

# Reducing the 30-Day Readmission Rate at Trillium Health Centre

*Avoidable Hospitalization Working Group – June 23, 2011*



EXCELLENCE • TEAMWORK • LEADERSHIP  
LEARNING • DIVERSITY • INTEGRITY

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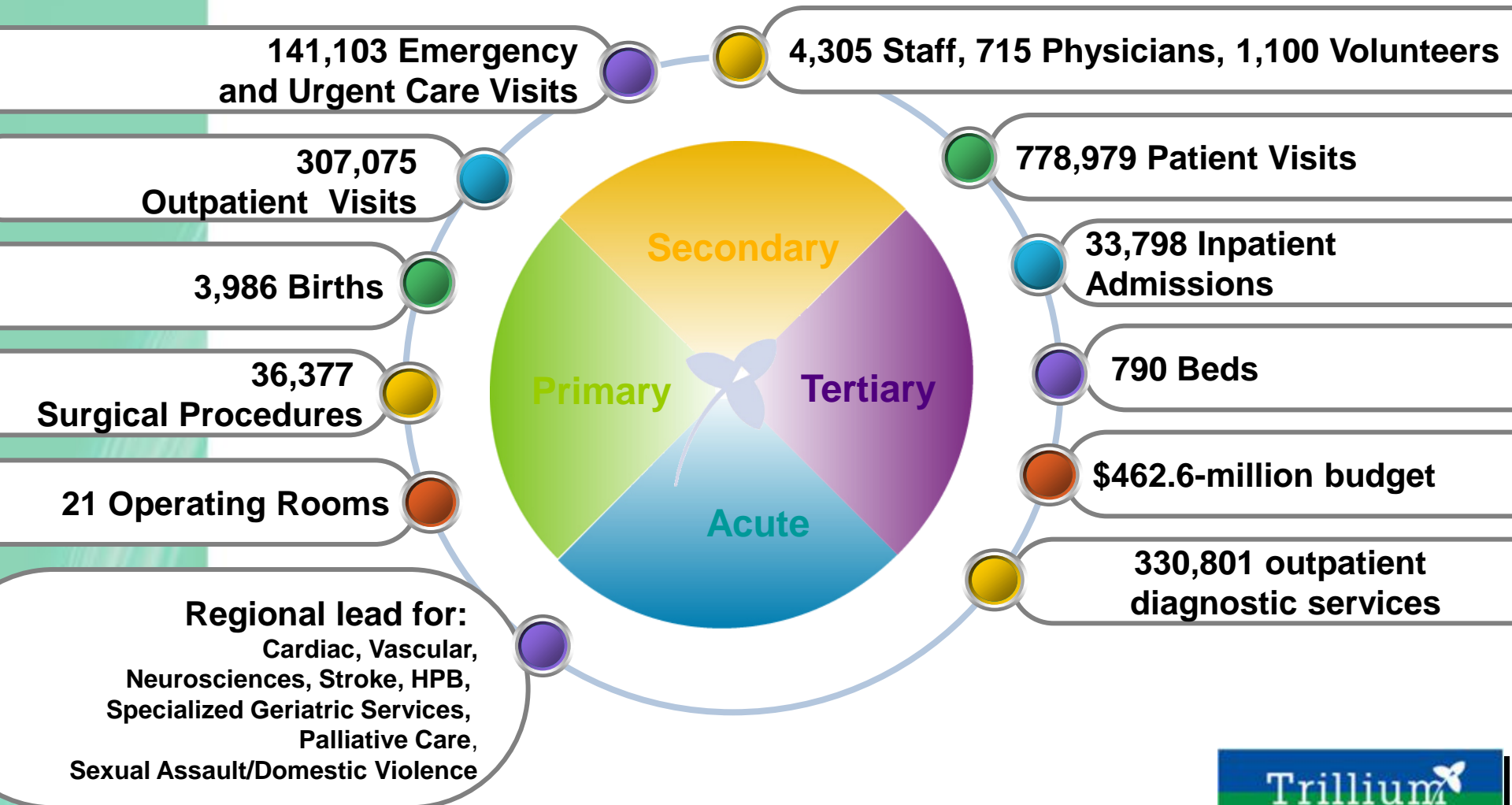
Physician Director, Patient Safety and Quality

**Susan Bisailon**

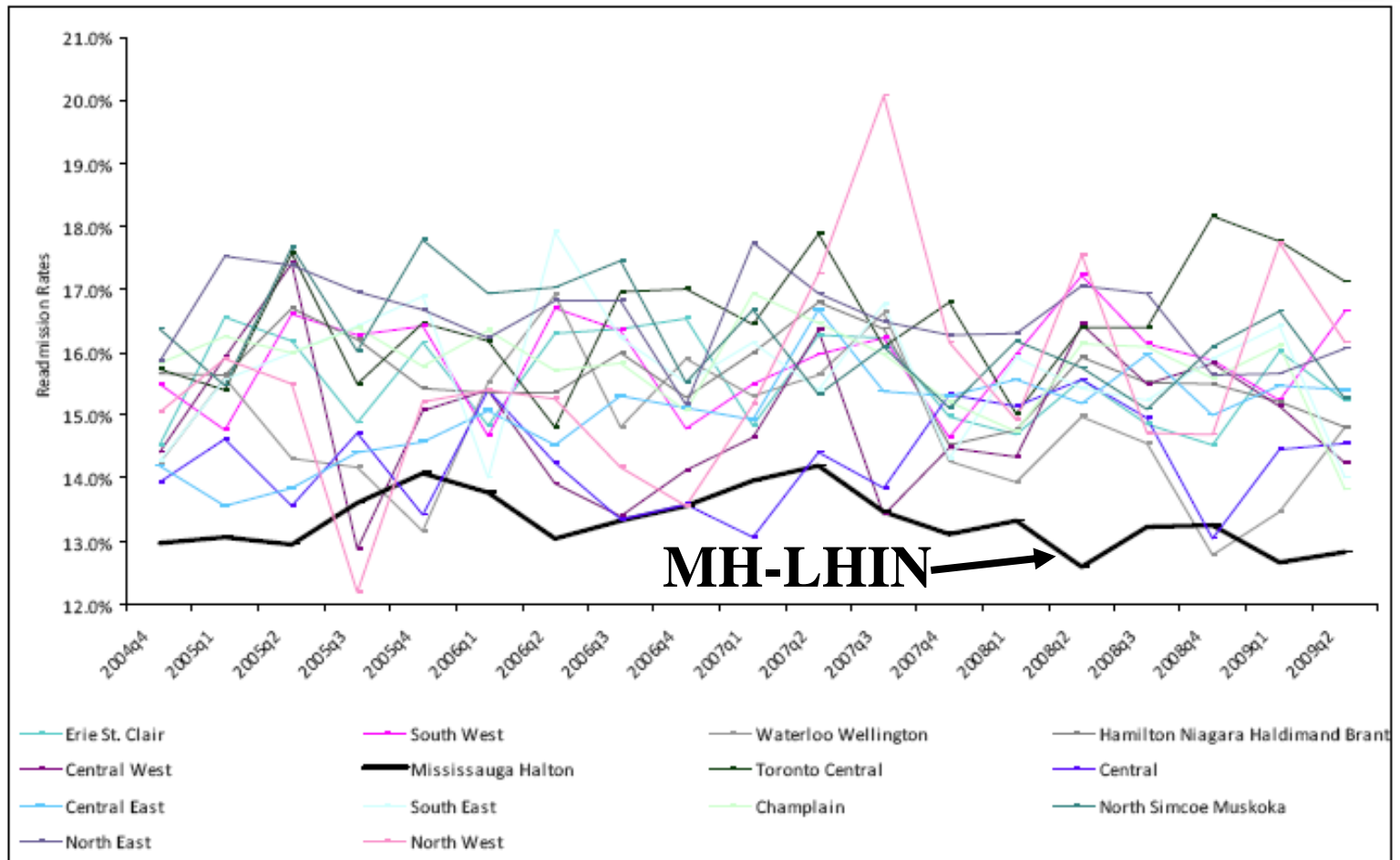
Executive Director, Clinical Operations



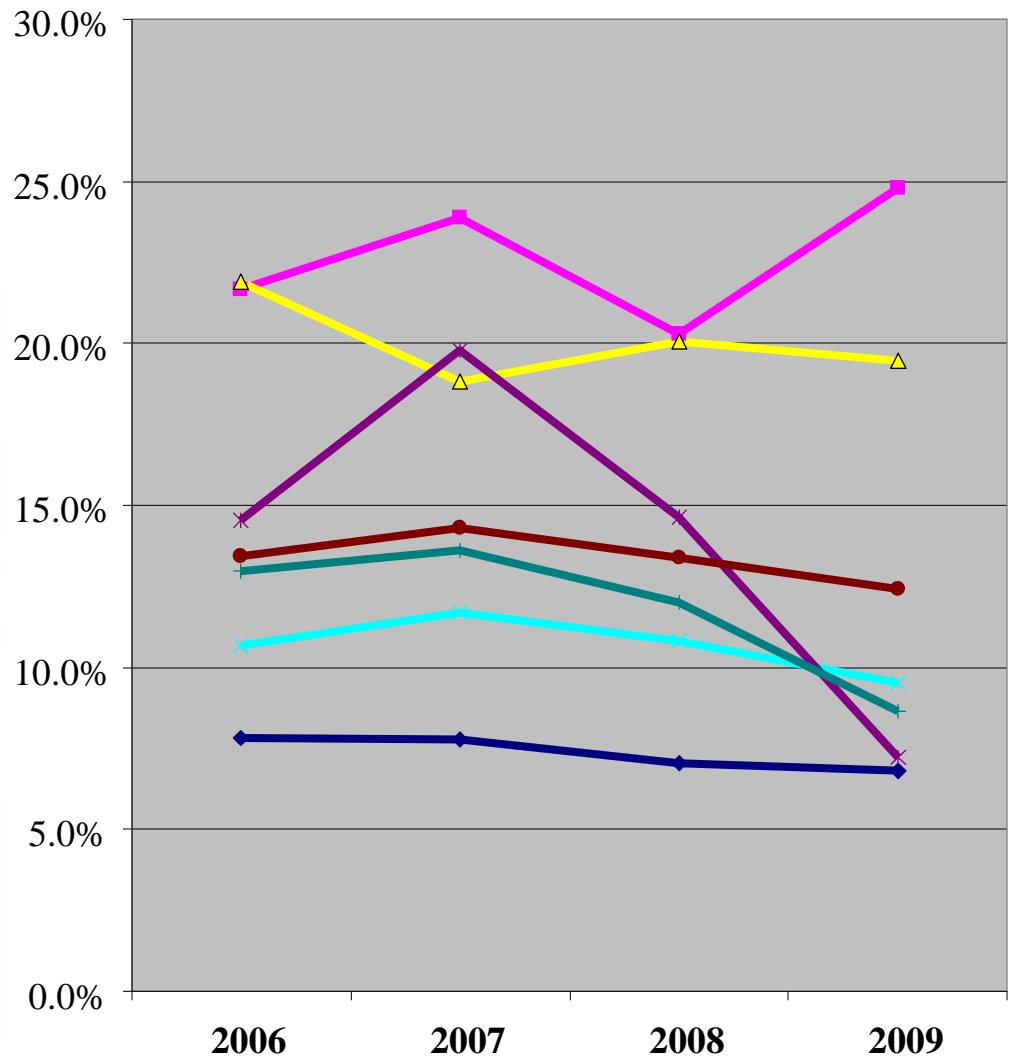
# Fast Facts: Trillium Health Centre 2010/11



# Readmission Rates by LHIN, 2006-2009



# Readmissions by CMG, 2006-2009



- ◆ Cardiovascular
- Congestive Heart Failure
- ▲ COPD
- × Cerebrovascular Accident
- \* Diabetes mellitus
- Gastrointestinal
- + Pneumonia

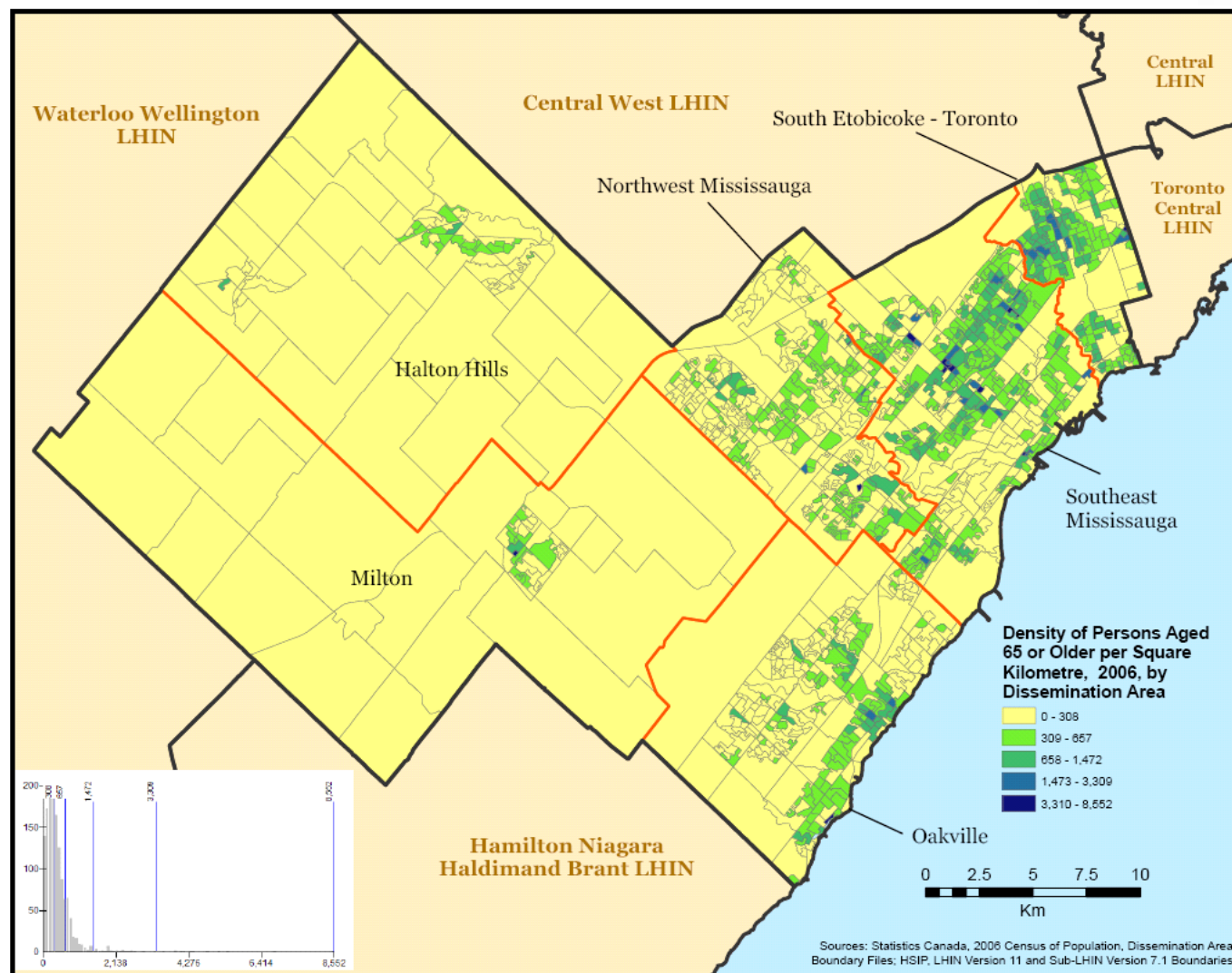


# How Did We Get Here?



- Chronic disease management (e.g., DM)
  - Patient education (e.g., AMI)
  - Palliative care
  - Transitions (program-specific)
  - Inpt and outpt focus on preserving cognition and improving function
  - Seniors strategy
  - Flow / ALC
- } Next slides

# MH-LHIN: Highest concentration of seniors by 2016 is in Trillium's catchment



# HOME FIRST

*On the Road to Standardized Discharge Practice Across the Continuum*

## ISSUE/PROBLEM

- Escalation in ALC Cases
- ER Gridlock Pressures

## PURPOSE

- Transfer the discharge process from hospital community
- Position THC/CCAC as leaders in discharge practices and placement of patients in appropriate care settings in the community
- ALC management that supports successful implementation with the 'HOME FIRST' and new LHIN strategies for managing patient care in the community

OPERATIONS



FUTURE  
STATE



SYSTEM  
SUPPORT

### Accountability Framework

- Flow Committees

### Joint Discharge Operations

- Daily review of ALC patients

### Hard to Place/Hard to Serve

- Individual Reviews

### Chronic Review

- CCC, Palliative

### Kaizen Event

- Value stream map
- Discharge redesign:  
-THC & THC/CCAC

### Technologies

- Medworxx
- WTIS-ALC Intern Upload Tool
- WTIS-ALC Beta Site
- Reporting/Transparency

### Flo Collaborative

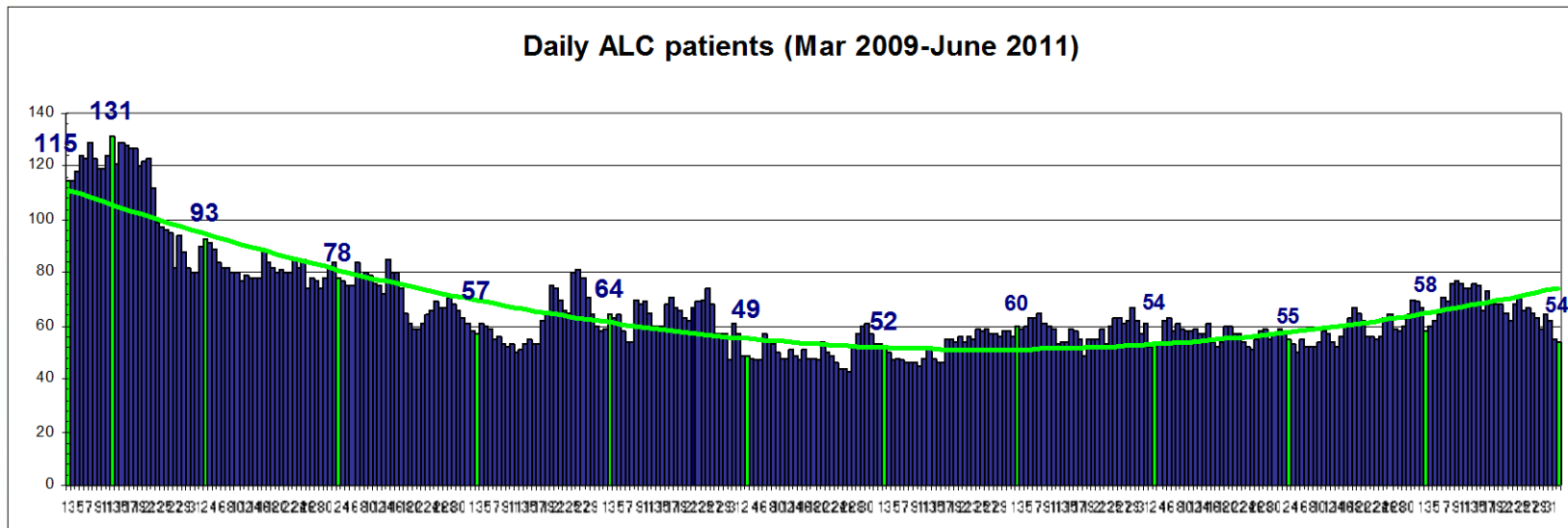
- Appropriate tools
- Education
- Increased collaboration
- Timely access and safe discharge

Standard  
Discharge  
Practices

Structure and Protocols  
Working Group

Discharge Redesign  
Work Group

# ALC patients by day 2009-2011



Sustaining our ALC percentage

- June 3, 2011 – 5%



# QIP Target FY2011/12



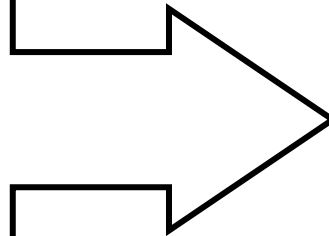
**Reduce 30-day readmissions in patients with selected CMGs from 12.3% (baseline) to 11.5 %**

# Organizational Strategy



## Inputs

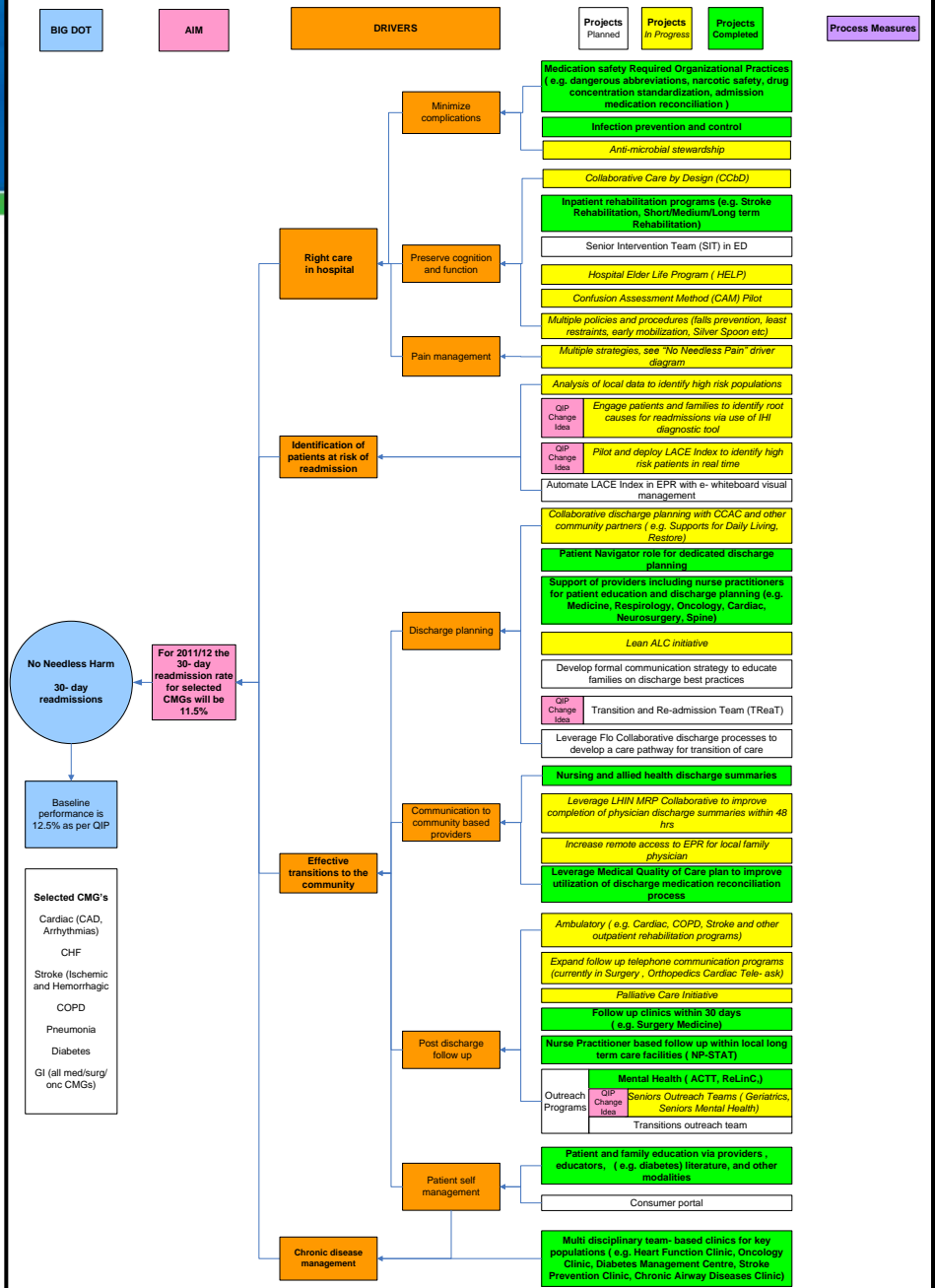
- Provincial and internal data
- Literature Review
- Catalogue current leading state
- 30 diagnostic interviews



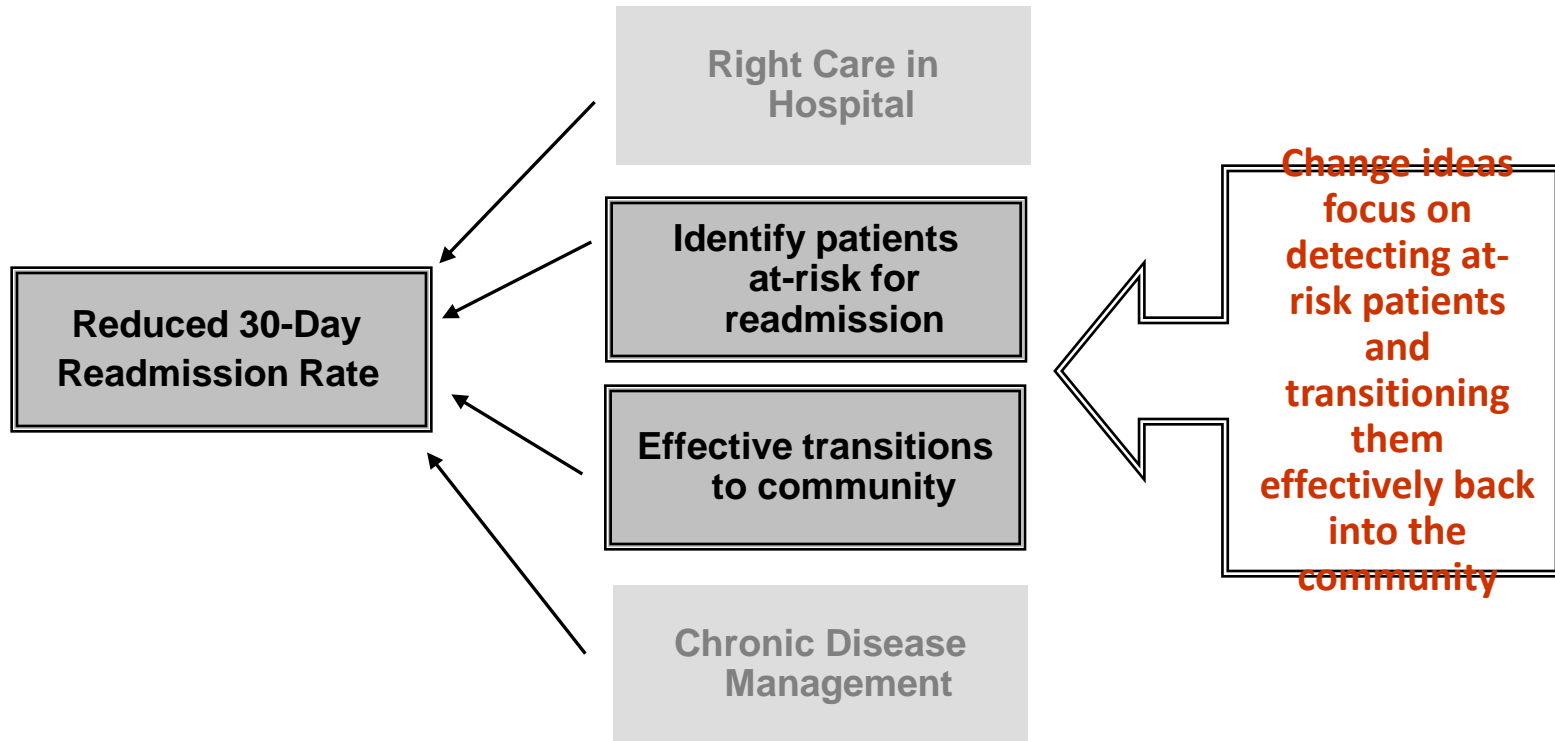
## Strategy

***Driver Diagram***

**No Needless Harm  
30-day Readmissions Draft 2**



# Targeted Change Ideas





# LACE Implementation



- Piloted on 3 wards March 1-10
  - Respiriology/medicine and 2 cardiology wards (enriched population)
- Clinical leaders trained
- Paper-based scoring tool (St Mike's)
- Calculated on day of discharge

# LACE – Results



- 50 patients
- LACE  $\geq$  10
  - 75% of cardiology patients
  - 60% of respirology/medicine patients
- Readmissions: 13 patients (26%)
  - 11 patients (85%) had LACE  $\geq$  10

# Lessons Learned



- Increased staff awareness
  - Avoidable hospitalization = quality issue
- Empowering: prevent ‘frequent flyers’
- Comorbidities difficult to find – patient interview often required
- 2-5 minutes per patient
  - Could be perceived as added work

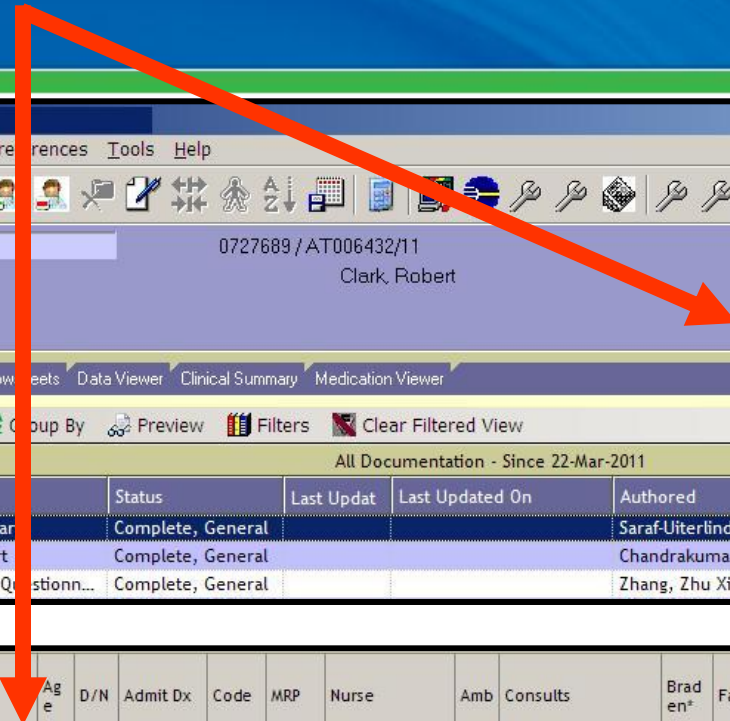
# Frontline Staff Recommendations



- Use prior to date of discharge
- Do not identify risk for its own sake
  - Must have resourced intervention to deploy for at-risk patients
- Many (all?) LACE variables in EPR
  - Can LACE be automated within EPR?
  - Link to visual management



# Visual Management



File Registration Edit View GoTo Actions Preferences Tools Help

M-MED4B-M401-1      0727689 / AT006432/11      88y      Female

Clark, Robert      WT: kg HT: cm BSA: m2

ARO History:      Code Status:      LACE Index Score: 14

ALLERGIES:

Patient List Orders Results Patient Info Documents Flow Sheets Data Viewer Clinical Summary Medication Viewer

Views Action List Time Interval Group By Preview Filters Clear Filtered View

All Documentation - Since 22-Mar-2011

Date	Document Name	Status	Last Update	Last Updated On	Authored	Signed	Entered By	Entered On
21-Jun-2011	Social Work Summary	Complete, General			Saraf-Uiterlinden, Jyotsna (Social Worker)			
21-Jun-2011	Consultation Report	Complete, General			Chandrakumar, Sandrasegaram (MD)		Med, Quist (.)	22-Jun-2011
15-Jun-2011	Patient Admission Questionn...	Complete, General			Zhang, Zhu Xin (RN)	15-Jun-2011 14:05		

Loc	Addition at Precautions	LOS	Patient	Age	D/N	Admit Dx	Code	MRP	Nurse	Amb	Consults	Brad en*	Falls*	AspirationRisk	NPO	PDD*	PDD Alert	Admitted From*	Interim D/C	D/C Plan*	Comments
401-1		9d		88y	<input type="checkbox"/>	GASTROINT			Clark, NICOLE	Ax1	OT, PT	13	-1			Acute	8d 22h	home			receiving blo
401-2		2d		87y	<input type="checkbox"/>	FALL/CONF			Ginzbu KAMLESH	Ax1		15	11			D/C <24h	0d 16h				cam needed.
402-1		5d		61y	<input type="checkbox"/>	HEPATITIS			El-Ashr KAMLESH	I			2			Acute	2d 4h	home			ERCP machin
402-2		2d		95y	<input type="checkbox"/>	ABDOMINAL			KAMLISH	Ax2		11	0			Acute	0d 16h	retireme		LTC	
403-1	Contact	1d		85y	<input type="checkbox"/>	CLOSTRIDIL			Newma RUBY	Ax2		6	7			Acute	0d 16h	LTC		LTC	CAM NEEDED
404-1		144d		80y	<input type="checkbox"/>	PERI-OP ISC			Lam, P NICOLE	Bed	RD, OT, PT	12	0			Acute	47d 22h	home		CCC	requires q3--
405-1		16d		86y	<input type="checkbox"/>	ACUTE OR			Moham ADELAIDE	Ax1	OT, PT	13	15			ALC	4d 23h			CCC	condition de
405-2										Ax1	OT					Acute	40d 0h				clo enagone
406-1		5d							El-Ashr ADELAIDE	Ax2	PT	15	2.5			Acute	2d 4h				CAM 8/16 (-)
406-2		22d		87y	<input type="checkbox"/>	FALL/PEG			Soh, Jc KAMLESH	Ax2	OT, PT	13	12.5			Acute	19d 22h			CCC	CAM done, si
407-1		7d		80y	<input type="checkbox"/>	FALL/RENA			Lam, P NICOLE	Ax1	PT	15	15			Acute	4d 23h	home			sob, wheezy

30

# Actions To Achieve QIP Goal



## 1. Broader engagement

- Validate / prioritize driver diagram change ideas
- Assess resource implications

## 2. Automate LACE

## 3. Develop a Transitions Team

- Defined population (seniors)
- At-risk by LACE

# Questions or Comments?

