

healthcare  
begins  
here.



@gapingvoid

# JOINING COMPASSION WITH TECHNOLOGY



niagarahealth  
Extraordinary Caring. Every Person. Every Time.

 St. Joseph's  
HEALTH SYSTEM

# ST. JOSEPH'S & NIAGARA HEALTH SYSTEMS

7 MEMBER ORGS

14 SITES

~\$1.3 BILLION

TOTAL BUDGET

13,000

STAFF & PHYSICIANS

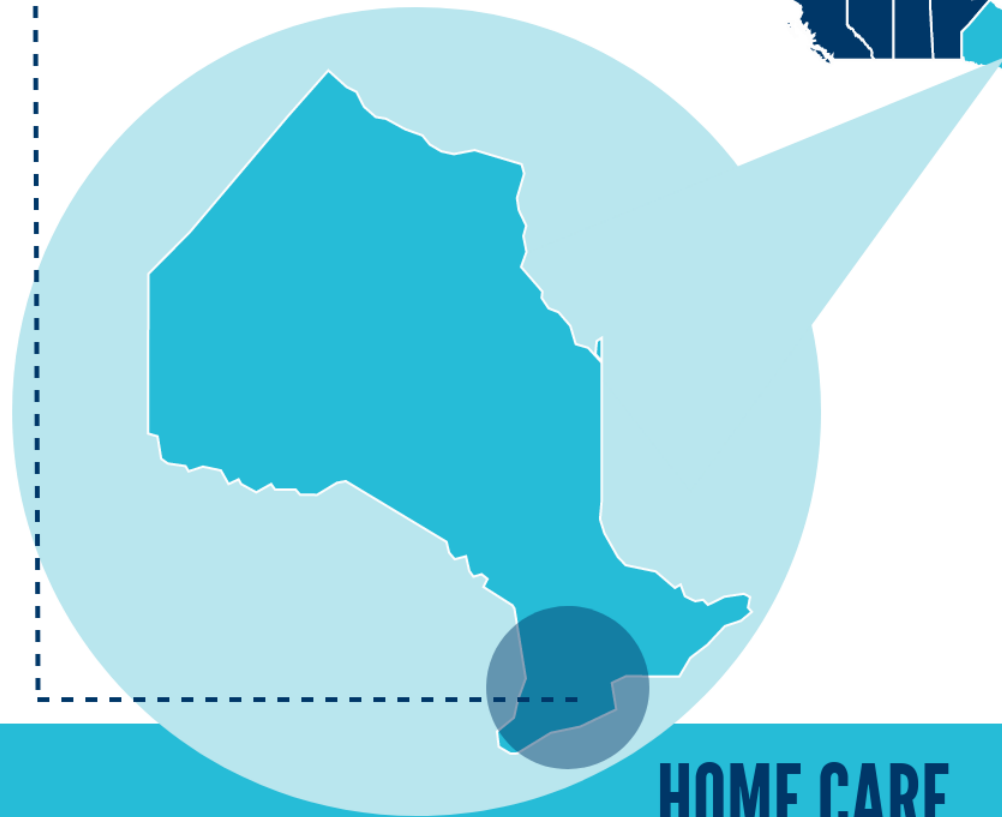
2,800

BEDS/UNITS

POPULATION OF

2.1 million

ONE OF THE  
**LARGEST**  
CORPORATIONS  
IN CANADA  
DEVOTED TO  
HEALTH CARE



FIRST INTEGRATED  
ACROSS CONTINUUM

SOCIAL  
SERVICES

**HOSPITAL**

COMMUNITY SERVICES

**HOME CARE**

OUTPATIENT  
CLINICS

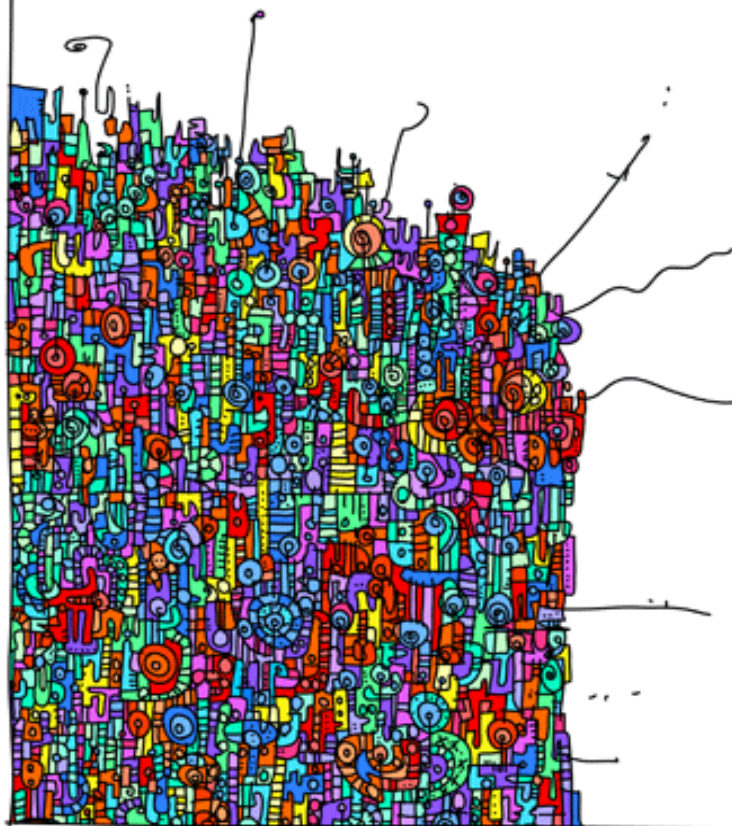
LONG TERM  
CARE

# In the heart of Canada, we are healthcare leaders in...



**RESEARCH**  
**HOME CARE**  
KIDNEY & URINARY HEALTH  
**ADVANCED SURGERY**  
CARDIAC CARE  
LONG-TERM CARE  
**DIGITAL HEALTH**  
MENTAL HEALTH & ADDICTIONS  
**LUNG CARE**  
CANCER CARE

BEYOND  
TRANSACTIONS.



@gapingvoid



# Partnerships & Business Development

## *Focus Areas:*

**‘Maximize *Epica* investment’**

**‘Supercharge  INTEGRATED  
COMPREHENSIVE  
CARE PROGRAM  
& enable shortest Length of Stay’**

**‘New Way – Additions & Mental Health’**

*Champion the Patient Experience*

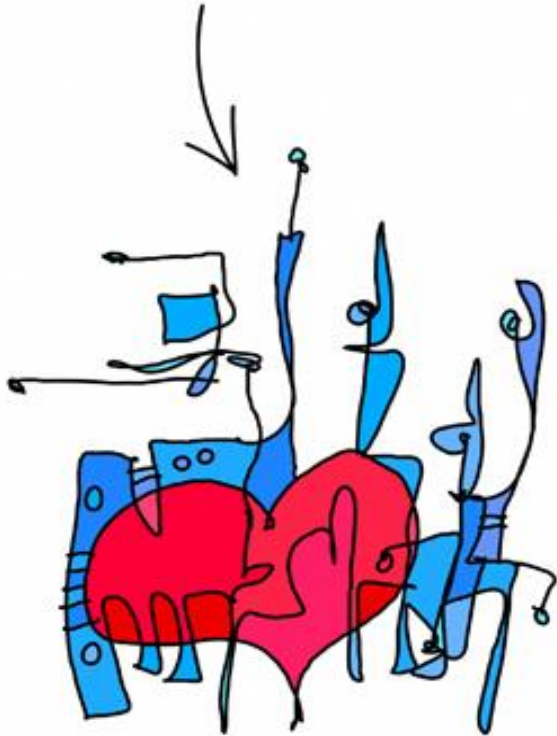
*Support our Staff*

*Evolve Scope of Practice*

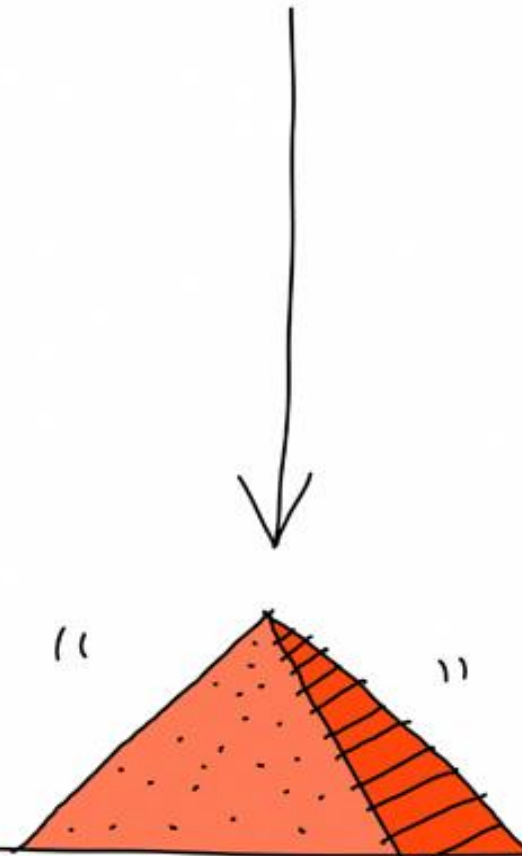
*Dramatically Improve RPM*



INNOVATION IS  
CULTURE,



NOT  
TECHNOLOGY.

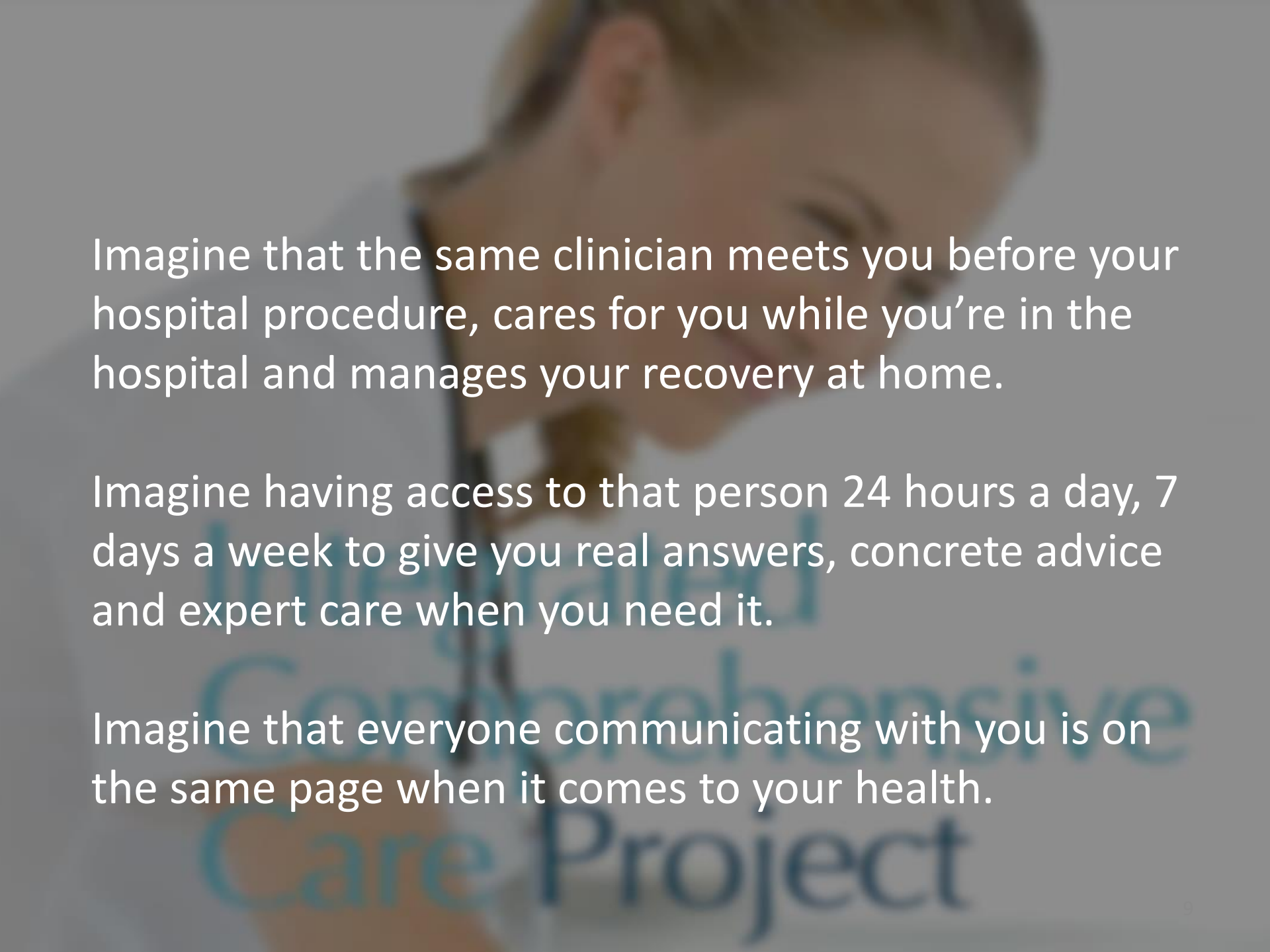




St. Joseph's  
HEALTH SYSTEM

# Integrated Comprehensive Care Project





Imagine that the same clinician meets you before your hospital procedure, cares for you while you're in the hospital and manages your recovery at home.

Imagine having access to that person 24 hours a day, 7 days a week to give you real answers, concrete advice and expert care when you need it.

Imagine that everyone communicating with you is on the same page when it comes to your health.

Integrated  
Comprehensive  
Care Project



## REVOLUTIONIZING CARE IN ONTARIO

**“Strong results at St. Joseph’s Health System in Hamilton encouraged us to expand these bundled care teams to communities across the province. These new care teams will make it easier for patients to transition out of hospital and to receive the care they need at home, where we know they’d rather be... delivering better access and better outcomes.”**

**- DR. ERIC HOSKINS**

**MINISTER OF HEALTH & LONG-TERM CARE**

# Integrated Care: Bundling episodes of care & funding

## Status Quo



## IFM Bundle

Integrated Health Care Team



Cost savings per patient: **\$4,000**

# Meet Ed

At 65 years old, Ed was diagnosed Chronic Obstructive Pulmonary Disease (COPD)



## Before the ICC Model:



Ed arrives to St. Joe's emergency department with shortness of breath.



Ed is discharged from the hospital without community support.



Ed returns to the emergency department four days later with shortness of breath and anxiety.



After 12 days in hospital, Ed is discharged home again. He is worried he will be back soon.



# Before the ICC Model:

Chronic Lung Disease and Heart Failure  
HNHB LHIN (Pop. 1.4 million)

**4500**  
HOSPITAL  
ADMISSIONS



**9157**  
EMERGENCY  
DEPARTMENT  
VISITS



**1489**  
HOSPITAL  
READMISSIONS



**2200**  
HOME CARE  
REFERRALS



**\$3,000,000+**  
IN HOME  
CARE COSTS



## OUR INTEGRATED COMPREHENSIVE CARE (ICC) MODEL:



### 8 ELEMENTS:

1. CLIENT CENTRED CARE
2. INTEGRATED CARE COORDINATORS
3. INTEGRATED TEAM COMMITTED TO STANDARDIZATION
4. SHARED DIGITAL HEALTH RECORD
5. SIMPLE, AVAILABLE TECHNOLOGY (EX. TABLETS)
6. READY ACCESS TO MEDICAL CARE
7. FLEXIBILITY IN THE DELIVERY OF CARE
8. BUNDLED FUNDING



# Meet Ed TODAY

At 65 years old, Ed was diagnosed Chronic Obstructive Pulmonary Disease (COPD)

## WITH OUR ICC MODEL:



Ed arrives to St. Joe's emergency department with shortness of breath and participates in his care planning with ICC coordinator.



Ed is discharged from the hospital with ICC home care support in place.



Ed has shortness of breath and anxiety. He calls the ICC 24/7 telephone support number. A home care nurse visits and uses a tablet to communicate with his specialist.

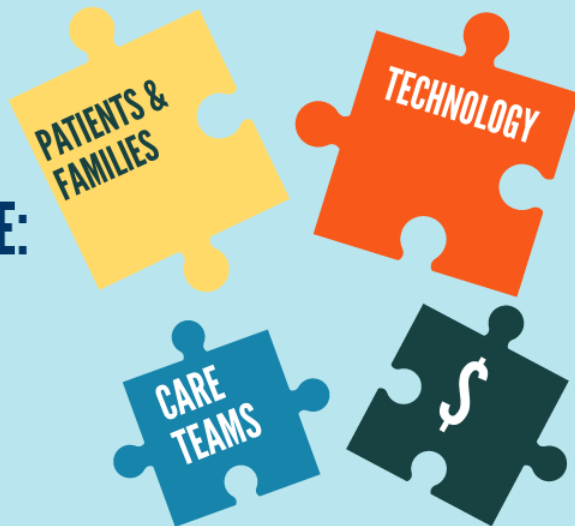


Ed goes to a follow up visit with his specialist, who has full access to his ICC medical records.

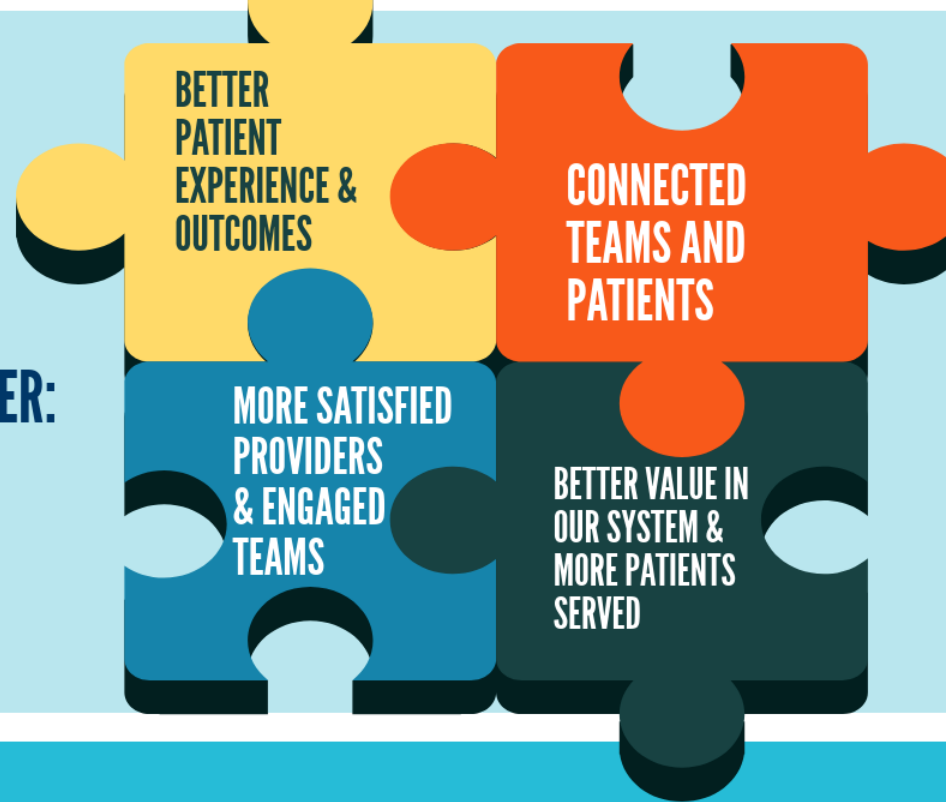


# IMPACT OF ICC MODEL

**BEFORE:**



**AFTER:**



## BY THE NUMBERS

CHRONIC DISEASE:  
**2,000**  
PATIENTS ENROLLED  
**7,536**  
HOSPITAL DAYS  
SAVED



**15,000**  
PATIENTS ENROLLED  
TO DATE  
GREATER THAN  
**30,000**  
HOSPITAL DAYS  
SAVED



**94%**  
OF ICC PATIENTS  
WERE CONTACTED BY  
A NURSE WITHIN  
**24 HOURS**





# NEXT STEPS



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# Artificial Intelligence

