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CONFERENCE ABSTRACT

The more we come together, the better care will be – UHN's Integrated Care Experience

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Claire Seymour[1], Melissa Chang, Courtney Bean, Hemjot Mal, Shiran Isaacksz

1: University Health Network, Canada

Introduction

University Health Network (UHN), a health system in Canada's largest urban centre, launched a new model of care to improve the care experience with a focus on integrating all aspects of care whether in or outside of a hospital. This Program is developed and delivered in partnership with VHA Home Healthcare as lead agency, home care provider, and collaborative partner to improve patient experience and outcomes. The Program launched rapidly with great results serving +13,000 patients. This presentation will share how trust, effective governance and leadership helped navigate challenges and partner with organizations, to transform how patient care is delivered.

Aims Objectives Theory or Methods

Co-designed by patients and providers, the integrated care experience is seamless, including health and social supports. The Program addressed common patient and caregiver complaints with one:

- Care team and primary contact
- 24/7 support line
- Digital health record
- Integrated fund

The success of this Program is rooted in the philosophy of "One Team" across all sectors from a care delivery and leadership standpoint. This provided the ability to break down barriers and improve communication and collaboration. Key objectives: improve the care experience, clinician satisfaction, quality outcomes and population health, including decreasing length of stay, readmissions and ED visits.

Highlights or Results or Key Findings

The integrated delivery team includes patient/caregiver partners, acute, home & community and primary care, finance and data, and regional government bodies. Patients undergoing surgery and living with chronic complex conditions are in scope.

The Program was live within four-months in Thoracic Surgery (June 2019). Established infrastructure and system-wide partnerships accelerated implementation to Chronic Heart Failure (spring 2020), COVID Care (spring 2020), and Vascular Surgery (fall 2020).

The program has benefited +13,000 patients and early evaluation results indicate improvements in care experience and health system outcomes: 28% shorter length of stay, 48% lower 90-day ED risk, and 33% lower 90-day readmission risk (for the low needs care paths).

The trust built among the “One Team”, and strong governance allowed us to adapt to a rapidly changing landscape and expedite expansion to support vulnerable populations. During the pandemic, care paths were adjusted to ensure care continuity, while delivering improved outcomes and experiences.

Conclusions

In less than two years +13,000 patients have benefited and new pathways continue to rollout. The Program continues to identify opportunities to develop partnerships and support shared decision-making across the health system. Ongoing efforts to evolve include expanding connections with community and social supports continue to be critical to success.

Implications for applicability/transferability sustainability and limitations

The Program has expanded while navigating challenges posed by a restructuring of health care delivery and the pandemic. Through effective governance, leadership and strong partnerships, the program established a sustainable foundation for rapid growth. This includes breaking new ground in looking at opportunities where regional collaborative efforts may be supported.