No Needless Harm
30-day Readmissions Draft 2

BIG DOT | **AIM** | **DRIVERS** | **Projects** Planned | **Projects** *In Progress* | **Projects** Completed | **Process Measures**

No Needless Harm

30- day readmissions

Baseline performance is 12.5% as per QIP

For 2011/12 the 30- day readmission rate for selected CMGs will be 11.5%

Selected CMG's

Cardiac (CAD, Arrhythmias)

CHF

Stroke (Ischemic and Hemorrhagic

COPD

Pneumonia

Diabetes

GI (all med/surg/ onc CMGs)

Right care in hospital

- Minimize complications
  - **Medication safety Required Organizational Practices (e.g. dangerous abbreviations, narcotic safety, drug concentration standardization, admission medication reconciliation)**
  - **Infection prevention and control**
  - *Anti-microbial stewardship*
- Preserve cognition and function
  - *Collaborative Care by Design (CCbD)*
  - **Inpatient rehabilitation programs (e.g. Stroke Rehabilitation, Short/Medium/Long term Rehabilitation)**
  - Senior Intervention Team (SIT) in ED
  - *Hospital Elder Life Program (HELP)*
  - *Confusion Assessment Method (CAM) Pilot*
  - *Multiple policies and procedures (falls prevention, least restraints, early mobilization, Silver Spoon etc)*
- Pain management
  - *Multiple strategies, see "No Needless Pain" driver diagram*

Identification of patients at risk of readmission

- *Analysis of local data to identify high risk populations*
- QIP Change Idea: *Engage patients and families to identify root causes for readmissions via use of IHI diagnostic tool*
- QIP Change Idea: *Pilot and deploy LACE Index to identify high risk patients in real time*
- Automate LACE Index in EPR with e- whiteboard visual management

Effective transitions to the community

- Discharge planning
  - *Collaborative discharge planning with CCAC and other community partners (e.g. Supports for Daily Living, Restore)*
  - **Patient Navigator role for dedicated discharge planning**
  - **Support of providers including nurse practitioners for patient education and discharge planning (e.g. Medicine, Respirology, Oncology, Cardiac, Neurosurgery, Spine)**
  - *Lean ALC initiative*
  - Develop formal communication strategy to educate families on discharge best practices
  - QIP Change Idea: Transition and Re-admission Team (TReaT)
  - Leverage Flo Collaborative discharge processes to develop a care pathway for transition of care
- Communication to community based providers
  - **Nursing and allied health discharge summaries**
  - *Leverage LHIN MRP Collaborative to improve completion of physician discharge summaries within 48 hrs*
  - *Increase remote access to EPR for local family physician*
  - **Leverage Medical Quality of Care plan to improve utilization of discharge medication reconciliation process**
- Post discharge follow up
  - *Ambulatory (e.g. Cardiac, COPD, Stroke and other outpatient rehabilitation programs)*
  - *Expand follow up telephone communication programs (currently in Surgery , Orthopedics Cardiac Tele- ask)*
  - *Palliative Care Initiative*
  - **Follow up clinics within 30 days (e.g. Surgery Medicine)**
  - **Nurse Practitioner based follow up within local long term care facilities (NP-STAT)**
  - Outreach Programs
    - **Mental Health (ACTT, ReLinC,)**
    - QIP Change Idea: *Seniors Outreach Teams (Geriatrics, Seniors Mental Health)*
    - Transitions outreach team
- Patient self management
  - **Patient and family education via providers , educators, (e.g. diabetes) literature, and other modalities**
  - Consumer portal

Chronic disease management

- **Multi disciplinary team- based clinics for key populations (e.g. Heart Function Clinic, Oncology Clinic, Diabetes Management Centre, Stroke Prevention Clinic, Chronic Airway Diseases Clinic)**

Trillium HEALTH CENTRE

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