INTEGRATED CARE
OVERVIEW & FAQ

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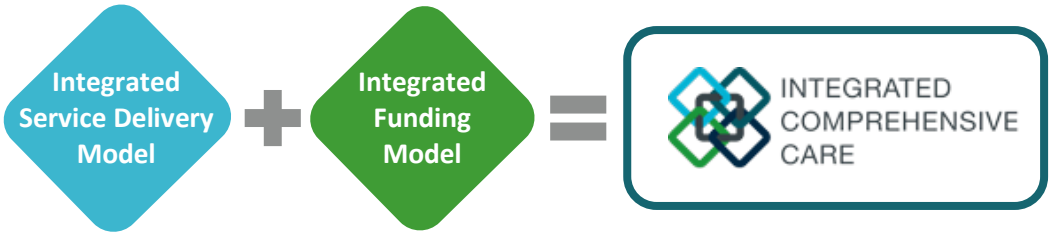
Integrated Care Enables Ontario Health Teams (OHT)

If you are a healthcare leader in Ontario, you know that there are continued pressures to create additional capacity and to 'end hallway healthcare'. You also know that maintaining the status quo is not sustainable. Our imperative is to find new ways to collaborate between traditional funding silos to deliver sustainable, person-centred care.

The Ministry of Health is working to address these pressures through the Bundled Care program, and health system restructuring with the creation of Ontario Health Teams (OHTs). These initiatives offer a unique opportunity to purposefully *co-design* how care is delivered in *partnership* with patients, families and caregivers through the adoption of new models of Integrated Care.

St. Joseph's Health System's **Integrated Comprehensive Care** (ICC) is an evidence-based model of Integrated Care that supports patients with ***One Team, One Record, One Number to Call, 24/7***. Our focus is to make the patient experience as seamless as possible, while utilizing existing resources across the healthcare continuum, to deliver an integrated and comprehensive care experience. ICC is sustainable, transformational system change enabled by an evidence-based *integrated service delivery and funding model*.



The Ministry of Health, through Ontario Health is introducing Ontario Health Teams (OHTs). This is a giant leap towards enabling seamless transitions in care for patients and their families. It also addresses ongoing transformation of the health system. The adoption of evidenced-based models of Integrated Care, such as SJHS Integrated Comprehensive Care will be a key enabler for OHTs and will contribute to their success.

What is Integrated Comprehensive Care?

Integrated Comprehensive Care is made up of four pillars: 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 I*ntegrated 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.

Patient and Provider Co-design

The principle of *patient and provider co-design* and the iterative nature of program development support the creation of trust, transparency and common purpose for all those involved in delivering care across the patient's continuum of care. ICC as a program is adaptable over time, which ensures its ongoing effectiveness. ICC's evidence-based approach must be firmly embedded in the cross-organizational culture, both in the clinical and administrative functions.

Defining Our Guiding Principles

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.

"From the very beginning, we focused first on answering the question

'what should we be doing with the patient'.

Only then did we turn our attention to figuring out how to fund it."

- Susan Hollis, CFO, SJHS -

This important shift in how to approach the work empowers everyone to work towards a seamless care experience for patients and their families. This is also what's required to build an Ontario Health Team, firmly founded on patient outcomes, strong provider partnerships and sustainable financial models.

SJHS Integrated Comprehensive Care model is empowering ongoing transformational system change at the front-line and can inform the development of sustainable Model of Integrated Care within your organization.

The Centre for Integrated Care would like to thank Laura V. L. and Nancy S., our generous and insightful patient advisors, who helped in the development of this paper.

Frequently Asked Questions on Integrated Comprehensive Care

1. Why should our organization consider working with SJHS and adopting the ICC model?

Hospitals and or OHTs need to adopt integrated service delivery and funding models approach because simply put, we are challenged to sustain the status quo. Patients seek better clinical outcomes and experience from their health system, and providers need to find a new sustainable approach to manage their precious financial and human resources. Since 2012, the evidence-based Integrated Comprehensive Care model has delivered impressive outcomes in all aspects of the *Quadruple Aim*, for over 20,000 patients, across numerous surgical and chronic complex care pathways. The results are clear – ICC is sustainable, transformational system change.

Furthermore, the educational materials, hand on experience and coaching resources available from St. Joseph's Health Systems **Centre for Integrated Care** will enable your organization to rapidly adopt the ICC model. Success will require commitment at all levels within your organization. The scale of the task should not be underestimated. The benefits however greatly outweigh the effort and 'ending hallway healthcare' clearly requires a new approach. Please visit www.SJHS.ca/integratredcare/CIC.

2. How do you measure success with the ICC model?

ICC program partners work together to identify priority outcomes for a defined patient population. These discussions are always supported by guiding principles developed in collaboration with all partners. While priority outcomes may differ by patient population in general, what we measure is guided by our commitment to:

1. Improving patient, family, and caregiver experiences
2. Improving care outcomes for patients
3. Providing patients, families and caregivers with better information and guidance to manage self-care
4. Increasing job satisfaction of front-line hospital, primary, home care providers
5. Decreasing Hospital length of stay (if priority outcome for patient population)
6. Decreasing ED visits
7. Decreasing readmission rates and days spent in hospital
8. Decreasing mortality rates
9. Ensuring all patients are contacted within 24 hours of discharge

These leading indicators are tracked and reviewed on a monthly basis with the ICC team.

3. What benefits have patients, caregivers and families seen?

From feedback received we know that patients, caregivers and their families have more peace of mind as a result of timely access to their care team. Most recent patient and caregiver survey results indicate an overall satisfaction of 98%. Patients also experience earlier discharge with fewer visits back to hospital, while getting care delivered at home, where they want to be. If and when patients are readmitted to hospital, they stay for a shorter period of time as data tells us there is a 30% reduction in hospital readmissions. An increased focus on patient education plays a significant role in ICC. It allows patients, families and caregivers to be actively involved in their care plan and empowers self-care.

4. What benefits have members of the integrated care team seen?

By involving all members of the care team in the design, implementation, and ongoing evaluation of the program there is a shared understanding of both the clinical and financial impacts of any one decision. Hospital, Home and Community Care team members can now see a patient's entire journey for the first time end-to-end. That has afforded us the opportunity to create flexibility and autonomy in the model so that all members of the team are empowered to make real-time decisions around patient care. Those decisions are based on what is best for the patient, the team and the system overall.

5. What benefits have the hospital / health system seen?

Our ICC program has resulted in a capacity savings of up to $4,000 per patient across the continuum, realized through a 30% reduction in emergency department visits and 30% reduction in hospital readmissions with a 98% patient satisfaction approval rating.

We have worked with various independent research and evaluation groups, beginning in 2012, to measure the impact the ICC model has had for patients and provider experience, clinical outcomes and system costs/sustainability.

Most recently, Health System Performance Research Network (HSPRN) conducted an independent peer reviewed evaluation of the MOH's Integrated Funding Model pilots which included our HNHB LHIN wide ICC program for Chronic Obstructive Pulmonary Disease (COPD) and Congestive Heart Failure (CHF) patients. Key findings related to the evaluation of our program included:

- With the 60 day program, the total number of days patients spent in the hospital was reduced by more than 20%
- Readmissions were also reduced up to 37%,
- There was an overall 20% relative reduction in Emergency Department visits.

In addition, the report highlights that if the HNHB ICC program for COPD and CHF patients was spread provincially to all 18,538 patients in Ontario, an estimated cost avoidance of 13,502 hospital days and $24.1M dollars could be achieved.

Please visit www.sjhs.ca/integratedcare for more information on ICC research.

6. What resources are required to deliver an ICC program?

From a human resources perspective, we begin with existing hospital, home and community-based resources, but apply them in a different way. We empower ***One Team*** to co-design and deliver evidence-based patient care plans that span the full care continuum. We also review care coordination processes, resources and infrastructure and reassign or add an ICC coordination function to better support patients, families and caregivers. To support program co-design, implementation and ongoing evaluation, we assign change management, patient and family advisory teams, finance, decision support, procurement, and IT resources. Once the program is operationalized, we align with (or expand) existing processes, management and reporting within the fund holder and delivery partner organizations.

From a financial perspective, we take the collective funding from the existing hospital, outpatient, home and community care services and then pool the dollars into a new financial 'bundle'. The ***One Fund*** exists to support all aspects of program delivery including any additional human, technology or other resources. It is funded by the overall health system savings achieved by the ICC program. An up-front investment of one-time funding may be required to support the change process.

7. Were patients, caregivers and families, involved in the program development?

In the development phase, patients are involved in every aspect, directly informing and guiding the work. As the work of ***One Team*** transition to implementation and ongoing operations, patients remain involved becoming active members of our governance structure. Through our patient and caregiver experience surveys we continue to learn and incorporate changes into our model. More recently, we have made a conscious effort to find out how we can better incorporate caregiver needs and perspectives into the model. After working with caregiver advisors and using resources from The Change Foundation, we have identified several areas in which we can do more to support caregivers as formal members of ***One Team***. The experience we have gained in this area serves as a template that can be applied within other organizations. We are committed to meaningful patient engagement and co-design.

8. What role has evidence and best practice had in the development of the ICC model?

Our program design, implementation, and evaluation work builds upon research and best practices developed through the International Foundation for Integrated Care (IFIC) and other leaders in this area.

The ICC key pillars incorporate integrated care essential features such as:

- Common Cause/Shared Goals
- Common Vision & Strategy
- Joint Funding & Planning
- Joint Service Delivery Model (Hospital and community providers)
- Evaluation Framework
- Quality Improvement Processes

9. How do team members work differently in the ICC model?

Hospital, primary, home and community care are ***One Team***. In the past, these groups have been operated and funded independently, with additional barriers between Home Care Service Provider Organizations. Patients, caregivers and families are integral and active members of our team. Key features of our team include:

- A high degree of trust gained through daily communications and collaboration.
- Consistent team members working with our patients.
- A Care Coordinator role to provide patient-centred navigation, education, intensive case management, and coordination of services to a group of patients in their care.
- The care team have regular meetings via 'virtual rounds', monthly readmission reviews and clinical in-person quarterly meetings, to discuss patient progress against care plan, interventions and/or/ updates, program metrics and outcomes.
- All team members document in the same digital health record in real time, communicate often and make joint decisions regarding changes to a patient's care.
- Each team member, from Personal Support Worker (PSW) to Surgeon, is highly respected within the team. They are valued for their knowledge, skill, experience and the interdependent role they play in the patients care journey.

10. What role does Care Coordination play within the ICC model?

Within the ICC model the *care coordination function* is a pivotal role. Traditionally care coordinator roles within our system have had to adhere to rigid guidelines with duplication of effort across oversight and delivery organizations. Whereas a coordinator within an ICC program use mutually agreed upon 'guiding principles' to empower members of the care team to make and act on changes in the best interests of the patient. The ICC Coordinator, as a key member of the Program embodies a shared sense of accountability across ***One***

Team. They provide patient-centred navigation, education, case management and coordination of services to a selected group of patients in their care.

11. What role should Digital Health technologies play in the ICC model?

Digital Health, including virtual care technologies, is an important enabler for the ICC model. It offers new opportunities to improve patient access, empowerment and self-care. We believe patients, families and caregivers* should, where possible, have access their own digital health record via a patient portal or mobile app, anywhere, anytime. We provide other options as well. There is phone or secure messaging, virtual visits (video) and/or in-person visits for follow up care with their care team. For providers, there is a shared digital health record and the full team participated in 'virtual rounds' to support the patient's recovery. We leverage simple available tools (e.g. Tablets, smartphones) and consider workflow implications, to make the user experience as seamless as possible.

Note: *Patients or legal guardians determine who has access to their health records by permissions settings. Additionally appropriate privacy and security assessment and audit measures are in place, to protect Personal Health Information (PHI).

12. Is Integrated Comprehensive Care financially sustainable?

The ICC program is sustainable. However, it requires agreement across a diverse group of stakeholders to pool financial, human and technology resources. It also requires a commitment to shared guiding principles for the program approach all of which results in sustainable transformational change. Working with stakeholders to define priority outcomes for a patient population and access data sources to inform key performance metrics enables development of robust program evaluation. This ensures the ability to assess the ongoing effectiveness of the program, document results, continue doing what is working and stop doing what is not.

From a financial perspective, by working within existing funding envelopes no net new funding should be required. Finance works with stakeholders to create and balance over time, ***One Fund*** or a 'bundle' to support select patient populations.

ICC enables healthcare leaders to develop new levers to breaks down traditional healthcare silos. Hospital cost avoidance gained from reduced length of stay, reduced ED visits and readmissions, are reallocated to fund 'new' enabling elements of the ICC model. For example, the care coordination role and shared digital record element in the ICC model. These savings can also be used to support the early discharge of patients (reduce length of stay) through the provision of Home and Virtual Care services, that are not currently funded.