

MEDIA RELEASE:

For Immediate Release

Expanding Integrated Comprehensive Care Program across HNHB LHIN for Patients with COPD and CHF – HNHB LHIN one of six Successful MOH Integrated Funding Model Projects

Norfolk General Hospital and the HNHB LHIN partners (appendix A) were approved by the MOH to spread and scale the St. Joseph’s Health System (SJHS) Integrated Comprehensive Care (ICC) model across all HNHB acute care hospital sites for hospitalized patients with a diagnosis of COPD and CHF. These patients will be followed for 60 days (short-stay) post discharge, when patients are at greatest risk of readmission.

Ontario’s Minister of Health and Long-Term Care, Dr. Eric Hoskins described the SJHS Integrated Comprehensive Care Project (ICC) as a vision for the future of care delivery in the province. Providing a “bundled” approach to health care that aims to guide patients throughout their entire medical treatment (hospital and home), the ICC project began in 2012 and has been applied to the Lung and Esophageal Cancer Surgery, Joint Replacements, and for patients with COPD and CHF. ICC has resulted in shortened hospital stays, improved patient satisfaction and fewer readmissions to the emergency department.

The expansion of the ICC model across all acute hospitals in HNHB for patients with COPD and CHF will transform patient care across the LHIN, providing an innovative, patient-centered, bundled approach to health care. Critical to the success of the ICC model is physician involvement and engagement. As the ICC program rolls out across the HNHB LHIN, key stakeholders and physician leads from hospital and community will be engaged in the development and implementation of the model

Key features of the ICC model include:

- 1) Integrated Care Coordinator** who is not only the link between hospital specialists, but also connects with necessary service providers in the community including primary care, home care, and specialists.
- 2) The use of mobile technology** such as tablets allows the teams to communicate with patients at home and cuts down on unnecessary trips to hospital.
- 3) Integrated Care Paths** to standardize care across all LHIN hospitals and community care to minimize unwarranted variation, complications, and unnecessary health care resource utilization and ensure care is provided in the most cost effective setting;



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- 4) **A Lead Homecare Agency** to maximize continuity, expertise and efficiency;
- 5) **Strong Client Engagement** to improve health outcomes and develop personalized action plans;
- 6) **High Team Engagement** to ensure continuity of care and thorough assessment of patient needs over the care path; and high collaboration/partnership with primary care providers to transition from hospital to community;
- 7) **24/7 Availability** for patients to have access to an Integrated Comprehensive Care Team Member;
- 8) **Timely Access to Medical Expertise** to maintain adherence to the bundled model;

We are working closely with our LHIN partners to implement this program in a phased approach starting with Burlington, and followed by Hamilton, South Zone, and Niagara. For more information please contact:

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Appendix A. Partner Organizations

- Brant Community Healthcare System
- HNHB CCAC
- HNHB LHIN
- Haldimand War Memorial Hospital
- Hamilton Health Sciences
- Joseph Brant Hospital
- Norfolk General Hospital
- Niagara Health System
- St. Joseph's Healthcare Hamilton and St. Joseph's Homecare
- West Haldimand General Hospital
- HNHB Primary Care Lead, LHIN Zone Chiefs & Chair McMaster University Department of Family Medicine
- North Hamilton Community Health Centre
- Grand River Community Health Centre
- Centre de Santé communautaire
- Niagara Falls Community Health Centre

"Our mission is to relieve illness and suffering, and help people live healthier lives."

