Home to Hospital to Home Transitions: LACE index

What is the LACE index?

Designed by Canadian physicians and evidence-based, the LACE index stratifies patients into those who are at low, moderate or high risk for readmission to hospital within 30 days after discharge. The LACE score is automatically calculated and updated in Connect Care, and it considers the following factors:

- **L**ength of stay
- **A**dmission type
- **C**omorbidity
- **E**mergency department visit

Plentiful evidence shows that patients with multiple comorbidities, frequent emergency room visits or other frailty indicators are more likely to present for readmission to hospital shortly after discharge. The LACE score breaks down into three categories, as follows.

LACE score breakdown

LACE score	Risk of readmission	Recommended primary care follow-up time
14-19	High	Within 14 days
7-13	Medium	Within 21 days
0-6	Low	Within 30 days

Where do you find the LACE index?

The LACE index is now auto-calculated in Connect Care; however, it is not auto-populated into every discharge summary. If the LACE index has been populated by acute care, you will find it in the discharge summary, most often within the “follow-up arrangements” section. Auto-populating the LACE index into discharge summaries is still a work in progress in acute care. But it’s a project that AHS is dedicated to developing, because of the LACE index’s potential as a quality improvement tool. Over the coming months you will see an increasing number of LACE index scores in discharge summaries.

Why use the LACE index?

As a complement to clinical judgment, the LACE index offers care teams a standardized tool for identifying patients who need timely follow-up care after discharge. When primary care providers receive their patients' LACE indexes, they know who needs more urgent follow-up, and can keep those patients from being readmitted to hospital—which helps improve transitions in care.

How do you put LACE into practice?

The LACE index gives all patients a score from 0–19. These figures can be used to inform clinical decisions on appropriate timing for follow-up care. For patients at high risk for readmission (14-19), the recommended time frame for follow-up is within 14 days of discharge.

The LACE index context

The LACE index is just one tool to be used as a complement to clinical judgment when planning patient discharge, along with other patient-centred factors like mental health, social determinants, co-morbidities, settings such as rural versus urban, etc. The LACE index should be used at the beginning of a transitional assessment to guide the decision-making process.

Picture this: A LACE index story

Dr. Lee notices a discharge summary in her EMR Inbox—looks like Rico was in hospital again. Scanning the summary, she notices Rico scored a 14 on the LACE index.

Not surprising, thinks Dr. Lee, given Rico's history of diabetes and congestive heart failure. Plus, according to the LACE score, Rico has been to the emergency department five times in the past six months.

Dr. Lee pulls aside Mira, the medical office assistant. "Let's get Rico in here as soon as possible," he says. "We can't risk him ending up in hospital again."

"You bet," says Mira. "Rico needs a bit of help with meds, and I don't think he drives."

"Right," says Dr. Lee. "We'll have to go over medication changes, wound care, and maybe even getting to the pharmacy. The sooner I see him, the better."

"I'm on it," Mira says, and picks up the phone.

For more information on the LACE index, or for a list of references:

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