Intensive Hospital to Home Plan Monthly Dashboard — SEPTEMBER 2012

from all Hospital Locations

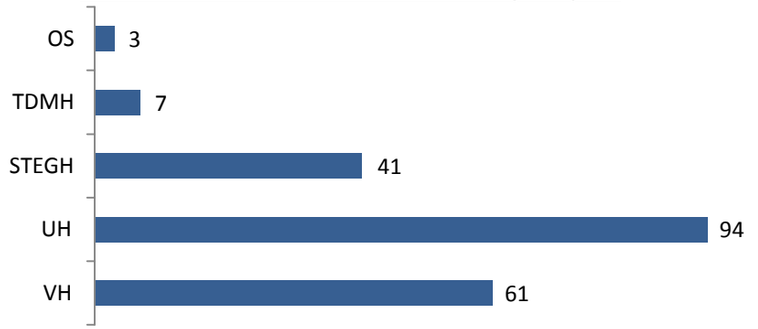
data caputred on 4 October for the month of September

Total Potential	Current Active Potential	Discharged Potential
280	8	272

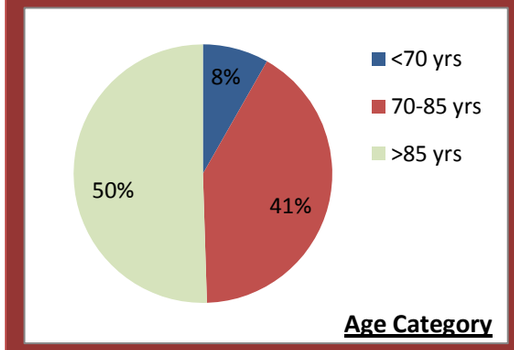
Total IH2HP	Current Active IH2HP	Discharged IH2HP
206	31	175

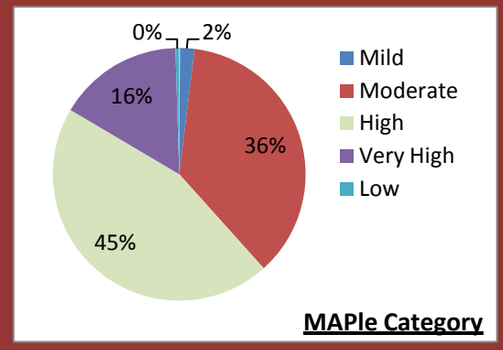
Mean LOS on IH2HP Plan	Median LOS on IH2HP Plan
20.8	27.0

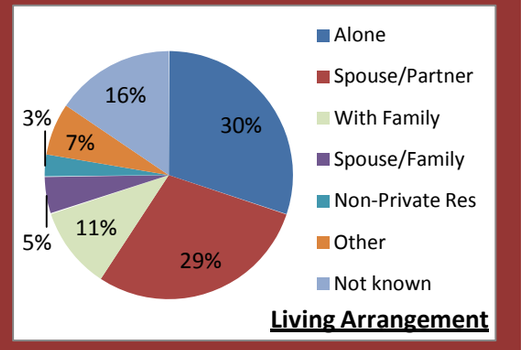
Number of Clients Referred to IH2HP by Hospital



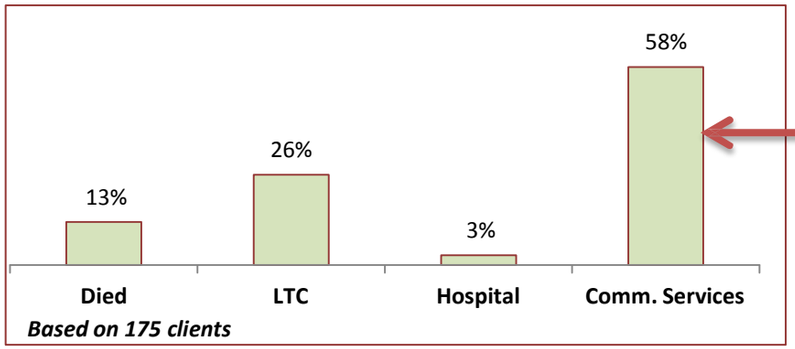
Client Characteristics - when referred to IH2HP







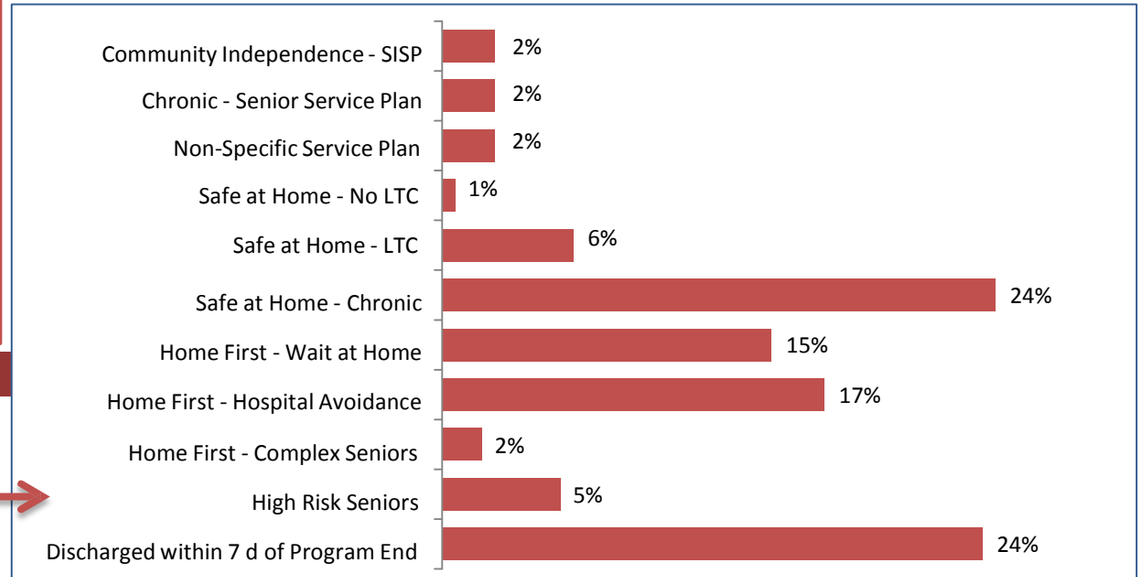
Clients Discharged from IH2HP - Discharge Dispositions



Community Service Clients could be CCAC, ADP, AL/SH, SDL and/or other Community Services Sector programs.

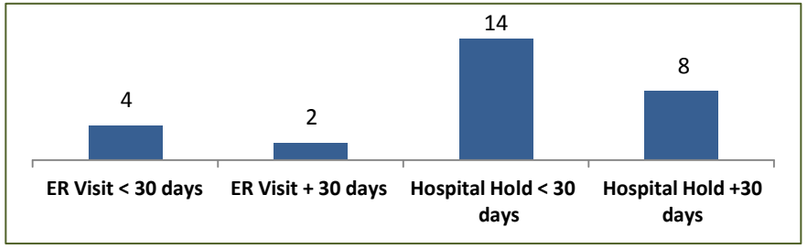
34% (60 of 175 clients) had an ADP visit authorzation and/or Supportive Housing Service after Discharge from plan.

After Discharge Service Profiles - of all clients discharged from IH2HP



Based on 175 clients discharged this from IH2HP referral code as of the end of September.

Clients Discharged From IH2HP - Re-admission to Hospital



The Community clients still on CCAC service have been categorized according to their Service profiles.

Created by Krista McMullen, Data Analyst, SW CCAC Business Intelligence

Intensive Hospital to Home Plan Monthly Dashboard - descriptions / definitions

Total potential is all the clients who have an active or inactive IH2HP Potential Client referral code.

Current **Active Potential** is all clients who have an active IH2HP Potential Client referral code.

Discharged Potential is all clients who have an inactive IH2HP Potential Client referral code.

Total IH2HP is all the clients who have an active or inactive IH2HP referral code.

Current Active IH2HP is all clients who have an active IH2HP referral code.

Discharged IH2HP is all clients who have an inactive IH2HP referral code.

The **Mean Length of Stay** is the mean number of days between the IH2HP referral start date and the IH2HP referral end date.

The **Median Length of Stay** is the mid point between the highest and lowest number of days between the IH2HP referral start date and the IH2HP referral end date.

Number of Clients referred by hospital location is the total number referred to the IH2HP Plan based on Referring Hospital location.

MAPle of all clients referred to the IH2HP Plan as of the start date of the referral.

Living Arrangement of all clients referred to the IH2HP Plan as of the start date of the referral.

Age Category of all clients referred to the IH2HP Plan as of the start date of the referral.

Readmission - Discharged Clients, mutually exclusive first instance of either a hold or ER referral code; having a hold before 30 days or after 30 days of discharge from IH2HP; displaying an ER referral code 30 days before or after discharge. Please note: this captures only CHRIS clients where readmission data has been entered. This does not mean that client is presently in hospital.

Destination / Dispositions - Based on clients discharged from the IH2HP Plan, the discharge disposition; not mutually exclusive as one client could be in multiple categories. The destination may not reflect the present location of the client.

After Discharge Service Profiles - active clients that have been discharged from IH2HP referral code - based on program analysis logic - mutually exclusive. In order to appropriately categorize clients into Service Profiles, the logic follows a specific order of operations. If the client does not meet the criteria for the first category, the logic is designed to automatically review the clients using the next operation until a match is found. The category order is: 1) Home First – IH2HP; 2) Peritoneal Dialysis; 3) Home First – Wait at Home; 4) eShift; 5) Safe at Home – LTC; 6) Home First – High Risk Seniors; 7) High Risk Seniors; 8) Safe at Home – no LTC; 9) Hip and Knee; 10) Home First – Hospital Avoidance; and, 17) Safe at home – Chronic. The categories used in this report are defined as follows:

Home First - Hospital Avoidance - referred from a Hospital or as a result of Hospital Hold. Greater than the average 1 hr./d Combined Homemaking following Admit / Hold End date. Within 28 days following Admits / Hold End Date. Not meeting the criteria for other service profiles.

Home First - Wait at Home - clients with an Active placement with a 1 or 1A crisis priority. Not meeting the criteria for other service profiles.

Home First - Complex Seniors - Clients with a RAI score > 16, over the age of 65, with an SRC of 93,94,95 and a MAPle of Very High. Not meeting the criteria for other service profiles.

Safe at Home - Chronic - Clients with a RAI score 11-16 and an SRC of 93,94,95. Not meeting the criteria for other service profiles.

Safe at Home - LTC - Clients with a RAI > 16, with an SRC of 93,94,95 and an Active LTC Referral. Not meeting the criteria for other service profiles.