CONNECTING SOUTH WEST ONTARIO

Analysis and Research: Supporting Care Coordinators in assessing risk and determining appropriate services

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 Home and Community Care (HCC) Intake Coordinators with referral intake, triaging and needs/risk assessment by providing them with a more complete picture of their patient's history and health care needs, while also flagging any potential risks in coordinating care.

Providing timely and effective care in the home and community

Funding for home and community care has increased by about $250 million per year since 2013 which has enabled two million more nursing and therapy visits and 12 million more personal support worker hours in the last decade, creating greater access to nursing care, physiotherapy, personal support and caregiver support.[1] The "Hospital at Home" model of care was introduced through Ontario's Action Plan for Seniors in 2013 to move the care into the patient's home. This was expected to promote increased patient satisfaction, reduce treatment complications, increase provider work satisfaction and reduce pressure on the acute sector as a result of fewer patients waiting for hospital admission from Emergency Departments.[2]

The Hamilton Niagara Haldimand Brant (HNHB) Local Health Integration Network (LHIN) coordinates and delivers home and community care/support to people living within the region. LHIN care coordinators work with patients and family caregivers to develop plans designed to meet their care/support needs and health goals.[3] The services offered by this group include therapy services, such as physiotherapy, occupational therapy, and speech-language therapy; as well as nursing services such as wound care, infusion administration, and general nursing.

Accessing EHRs supports assessing patient care needs and identifying any associated risks

The team of intake care coordinators at the Burlington Home and Community Care office use ClinicalConnect in all aspects of their roles – from determining urgency of a referral through to conducting a needs/risk assessment with the patient, and arranging the required services. Referrals, which may come from family doctors, outpatient clinics, hospitals or individuals (self-referral), often have only a couple of words describing the service being requested. Without an understanding of the associated background on the patient's condition or reason for the request, it is difficult to determine urgency. By accessing the patient's EHRs, the intake coordinator is able to "fill in the blanks" in the patient's history and determine potential needs; thereby, being better able to assess the priority that should be placed on the referral.

Once the triage coordinator has received and triaged the request, the assigned care coordinator conducts a phone assessment with the patient in order to confirm the services needed as well as any associated risks. By accessing ClinicalConnect, details can be verified rather than relying solely on the patient's / caregiver's understanding and recollection. Without access to ClinicalConnect, or if the patient's EHRs are not in ClinicalConnect, the care coordinator may be required to do an in-person visit to properly confirm the needs, possibly delaying the patient's access to needed services. Several examples of how ClinicalConnect has provided value both to the patient and to the home and community care providers are highlighted in Figure 1 which has been organized according to the four Health Quality Ontario (HQO) dimensions.

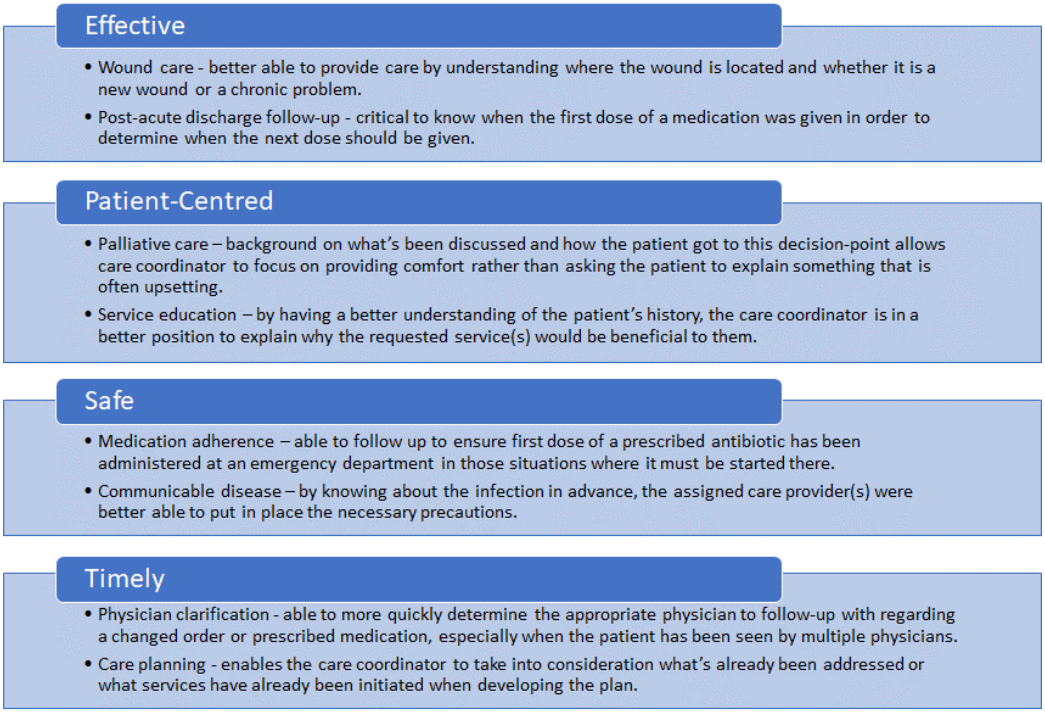

Figure 1: Examples of benefits to being able to access EHRs

Testimonials

"ClinicalConnect has been an instrumental tool for my position in Access at the HNHB LHIN. ClinicalConnect enables me to review the patient's health history and current health status which is helpful when the family and patient are feeling overwhelmed and having difficulty recalling information. It also prevents the patient from having to repeat their story over and over. As the capacities and capabilities of ClinicalConnect continue to grow, I am encouraged by the promise and potential of this platform to continue to provide even more integration between all health care sectors."

Sue Riordon, Care Coordinator, HNHB LHIN Home and Community Care

"I use ClinicalConnect daily, and often multiple times each day, to help to fill in the blanks and round out the picture being obtained for the patient we are trying to arrange services for. Having a complete understanding of the person's health conditions and treatments is essential in helping to plan the most appropriate services to help meet their needs and ensure they get the right services, in the right place at the right time."

Chris White, Care Coordinator, HNHB LHIN Home and Community Care

Questions

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Sources

[1] Ministry of Health and Long-Term Care. (2015). Aging with Confidence: Ontario's Action Plan for Seniors.
[2] Ontario Senior's Secretariat. (2013). Independence, Activity and Good Health. Ontario's Action Plan for Seniors.
[3] Hamilton Niagara Haldimand Brant LHIN. (2018). A Guide to HNHB LHIN Home and Community Care. Retrieved from: http://healthcareathome.ca/hnhb/en/partner/Documents/DOCN_20180321_CONNECTING%20YOU%20WITH%20HOME%20AND%20COMMUNITY%20CARE_PATIENT%20FAMILY%20PAMPHLET_WEB_FINAL.pdf

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