

Innovative patient-centred model improves health care across the Hamilton Niagara Haldimand Brant region

Unique program reduces emergency visits and length of hospital stay

NEWS

June 29, 2016

HAMILTON, June 29, 2016 – Patients in the Hamilton Niagara Haldimand Brant (HNHB) LHIN region are experiencing shorter hospital stays, fewer visits to the emergency department and have a stronger feeling of confidence in recovering at home with a new patient-centered care model, called Integrated Comprehensive Care (ICC).

“This model will help other people, because it’s helped me considerably,” says Gordon Hopmans, former ICC patient at Joseph Brant Hospital. “There is somebody there caring for you, not just when you are in the hospital, but in your own home. The ICC team taught me what to look for and what to do to prevent me from being rushed off back to the hospital.”

St. Joseph’s Health System successfully piloted the ICC model, where it resulted in a 30 per cent decrease in length of hospital stays and a 40 per cent reduction in hospital readmission rates among enrolled patients. The positive results from the pilot program has uniquely led to the ICC model being the first of its kind to ever be officially signed into adoption by all partners in the HNHB Local Health Integration Network. The program has expanded to all acute care hospitals in the HNHB LHIN for patients who require short-term care at home following hospitalization for chronic obstructive pulmonary disease (COPD) and congestive heart failure (CHF).

“The results have been dramatic, truly proving that we are transforming the health-care system and are putting patients first,” says Dr. Kevin Smith, President and CEO, St. Joseph’s Health System. “It’s through the development of innovative programs like Integrated Comprehensive Care that we can break down silos and wrap care around patients to help them feel more confident as they transition from hospital to home.”

The ICC model helps patients transition more smoothly out of the hospital and into their homes by coordinating home care and ensuring that the majority of their healthcare team remains the same. Patients treated in hospital for COPD and CHF are assigned an Integrated Comprehensive Care Coordinator who serves as a link between specialists and providers in the community, including primary care. The ICC Coordinator works closely with a lead homecare agency, St. Joseph’s Home Care to arrange home care services. The Coordinator follows patients for 60 days after discharge from the hospital, the period during which they are at greatest risk of complications and readmission, and will be accessible 24 hours a day, seven days a week to provide support. The ICC team also provides education for patients to help them manage their disease with greater confidence.

“Many more patients with chronic obstructive pulmonary disease and congestive heart failure will now experience seamless transitions between hospital and home thanks to the expansion of the Integrated Comprehensive Care program to all hospitals in the Hamilton Niagara Haldimand Brant (HNHB) Local Health Integration Network (LHIN),” says Donna Cripps, Chief Executive Officer, Hamilton Niagara Haldimand Brant Local Health Integration Network. “This innovative program, which was pioneered by St. Joseph’s Healthcare Hamilton in 2011, is demonstrating

significant improvements in access to and quality of care and we are excited that more patients can access this care, closer to home.”

Key features of the new HNHB LHIN-wide program include:

- **One contact for the patient to call.** An Integrated Comprehensive Care Coordinator provides a seamless care experience by arranging all care for the patient. They are one point-of-contact for the patient to call when they have a question about their health or to coordinate further medical care.
- **24/7 patient access to care.** The ICC team is available whenever the patient needs help.
- **Personalized patient care** to improve health outcomes and develop action plans specific to the patient’s needs.
- **Continuity of care** delivered through the collaboration and partnership of healthcare specialists, primary care providers and homecare team members.
- **Timely and efficient access to medical expertise** through the use of a single **electronic Client Health Record** across the hospital and community.
- **Standardized care** across all LHIN hospitals and community care providers to minimize variation, complications and unnecessary healthcare resource use.

QUICK FACTS

- **Project partners include:** St. Joseph's Healthcare Hamilton, Brant Community Healthcare System, Centre de Santé Communautaire, Grand River Community Health Centre, Haldimand War Memorial Hospital, Hamilton Health Sciences, HNHB Community Care Access Centre, HNHB Local Health Integration Network, HNHB Primary Care lead, Joseph Brant Hospital, Niagara Falls Community Health Centre, Niagara Health System, Norfolk General Hospital, North Hamilton Community Health Centre, St. Joseph's Home Care, West Haldimand General Hospital.
- Comprehensive Care was designed by St. Joseph’s Healthcare System, and was the first healthcare initiative in Ontario to show the benefits of an Integrated Comprehensive Care approach between the hospital and the community.