South West LHIN

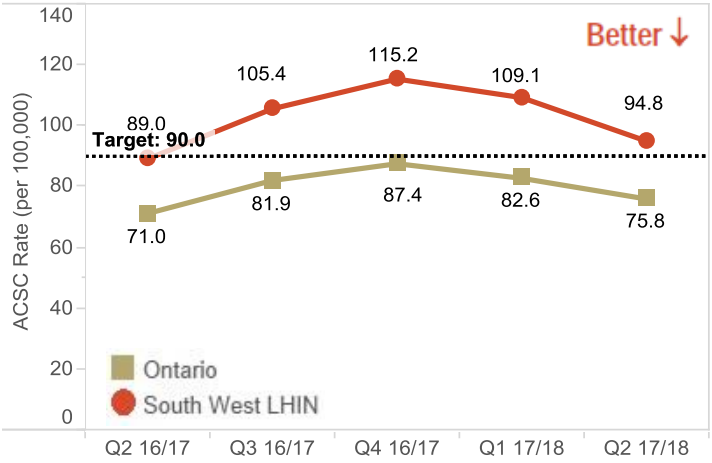
Preventing and Managing Chronic Conditions

How Will We Know We Have Been Successful?

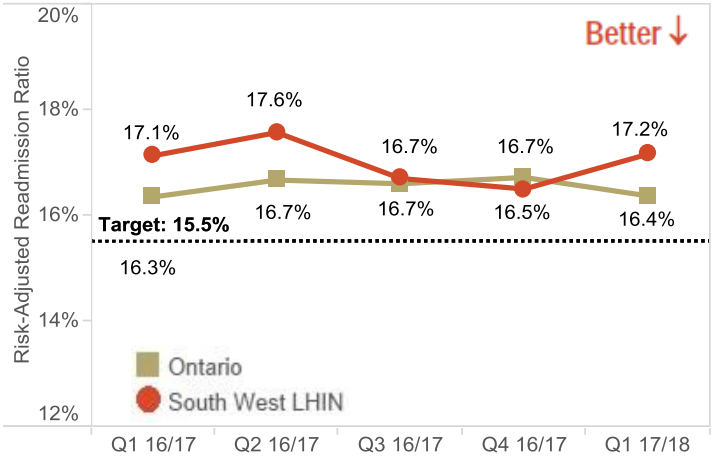
- Fewer people need to be hospitalized for chronic conditions
- Improved transitions of care following a hospital stay

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 Q2 17/18, rates of avoidable admissions for ambulatory care sensitive conditions were 5% above the South West LHIN's target.
- Readmission rates in Q1 17/18 were above expected for acute myocardial infarction (+51%), pneumonia (+8%) and gastrointestinal disorders (+8%). Excess readmissions were largely attributable to additional readmitted cases at St. Thomas Elgin General Hospital, and a few cases spread across the regions' small rural sites.
- Readmission rates for chronic obstructive pulmonary disease (COPD) remain below the LHIN's expected rate (8%). 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 is currently participating in Cohort 12 of the IDEAS Advanced Learning Program.
Executing: **a) Health Links -** Over 2,250 coordinated care plans had been completed by the end of Q3 17/18, covering 5.1% of the estimated target population across the South West LHIN. Residents supported by Coordinated Care Plans have experienced a 26% reduction in Emergency Department visits, a 35% reduction in unplanned admissions to hospital, and a 49% 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) -** Outcomes of the CC2H project in London 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. Work is underway to spread the CC2H model to residents of Elgin and Oxford through St. Thomas Elgin General Hospital with enrollment expected in Q1 18/19. **c) South West Self-Management –** The Self West Self-Management program offered 25 patient, one caregiver and 22 provider workshop/courses throughout Q3 17/18. Self-paced eLearning courses are now available online.
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 priorities and planning.