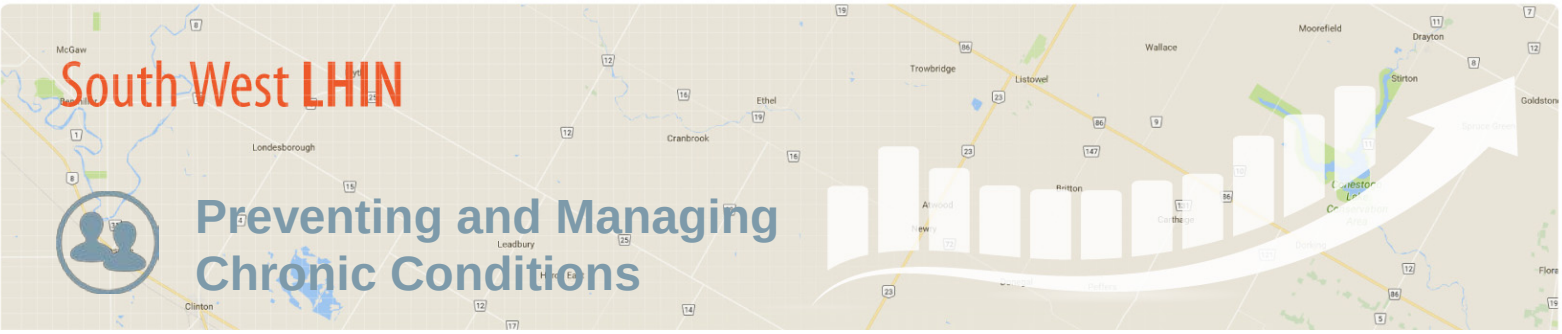
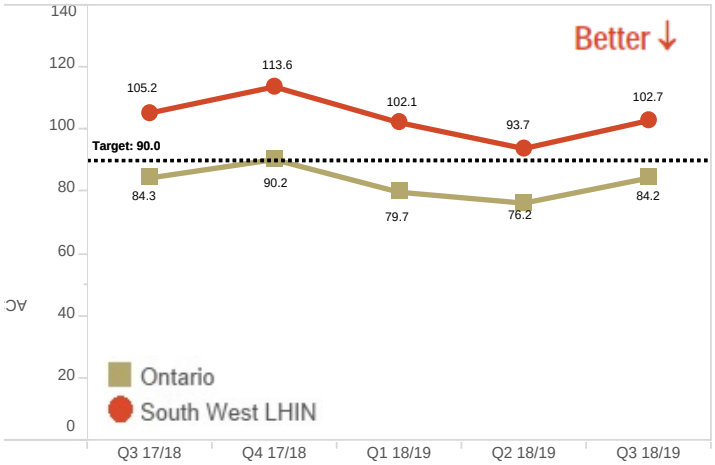


How Will We Know We Have Been Successful?

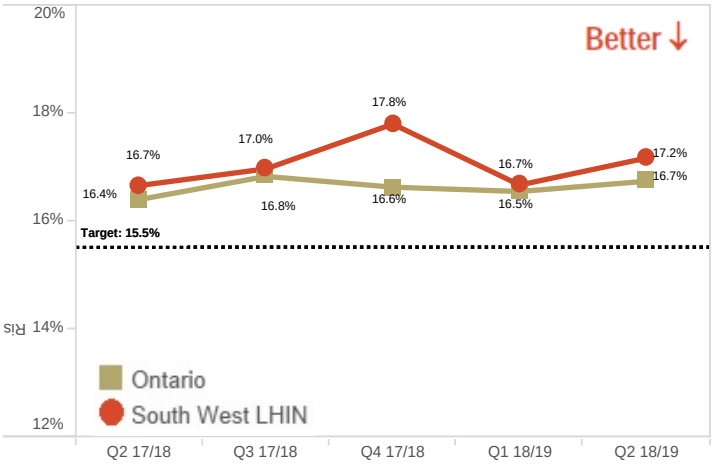
- Fewer people need to be hospitalized for chronic conditions
- Improved transitions of care following a hospital stay

How Are We Doing?

#11. Hospitalization Rate for Ambulatory Care Sensitive Conditions (ACSC)



#12. Readmissions Within 30 Days for Selected HBAM Inpatient Grouper (HIG) Conditions



- From Q2 18/19 to Q3 18/19, the rate of avoidable admissions for ambulatory care sensitive conditions increased by 9.6% and remains worse than the provincial rate.
- The readmission rate for select chronic conditions worsened from 16.7% in Q1 18/19 to 17.2% in Q2 18/19. With the exception of one quarter (Q4 17/18), the South West LHIN has demonstrated readmission rates within 0.5% of the rate clinically expected given the medical complexity of hospitalized residents. For Q2 18/19, the LHIN had (overall) 21 more readmissions than were expected.

What Is Impacting Performance?

Initiating & Planning

- **Indigenous-led Care Coordination Pathway -** An Indigenous-led early test of change for culturally safe coordinated care planning is currently participating in Cohort 12 of the IDEAS Advanced Learning Program.
- **Expanding and Enhancing Interprofessional Primary Care (IPC) Teams -** This initiative is designed to expand and enhance access to IPC teams for individuals experiencing barriers to care in London.
- **Bundled Care - Integrated Dialysis Care -** This model is aimed at supporting equity and improving patient experience related to assisted peritoneal dialysis delivered in homes and long-term care homes.
- **Patient Oriented Discharge Summaries (PODS)** - Work is underway with the Clinical Quality Improvement Committee at London Health Sciences Centre to simplify language used in discharge summaries for cardiac patients to improve understanding of and compliance with directions. A similar effort is underway at Woodstock Hospital focusing on inpatient medicine.

Executing

- **Health Links -** Over 3,600 coordinated care plans had been completed by the end of Q4 18/19.
- **Connecting Care to Home (CC2H) -** Outcomes in London suggest an estimated 50% of inpatient days and 50% of acute hospital and community care costs can be saved by bundling care for patients with mild to moderate COPD and CHF.
- **South West Self-Management -** The Self West Self-Management program offers patient, caregiver and provider workshop/courses as well as self-paced eLearning courses.

Monitoring & Closing

- None at this time.

Potential Future Opportunities and Considerations

- The South West LHIN is dispersing leadership for coordinated care planning, actively onboarding primary care and community support service agencies to Health Partner Gateway, and embedding the Health Links approach to care into sub-region planning.