



At or better than target.
Continue to Monitor.



Within 5% of target. Monitor
and take action as appropriate.



Below target by more than 5%.
Take action and monitor progress.



No target identified
or available.

WHAT IS BEING MEASURED?

Chronic diseases represent the most common reasons patients are readmitted to Bluewater Health. This measure tracks the percentage of patients with an initial diagnosis of:

1. Acute Myocardial Infarction (AMI)
2. Cardiovascular
3. Cerebrovascular Accident (Stroke)
4. Chronic Obstructive Pulmonary Disease (COPD)
5. Congestive Heart Failure (CHF)
6. Diabetes mellitus
7. Gastrointestinal
8. Pneumonia

Patients with an above listed diagnosis that are discharged from Bluewater Health and who are then readmitted within 30 days of that initial discharge are captured in this metric. The readmission must be for an urgent condition (i.e. non-elective admission) but not necessarily for the same diagnosis they were originally discharged with.

WHY IS THIS IMPORTANT?

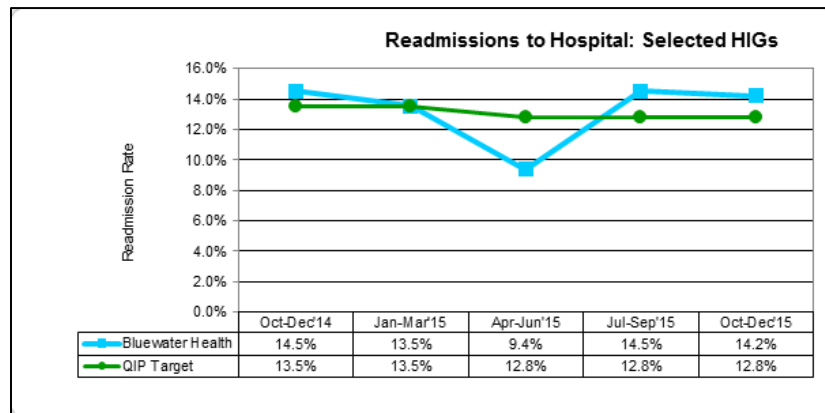
Measuring how often patients discharged from hospital actually return to hospital reveals how well we have prepared them for discharge, including how well we have set up linkages with community providers to help meet patients' needs while at home. This measure is one of Bluewater Health's top priorities in our Quality Improvement Plan (QIP) for the 2016-17 fiscal year.

WHAT IS THE TARGET?

Bluewater Health will monitor its performance relative to provincial averages and targets that are provided by the Erie-St. Clair Local Health Integration Network (LHIN) on a quarterly basis.

HOW ARE WE DOING?

For the most recent period where data is available (October to December 2015), the 30 day rate of readmission for the above cohort of patients discharged from Bluewater Health is 14.2% which is above the 12.8% target.



Preferred trend/
direction



WHAT ACTIONS ARE WE TAKING?

In an effort to reduce the 30 day readmission rate for patients, Bluewater Health will continue to:

- Monitor readmission for the select HIG conditions on a case by case basis as necessary
- Continue to work with our Community partners to ensure the continuum of care for our patients post-discharge
- Continue to make follow up phone calls to our discharged patients to monitor their recovery

WHERE CAN I LEARN MORE ABOUT THIS MEASURE?

- [Contact us](#)

FREQUENCY REPORTED: Quarterly

NEXT UPDATE: December 2016