South West LHIN

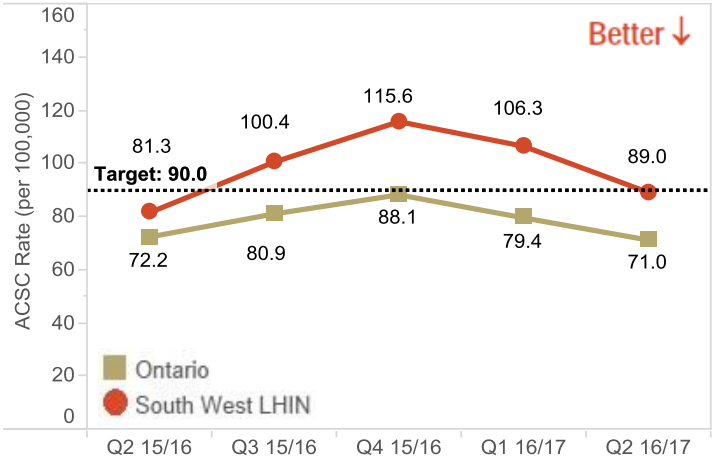
Preventing and Managing Chronic Conditions

How Will We Know We Have Been Successful?

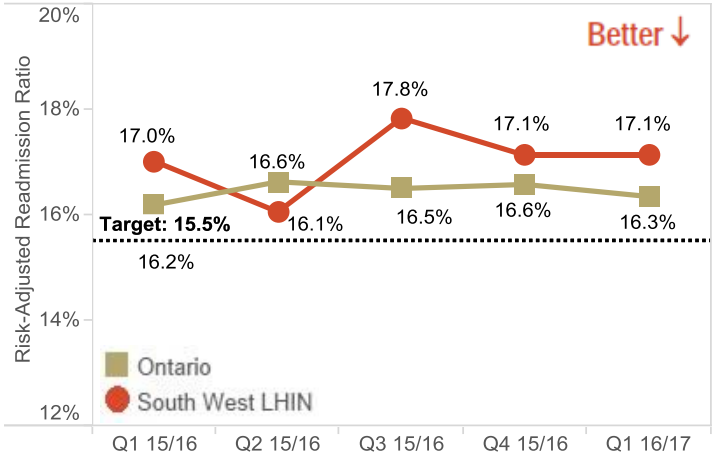
- Fewer people need to be hospitalized for chronic conditions
- Improved transitions of care following a hospital stay

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 Q2 16/17, rates of avoidable admissions for ambulatory care sensitive conditions fell below the South West LHIN's target in London Middlesex (77.4 per 100,000 residents) and Oxford & Norfolk (85.7 per 100,000 residents). Rates in the remaining sub-regions have been above the South West LHIN target for the past four quarters.
- In Q1 16/17, readmissions rates for chronic obstructive pulmonary disease (COPD) were 20% below the LHIN's expected rate, attributable to fewer readmissions for COPD at London Health Sciences Centre. This is the first quarter where the South West LHIN expected to see a reduction in COPD-related readmissions resulting from the concentrated efforts of the London-Middlesex Health Link, the Integrated Funding Model Project, and Telehomecare. Excess readmissions in Q1 16/17 were primarily attributable to an increase in pneumonia.

What Is Impacting Performance?

Initiating & Planning: Health Links - Oxford and Elgin Health Links received one-time funding to proceed with implementation planning.
Executing: a) Health Links - Over 900 coordinated care plans had been completed by the end of Q3 16/17, covering 2.6% of the estimated target population in the four active Health Links. Client data is demonstrating fewer Emergency Department visits and hospitalizations.
b) Integrated Funding Model - 87 residents with chronic obstructive pulmonary disease were enrolled in London by the end of Q3 16/17. Outcomes suggest significant reductions in hospital lengths of stay, fewer Emergency Department visits and readmissions. **c) IDEAs Spread Project -** In Q3 16/17, the South West LHIN Clinical Quality Table (CQT) began monitoring the proportion of discharge summaries sent within 48 hours of acute discharge through the CQT Dashboard. 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).
Monitoring & Closing: a) Telehomecare - 353 clients have been enrolled in Telehomecare as of Q3 16/17, achieving 88% of the program's targeted fiscal enrollment (n=400). The Telehomecare program is currently holding at funded capacity.

Potential Future Opportunities and Considerations

- 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 will occur in Q4 16/17.
- Continuity and spread of Diabetes Coordinated Access as a key enabler to chronic disease management will be explored for fiscal 17/18.