South West LHIN

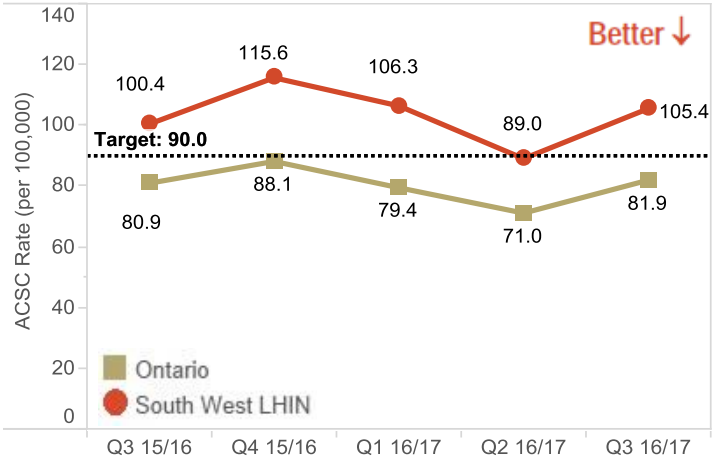
Preventing and Managing Chronic Conditions

How Will We Know We Have Been Successful?

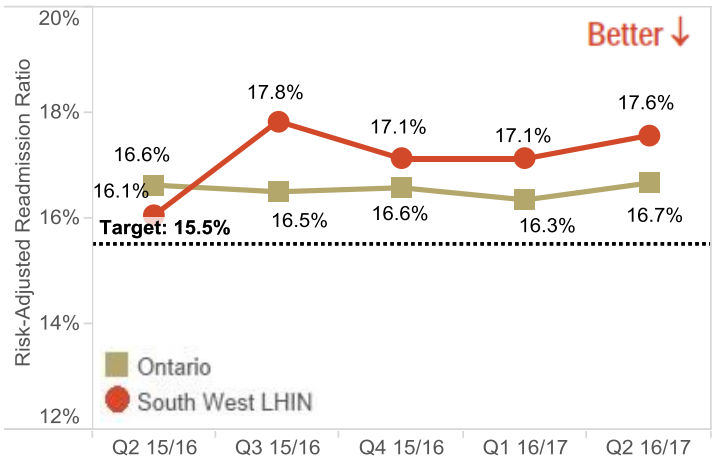
- Fewer people need to be hospitalized for chronic conditions
- Improved transitions of care following a hospital stay

How Are We Doing?

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



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



- High rates of avoidable hospitalization for chronic conditions have resulted in unnecessary days and cost in South West LHIN hospitals.
- In Q3 16/17, rates of avoidable admissions for ambulatory care sensitive conditions were 17% above the South West LHIN's target.
- In Q2 16/17, readmissions rates for chronic obstructive pulmonary disease (COPD) were 11% below the LHIN's expected rate, attributable to fewer readmissions for COPD at London Health Sciences Centre and Grey Bruce Health Services. Excess readmissions in Q2 16/17 were primarily attributable to 20 excess readmissions indexed for diabetes and congestive heart failure (CHF) at London Health Sciences Centre, and an increase in readmitted stroke cases accumulating across the district stroke centres located in Grey, Bruce and Oxford.

What Is Impacting Performance?

Initiating & Planning: **a) Health Links -** Oxford and Elgin Health Links have begun to proceed with implementation planning.
Executing: **a) Health Links -** Over 1,500 coordinated care plans had been completed by the end of fiscal 16/17, covering 3.5% of the estimated target population across the South West LHIN. Client data suggests a 15% reduction in emergency department visits, a 22% reduction in unplanned admissions to hospital, and a 47% reduction in hospital days stayed within six months of the initial care conference for residents supported by a Coordinated Care Plan. Grey Bruce, Huron Perth and London Middlesex Health Links are all currently engaged in planning for sustainability. **b) Integrated Funding Model -** 109 residents with COPD and three residents with CHF were enrolled in London by the end of fiscal 16/17. Outcomes suggest an estimated 50% reduction in inpatient lengths of stay and a 50% reduction in acute/community care costs can be anticipated by supporting patients with mild-to-moderate COPD and CHF through bundled care. **c) IDEAs Spread Project -** The South West LHIN Clinical Quality Lead continues to engage Medical Advisory Committees throughout the LHIN to promote policy regarding timely discharge summary communication (80% sent within 48 hours). Timely discharge summary communication has been integrated into the 2017/18 hospital Quality Improvement Plan template.
Monitoring & Closing: **a) Telehomecare -** 503 clients were enrolled in Telehomecare in fiscal 16/17, achieving 126% of the program's targeted enrollment (n=400). Referrals to the Telehomecare program are still primarily received from Home and Community Care (CCAC).

Potential Future Opportunities and Considerations

- Health Partner Gateway to enable secure exchange of client health information between care partners.
- Integrating coordinated care planning processes into existing service programs (memory clinics, falls prevention programs).