ICC Guiding Principles

We work together as ***One Team*** made up of patients/caregivers, hospital, home and community-based team members, including primary care, all working collaboratively. Care is provided using ***One Record***, meaning there is a complete shared care plan/digital health record accessible by all members of ***One Team***. There is ***One Number to Call, 24/7***, to provide patient, families and caregivers access to the care team. These components of the *Integrated Service Delivery* model are enabled by an integrated funding model, which we refer to as ***One Fund***. Integrated funding is a key enabler for system redesign; it aligns the right incentives, empowers stakeholders and drives value across the care continuum.

One Team

- ***Person centred care***: Patients/clients are encouraged to learn about and participate in self-care. They are shown best practices and provided with educational supports that are reinforced throughout the care path by each member of the team.
- ***Integrated care team:*** The team is empowered to be successful in their roles with a shared accountability for the patient experience and outcomes.
- ***Integrated Care Coordinators:*** An individual who is accountable to the care team (including to the patient) and bundle holder. A Care Coordinator follows a patient across their continuum of care, regardless of care setting.
- ***Committed to standardization:*** Patients are supported by common interdisciplinary care pathways that are informed by best practices and evidence-based care.
- ***Flexibility in the delivery of care:*** With a flat reporting structure and a focus on continuous improvements, team members can make immediate decisions and respond to individual patient needs.

One Record

- ***A shared electronic health record:*** There is one record accessible by ***all*** members of the care team, including the patient. The digital record also serves as a hub for communication across the team.
- ***Simple, available technology***. Team members use smartphones and or tablets to provide flexibility in communication, real-time decision making and action.

One Number to Call 24/7

- ***One door to care:*** 24/7 care is available through a community-based contact number for patients to access team members.
- ***Virtual access to health records for patients and families:*** Patients can also access team members via a patient portal/mobile app with secure messaging and virtual (video) visits options.

One Fund

- ***Integrated funding model:*** There is a shared understanding of costs, outcomes, and the role of each partner in achieving improved outcomes.
- ***A single point of accountability*****:** the '***One Fund*** holder' who empowers the care team to facilitate improved patient experience and outcomes.

- ***Risk / gain sharing model:*** *with full transparency in mutually agreed to reporting between care providers*

As our four pillars reinforce, there is a need for ***One Fund***, but we need to start with the ICC Patient Promise: ***One Team, One Record, One Number to Call, 24/7***. This pivots the conversation to focus on the patient first; not the financial considerations.