

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

The cSWO Regional Clinical Viewer, ClinicalConnect™ supports Hamilton Niagara Haldimand Brant's (HNHB) Nurse-Led Outreach Team (NLOT) in effectively transitioning long-term care (LTC) residents from hospitals, and enabling the team members to better treat them while in the LTC home, avoiding non-urgent emergency department (ED) visits.

Nurse-Led Outreach Teams help LTC residents avoid hospital visits

“In 2013-2014 it was estimated that more than 1.4 million visits to Canadian emergency departments were potentially avoidable”¹. Of the one in three ED visits by LTC seniors, 24 per cent were for potentially preventable conditions and 10 per cent were for less or non-urgent reasons¹.

Older, more vulnerable patients are at greater risk for medical complications, functional decline and poorer health-related quality of life while in hospital². Therefore, it is important to prevent avoidable ED visits whenever possible to not only provide the best care for LTC residents, but also to ensure the most effective use of limited health care resources³.

One way that the HNHB Local Health Integration Network (LHIN) is improving care for LTC residents is through the support of a NLOT. Since 2008, just over a dozen Nurse-Led Outreach teams have been established in Ontario⁴. Members of these teams travel to LTC homes to provide support in transitioning residents from the hospital back to the LTC home, and managing their medical conditions so that unnecessary ED visits can be avoided³. According to an HNHB LHIN News Bulletin from August 2013, “people living in long-term care homes supported by nurse-led outreach teams visit the emergency department for non-urgent issues 50 per cent less often as they did before the teams were put in place.”⁴

ClinicalConnect usage by Nurse-Led Outreach teams

HNHB LHIN's Nurse-Led Outreach Team, which is currently comprised of eight nurse practitioners, two registered nurses and a clinical educator, have become dependent on having access to ClinicalConnect during and following transitions from the hospital. This access helps reduce the communication gap between the hospital and the LTC home, resulting in more seamless transitions. Being able to review transcriptions, lab results, medications, etc. makes it easier to find the right contact at the hospital, avoid unnecessary duplicate lab tests, and be better informed when communicating with the patient's family.

Furthermore, having access to information about the resident’s patient history, including past hospital stays, enables the NLOT nurse practitioner to provide the necessary treatment within the LTC home, avoiding an unnecessary ED visit.

Since September 2016, the team has been using a locally developed database to track their visits and outcomes and began tracking which visits involved accessing ClinicalConnect in May 2017. Figure 1, which has been revised to reflect updated data provided as of August 2017, shows that over a one year period, 43 per cent of the total number of NLOT LTC home visits were for support where ED transfers were being considered. Of these, 94 per cent were avoided, with only 6 per cent resulting in ED transfers. Figure 2 highlights how accessing ClinicalConnect has contributed to these positive results based on four months of data.

Testimonial

“ClinicalConnect has been instrumental to my clinical practice and I could not imagine functioning effectively as a care provider without it now. For new admissions to LTC, having access to ClinicalConnect has enabled me to help LTC homes provide more seamless transitions in care by helping to fill in information gaps. Having access to transcriptions and test results has provided our team with a viable solution to information access and communication issues between sectors that have been problematic for years. 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 benefit to our most vulnerable seniors by ensuring that their care providers remain on the same page.

Jennifer Burgess, Nurse Practitioner, Nurse-Led Outreach Team, Shalom Village Nursing Home

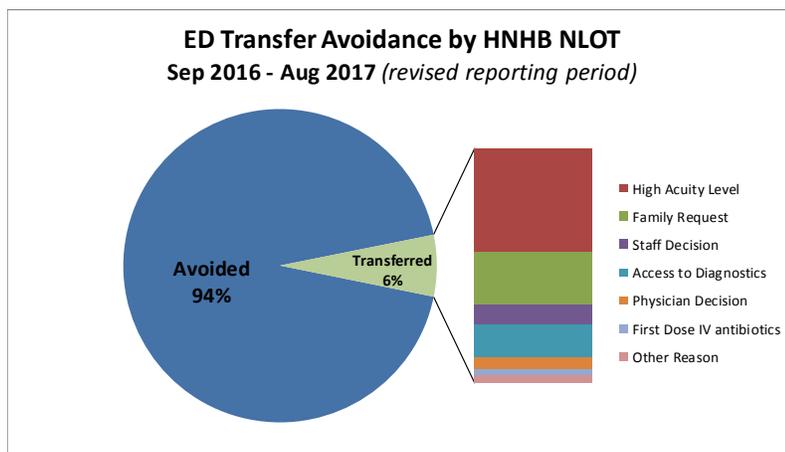


Figure 1- Chart depicting the percentage, over a one year period, of NLOT visits for potential ED visits where they were able to avoid ED transfers.

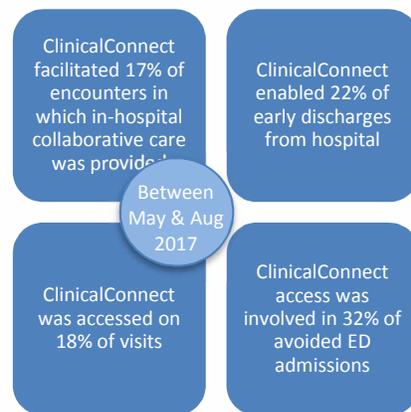


Figure 2- Results of the data tracked by the NLOT members on visits involving ClinicalConnect access between May and August 2017.

Questions

Authored by Wanda Hemsworth, Benefits Realization Lead, and Beth Murray, Benefits Realization Analyst, cSWO Change Management and Adoption Delivery Partner, HITS eHealth Office at Hamilton Health Sciences. For questions, comments, or to participate in cSWO’s Analysis and Research program, please contact: cSWOresearch@lhsc.on.ca.

Sources

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