



Integrated Comprehensive Care Project

PROJECT SUMMARY & INTERIM RESULTS
FEBRUARY 2013

Imagine a healthcare model where the clinician who meets you before your hospital procedure, cares for you while you're in the hospital, and manages your recovery at home is the same person. Imagine having access to that person 24 hours a day, 7 days a week. That when you have a concern, you get real answers and expert clinical care when you need it most. Imagine your home care and hospital clinicians communicating with you and with each other seamlessly so that everyone is always on the same page when it comes to your health.

That is Integrated Coordinated Care

Mrs. Adams: A tale of two healthcare journeys



Journey A: The Traditional Patient Experience

Patient Scenario:

Mrs. Adams underwent joint replacement surgery at the hospital. After surgery, she was discharged home and is receiving rehabilitation therapy, coordinated by her local Community Care Access Centre. She has a follow up visit with her family doctor in a few months, but has recently been experiencing soreness and pain in her new joint.

Mrs. Adams is wondering:

- Who should I call/see to ask about my knee pain?
My surgeon? My family doctor? My rehabilitation therapist?
- I wonder if this is normal. Should I just wait?
- Maybe I should just go to the emergency room to make sure there's nothing wrong.
- I wish there was someone I could talk to.

Journey B: The St. Joseph's Health System Experience

Integrated Comprehensive Care through St. Joseph's Health System

What if all of Mrs. Adams' care was provided by a single healthcare organization? What if there were no transfers of patient care, but rather, a continuous healthcare journey, led by a knowledgeable and highly accessible case navigator? Would the patient outcomes improve? What if we used the latest in communications technology to link patients to their care providers? Would their satisfaction improve? Would readmissions decrease and cost savings to the provincial healthcare system be realized? These are precisely the questions that St. Joseph's Health System is poised to answer through the Integrated Comprehensive Care Project (ICC).



As St. Joseph's Health System (SJHS) includes both an acute teaching hospital and a home care provider in the same city, it is uniquely positioned to demonstrate and evaluate an integrated, comprehensive new approach to patient care. Through the support of our area LHIN, made possible by funding from the Ministry of Health and Long-term Care, and with the invaluable collaboration and feedback from the patients and families we are honoured to serve, St. Joseph's Health System has been delivering integrated care for select patient groups since March 2012. Early results demonstrate that ICC is an effective, efficient and patient-centred model that has the opportunity to dramatically change the patient's experience in Ontario's health care system while realizing potential cost savings as well.

How Does it Work? A First Look at the Integrated Comprehensive Model of Care

In the US and other jurisdictions, and for specific patient populations, a single health care provider may be given a bundled payment to provide for both the acute hospital care and the community-based care that the patient will need to transition successfully back to independent living. This model underpins the United States' move to Accountable Care Organizations and is already in place in several progressive providers such as Kaiser Permanente.

The Fundamental Paradigm Shifts:

At the heart of this project is a highly feasible dual evolution:

- 1 The integration of case management across hospital and community care settings will re-engineer case management by introducing Case Navigators to follow patients from their hospital admission, through discharge to their home, and finally to independent living. This provides exceptional continuity of care that is unparalleled in Ontario's health care system today but is clearly aligned with the province's desire to deliver 'obsessively patient focused' care, as well as recommendations set out in the Drummond Report (2012).
- 2 A bundled model of funding based upon predetermined payments for specific patient populations will empower and encourage healthcare organizations to strive to achieve excellent patient outcomes while reducing unnecessary costs caused by complications, readmissions, wait times and unnecessary days in hospital. The healthcare provider carries the risk associated with these costs, but also has a model of care in place that can help to prevent them.



What our patients are saying

"I thought the ICC program was great! I've had three previous joint replacements at SJHH and by far, this program enabled me to have the fastest and best recovery."

"The project gave my mom peace of mind. Having access to her case navigator made her feel like she wouldn't have to go to the ER when she had a healthcare concern."

"I was very happy with my healthcare from St. Joe's. I really enjoyed using Face Time (on the iPad). I thought it worked very well."

What Patient Populations Are Eligible for the Pilot Project?

St. Joseph's Health System has identified the following three highly relevant and broadly applicable patient types to participate in the pilot for the Integrated Comprehensive Care Project:



THORACIC SURGERY OR COMPLEX PLEURAL SPACE

Approximate Number of Cases Per Year

430



TOTAL JOINT REPLACEMENTS (HIP OR KNEE)

Approximate Number of Cases Per Year

520



CHRONIC DISEASES (COPD OR CHF)

Approximate Number of Cases Per Year

115

What our ICC Project Team Members are saying

"I believe this project is taking health care in the community to the next level. "

"The ICC Project gave us the chance to utilize new ideas and partner it with technology to bring the client the best possible care. Being able to speak to team members in real time and view patient files while in the community have given this team a true advantage and pushed us to the cutting edge when it comes to patient care."



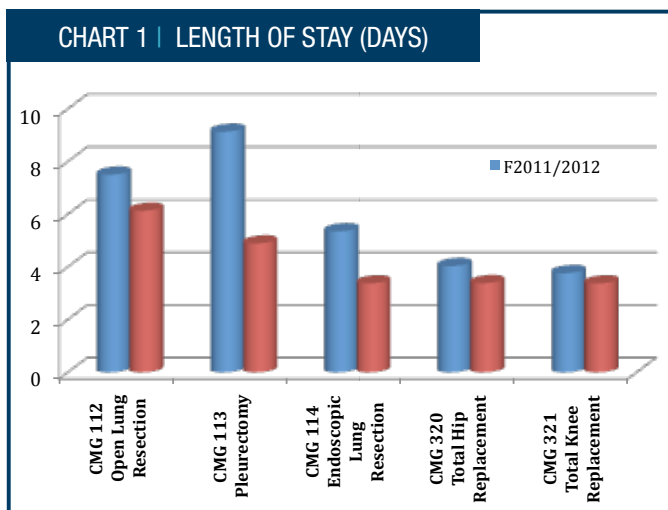
Integrated Comprehensive Care: Project Evaluation

What are the impacts of Integrated Comprehensive Care?

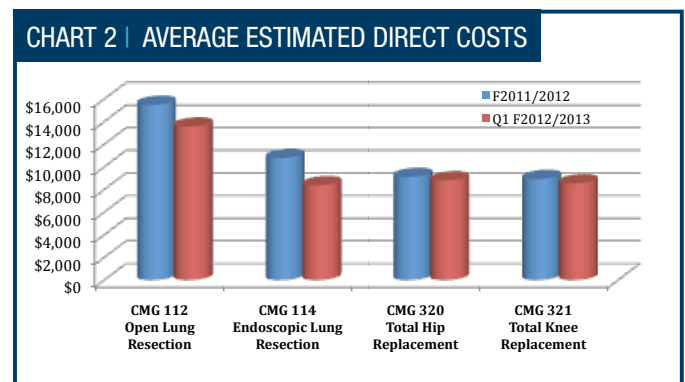
St. Joseph's Health System has engaged Programs for Assessment of Technology in Health (PATH) Research Institute to conduct an analysis of the ICC project. Following is a summary of the project's interim results as of December 2012.

At a glance:

- Overall reduction the number of days spent in hospital for total joint replacement and thoracic surgery
- Realization of significant healthcare savings in direct case costs
- Home care services are proving to be a more cost-effective way of transitioning patients back to independent living.
- Improved transitions in care, enhanced communication
- Improved overall patient satisfaction with the healthcare journey



The chart above depicts the number of days that selected patient types spend in hospital in traditional care model (blue columns) contrasted with the ICC model (red columns). As you can see, the number of days spent in hospital decreased in all segments realizing significant cost savings to the healthcare system.



The chart above depicts the estimated direct healthcare costs per case in the traditional model of care (blue columns) contrasted with the ICC mode of care (red columns). Significant healthcare savings were realized in direct costs per case through the ICC model.

Critical Success Factors

1. Integrated Care Coordinators/Case Navigators
2. Partnership with a service provider in the community
3. Shared electronic health record
4. Timely access to medical care
5. Flexibility in communication: Skype, phone calls, emails etc.
6. Central contact number: Patient access to the team (24/7)

Future Opportunities

1. Replicate across different patient types
2. Replicate across different care teams