South West LHIN

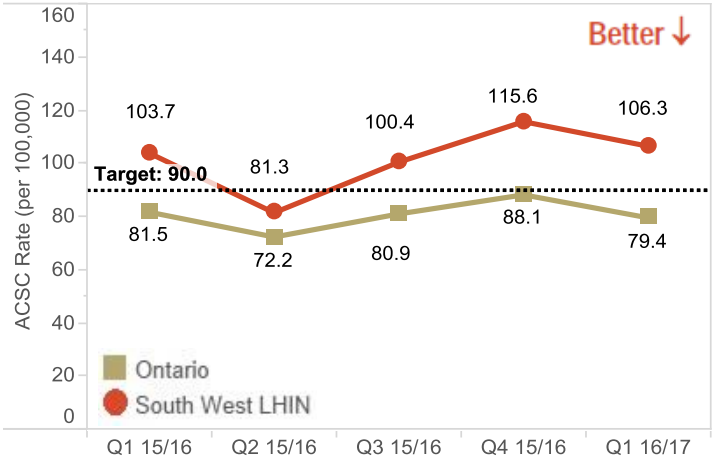
Preventing and Managing Chronic Conditions

How Will We Know We Have Been Successful?

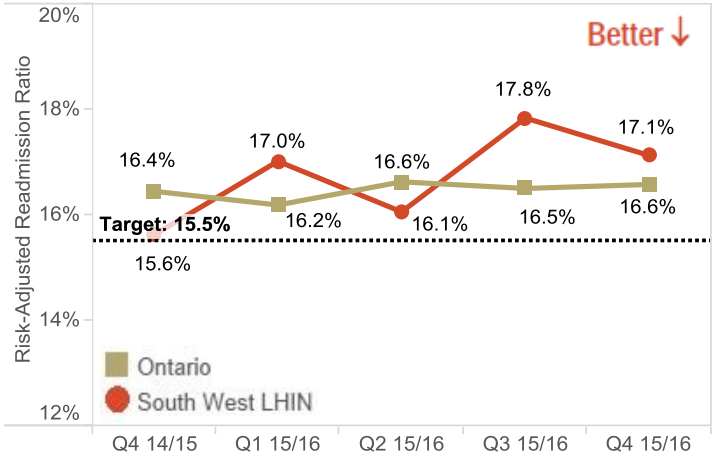
- Fewer people need to be hospitalized for chronic conditions
- Improved transitions of care following a hospital stay

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



- Rates of avoidable hospitalization for chronic conditions have increased in the South West LHIN over the past fiscal year resulting in more unnecessary days and cost in hospital.
- Avoidable hospitalizations have been above the South West LHIN's target in all five sub-regions over the past two quarters. Sub-region rates ranged from 91 to 120 avoidable admissions per 100,000 residents in Q1 16/17.
- While readmission rates are improving for many hospitals, more patients are readmitted in the South West LHIN than would be expected for congestive heart failure, pneumonia, chronic obstructive pulmonary disease (COPD), and gastrointestinal infections.

What Is Impacting Performance?

Initiating & Planning: None at this time
Executing: **a) Health Links -** Four of six active Health Links are coordinating care for residents. Over 800 coordinated care plans have been completed to date, covering 2.3% of the estimated target population. Data is demonstrating fewer Emergency Department visits and hospitalizations. **b) Integrated Funding Model -** 68 residents with chronic obstructive pulmonary disease were enrolled in London by the end of Q2 16/17. Outcomes suggest significant reductions in hospital lengths of stay, fewer Emergency Department visits and readmissions. **c) IDEAs Spread Project -** Spread, risk, and mitigation planning strategies were approved by the Hospital Medical Advisory Committee at London Health Sciences Centre to support adoption and implementation of the 48 hour discharge summary timeliness standard (80% sent within 48 hours). Engagement with remaining hospital committees is ongoing. Chief Nursing Executives have identified spread of the IDEAs project as one of three workplan priorities.
Monitoring & Closing: **a) Telehomecare -** 195 clients have been enrolled in Telehomecare as of Q2 16/17, achieving 49% of the program's targeted fiscal enrollment (n=400). Readmission rates in Q4 15/16 were above expected by 5% for congestive heart failure, and 1% for COPD.

Potential Future Opportunities and Considerations

- Elgin and Oxford Health Links are ready to begin care coordination for residents. Funding is expected in Q3 16/17.
- Increased education of and referrals to Health Links; proactive identification of users with high care needs in hospital.
- Expansion of the Integrated Funding Model to include residents with congestive heart failure.