# Cardiovascular Ambassador Project plan template

## Who this template is for

This example template is for health services who want to embed locally relevant and evidence-based models of care to improve the management of, and increase the time spent in the community for, those living with cardiovascular disease. This template is based on the statewide Cardiovascular Ambassador Project and provides a step by step guide to mapping out your improvement using theories from the [Model for Improvement](https://www.safercare.vic.gov.au/improvement/step-by-step-guide-to-using-the-model-for-improvement).

## How to use this template

Each section includes instructions, links to relevant quality improvement resources as well as helpful tips learned from the Ambassador project. Use this template in conjunction with the “Guide to developing a local model of care to improve cardiovascular care at your health service” document. Complete each section as you go, add/remove items as required. Remember, this template is a guide only and you can customise it to suit your health service’s unique circumstances and the needs of your local cohort.

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# 1. Background

## **Project overview**

Provide a brief background on why you are undertaking this improvement work. Include any relevant information for your project.

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## **Local background - understanding the current state**

Understanding your health service involves knowing the steps in the journey for a patient and their family or carers through the health service, and the factors affecting their experiences and outcomes. Detailed understanding of this will help you and the team identify where there are inconsistencies, gaps, duplications, inefficiencies, or delays. Conduct a patient journey mapping exercise, review your data, gain patient perspectives and anecdotal evidence. Use these to define the problems and gaps you intend to address and improve upon within your health service. What does the data tell you? What do your consumers need? Reflect your findings in the table below.

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| \*Tip: Review your local readmission data (i.e. via your health information services) and do a ‘deep dive’ case studies on 3-5 readmitted patients can help with the journey mapping exercise and shed light on gaps/inefficiencies in your service. You can also use the Victorian Cardiovascular Dashboard as a means to benchmark where your health service is compared to others in your region or state-wide level. If you require access to the Dashboard, email [portal.support@vahi.vic.gov.au](mailto:portal.support@vahi.vic.gov.au).  You can use your own process mapping template or find some here:  [Process mapping](https://www.ihi.org/sites/default/files/QIToolkit_Flowchart.pdf)  [Affinity mapping](https://www.vic.gov.au/affinity-mapping)  [Cause and effect (fishbone/Ishikawa) analysis](https://www.ihi.org/resources/tools/cause-and-effect-diagram)  [IHI QI Essentials toolkit](https://www.ihi.org/resources/tools/quality-improvement-essentials-toolkit) |

# Project aim

## **Project aim & objectives**

Use the learnings you have from exploring your current state and baseline data (see section 4) to set an aim. Review the driver diagram provided in [Appendix 1](#_APPENDIX_1-_Planning). To achieve the aim, what actions need to occur? Set an aim that is specific, measurable, achievable, relevant, and timely (SMART) for your team. Consider, How much do you want to improve by? What is your timeframe? Is it a realistic match for how much you want to improve by and the complexity of your system? Is there a particular part of your service you want to focus on?

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| **Local project aim example:**  By [insert date] we will reduce the rate of acute unplanned hospital readmissions for [insert the targeted heart condition/s\*] by [insert %] in [health service].  \*Tip: set a goal that will energise and motivate, that is not out of reach or too easy. Reducing readmissions is one aspect of improving cardiovascular care. See section 4 for more guidance on how to set a project outcome measure.  \*Atrial fibrillation, ischemic heart disease and/or heart failure |

# Project approach

## Project scope

Cardiac conditions that were the priority focus for the Ambassadors project included HF, AF, and AMI. The decision of which condition/s to focus on will be at the discretion of each health service, and be based on readmission rates, current practice and pre-existing models of care, gaps in patient care and the volume of patients cared for with each condition. Reflect which cardiac diagnosis will be the focus of your model of care below.

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| **Which cardiac diagnoses are the focus of your model of care?**  Heart failure  Atrial fibrillation  Ischaemic heart disease  Other: Click or tap here to enter text.  **Estimate number of separations\* a month after an episode of care for target condition?**  Tip: Hospital sites with low numbers of patients admitted with a particular cardiac condition are encouraged to consider broadening their focus to more than 1 cardiac diagnosis (e.g. HF & AMI). This section will detail the who and where of your proposed model of care.  **In scope setting:**  In which settings will your model of care focus and why? (ward, inpatient, outpatient, community)  **Out of Scope setting:**  In which settings will your model of care not focus upon and why? (ward, inpatient, outpatient, community)  \*Separation - The process by which an episode of care for an admitted patient cease. |

## Model of care

Incorporating the learnings from your gap analysis (section 1), design a model of care that achieves clinical goals and facilitates easy integration with your health service’s existing environment. As you plan your model of care, consider your resources, team structure and think about the timing for introducing each intervention and what dependencies might exist. Multifaceted interventions are most likely to be successful and project teams should compile a series of interventions into a model of care to improve quality of care and transitions.

Examples of interventions implemented through the Ambassador project can be seen in the table below. Appendix 2 provides an overview of the models of care implemented by participating health services.

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| **Inpatient** | Emergency Department Diversion  Bundles of care that streamline and standardise care processes for patients admitted with cardiovascular disease.  Inpatient cardiac coordinator who provides inpatient cardiac education, improve referral pathways, coordination of specialist care and discharge support, coordinates follow up with GP within 7 days.  Multidisciplinary case conferences for readmitted patients to identify and discuss reasons for readmission and develop a management plan.  Support or improve HITH services |
| **Outpatient** | Telehealth cardiac specialist clinics that provide telemedicine support to regional health services.  Nurse led or coordinated post discharge or titration clinics to ensure up-titration and monitoring of evidence-based pharmacotherapy.  Follow-up phone call service for recently discharged patients deemed medium- to high-risk of readmission.  Improve cardiac rehab services |
| **Community** | Home visiting specialist nurses to improve cardiovascular care in the community.  Improve and collaborate with chronic disease management (HARP) and exercise rehabilitation programs.  Collaborate with primary care settings to improve transitions and cardiac care in GP clinics.  Advanced care planning and shared decision-making improvement initiatives.  Improved timely palliative care referral and end of life support in a cardiovascular patient’s preferred setting. |

Use the table below to describe your model of care, the interventions, multidisciplinary team, and schedule of implementation.   
Consider reviewing the following supporting resources as you prepare your model of care:

* Agency for Clinical Innovation, 2013. Understanding the process to develop a Model of Care An ACI Framework. ACI, NSW. Access [here](https://www.aci.health.nsw.gov.au/__data/assets/pdf_file/0009/181935/HS13-034_Framework-DevelopMoC_D7.pdf)
* Agency for Clinical Innovation, 2019. Chronic Heart Failure Organisational Models. ACI, NSW. Access [here](https://aci.health.nsw.gov.au/__data/assets/pdf_file/0020/602219/ACI_LBVC_CHF_Organisational_Model.pdf)
* National Heart Foundation of Australia, 2016. Heart Failure Toolkit. NHFA. Access [here](https://www.heartfoundation.org.au/getmedia/430f5ff5-35d3-4e17-9f01-b3da4f159c68/Heart_Failure_Toolkit_Web.pdf)

| **Intervention/ Change Name** | **Description** | **Multidisciplinary Team involved** | **Resources required** | **Schedule** |
| --- | --- | --- | --- | --- |
| *1.* ***Example only:*** *Inpatient nurse educator/ navigator/ discharge coordinator* | *This intervention will create a new role as a nurse navigator and support for all patients admitted with heart failure, atrial fibrillation, or ischaemic heart disease. The role will identify in scope patients, review them on the ward, ensure they are seen by the appropriate treating teams and evidence-based care provided. Bedside and discharge patient, carer education will be provided with referral to HARP/HIP and rehab. The follow up call intervention will also be provided by this RN.* | *Cardiac Liaison RN*  *Ward Nursing staff*  *Cardiac Rehabilitation staff*  *HIP services*  *Cardiology and Gen Med medical teams*  *Early discharge clinic staff* | *Patient and carer education resources*  *Bespoke medical record decision support inpatient list*  *Tracking sheet for reviewed patients*  *Readmission risk assessment tool* |  |
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## 3.3 Key milestones

For each intervention, consider the key activities and describe what is necessary to deliver it. Which interventions will you introduce first as your model of care is built and are there certain prerequisites (dependencies) that need to be met before the next intervention is introduced? Examples of activities and timing have been provided below.

| **Intervention/ Change name** | **Activities** | **Timeframe** | **Achieved by** |
| --- | --- | --- | --- |
| *1.* ***Example only*** *Inpatient nurse educator/ navigator/ discharge coordinator* | *-Engage ward staff, introduce new role, key tasks, and schedule monthly in services to standardise inpatient education and discharge planning for in scope cardiac patients*  *-With ward representatives and patients, set up an inpatient education resource pack for in scope patients, source resources and create dissemination plan*  *-Engage decision support to obtain a daily list of in scope patients for model of care* | *2 weeks*  *5 weeks*  *4 weeks* | *August 1st, 2024*  *August 14th, 2024*  *August 14th, 2024* |
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# Measurement plan

With any improvement work, data Is key to understanding whether the changes you are implementing are having an impact. A measurement strategy outlines key performance indicators of success and is essential in tracking progress of your model of care. You and your team will collect and learn from data in real time, using annotated charts to understand your impact, adjust your hypotheses along the way, and see progress towards your aim. Don’t forget the equity lens, segment your data by social groupings can help target improvement efforts to those who may be most disadvantaged.

You may wish to use measures from the Ambassador project as listed in Table 1, or develop your own [family of measures](https://www.ihi.org/resources/how-to-improve/model-for-improvement-establishing-measures) to suit your context.

Helpful tools:

* [Cultural responsiveness framework – Guidelines for Victorian health services](http://www.health.vic.gov.au/publications/cultural-responsiveness-framework-guidelines-for-victorian-health-services)
* [Designing for Diversity](http://www.health.vic.gov.au/populations/designing-for-diversity)

Tip: Use existing data sets where possible (i.e. hospital administrative data on 30/90 day readmission rates). Start small, pick 1-2 process measures and as you grow your model of care then introduce other interventions/measures. Consolidate measures where possible. If using hospital data: Request the following principal diagnosis discharge codes: Heart failure I50 (including I50.0, 150.1, I50.9) , Atrial Fibrillation I48 (including I48.0, 148.1, 148.2, 148.3, 148.4, I48.9), Ischemic Heart Disease I20-125 with subsets. Exclude CABG (Coronary artery bypass graft surgery) if your interventions and settings will not support these patients.

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| **Table 1: Family of measures – Ambassador project** | |
| **Outcome measures** | * Percentage of patients with HF/AF/AMI readmitted within 30 days of being discharged from unit/cohort of focus * Percentage of patients with HF/AF/AMI readmitted within 90 days of being discharged from unit/cohort of focus |
| **Process measures** | * Percentage of patients who receive inpatient education, support and discharge planning from dedicated cardiac liaison nurse while an inpatient. * Percentage of patients whose medical record reveals they have documented evidence of a discharge prioritisation tool was utilised (5 steps to safe discharge, 6 steps to cardiac recovery). * Percentage of patients who at follow up phone call or clinic can recite/recall at least 2 key self-management messages to manage their condition, respond to changing symptoms, escalating care to a health professional or optimise their wellbeing. * Percentage of patients who are referred to a structured exercise program or chronic disease management service, or palliative care service within 48 hours of discharge. * Percentage of patients who attend a follow up clinic appointment to support management of their cardiac condition within thirty days of discharge from hospital. * Average time (in days) from discharge to follow up in a clinic established within the Ambassador project nurse led/coordinated clinics. * Percentage of patients (or carers) who receive a phone call within 48hours of discharge by a member of care team, to discuss hospital stay, early identification of worsening symptoms and management plan? * Percentage of patients where discharge summary is transmitted within 48 hours of discharge to the next site of care |
| **Balance measures** | * Length of inpatient stay for target cardiac condition |

## Measurement strategy

For each of your interventions, use the table below to list which measures you will collect. Decide how you will identify in scope patients and how you will identify their outcomes via lists or spreadsheets. You will need to collect just enough data to learn whether your changes are having an impact on your system. Too much and all your time will be taken up with data collection. Too little and you won’t learn effectively. A good place to start is to sample 20 patient records per week, noting that your data collection opportunities will vary depending on your service size.

Tip: As a guide you will need 1-2 outcome measures aligned to your aim (frequency: monthly), up to 5 process measures aligned to activities or practices logically connected to your aim (frequency: weekly), 1-2 balancing measures to monitor potential indirect impacts in your system (frequency: monthly).

Manual data collection, whilst more accurate than administrative data, can be burdensome especially for teams who don’t have a dedicated resource conducting the project. In these situations it is suggested that administrative data is used to keep track of readmission rates.

The Victorian Cardiovascular Dashboard is another resource with the added benefit of providing risk adjusted data, however there can be a delay in these which makes it difficult to gage whether your interventions are having an impact.

| **Measurement** | **Definition** | **Data Collection Method/Reporting Frequency** | **Numerator** | **Denominator** | **Evidence Source** |
| --- | --- | --- | --- | --- | --- |
| **Outcome measure**  Percentage of patients with heart failure, atrial fibrillation or ischaemic heart disease patients readmitted within 30 and 90 days of being discharged from unit/cohort of focus | In scope= discharged alive to community after heart failure, atrial fibrillation, or ischaemic heart disease principal case of admission from the unit/cohort of focus where project initiatives are active.  Principal diagnosis = The main condition that required a patient to be hospitalised as opposed to an associated condition, or comorbidity which is mentioned in the patient’s medical history but not the primary reason for their admission.  \*\*If using admin data sets these definitions are pre-determined. | Monthly | Number of in scope \*patients with a discharge principal diagnosis of heart failure, atrial fibrillation or ischaemic heart disease who represent for any cause within 30 days (and 90 days) via the emergency department or unplanned admission to the discharging hospital | Number of patients with a discharge principal diagnosis of heart failure, atrial fibrillation or from unit/cohort of focus in the previous 30/90 days, who have stayed greater than 24 hours and who were discharged alive, and not against medical advice | Administrative data or manual data collection |
| **Balancing Measure**  Length of inpatient stay for target cardiac condition | Length of stay for acute, inpatient medical stay, excluding Hospital in The Home and rehabilitation. | Monthly | total number of patient days, from admission to discharge, for all patients with a principal discharge diagnosis of heart failure, atrial fibrillation, or ischemic heart disease over a month | Total number of patients discharged with a principal diagnosis of heart failure, atrial fibrillation, and ischemic heart disease over a month | Engage hospital records team to regularly collect a monthly report. \*See codes provided above |
| **Process measure 1 (EXAMPLE)**  Percentage of patients who are referred to a structured exercise program or chronic disease management service, or palliative care service within 48 hours of discharge | How many patients are referred to either a chronic disease management service, a structured exercise program/service, a cardiac or heart failure rehabilitation service, or community palliative care within 48 hours of discharge | Weekly – spreadsheet | Number of patients discharged from ward of focus with documented evidence of referral to any of these support services within 48 hours of discharge | Number of patients discharged alive to community or number of audited patients in the week | Patient records  (Referral has to be made other does not count in numerator) |

## Baseline Measures

Use the planning and set up stage to collect baseline measures relevant for you model of care before beginning to test changes. Where possible, collect baseline data for priority populations to track progress and impact of your interventions.

Tip: Use existing data where possible i.e. hospital administrative data for readmission rates and length of stay, waitlists for outpatient clinics/cardiac rehab, length of stay For novel interventions where no baseline exists, a run-in period is recommended i.e. implement your intervention for at least 4 weeks, then this can form your baseline..

| **Description** | **Time period** | **Result** | **Comment** |
| --- | --- | --- | --- |
| ***Example only****: Unplanned all cause readmission at 30 days for atrial fibrillation to Highlands Hospital* | *June to July 2021* | *6 readmissions/ 31 in scope discharges= 19 percent* | *Low COVID demand*  *Non-existent influenza season*  *No patients readmitted more than once in time period* |
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# Project Organisation

## Local Project Team

Effective improvement in our complex healthcare system requires a team approach to share the work and to provide diverse knowledge and experience. Build your project team and use this table to delegate roles and responsibilities. Ideally, your team will include: a project lead who will be responsible for coordinating and driving the work (i.e. the Cardiac Liaison Nurse ‘CLN’), at least one consumer with lived experience of your health service, someone with quality improvement knowledge and experience with training in improvement science, multidisciplinary representation with strong clinical leadership (i.e. nursing, medical, pharmacy, allied health), and an executive sponsor (see section 6 – project plan approval).

Tip: consider what can be delegated across the team to enable the CLN in leading more innovative and complex interventions e.g. setting up titration clinics, telehealth etc.

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| --- | --- | --- |
| **Name**  **Position** | **Project Role** | **Project Responsibilities** |
| ***Example*** *(Adapt as required)* | *Cardiac Liaison Nurse* | *Plans, coordinates, and delivers the model of care in collaboration with multidisciplinary team*  *Collects and report outcomes and process measures*  *Runs a weekly early discharge clinic with General Medicine physician*  *Nurse navigator- Reviews all in scope patients on ward and within 48 hours discharge via phone call- educates, refers, supports* |
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## Consumer Engagement Plan

How will patient and carers be involved in the planning, implementation, and evaluation of your project? How will the patients voice be represented? According to consumers, what would be the measure that demonstrates your model of care made a difference?

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| \*Tip: If you are unsure where to start with consumer recruitment, you may be able to reach out to the consumer liaison service in your hospital for support.  Resources: [SCV Partnering in healthcare framework](https://www.safercare.vic.gov.au/support-training/partnering-with-consumers/pih) |

# Project plan approval

Support from your health service executive leadership is critical to enabling protected time to dedicate to the improvement work, access to resources, removal of barriers to progress and organisational commitment, championing your work within your health service and helping you sustain will and engagement throughout the work. Have your executive sponsor review the contents of this project plan and agree it adequately describes the problem/opportunity, benefits and preferred project approach including the attachments.

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| --- | --- |
| Local Executive Sponsor | |
| **Name:** |  |
| **Position:** |  |
| **Date:** |  |

## APPENDIX 1- Planning support tools -Driver Diagrams

### Example Driver Diagram

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **AIM** |  | **PRIMARY DRIVERS** | **SECONDARY DRIVERS** | |
| By June 2023 we will reduce the rate of unplanned all  cause hospital readmissions\* for the targeted# heart conditions in participating health services by 20%.  *\*An unplanned hospital readmission occurs when a patient who has been discharged from hospital (index admission) is admitted again via the emergency*  *department within a certain time for any cause.* |  | Increase in patient and carer knowledge, skill, and confidence to self-care\* | ‹ | Patient and carer self-management education that is disease specific, adapted for health literacy and individual priorities |
|  | ‹ | Distribution and use of patient support resources in preferred language |
|  | ‹ | Care processes and structures to support development and maintenance of self-care skills |
|  | Timely and effective care  and support upon transition between care settings | ‹ | Follow up within 2 weeks of discharge from hospital |
|  | ‹ | Appropriate referral and promotion of chronic disease management program and structured exercise |
|  | ‹ | Improved communication and collaboration between care settings |
|  | ‹ | Timely specialist follow up within one month of discharge |
|  | High quality  evidence-based care | ‹ | Standard evidence-based care pathways/ bundle |
|  | ‹ | Medication prescribing, adherence, and titration support |
|  | ‹ | Care Coordination and access to specialist care as inpatient, outpatient, community dwelling |

## APPENDIX 2 - Participating health services models of care matrix

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Model of care​** | **Alfred Health​** | **Austin Health​** | **Bairnsdale Regional Health​** | **Grampians Health - Ballarat​** | **Barwon Health​** | **Bass Coast Health​** | **Bendigo Health​** | **Eastern Health – Box Hill​** | **Echuca Regional Health​** | **Goulburn Valley Health​** |
| In-scope condition(s)​ | AF​ | HF​ | HF, AF, AMI​ | HF​ | HF​ | HF, AF, AMI​ | HF​ | HF​ | HF, AF, AMI​ | HF, AF, AMI​ |
| ED diversion ​ | ​ | Y​ | ​ | ​ | ​ | ​ | ​ | ​ | ​ | ​ |
| Follow-up calls​ | Y​ | Y​ | Y​ | Y​ | Y​ | Y​ | Y​ | Y​ | Y​ | Y​ |
| Establish /coordinate specialist follow-up clinics​ | Y​ | Y​ | Y​ | Y​ | ​ | ​ | ​ | ​ | ​ | ​ |
| Nurse led clinics  ​ | Y​ | ​ | Y​ | Y​ | ​ | ​ | ​ | ​ | ​ | Y​ |
| Establish new HF rehab service ​ | ​ | ​ | ​ | Y​ | ​ | Y​ | ​ | ​ | Y​ | ​ |
| Support/improve HITH​ | ​ | ​ | ​ | Y​ | Y​ | Y​ | ​ | ​ | Y​ | ​ |
| Improve referral pathways  ​ | ​ | ​ | Y​ | Y​ | Y​ | Y​ | Y​ | Y​ | ​ | ​ |
| Care bundles/EMR care sets ​ | ​ | ​ | ​ | Y​ | ​ | Y​ | ​ | Y​ | ​ | ​ |
| Multidisciplinary team rounds (inpatient, remote)  ​ | ​ | ​ | ​ | Y​ | ​ | ​ | ​ | ​ | Y​ | Y​ |
| Engage GPs/other community services  ​ | ​ | ​ | ​ | Y​ | Y​ | ​ | ​ | ​ | ​ | ​ |
| Staff education/discharge processes  ​ | ​ | ​ | Y​ | Y​ | Y​ | Y​ | Y​ | Y​ | Y​ | Y​ |
| Develop inpatient tools/systems, order tests  ​ | ​ | ​ | ​ | ​ | ​ | Y​ | Y​ | Y​ | ​ | ​ |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Model of care​** | **Mercy Hospital​** | **Mildura Base Public Hospital​** | **Monash Health​** | **Northeast Health - ​**  **Wangaratta​** | **Northern Health​** | **Peninsula Health - Frankston​** | **Royal Melbourne Hospital​** | **St Vincent's Hospital Melbourne​** | **Western Health - Footscray​** | **Western Health - Sunshine​** |
| In-scope condition(s)​ | HF​ | HF, AF, AMI​ | HF​ | HF, AF​ | HF​ | HF​ | HF​ | AMI​ | HF​ | AMI​ |
| ED diversion ​ | ​ | ​ | Y​ | ​ | ​ | ​ | ​ | ​ | ​ | ​ |
| Follow-up calls​ | Y​ | Y​ | ​ | Y​ | Y​ | Y​ | Y​ | Y​ | Y​ | Y​ |
| Establish /coordinate specialist follow-up clinics​ | Y​ | ​ | ​ | ​ | Y​ | Y​ | Y​ | ​ | Y​ | Y​ |
| Nurse led clinics  ​ | ​ | ​ | ​ | ​ | Y​ | ​ | Y​ | Y​ | ​ | ​ |
| Establish new HF rehab service ​ | ​ | ​ | ​ | Y​ | ​ | ​ | ​ | ​ | ​ | ​ |
| Support/improve HITH​ | Y​ | Y​ | Y​ | Y​ | ​ | ​ | ​ | ​ | ​ | ​ |
| Improve referral pathways  ​ | Y​ | Y​ | ​ | Y​ | ​ | ​ | ​ | Y​ | Y​ | Y​ |
| Care bundles/EMR care sets ​ | Y​ | ​ | ​ | Y​ | ​ | ​ | ​ | ​ | ​ | ​ |
| Multidisciplinary team rounds (inpatient, remote)  ​ | Y​ | ​ | ​ | ​ | ​ | ​ | ​ | ​ | Y​ | Y​ |
| Engage GPs/other community services  ​ | ​ | Y​ | ​ | Y​ | ​ | ​ | ​ | ​ | Y​ | ​ |
| Staff education/discharge processes  ​ | Y​ | Y​ | ​ | Y​ | ​ | Y​ | Y​ | Y​ | Y​ | Y​ |
| Develop inpatient tools/systems, order tests  ​ | ​ | ​ | ​ | ​ | ​ | ​ | Y​ | ​ | ​ | ​ |