

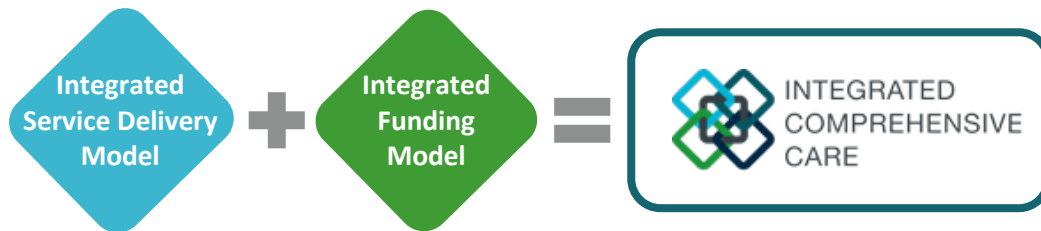
# WHAT IS INTEGRATED COMPREHENSIVE CARE

By Carrie Anne Beltzner, Fraser Edward, Carolyn Gosse & Arlene Howells

In 2012, St. Joseph's Health System pioneered an approach to Integrated Care for *Surgical and Chronic Complex* patient populations. Our model proved very successful and the Ministry of Health asked us to coach other organizations across the province. We called our model: Integrated Comprehensive Care (ICC).

## What is Integrated Comprehensive Care?

ICC is an evidence-based Model of Care that supports patients with **One Team, One Record, One Number to Call, 24/7**. ICC is enabled by a co-designed *integrated service delivery* model and an *integrated funding* model, which we refer to as **One Fund**. 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 enables sustainable transformational system change.



## Patient, Family and Caregivers Perspective

Your care team meets you before your hospital procedure, cares for you while you're in the hospital and manages your recovery at home. You can access your care team 24 hours a day, 7 days a week via **One Number to Call**. You can get answers, informed advice and expert care when and where you need it. You will also feel confident as they are all working from **One Record** – your Digital Health information; which you can also access via online patient portal or mobile app.

## Front Line Provider Perspective

You will be a member of an empowered team where hospital, home care, and primary care providers work together as **One Team** with shared accountability for their patients. As a team, you co-design solutions together with everyone involved (including patients) to break down silos across all areas of patient care. You have ready access to each other, the information you need in **One Record** and most importantly are enabled each day to deliver better clinical outcomes and a better experience for patients and providers.

## Leadership Perspective

As a health system, we are trying to create more patient care capacity, increase information exchange, improve service delivery and manage better patient flow across the care continuum. ICC's *One Fund* allows healthcare leaders to develop new levers to break down traditional healthcare silos. It allows and empowers *One Team* using *One Record* to support a patient from hospital to home, which helps to reduce hospital Length of Stay and streamline discharge into the community. New direct partnerships with Home Care service provider organizations bring innovation in care delivery, such as virtual care. It also helps to break down barriers between hospital and community to better and transparently manage patient transitions. We can look forward to reducing unplanned Emergency Department (ED) visits and readmission rates while improving overall health system sustainability through better cost management.

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

- Dr. Carolyn Gosse, VP Integrated Care, SJHS -

## Health System Opportunity

As a health system, we are working together to create our collective vision for how Ontario Health Teams will achieve the *quadruple aim*. We are finding new ways of working together as system partners in the co-design and strategic use of each of the required eight OHT building blocks. Within this context the learning gained from our ICC journey, will inform our approach as we focus on additional marginalized populations and continue to address social determinant of health. The application of Models of Integrated Care will act as a catalyst to unlock value within and across Ontario Health Teams.

---

SJHS Integrated Comprehensive Care model has been co-designed with patient, family and caregiver advisors, front line providers and administrators; it is based on international best practices and is evidence-based.

For more information please visit [www.sjhs.ca/integratedcare](http://www.sjhs.ca/integratedcare).

*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.*