South West LHIN

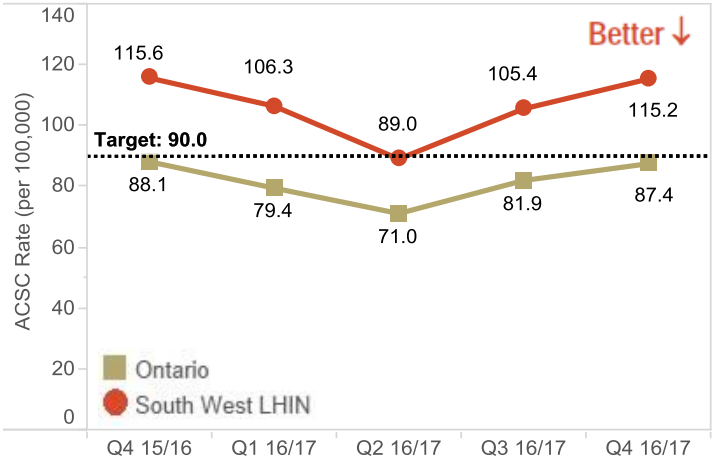
Preventing and Managing Chronic Conditions

How Will We Know We Have Been Successful?

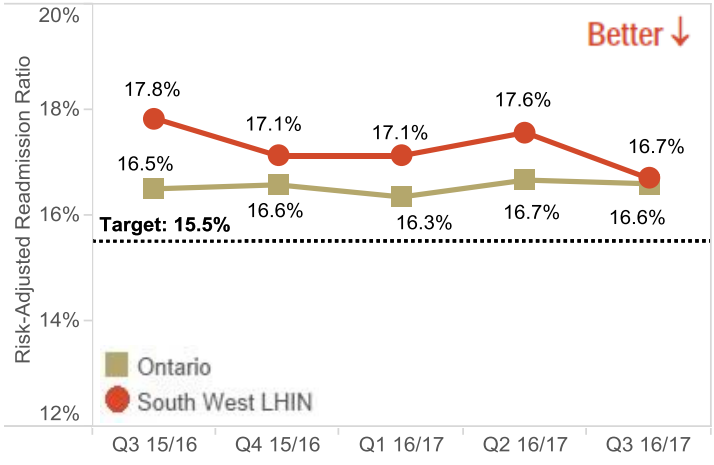
- Fewer people need to be hospitalized for chronic conditions
- Improved transitions of care following a hospital stay

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



- In Q4 16/17, rates of avoidable admissions for ambulatory care sensitive conditions were 28% above the South West LHIN's target.
- Readmission rates for select chronic conditions have slowly declined throughout the South West LHIN over the past year, with several quarters demonstrating rates lower than or equal to the rates clinically expected given the medical complexity of hospitalized residents. In Q3 16/17, readmission rates for chronic obstructive pulmonary disease (COPD) remained 6% below the LHIN's expected rate. Declining readmissions for COPD reflect the continued efforts of the London Middlesex and Grey Bruce Health Links, the Connecting Care to Home Project (CC2H), and Telehomecare to improve coordination of care for patients with mild to moderate COPD.

What Is Impacting Performance?

Initiating & Planning: **a) Indigenous-led Care Coordination Pathway -** An Indigenous-led early test of change for culturally safe coordinated care planning has been selected to participate in Cohort 12 of the IDEAS Advanced Learning Program.
Executing: **a) Health Links -** Over 1,700 coordinated care plans had been completed by the end of Q1 17/18, covering 3.9% of the estimated target population across the South West LHIN. Residents supported by Coordinated Care Plans have experienced a 20% reduction in Emergency Department visits, a 28% reduction in unplanned admissions to hospital, and a 46% reduction in days stayed in hospital within six months of their initial care conference. Grey Bruce, Huron Perth and London Middlesex Health Links are all currently engaged in planning for sustainability. **b) Connecting Care to Home (CC2H) -** 134 residents with COPD and 27 residents with Congestive Heart Failure (CHF) were enrolled in London by the end of Q1 17/18. Outcomes suggest an estimated 50% of inpatient days and 50% of acute hospital and community care costs could potentially be diverted by supporting patients with mild to moderate COPD and CHF through bundled care.
Monitoring & Closing: None at this time.

Potential Future Opportunities and Considerations

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