AHS Report on Performance
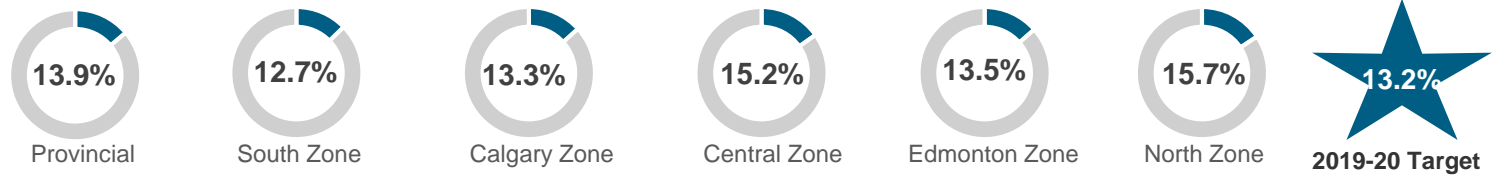# Q3 2019-20

DEFINITION: The percentage of medical patients with unplanned readmission to hospital within 30 days of leaving the hospital (excluding admissions for surgery, pregnancy, childbirth, mental health diseases and disorders, palliative care and chemotherapy for cancer).

WHY THIS IS IMPORTANT: High rates of readmission act as a signal to hospitals to look more carefully at their practices, including discharge planning and continuity of services after discharge. Rates may be impacted due to the nature of the population served by a facility (elderly patients and patients with chronic conditions) or due to different models of care and healthcare services accessibility. The lower the percentage, the better as it demonstrates that fewer people are being readmitted shortly after being discharged.

Unplanned Medical Readmissions, Q2YTD 2019-20

Provincial	South Zone	Calgary Zone	Central Zone	Edmonton Zone	North Zone	2019-20 Target
13.9%	12.7%	13.3%	15.2%	13.5%	15.7%	13.2%

Unplanned Medical Readmissions Trend

Zone Name	Site Name	2014-15	2015-16	2016-17	2017-18	2018-19	Q2YTD 2018-19	Q2YTD 2019-20	Trend	2019-20 Target
Provincial	**Provincial**	**13.6%**	**13.7%**	**13.6%**	**13.6%**	**13.8%**	**14.0%**	**13.9%**	⇨	**13.2%**
South Zone	**South Zone**	**13.4%**	**14.2%**	**13.9%**	**13.9%**	**13.0%**	**13.7%**	**12.7%**	☆	**13.2%**
	Chinook Regional Hospital	13.4%	14.0%	13.3%	12.7%	11.6%	11.7%	12.3%	☆	13.2%
	Medicine Hat Regional Hospital	12.4%	14.1%	13.8%	13.9%	13.2%	13.8%	12.7%	☆	13.2%
	Other South Hospitals	14.7%	14.5%	14.9%	15.5%	14.8%	16.3%	13.3%	⇧	13.2%
Calgary Zone	**Calgary Zone**	**12.2%**	**12.3%**	**12.3%**	**12.5%**	**12.8%**	**12.9%**	**13.3%**	⇩	**13.2%**
	Foothills Medical Centre	12.1%	12.3%	12.3%	12.3%	12.7%	12.6%	13.1%	☆	13.2%
	Peter Lougheed Centre	12.3%	12.8%	13.1%	12.6%	12.6%	12.5%	13.6%	⇩	13.2%
	Rockyview General Hospital	11.9%	12.0%	12.1%	12.4%	12.8%	13.2%	13.3%	⇨	13.2%
	South Health Campus	12.3%	12.0%	11.4%	12.3%	13.4%	14.1%	13.3%	⇧	13.2%
	Other Calgary Hospitals	13.7%	12.5%	13.0%	13.4%	12.9%	12.1%	14.3%	⇩	13.2%
Central Zone	**Central Zone**	**14.9%**	**15.0%**	**14.8%**	**14.2%**	**14.9%**	**15.1%**	**15.2%**	⇨	**13.2%**
	Red Deer Regional Hospital Centre	13.8%	14.0%	13.0%	13.1%	14.0%	13.9%	13.6%	⇨	13.2%
	Other Central Hospitals	15.3%	15.4%	15.6%	14.6%	15.3%	15.5%	15.9%	⇨	13.2%
Edmonton Zone	**Edmonton Zone**	**13.8%**	**13.6%**	**13.6%**	**13.9%**	**14.2%**	**14.3%**	**13.5%**	⇧	**13.2%**
	Grey Nuns Community Hospital	12.3%	13.2%	12.7%	12.7%	14.2%	14.7%	12.9%	☆	13.2%
	Misericordia Community Hospital	13.7%	13.5%	15.0%	14.2%	15.1%	15.5%	14.5%	⇧	13.2%
	Royal Alexandra Hospital	14.0%	13.7%	13.1%	14.2%	13.9%	14.0%	13.6%	⇨	13.2%
	Sturgeon Community Hospital	13.7%	13.4%	13.1%	13.8%	14.9%	16.0%	13.1%	☆	13.2%
	University of Alberta Hospital	14.5%	14.2%	14.4%	14.5%	14.5%	14.0%	14.0%	⇨	13.2%
	Other Edmonton Hospitals	12.7%	11.9%	12.9%	12.0%	12.4%	12.4%	12.3%	☆	13.2%
North Zone	**North Zone**	**15.3%**	**15.3%**	**15.2%**	**14.8%**	**14.7%**	**14.8%**	**15.7%**	⇩	**13.2%**
	Northern Lights Regional Health Centre	12.8%	13.3%	14.2%	15.0%	13.5%	14.5%	14.4%	⇨	13.2%
	Queen Elizabeth II Hospital	11.9%	13.3%	13.4%	11.7%	12.3%	12.1%	12.8%	☆	13.2%
	Other North Hospitals	16.1%	15.9%	15.6%	15.3%	15.3%	15.3%	16.4%	⇩	13.2%

Trend Legend: ☆Target Achieved ⇧Improvement ⇨Stable: ≤3% relative change compared to the same period last year ⇩Area requires additional focus

Total Discharges

Zone	2015-16	2016-17	2017-18	2018-19	Q2YTD 2018-19	Q2YTD 2019-20
Provincial	**114,313**	**114,400**	**114,717**	**114,908**	**57,260**	**58,441**
South Zone	9,688	9,885	9,598	9,322	4,799	4,494
Calgary Zone	35,594	35,712	36,842	36,926	18,104	19,206
Central Zone	16,898	16,811	16,298	15,516	7,812	7,657
Edmonton Zone	37,859	37,853	37,828	39,526	19,555	20,309
North Zone	14,274	14,139	14,151	13,618	6,990	6,775

Source(s): AHS Provincial Discharge Abstract Database (DAD), as of January 30, 2020
Notes:
- This quarter is a quarter later due to requirements to follow up with patients after end of reporting quarter.
- This indicator measures the risk-adjusted rate of urgent readmission to hospital for the medical patient group, which is adapted from the CIHI methodology (2016).

Improve Patient and Population Health Outcomes

Objective 5: Improving health outcomes through clinical best practices with a focus on wait times and access.

WHY THIS IS IMPORTANT

AHS strives to improve health outcomes through clinical best practices by supporting the work of our Strategic Clinical Networks™ (SCNs), increasing capacity for evidence-informed practice, and gaining better access to health information.

AHS PERFORMANCE MEASURE

Unplanned Medical Readmissions is the percentage of medical patients with unplanned readmission to hospital within 30 days of leaving the hospital. This excludes admissions for surgery, pregnancy, childbirth, mental health diseases and disorders, palliative care, and chemotherapy for cancer.

UNDERSTANDING THE MEASURE

Although readmission may involve complex external factors, high rates of readmission act as a signal to hospitals to look more carefully at their practices, including discharge planning and continuity of services after discharge.

Rates may be impacted by the nature of the population served at a facility (elderly patients and patients with chronic conditions) or due to different models of care and healthcare service accessibility.

The lower the percentage the better, as it demonstrates that fewer people are being readmitted shortly after discharge.

HOW WE ARE DOING
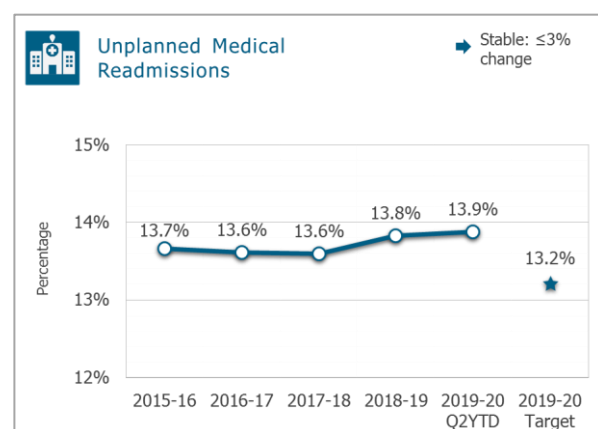
Source: Discharge Abstract Data (DAD) – AHS Provincial
Note: This measure is reported a quarter later due to follow-up with patients after the reporting quarter.

While unplanned medical readmission rates have remained stable year-over-year, target was not achieved in Q2. (This is a lag measure where data is reported a quarter later.) In most cases, medical readmissions are caused by patients with complex health needs such as chronic obstructive pulmonary disease (COPD), heart failure (HF), and pneumonia. AHS' work on the COPD and HF care pathways and transition practices will help drive improvement.

WHAT WE ARE DOING

AHS continues to increase capacity for evidence-informed practice and policy through enhanced data sharing, research, innovation, health technology assessment, and knowledge translation.

- AHS has implemented a **Health Innovation Implementation and Spread (HIIS) Fund** to bridge the funding gap between evidence generation and operational funding. Implementation continued in Q3 for the five innovation projects that were awarded funding in 2018-19:

  - **Building Capacity in Pediatric Mental Health (CanREACH)** is a six-month training program that educates primary care providers as the first contact and ongoing support for children with mental health disorders. The program aims to improve care through early identification and intervention of mental health conditions.

  - **ECHO-Plus** aims to spread the Extended Community Health Outcomes (ECHO) model of care which increases access to Hepatitis C care for underserved populations by using telehealth technologies to train and support primary care providers to effectively and safely care for individuals with Hepatitis C.

  - The **Family Integrated Care (FICare)** model is a dynamic model of care that provides parents with the knowledge, skills, and confidence to care for their baby at home to support earlier discharge and reduce neonatal intensive care lengths of stay.

  - The **Alberta Facilitated Cancer Diagnosis Pathways** aim to expedite lymphoma and colorectal cancer diagnoses through centralized referrals, radiology-facilitated biopsies and investigations, and navigation supports.

  - Expanding the **Primary Care Supports for Digestive Health Care** program across the province will help address long wait times for gastroenterology specialist consultations and endoscopies. Supports include care pathways and telephone and electronic advice request options.

- **Partnership for Research and Innovation in the Health System (PRIHS)** focuses on supporting health research and innovation

projects that improve quality of patient care and services while reducing costs in the healthcare system. Six projects continued implementation in Q3:

o The Improving Acute Care for Long-Term Care Residents project aims to reduce the number of transfers from long-term care facilities to an emergency department. A referral pathway will be used to identify patients that can safely be treated by a community paramedic directly in the patient's care facility.

o The Cirrhosis Care Alberta Program (CCAP) will improve quality of care and reduce acute care utilization for patients with advanced cirrhosis by utilizing best practice guidelines and tools for care transitions, providing on-demand system and disease management support, and enabling virtual monitoring to support care between scheduled visits.

o The South Zone Indigenous Patient Navigation Model will work with Indigenous patients and families to co-design a navigation model with the goals of providing smoother access to services, creating better connections to health and other community services, and improving health outcomes.

o The Virtual Supervised Consumption project aims to improve patients' and families' experiences and health outcomes by removing barriers such as stigma, geographic distance, and community resistance to supervised consumption services. When a client calls the service, an operator will monitor the client after substance use, dispatch emergency medical services if the client becomes unresponsive, and provide information on resources for safer use and treatment.

o The Innovative Models of Acute Pediatric Mental Health and Addiction Care project responds to recommendations for a service redesign that provides support to youth and their families when they present to the emergency department for an acute mental health or addiction concern. With families at the centre, this project will implement and evaluate a new model of acute mental health and addiction care that connects children and families with the resources they need.

o The Enhancing Community Health Through Patient Navigation, Advocacy, and Social Support (ENCOMPASS) study aims to improve health outcomes for patients with multiple chronic conditions by linking them to a Community Health Navigator who will assist with system navigation, understanding information, locating community resources, and supporting self-management.

Strategic Clinical Networks™ (SCNs™):

SCNs™ bring together clinicians, researchers, patients, and policymakers to drive innovation and research, standardize care, share best practices, improve access to services, and improve health system sustainability.

- The Starting Dialysis on Time at Home on the Right Therapy (START) project, part of the Kidney SCN™, maximizes the safe and effective use of peritoneal dialysis, ensures patients are starting dialysis at the appropriate time, improves outcomes and experiences, and reduces healthcare costs. The project demonstrated an ability to reduce the proportion of patients initiating dialysis earlier than recommended. The project has transitioned to operations for ongoing monitoring.

- The Provincial Breast Health Initiative, part of the Cancer SCN™, aims to improve breast cancer care by implementing pathways that reduce diagnostic delays, provide appropriate surgery, and support information sharing with patients, families, and care providers. As of Q2YTD, AHS increased the percent of same-day mastectomies by 31% compared to the same period last year. (This is a lag measure where data is reported a quarter later.)

- The Elder Friendly Care (EFC) initiative, part of the Seniors Health SCN™, supports collaboration among care teams to reduce restraint use, prevent delirium and falls, increase mobility, enhance sleep, and support more effective and timely discharge of older adults. EFC continues to be a focus on more than 50 medical/surgical units in 11 acute care sites across the province. Care plans for EFC practices (including restraints, delirium, and behaviour maps) have been built into the new electronic medical record system.

- The Chronic Obstructive Pulmonary Disease and Heart Failure (COPD/HF) Care Pathways, part of the Respiratory Health and Cardiovascular Health & Stroke SCNs™, utilize standardized forms and processes to support patients from hospital admission through to discharge into community or primary care settings. These pathways have been shown to reduce hospital readmissions, reduce length of stay in hospital, and improve patient outcomes and experience through coordinated care. COPD readmission rates in Q2YTD (19%) remained stable compared to the same period last year (19%) (This is a lag measure where data is reported a quarter later.)

- The Repetitive Transcranial Magnetic Stimulation (rTMS) initiative, part of the Addiction and Mental Health SCN™, provides an innovative, non-invasive procedure to Albertans with treatment-resistant depression that has proven to be effective and safe. Five sites continue to offer the service and are showing improved patient outcomes and access.

SCNs™ are implementing initiatives such as the National Surgical Quality Improvement Program (NSQIP) and Enhanced Recovery After Surgery (ERAS) which impact wait times and access, reduce variation in practice, decrease length of stay, and increase quality of surgical care provincially. In Q3, AHS' surgical sites gathered data to support prioritization of surgical quality improvement programs.