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CONFERENCE ABSTRACT

Evaluation of an Integrated Care Program for Thoracic Surgery at a Hospital in Ontario, Canada

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Introduction

Transitions in care from hospital to community can be challenging for post-operative patients. In June 2019, the University Health Network in Toronto, Canada implemented a Thoracic Surgery Integrated Care Program (ICP) to support comprehensive care in the hospital-to home continuum. We conducted a process evaluation to understand patient, caregiver and provider experiences to identify areas for improvement, which was complemented by an outcome evaluation to assess Program benefits relative to quality outcomes and hospital costs. A stakeholder group including patient representatives, providers, and researchers provided critical input on the evaluation plan, interpretation of results and recommendations.

Aims Objectives Theory or Methods

We conducted a mixed methods evaluation to assess the first nine months of the program, which included: 18 interviews with patients and caregivers to understand experiences with dimensions of care; focus group with thoracic surgeons and interviews with IC leads and lead surgeons to understand experiences with care delivery; and analysis of hospital administrative databases to quantitatively evaluate quality outcomes and costs between IC patients and historical patients discharged a year prior to program implementation. The retrospective cohort analysis assessed readmission risk, emergency department (ED) visit risk, length of stay (LOS), and hospital costs, adjusting for age, sex, and residence.

Highlights or Results or Key Findings

The ICP was successful in providing effective coordination and continuity of care, especially during the post-discharge period. Providers reported the ICP supported them in delivering a comprehensive and person-centered care experience. Patients/caregivers expressed confidence in transitioning home with 24/7 access to an IC Lead familiar with their surgery; however, they also identified gaps in educational and caregiver supports. Providers identified a need to strengthen links with primary care physicians and other providers in the patient's circle of care to improve informational continuity and team integration. In low care pathways, the 90-day ED risk of IC patients was 48% lower (95% CI: 0.31-0.87) and LOS was 28% lower (95% CI: 0.60-0.86) than those

of the historical cohort. Readmissions were 33% lower (95% CI 0.38-1.18) and hospital costs were 4% lower (95% CI: 0.79-1.16); however, small sample sizes did not permit conclusive findings.

Conclusions

The ICP achieved notable successes in providing effective healthcare experiences for patients and caregivers, positive experiences among providers, and early evidence of program benefits on reduced ED visits and LOS. The results were used to guide ICP improvements and inform expansion to other IC pathways in the hospital.

Implications for applicability/transferability sustainability and limitations

Qualitative findings may not reflect the experience of all program patients, caregivers, and providers. Data on quality indicators and costs were limited to the specific hospital, thus omits visits and costs to external institutions. Further analyses with an increased sample size will be important to demonstrate the robustness of findings.