‘To do a lot right, do a little wrong’:

Integrated Care. Creating Better Healthcare Experiences.

Longwoods Breakfast Series

March 22, 2023

Dr. Kevin Smith, President & CEO, University Health Network

Dr. Kathryn Nichol, President & CEO, VHA Home HealthCare

Dr. Carolyn Gosse, Vice President, Clinical, UHN at Home and Seniors Care

Mr. Courtney Bean, Vice President, Strategic Solutions and Partnership, VHA Home HealthCare

UHN Toronto General Toronto Western Princess Margaret Toronto Rehab Michener Institute

Connected Care UHN

UHN @Home

VHA Home HealthCare

Creating More Independence

The Integrated Care Experience

An evidence-based model of care aimed at improving the patient, caregiver and care provider experience, with a focus on creating a seamless experience for the patient across the health continuum

Patient care that is **coordinated** across professionals, facilities, and support systems; **continuous** over time and between visits; **tailored** to the patients' needs and preferences; and **based on shared responsibility** between patient and caregivers for optimizing health.

– **Celine Schillinger**

Singer, S. J. et al, Defining and Measuring Integrated Patient Care: Promoting the Next Frontier in Health Care Delivery. Med. Care Res. Rev. 68, 112-127 (2011)

> Care that is integrated across settings and disciplines is rapidly becoming the ideal of modern health service delivery.

Litchfield, Ian et. al. (2022). The move towards integrated care: Lessons learnt from managing patients with multiple morbidities in the U.K. Health Policy, 126(8), 777-785

Literature suggests **successful** models include:

- Dedicated physician leadership
- Digital health tools
- Standardized models of care
- Ease of communication for patients and care team
- Single fund holder
- Investment in team education and development
- Aligned incentives to reward desired results

Introducing Our Organizations

UHN
Toronto General
Toronto Western
Princess Margaret
Toronto Rehab
Michener Institute

VHA Home HealthCare
Creating More Independence

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One Team

An **Integrated Care Lead** is the primary point of contact for one **consistent care team**

One Record

One **shared digital health record** is available to track calls, in-person visits, medication, supplies and equipment

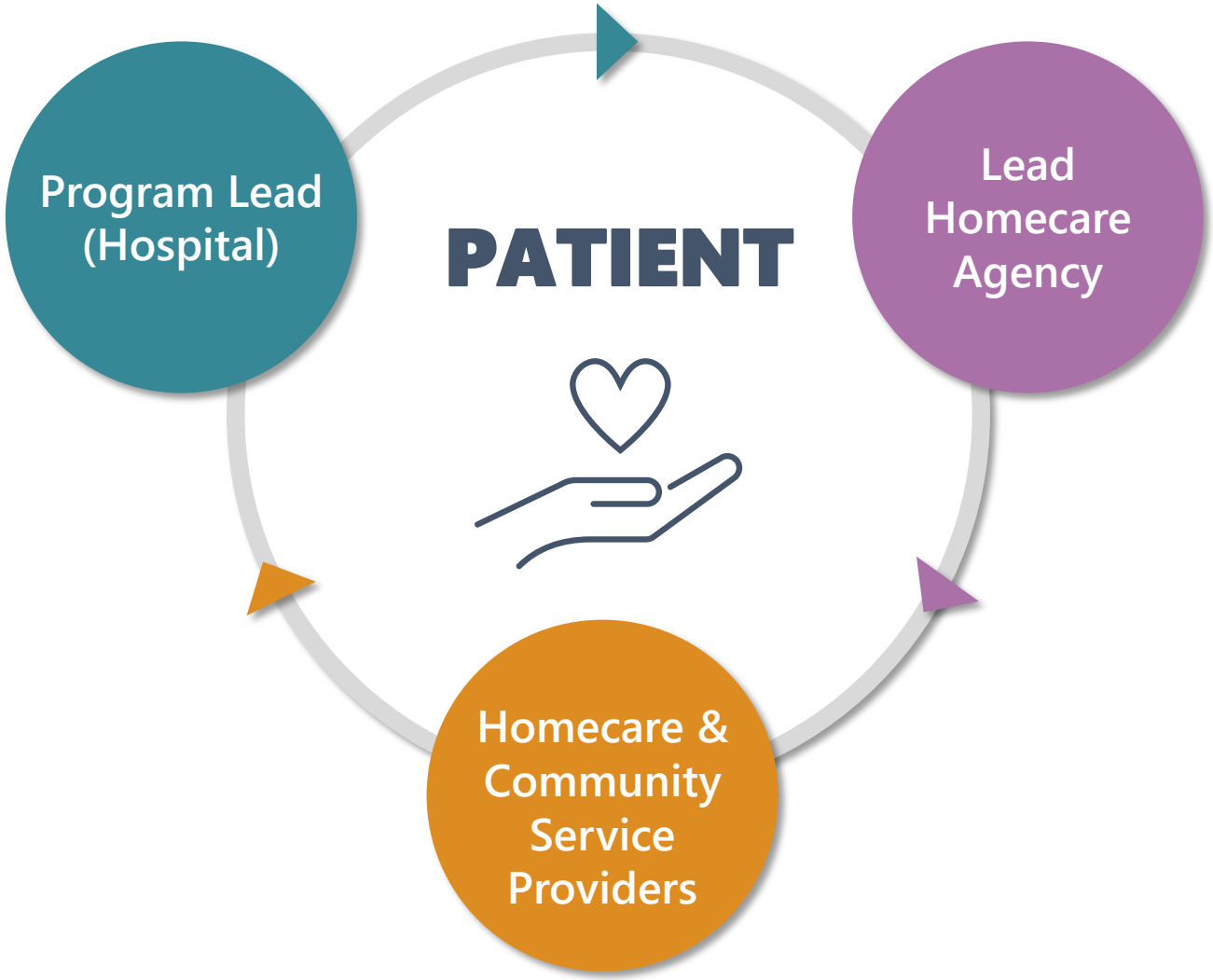
One Number to Call

A **24/7 phone line** is available to patients and caregivers

One Integrated Fund

allows for flexibility to provide patients with **support when and where needed**

Integrated care organizational structure



Focus on Patient & Caregiver Needs

Support Care Provider Satisfaction & Quality of Work Life

Care Model Drives the Integrated Funding Model

Commit to Meet Key Metrics

8 INTEGRATED CARE GUIDING PRINCIPLES

Enable Connected Care in a Digital World

Ensure Sustainability and Scalability

Act in a Transparent, Fair & Reasonable Way

Shared Accountability

Traditional Healthcare vs. Integrated Care

PATIENT JOURNEY	Arrival & Referral	Hospital Stay	Discharge Planning	Recovery @ Home
TRADITIONAL HEALTHCARE MODEL			• Eligibility assessment completed by **hospital care coordinator** • Timing/type(s) of home care services unknown to team	• Transfer to **community care coordinator** • Multiple medical records, numbers to call • May have multiple **care providers** • Limited information between providers • No direct access back to hospital team
INTEGRATED CARE MODEL	• **Integrated Care Lead** introduces Program at the earliest point in admission • Reviews expectations for hospital stay	• **Integrated Care Lead** embedded in patient unit to support personalized care needs and earliest return home	• Co-create care plan with hospital team, patient and care partners • Simultaneous planning with home care provider for flexible care	• **Integrated Care Lead** remains point of contact • ONE medical record, number to call 24/7 • ONE **team** • Hospital info. shared with home team • Timely documentation of visits • Timely access to hospital team • Commitment to continuity of care

Hospital Team | **Hospital Care Coordinator** | **Community Care Coordinator & Multiple Providers**

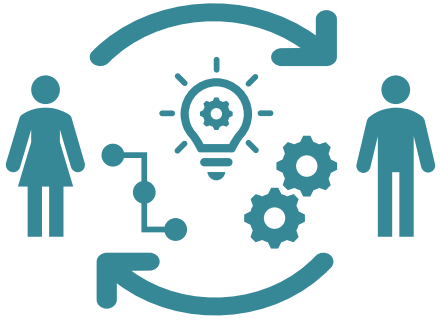
Hospital Funds | **Home Care Funds**

Hospital, Integrated Care Lead and dedicated home care team

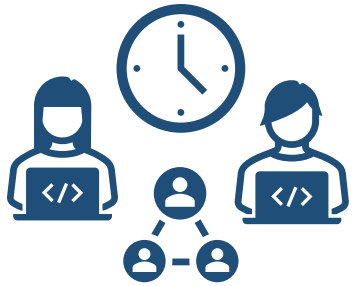
ONE fund driving capacity and outcomes

Role of Lead Homecare Agency

24/7 ON CALL (NURSING & PROGRAM SUPPORT)



PATHWAY CO-DESIGN



SCHEDULING COORDINATION

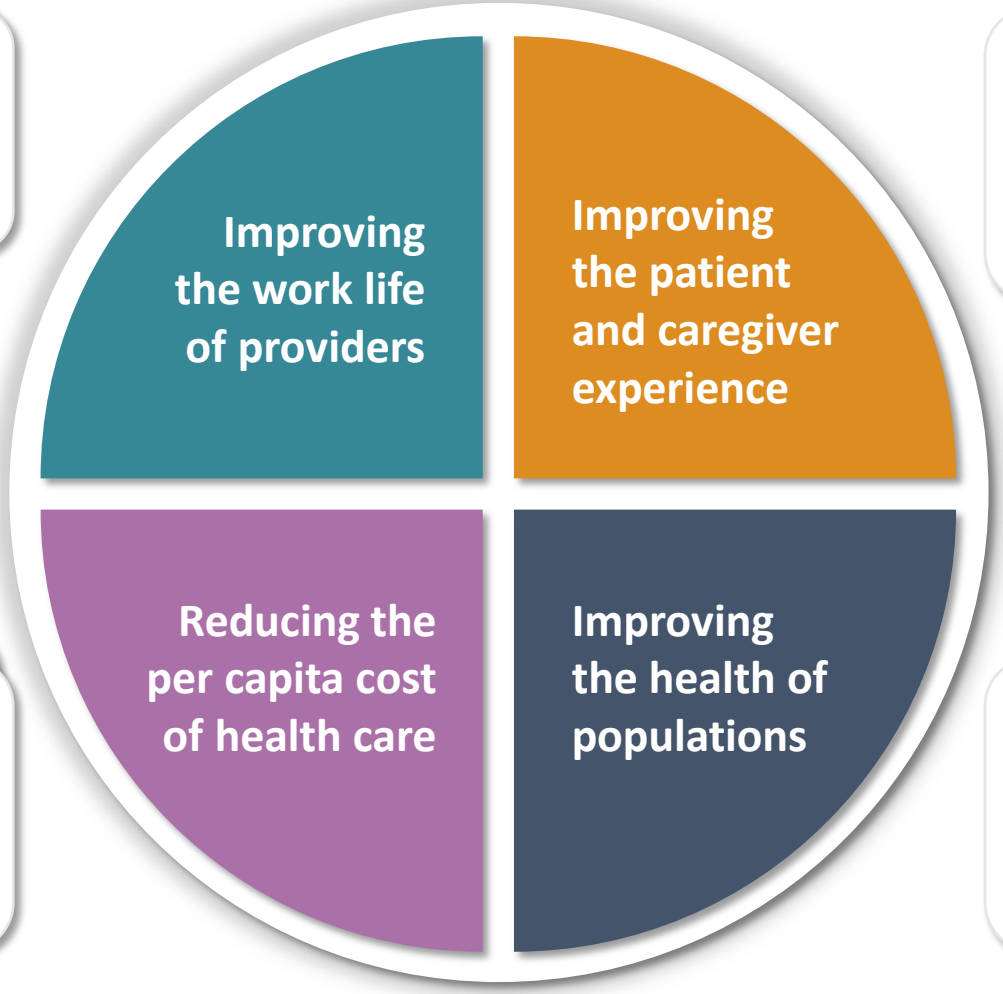
PARTNERS & VENDORS

DIGITAL

KEY SUCCESS FACTORS

- Learning Culture
- Trust & Openness

- Integrated Care led coordination
- Multidisciplinary services
- Shared digital platforms



- Salaried homecare
- Flexible funding distribution

- Defined populations
- Targeted geography
- Co-designed pathways


LEARNING
TEAMWORK
TRANSPARENCY
UNDERSTANDING
SHARED
OWNERSHIP
TRUST
ITERATIVE
PARTNERSHIP

Patient Experiences

"Everyone I spoke to was prompt, extremely helpful and reassuring and… potentially ***saved at least two, non-essential trips to the ER."***

"You can breathe knowing the someone is coming into the house."

Timely Access to Care

- **2,762** calls to the 24/7 phone line to date

The Right Care in the Right Place

- **11,000** homecare visits to date

Compassionate & Equitable Care

- Providers have time and knowledge for **comprehensive, whole-person care**

Summary of Provider FEEDBACK

*"I would **recommend** the UHN IC program for my own family member.*

*Based on my experience within other organizations, the UHN IC program has by far **exceeded my expectations**. "*

+70% Felt their clinical skills were enhanced working within the UHN IC Program

+85% Felt they were equipped with resources to address any clinical concerns within the UHN IC Program

+75% Felt the UHN IC Program offered opportunities for professional growth

+90% Would recommend the UHN IC Program for their own family member

Meet Reva

A caregiver to her brother with complex needs who had a surgery at UHN

Reva appreciated:

- Clear information during the hospital stay and what to expect during recovery at home
- 24/7 phone line and being able to talk to someone who understands her brother's care needs
- Kind and experienced care team members in the home

*"I **knew what to expect**, what was to be delivered to the home. [With the] 24/7 line, any issues I could call the number."*

*"You can breathe knowing that someone from the team is coming into the house. If it wasn't for the Integrated Care Program I don't know what we would have done. **We would have ended up back in ER**."*

*"I **felt included** as part of the care team and in decision making and felt very supported and comfortable that the nurse knows to escalate - it was so reassuring that there is someone [IC Lead]."*

Reimagining how we deliver tomorrow's care

Where we started, where we are, and where we are going

Proof of Concept in Thoracic Surgery

Findings from the Early 3rd Party Evaluation

(Jun 3, 2019 to Feb 28, 2020)

PATIENT, CAREGIVER & CLINICIAN EXPERIENCE

Effective transition to home & care coordination

IC lead functioned as effective point of contact post-discharge

Effective interactions & communications

Appreciated sustained communications and providers who know their medical history

Person-centered care

Pts & caregivers felt listened to, involved in decisions about care, developed strong rapport w/ IC leads

Patient preparedness

Increase in patient confidence to manage health after discharge

QUALITY OUTCOMES

(Low Care Path; Adjusted 90-day risk)

Length of Stay

↓28%

Emergency Department Visits

↓48%

Hospital Readmissions

↓33%

Supporting Seamless Care

Improving Quality & Safety of Care

- ✓ Reinforcing best practice
- ✓ Supporting smoother transitions in care
- ✓ Preventing barriers to discharge
- ✓ Better managing complications

As part of the IC Program, care path and complication guidelines were developed for each Pathway and includes information about the surgery/inpatient stay, any potential complications that may arise, expected recovery, and the standard care experience and guidelines for supporting each of the homecare visits

Expanding our Evidence-Based Model of Care

*Pathways have improved the care experience for **~34,420 cases** to date*

UHN Ajmera Transplant Centre

Liver
February 2023
***7** enrolled to date*

Lung
Estimated go live: May 2023

UHN Krembil Brain Institute

UHN Medicine Program

COVID Care
April 2020
***30,990** enrolled to date*

ED Pneumonia, Influenza
November 2021
***15** enrolled to date*

Advancing Care: Admission avoidance
Estimated Go-live: March 2023

GIM COVID, CHF, COPD
January 2022
***287** enrolled to date*

Advancing Care:
CHF – Regional
COPD - Regional

Diabetes
Estimated go live: TBD

UHN Peter Munk Cardiac Centre

CHF Cardiology
May 2020
***291** enrolled to date*

Vascular Surgery
October 2020
***301** enrolled to date*

Cardiovascular Surgery
July 2021
***814** enrolled to date*

UHN Princess Margaret Cancer Centre

UHN Schroeder Arthritis Institute

Hip, Knee, Shoulder
August 2022
***71** enrolled to date*

Remaining Orthopedic
Estimated go live: May 2023

UHN Sprott Surgery

Thoracic Surgery
June 2019
***1,644** enrolled to date*

Legend | Implemented IC Pathways | Under implementation