CONNECTING SOUTH WEST ONTARIO

Analysis and Research:

Enabling home and community care case management and care coordination

Evaluating benefits is an important component of the connecting South West Ontario (cSWO) Program that helps to support and demonstrate the realization of health system benefits through the adoption of electronic health records (EHRs). By pursuing the measurement of organizational value (improvements in the efficiency of care delivery such as time-savings and redirected resources) and clinical value (patients undergo fewer unnecessary tests, patients have improved access to care), patients ultimately benefit from higher quality, better informed clinical decision-making.

The cSWO Analysis and Research program uses a research-based approach to identify areas of clinical best practice that are affected by the use of EHRs, and works collaboratively with clinicians to understand the value of EHRs. This formative evaluation process informs change management and adoption, and enables clinicians to use EHRs more effectively. This research does not include the use of any personal health information.

This document is one in a series of case studies which describe the clinical value of EHRs in different clinical settings and contexts, particularly with respect to clinical best practices. The work of the cSWO Analysis and Research program is ongoing; depending on the circumstance, these cases occasionally raise questions for further investigation, and clinicians are invited to participate in analysis and research to continue to develop these answers.

Value statement

Access to electronic health records (EHRs) through the cSWO Regional Clinical Viewer, ClinicalConnect™, supports the Six Nations Home and Community Care (HCC) team in providing efficient case management and improved care coordination and system navigation for their patients.

Providing access to culturally appropriate home and community care services

The Hamilton Niagara Haldimand Brant (HNHB) Local Health Integration Network (LHIN) supports Indigenous health programs and services by funding Indigenous health service providers to deliver community-driven and culturally based programs and services including mental health and addictions, case management, crisis intervention, palliative care, patient navigation and advocacy, Traditional medicine, in-home services and supports, caregiver supports and long-term care (LTC).[1] The LHIN established an Indigenous Health Network (IHN) which aims to address the health needs of local communities as well as the health-specific recommendations identified in the Truth and Reconciliation Commission of Canada's (TRC) Final Report and Calls to Action.[1]

Six Nations Health Services, one of the members of the IHN, is dedicated to ensuring that each individual is respected and valued by providing, promoting, protecting and advocating for holistic health home and community care services for current and future generations of the Six Nations Community.[2] The Six Nations Home and Community Care program is one of many within the organization, each working in collaboration with one another to provide holistic and culturally safe services in-home for individuals from newborns to seniors within the Grand River Territory. Services are provided in a manner that considers the person's physical, social, spiritual and emotional needs, recognizing that each person functions within their own unique family and community context.

The four registered nurse case managers in the Home and Community Care Program, perform assessments for patients that are referred to the program from doctors, family, friends or self. An initial visit is made to assess the physical and emotional needs of the patient and a plan of care is developed which can include referrals to the other medical, rehabilitative or supportive services.

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EHR access improves care coordination and informs clinical decision-making

The case managers at Six Nations find access to ClinicalConnect invaluable when it comes to providing seamless services and informed clinical decision-making for their patients. The worklist feature, for example, improves efficiency in case management, allowing them to track their patients' admissions and discharges, including screening for potential risks during discharge planning. Plus, the new timeline feature provides quick access to what is happening with patients who have frequent hospital visits.

With access to the patient's EHRs, conversations between the case managers and the acute units are more efficient and effective. One of the case managers identified improved collaboration with the Juravinski Cancer Centre, for instance, as both care providers can be viewing the patient's records in ClinicalConnect simultaneously, while developing a comprehensive care plan. She is also able to minimize any risks/gaps in the multi-disciplinary care plan, such as the surgical consult being scheduled before the prerequisite tests are done. By fully understanding the care plan, the case manager can be a guidance resource for her/his patients and their families by confirming that any follow-up appointments have occurred and if not, helping to arrange for them to take place, while also proactively ensuring that unnecessary duplicate testing is avoided.

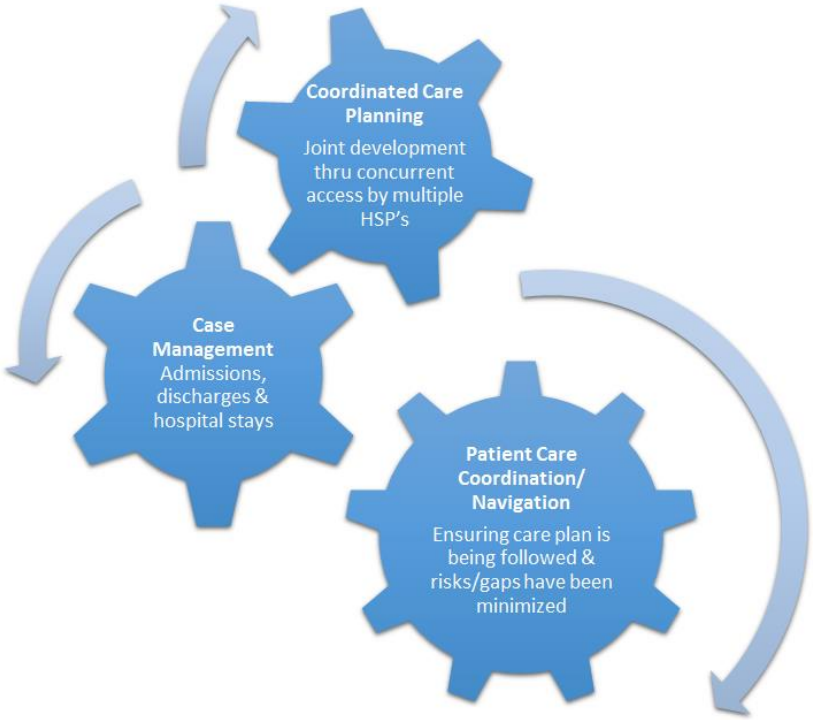

Figure 1: Benefits of Accessing Patient EHRs for Six Nations Home and Community Care

Testimonial

"Current health care human resource challenges and barriers impact availability of the required resources for conversations and updates. ClinicalConnect access helps bridge that gap by supporting care coordination and review of diagnostics and results."

Case Management, Six Nations LTC HCC

Questions

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Sources

[1] Hamilton Niagara Haldimand Brant LHIN. (2018). Indigenous Peoples' Health and Wellness. Retrieved from: http://www.hnhblhin.on.ca/goalsandachievements/integrationpopulationbased/indigenoushealthandwellness.aspx

[2] Six Nations Health Services, Long Term Care/Home and Community Care. (2018). Retrieved from: http://snhs.ca/ltcPhi.htm

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