Isaacksz, Shiran 2020 Partnering to spread & scale: How two health systems came together to better the integrated care experience. *International Journal of Integrated Care, 21(S1)*:A82, pp. 1-8, DOI: doi.org/10.5334/ijic.ICIC20506

CONFERENCE ABSTRACT

Partnering to spread & scale: How two health systems came together to better the integrated care experience

ICIC20 Virtual Conference – September 2020

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Introduction

In Ontario, Canada two large health systems came together to scale out an evidenced based integrated care model. St. Joseph's Health System (SJHS) Integrated Comprehensive Care (ICC) program began (2012) in Ontario, Canada within a single surgical stream and has since scaled to all surgeries and complex/chronic patients across a large regional area (patient population of 1.4M).
University Health Network (UHN), Canada's largest hospital-based research organization, partnered with SJHS including St. Joseph's Home Care and VHA and in four months, rolled-out this model in surgery. Learnings from this partnership are immense. This presentation will share what worked and needed to be adjusted for the diverse needs of Canada's largest urban centre (Toronto).

Practice Change Implemented

Working in partnership following ICCs evidenced based approach to integrated care of One Team, One Record, One number to call 24/7, One Fund, and co-designing with patients and providers the program was implemented within 4 months launching in June 2019. This patient-led program focused on what the most pressing needs and concerns were for patients and is already receiving anecdotal reports of improvements for hundreds of patients, their caregivers as well as clinicians.

Aim and Theory of Change

Improving patient/caregiver experience, quality of work life for providers, cost effectiveness and quality outcomes & health are main aims of ICC (Quadruple Aim). Change efforts focused first on demonstrating success within a small patient population and are now supporting spread across UHN, Canada's largest education and research hospital.

Targeted Population and Stakeholders

UHN Thoracic surgical stream (1,500 patients a year), all remaining surgical streams, more complex COPD/CHF/Pneumonia, and social medicine pathway. By 2020 the program expects to reach thousands of patients. Stakeholders include patient partners, caregivers

existing and new Home & Community care providers, community health centers, existing complimentary programs; specialty clinics and physicians, primary care teams; patients and caregivers; acute care hospitals; government

Timeline

4 months for first surgical stream, 6 months for COPD/CHF/Pneumonia, final year for remaining surgical streams and Social Medicine work is ongoing

Highlights

Successfully duplicated/transplanted evidenced-based model of integrated care within a different geographic region and hospital culture.
Creation of One Team, One Record, One Number to call 24/7, One Fund resulting in:
•Improved transitions
•Reduced length of stays
•Avoidance of Unnecessary Emergency Department visits
•Consistency in Care
•Improved Communication and Collaboration

Sustainability/Transferability

Similarities with respect to geographic make-up and distribution of patient population and strong relationship across leadership teams enabled a 'leap of faith' taken supported by a confidence in the successes demonstrated within SJHS. Transferability was impacted by need to navigate pre-existing partnerships, size and acuity of patient population.

Conclusions

Through this partnership the team has many insights to share. Key areas of discussion and learning include:
•Implementing and applying the foundational elements of the ICC model
•The importance and learnings from patient and frontline led co-design
•Opportunities and impact of financial levers to support sustainable system change
•Access to and use of simple available technology to enable an integrated team approach