CONNECTING SOUTH WEST ONTARIO

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 Behavioural Supports Ontario (BSO) Transitional Leaders (TLs) in the Hamilton Niagara Haldimand Brant (HNHB) Local Health Integration Network (LHIN) in developing care plans to aid in the transition of patients with responsive behaviours into long-term care (LTC) homes.

BSO program provides quality care for individuals with complex and responsive behaviours

The BSO program is a $40 million provincial initiative focused on providing quality care for individuals with complex and challenging mental health, dementia or other neurological conditions. Responsive behaviours, which include wandering, aggression, resistance or many other types of behaviours, are in response to a real or perceived stimulus, and may result in risk for the individual and/or others, or provide challenges for caregivers. The behavior may be occurring as a result of an unmet need or desire that can no longer be communicated by the individual - such as pain, confusion with the environment, or other social triggers.[1,2]

One of the services offered by the BSO program is support to seniors in the community transitioning to long-term care. Transitional Leaders, who are regulated health professionals, work in collaboration with the patient, family, and community partners to facilitate a holistic and supportive approach to care for persons presenting as high risk for responsive behaviours on transition to a long term care facility.[2] The TLs help fill a gap for patients in crisis awaiting placement while in the community and help LTC homes better prepare and plan for admission of residents.[3]

The BSO TL's mandate is to:

- Start assessing and planning for transition weeks before admission;
- Collaborate and learn what is working well from providers in community, primary and specialty care, and develop a behavioural plan;
- Facilitate a "best match" for the patient with family, HNHB LHIN and LTC;
- Support day of transition to LTC and for a minimum 6 weeks post-admission; and
- Arrange for intensive support by the BSO LTC Mobile Team as determined in the Transitional Care Plan.

An LTC staff member responding to a survey conducted in 2017 indicated that "The transition from community to LTC home is a sensitive time. Having access to supports that make the move easier and more personal has been a gift."[4]

EHR access supports development of transitional care plans

There are ten FTE (full-time equivalent) TL positions supporting patients within HNHB LHIN: three in Niagara, 3.5 in Hamilton, one in Brant, one in Haldimand Norfolk and 1.5 in Burlington. They access ClinicalConnect to gain a comprehensive understanding of the patient's history including recent and past hospital and geriatrician visits, previous assessments, lab results, DI reports, discharge summaries, transcriptions, and home and community care history, particularly other services involved in the patient's care. They find that the reports and discharge summaries from the BSO Community Outreach Team and COAST are particularly helpful, as are doctors' notes. This information enables them to assess and stabilize the patient prior to placement in the LTC home, as well as develop a collaborative Transitional Care Plan (TCP) that builds on the patient's strength to carry them through the transition and beyond. Figure 1 describes several examples where access to patient EHRs has enabled care planning, diagnosis confirmation and decision making.

Care Planning

Example #1:

- Patient was recently discharged from West 5th, St. Joseph's Healthcare Hamilton where he had been an inpatient for the last 7 years in response to a not criminally responsive charge.
- Referral package didn't provide much detail, however in ClinicalConnect the TL was able to access the diagnosis (acute psychosis), as well as specific incidents, triggers, and interventions that worked.
- Resulted in ability to add this additional information into the assessment, which provided a much more complete picture for use by the LTC home.

Diagnosis Confirmation

Example #2:

- The referral indicated a diagnosis of dementia, however the family did not agree with that diagnosis.
- Access to ClinicalConnect showed that the patient had actually been diagnosed with cognitive issues and not dementia.
- The TL was then able to update the referral/care plan with the correct diagnosis and adjust the plan appropriately.

Decision Making

Other Examples:

- During a care conference, the TL was able to quickly access the information required to answer the doctor's specific questions about the patient's condition/history.
- Access to previous lab results showed a history of renal failure for the patient, which could then be factored into the patient's treatment plan.
- Access to lab results helped TL determine reason for the patient's delirium and arrange for the proper treatment.

Figure 1 - Examples of how access to EHRs viewable through ClinicalConnect has supported the BSO TLs

Testimonial

"In one particular case, the information gleaned from ClinicalConnect was vitally important and impacted staff and client interactions, as well as recommended strategies to assist with the management of the client's behavioural manifestations to be developed and implemented. Access to historical and recent specialist assessments, specialized units documentation and information from involved community care partners, allows me to have a fuller scope of understanding of the medical and social history and partnered community care involvement. Through this, I am better able to fully provide health care support to the client, in my role as a BSO Transitional Lead, and in this case, [ClinicalConnect] was invaluable in facilitating a more successful transition from hospital to Transitional Care Unit to long-term care."

Rosemarie Sears, Behavioural Supports Ontario Transitional Lead – Burlington & Hamilton

Questions

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Sources

[1] HNHB *Goals and Achievements – Behavioural Supports Ontario*. Retrieved from http://www.hnhblhin.on.ca/goalsandachievements/integrationpopulationbased/olderadultstheirfamiliesandcaregivers/supportforfamiliesandcaregivers/BehaviouralSupports.aspx

[2] HNHB *Behavioural Supports Ontario Transitional Lead and PSW*. Retrieved from http://hnhb.behavioursupportsontario.ca/Uploads/ContentDocuments/HNHB%20BSO%20Transitional%20Lead%20job%20posting%201%20Dec%202016.pdf

[3] HNHB LHIN Behavioural Supports Ontario Transitional Lead Program Update (June 2017). Retrieved from http://hnhb.behavioursupportsontario.ca/Uploads/ContentDocuments/BSO%20Transitional%20Lead%20Program_%20HISST%20Meeting%20June%2027%202017.pdf

[4] Behavioural Support Ontario. *Annual Report 2017-18: A Year of Accomplishments.* Retrieved from www.behavioursupportsontario.ca

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