Welsh Model – Five pathways to facilitate home first care delivery services. Admission avoidance, Early supported discharge, Care home.

New South Wales Health. (2018). **Adult and paediatric hospital in the home**. Link.

- 5.3 Patient selection - If HITH care were not available, the patient would be admitted in hospital. Services should have a local policy to standardise and document the patient selection criteria.

Queensland Department of Health. (2014). **Hospital in the home guidelines.** Link.

- 11.1 Screening of eligible patients - The assessment needs to identify any potential treatment and environmental risks to the patient.

Victorian Department of Health (2012). **Hospital in the Home Guidelines.** Link.

- Eligibility - Patients are eligible for HITH admitted care if they meet any of the following 'criteria for admission' as per the Victorian hospital admission policy. HITH services develop effective selection criteria.

PEER-REVIEWED LITERATURE – MOST RECENT FIRST

Articles are grouped by theme:

- Patient Identification
- Cost Analysis
- Interprofessional Teamwork
- Patient Communication
- Pharmacy
- Program Implementation

Each article summary contains excerpts from the abstract and an online link.

PATIENT IDENTIFICATION

Kidd. (2022). **Collaboration Among Providers to Treat COVID-19 Patients at Home Opens Beds for Those with More Serious Illness.** *Online Journal of Issues in Nursing 27*(2) . Full text.
This article discusses how we initially approached identification of severity and the methods we used to implement the protocol. The results section offers information about the number of patients utilizing this protocol between April and December 2020; patient and physician satisfaction; and considers strengths and weaknesses of the program. In conclusion, the EHSM protocol allowed patients to receive high quality emergent care at home and increased access to hospital emergency departments and inpatient hospital beds for more seriously ill patients.

Lim, S. M., et al. (2021). **Home First! Identification of Hospitalized Patients for Home-Based Models of Care**. *Journal of the American Medical Directors Association 22*(2): 413-417.e411. Full text.
To determine the proportion of hospitalized inpatients suitable for an acute and subacute home-based inpatient bed substitutive service, to examine the ability of treating teams to identify suitable patients for this service, and to examine potential barriers toward inpatients receiving home-based care. A substantial proportion of hospitalized older patients could use home-based inpatient bed substitutive services. Clinicians experienced in home-based care are more skilled than ward-based clinicians in identifying suitable patients for this care model.

Charles, L., et al. (2020). **Improving transitions from acute care to home among complex older adults using the LACE Index and care coordination**. *BMJ open quality 9(*2). Full text.
The objective of this study was to determine the improvement in transitions from an intervention identifying complex older adult patients in acute care and supporting their discharge into the community. Identifying complex patients at high risk for readmission and supporting them during transitions from acute care to home potentially decreases lengths of hospital stay and prevents short-term ED revisits and long-term readmissions.

COST ANALYSIS

Edgar, K., et al. (2024). **Admission avoidance hospital at home.** *Cochrane Database of Systematic Reviews*(3). Full text.
Hospital at home decreases the amount of time patients spend in hospital, while length of stay in hospital at home tended to be longer than a typical hospital stay. Due to the small size of most of the studies, we are moderately confident that admission avoidance hospital at home does not make a difference to the number of people who died when compared to in-hospital care. We are moderately confident in the evidence for cost because only three trials looked at this fully.

Hernandez, C., et al. (2023). **The Value of Admission Avoidance: Cost-Consequence Analysis of One-Year Activity in a Consolidated Service.** *Cost Effective Resource Allocation 22*(1):30**.** Full text.
A retrospective cost-consequence analysis of all first episodes of HaH-HA, directly admitted from the emergency room (ER) in 2017-2018, was carried out. The study showed higher performance and cost reductions of HaH-HA in a real-world setting. The identification of sources of savings facilitates scaling of hospital avoidance.

Saenger, P. M., et al. (2022). **Cost of home hospitalization versus inpatient hospitalization inclusive of a 30-day post-acute period**. *Journal of the American Geriatrics Society 70*(5): 1374-1383. Full text.
Our objective was to determine if combined acute and 30-day post-acute costs of care were lower for HaH patients compared to inpatient comparisons in a Center for Medicare and Medicaid Innovation Center demonstration of HaH. HaH combined with 30-day post-acute transition care was less costly than inpatient care.

Achanta, A., et al. (2021). **Hospital at Home: Paying for What It's Worth.** *American Journal of Managed Care 27*(9): 369-371. Full text.
As we increasingly adopt the Acute Hospital Care at Home program and similar home-based services, it is crucial to better define the value of these programs and their appropriate reimbursement rates. We provide a framework centered around cost, quality, and equity to help accomplish this task. To create sustainable reimbursement mechanisms for hospital-at-home programs, we first need a better definition of the value provided by this model of care.

INTERPROFESSIONAL TEAMWORK

Chouliara, N., et al. (2024)**. Getting the message across; a realist study of the role of communication and information exchange processes in delivering stroke Early Supported Discharge services in England.** *PloS one 19*(3): e0298140. Full text.
The quality of communication processes between professionals delivering ESD and external stakeholders may have a role to play in streamlining this process. Maintaining good communication and engagement with key stakeholders may help achieve a streamlined hospital discharge process and timely delivery of ESD. ESD services should actively manage communication processes with external partners. A shared cross-service communication strategy to guide the provision of information along to continuum of stroke care is required. Findings may inform efforts towards the delivery of better coordinated stroke care pathways.

Felix, H. M., et al. (2023). **Impact of an Acquisition Advanced Practice Provider on Home Hospital Patient Volumes and Length of Stay.** *Healthcare 11*(3). Full text.
This retrospective cohort study evaluates the impact of the addition of a dedicated ACH patient acquisition Advanced Practice Provider (APP) on average length of stay (ALOS) and the number of patients admitted into the program between in Florida and Wisconsin between 6 July 2020 and 31 January 2022. The addition of a dedicated patient acquisition APP resulted in significantly higher patient volumes but did not affect transition time or ALOS. Other hospital-at-home programs may consider the addition of an acquisition APP to maximize patient volumes.

Nageswaran, S., et al. (2020). **Transitioning children with medical complexity from hospital to home health care: Implications for hospital-based clinicians**. *Hospital Pediatrics 10*(8): 657-662. Request article.
This qualitative study was conducted in western North Carolina between 2012 and 2014 and involved a focus group of 14 hospital- and community-based stakeholders and 4 focus groups of 18

home health nurses. There are gaps in the system of transitional care of CMC. Potential strategies to improve transitional care of CMC between the hospital and home health care services exist.

Ross, H., et al. (2021). **The unique role of the social worker within the Hospital at Home care delivery team.** *Social Work in Health Care 60*(4):354-368. Request article.
Hospital at Home (HaH) provides acute, hospital-level care at home and post-discharge follow-up. Through a review of 293 HaH admissions conducted by an urban, multidisciplinary HaH program from 2014 to 2017, we find that the social worker is involved in 71% of admissions and plays a crucial role in pre-emergency department discharge home care and safety screening, home intake, follow-up support, and transition of care to primary care providers and community-based services.

Sterling, M. R., et al. (2020). **Understanding the Workflow of Home Health Care for Patients with Heart Failure: Challenges and Opportunities**. *Journal of General Internal Medicine 35*(6): 1721-1729. Full text.
Our findings suggest that HHC for HF patients occurs in discrete steps, each with different challenges. Rather than a one-size-fits-all approach, various interventions may be required to optimize HHC delivery for HF patients in the post-discharge period.

PATIENT COMMUNICATION

Allen, J., et al. (2022). **Improving transitional care communication for older Australians from hospital to home: Co-design of the TRANSITION tool**. *Health & Social Care in the Community 30*(6): e4223-e4238. Full text.

This study aimed to develop and evaluate a communication tool to guide transitional care for older patients. Data collected from semi-structured interviews and co-design focus groups were used to develop a prototype communication tool to guide conversations about discharge care between healthcare practitioners and older patients. The communication tool provides an evidence-based resource for ward nurses to support transitional care continuity in multidisciplinary models.

Barreto, E. A., et al. (2021). **The role of race, ethnicity, and language in care transitions.** *American Journal of Managed Care 27*(7): E221-E225. Full text.
To identify areas where transition from hospital to community could be improved, with a special focus on racial, ethnic, and language differences. Our findings highlight the enhanced difficulties that diverse patients may experience when transitioning from hospital to community-based settings. When considering how to best address the complex needs of diverse populations, interventions must be sensitive to the presence or absence of others, potential digital divides, and medical interpretation.

Knight, S. W., Et al. (2019). **Hospital-to-homecare videoconference handoff: improved communication, coordination of care, and patient/family engagement.** *Home healthcare now 37*(4): 198-207. Full text.
The purpose of this project was to determine the feasibility and effectiveness of videoconference handoffs between inpatient, case management, and home care nurses, and the patients/families during transitions of care from hospital to home care. Participants discussed the patient's status, safety concerns, ongoing plan of care, what the patient/family could expect at home, and the

coordination of equipment/supply needs and postdischarge visits. Videoconference handoffs (n = 10) were found to be feasible and address gaps in communication, coordination of care, and patient/family engagement during transitions from hospital to home care. Post pilot, nurses agreed the videoconference handoffs should continue with minimal modifications.

Jones, C. D., Et al. (2019). **Quality of hospital communication and patient preparation for home health care: results from a statewide survey of home health care nurses and staff.** *Journal of the American Medical Directors Association 2*0(4): 487-491 . Full text.
Communication between hospitals and HHC is suboptimal, and patients are often not prepared to receive HHC. Providing EHR access for HHC clinicians is a promising solution to improve the quality of communication.

PHARMACY

Juaton, M., et al. (2022). **Healthcare workers' experiences of transitioning natalizumab infusions from hospital services to an in-home setting: A qualitative study**. *Australian Journal of Advanced Nursing 39*(1): 2020.391.240. Full text.
This study explored healthcare workers' experiences of transitioning infusions of natalizumab from hospital to patient-centred model of home care. Background(s): Hospital in the home is one of the fastest growing healthcare delivery models. In Australia, intravenous infusions are rarely available at home for chronic disease patients, such as those with multiple sclerosis. A recent trial of natalizumab infusions at home for patients with multiple sclerosis required both the hospital and hospital in the home staff to consider the logistics of how this transition could be achieved safely. Managing the logistics of delivering a flexible and safe home therapy service was an important part of this model of care.

Peinovich, M., et al. (2022). **Developing pharmacy services in a home hospital program: The Mayo Clinic experience**. *American Journal of Health-System Pharmacy 79*(21): 1925-1928. Full text.
This article describes the development of pharmacy services in a home hospital program in an attempt to help other organizations create their own home hospital pharmacy programs. Caring for acutely ill patients in their home was a novel idea when Mayo Clinic began considering this in January 2020. Home hospital medication management is both complex and ripe with opportunities for pharmacy engagement.

PROGRAM IMPLEMENTATION

Wallis, J. A., et al. (2024). **Factors influencing the implementation of early discharge hospital at home and admission avoidance hospital at home: a qualitative evidence synthesis.** *Cochrane Database of Systematic Reviews*(3). Full text.
Implementing Admission Avoidance and Early Discharge Hospital at Home services requires early development of policies, stakeholder engagement, efficient admission processes, effective communication and a skilled workforce to safely and effectively implement person-centred Hospital at Home, achieve acceptance by staff who refer patients to these services and ensure sustainability.

Gorbenko, K., et al. (2023). **A national qualitative study of Hospital-at-Home implementation under the CMS Acute Hospital Care at Home waiver**. *Journal of the American Geriatrics Society 71*(1): 245-258. Full text.
This study sought to describe AHCaH implementation processes and strategies at the national level and identify challenges and facilitators to launching or adapting a HaH to meet waiver requirements.

Implementation of AHCaH waiver is a complex process that requires building components in compliance with the requirements to extend the hospital into the home, in coordination with internal and external partners. The study identified barriers that potential adopters and proponents should consider alongside the strategies that some organizations have found useful.

Loveland, P. M., et al. (2022). **Geriatric home-based rehabilitation in Australia: Preliminary data from an inpatient bed-substitution model.** *Journal of the American Geriatrics Society 70*(6): 1816-1827. Full text.
The aim of this study is to describe a home-based bed-substitution rehabilitation model for geriatric inpatients, including patient phenotype, and health outcomes at preadmission, admission, discharge, and three-month follow-up. Hospitalization-associated decline in mobility and functional independence improved at discharge and three-months but was not fully reversed in the multidisciplinary home-based geriatric rehabilitation bed-substitution service.

Oikonomou, E., et al. (2020). **Validation of the Partners at Care Transitions Measure (PACT-M): assessing the quality and safety of care transitions for older people in the UK.** *BMC health services research 20*(1): 608. Full text.
The Partners at Care Transitions Measure (PACT-M) is a patient-reported questionnaire for evaluation of the quality and safety of care transitions from hospital to home, as experienced by older adults. The PACT-M has shown evidence to suggest that it is a reliable measure to capture patients' perception of the quality of discharge arrangements and also on patients' ability to manage their care at home one month post discharge. PACT-M 1 is a marker of patient experience of transition and PACT-M 2 of coping at home.

Samaranayake, C. B., et al. (2020). **Respiratory acute discharge service: a hospital in the home programme for chronic obstructive pulmonary disease exacerbations (RADS study).** *Internal Medicine Journal 5*0(10): 1253-1258. Full text.
This pilot study aimed to determine the efficacy and safety of the programme in an Australian tertiary hospital. Early supported discharge care model with nurse-led community-based recovery after an acute exacerbation of chronic obstructive pulmonary disease in selected patients is safe and has the potential to provide greater flow through the hospital systems with cost effective care.

APPENDIX

SEARCH METHODOLOGY

A systematic search was conducted for literature. The results were screened by librarians using Covidence.

SEARCH LIMITS

- English-language
- Published within the last 10 years

DATABASES SEARCHED

- Medline – index of peer reviewed articles across health sciences and medicine.
- Embase – index of biomed and pharmacological peer reviewed journal articles.
- Emcare – index of nursing, allied health, critical-care medicine and more.
- Cochrane Library – collection of databases containing high-quality independent evidence.
- Grey literature – Google, Google Scholar, Trip database, Biomed Central Proceedings.

SEARCH TERMS

Concept	MeSH headings	Keywords
Inpatient	Hospitalization, Inpatients, Emergency Service, Hospital	Inpatient, hospitalisation, hospitalization, hospital, ward, admitted, admission, care, based, environment, setting, patient, emergency department
Home Based Care	Home Care Services, Homecare Services, Hospital Based	hospital in the home, hith, own home, home first, home healthcare, bed substitution, early supported discharge
Transfer	Patient Transfer, Transitional Care, Hospital to Home Transition	Patient transfer, bed substitution
Outcomes	Time Factors, Length of Stay, Patient Selection, Program Evaluation, Hospital Planning, Costs and Cost Analysis, Quality of Healthcare	Length of stay, alos, patient identification, patient prioritisation, aptiet selection, ongoing review, early discharge planning, costs, economics, quality, safety, safe

MEDLINE SEARCH STRATEGY

Ovid MEDLINE(R) ALL <1946 to April 29, 2024>

1 Hospitalization/ or Inpatients/ or Emergency Service, Hospital/ 247975
2 (in?patient* or hospitali*).tw,kw. 475744
3 ((hospital or ward or admitted or admission) adj3 (care or based or environment or setting or patient)).tw,kw. 210737
4 (emergency adj3 (department* or unit* or ward or present*)).tw,kw. 147079
5 1 or 2 or 3 or 4 838920
6 Home Care Services/ or Home Care Services, Hospital-Based/ 38736
7 (hospital in the home or hith or own home or home first or home healthcare).tw,kw. 3433
8 ((hospital or care) adj2 home).tw,kw. 36523
9 ((bed or bed?based) adj3 substitut*).tw,kw. 25
10 (discharge* adj (early or support*)).tw,kw. 790
11 6 or 7 or 8 or 9 62167
12 Patient Transfer/ or Transitional Care/ or Hospital to Home Transition/ 11153
13 (patient adj5 (transfer* or transition*)).tw,kw. 12249
14 (substitut* adj (service* or model* of care or bed*)).tw,kw. 50
15 12 or 13 or 14 22030
16 Time Factors/ or "Length of Stay"/ 1321933
17 (timing or length of stay or los or alos).tw,kw. 310239
18 Patient Selection/ 69797
19 (select* or consider* or prioriti?e or priorit?sation or priorit?sing or identify or identification or suitable or suitability).tw,kw. 6784737
20 "Review"/ or Program Evaluation/ 3378404
21 ((program or ongoing) adj3 (review* or analy* or assess* or evaluat*)).tw,kw. 47506
22 Hospital Planning/ 5622
23 (early discharge plan* or patient home?care plan*).tw,kw. 112
24 "Costs and Cost Analysis"/ 51951
25 (cost* or flow or economic*).tw,kw. 1967771
26 "Quality of Health Care"/ 78084
27 (quality or safe or safety).tw,kw. 2428213
28 16 or 17 or 18 or 19 or 20 or 21 or 22 or 23 or 24 or 25 or 26 or 27 12881858
29 5 and 11 and 15 and 28 417
30 limit 29 to (english language and last 5 years) 180

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