CONNECTING SOUTH WEST ONTARIO

Analysis and Research:

Enabling virtual clinical assessments by Central Intake Coordinators

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™, enables the Behavioural Supports Ontario (BSO) and Specialized Geriatric Services (SGS) Central Clinical Intake Coordinators in the Hamilton Niagara Haldimand Brant (HNHB) Local Health Integration Network (LHIN) to complete virtual clinical assessments on incoming referrals in order to connect patients and caregivers to the most appropriate service provider.

Coordinated Clinical Intake supports timely and equitable access to specialized geriatric services

Specialized Geriatric Services are commonly defined as comprehensive, coordinated hospital and community-based geriatric medicine, geriatric psychiatry (including mental health and behavioural support services) and specific primary care services (i.e., Primary Care Memory Clinics, Care of the Elderly Primary Care Physicians). They include health services focused on the provision of care to elderly people with complex physical, physiological, cognitive, mental and social health concerns by expert health professionals, which can significantly contribute to an elderly person's ability to remain in their home[1,2].

The estimated population living with frailty* in Canada in 2019, is over half a million which represents approximately 25 per cent of the total population over the age of 65[1]. Finding ways to provide services to this growing population is a priority for HNHB LHIN and the Regional Geriatric Programs (RGPs) of Ontario. A working group, consisting of representatives from Alzheimer Society of Brant, Haldimand Norfolk (HN), Hamilton Halton; BSO Community and Strategic Teams; Community Addiction and Mental Health Services (CAMHS) of HN; Hamilton Health Sciences (HHS); LHIN Home and Community Care (BSO Connect); Niagara Health; and St. Joseph's Healthcare Hamilton (SJHH), was formed in 2017-18 to develop a shared understanding of the current state within the LHIN and identify future opportunities for improving these services. The group found that:

- Wait times for these services were varied (and at times lengthy);
- There were multiple access points; and
- Patients and families reported that they had to repeat their stories multiple time to various care providers[3].

As a result of the working group findings and recommendations, a Central Clinical Intake (CCI) service was developed and implemented in the HNHB LHIN for community-based BSO and SGS, including geriatric medicine and geriatric mental health. This region-wide service, which is being managed by the Regional Geriatric Program Central (RGPc) at HHS, is expected to benefit the health care continuum by reducing and balancing the wait-times between specialists, coordinating services, reducing administrative inefficiencies, reducing duplicate referrals, and improving the patient experience by being more responsive and providing options to ensure that patients are connected with the most appropriate services.

Access to patient EHRs supports completion of comprehensive virtual clinical assessments

The newly formed SGS CCI team for HNHB LHIN is currently composed of two clinical intake coordinators, an administrative coordinator and a team lead, and is based at St. Peter's Hospital in Hamilton. Stacey Baird and Jena Tassone, the two intake coordinators, are responsible for conducting a virtual clinical assessment (modelled after the Comprehensive Geriatric Assessment framework[4]) for each referral received to determine the most appropriate service provider and highlight risks to support them in prioritizing patient care needs. The assessment involves reviewing and summarizing the patient's history, including past diagnoses, hospital and outpatient visits, and diagnostic test results. It is enabling them to realize many of the expected benefits, such as:

- Identifying potentially duplicate or unnecessary referrals, which in turn avoids unnecessary assessments that are potentially stressful for the patients and caregivers.
- Ensuring continuity of care for patients who had previously been seen by a specific geriatrician or geriatric psychiatrist and building opportunities for collaboration amongst service providers.
- Highlighting risks to support prioritizing patient care needs and informing when appointments are booked.
- Providing the assigned service provider with a comprehensive understanding of the patient's history allowing them to be better prepared when meeting with the patient and caregiver, improving the patient experience[5].

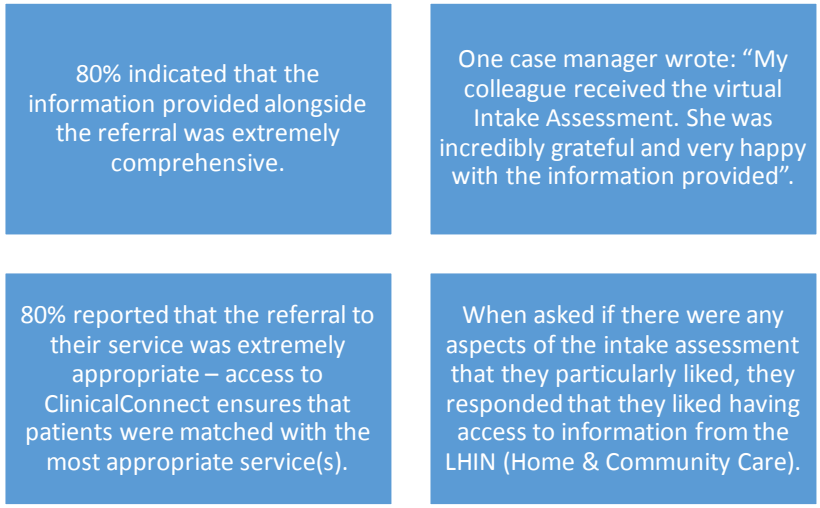
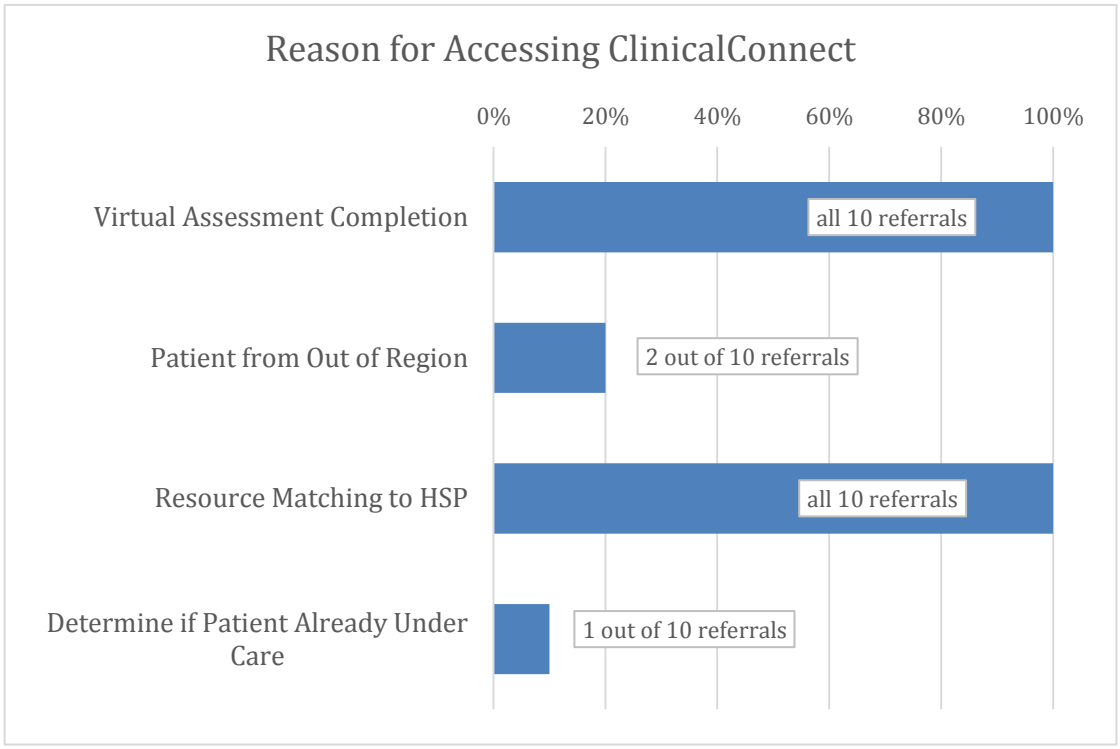


Figure 1: Results of a survey conducted by the intake team on the value of the virtual clinical assessments as seen by the service providers

For every intake assessment completed, the following ClinicalConnect modules are accessed: Visits, Transcription, Health Records, Home/Community Care, Labs, Radiology, and Pharmacy (Home Meds). With the exception of scanned documents such as allied health notes, outpatient consult notes, and community clinic notes which had to be obtained from SJHH's Dovetale system or primary care providers, the majority of the required information could be found in ClinicalConnect.

> "Central Intake relies heavily on ClinicalConnect to be able to do our daily jobs. Without the information that ClinicalConnect provides access to, there would be no assessment."
> - Jena, Clinical Intake Coordinator, BSO/SGS CCI

Over the past month, the team has been tracking the reasons and benefits associated with accessing ClinicalConnect. The following charts and examples/feedback from the intake coordinators highlight their findings:



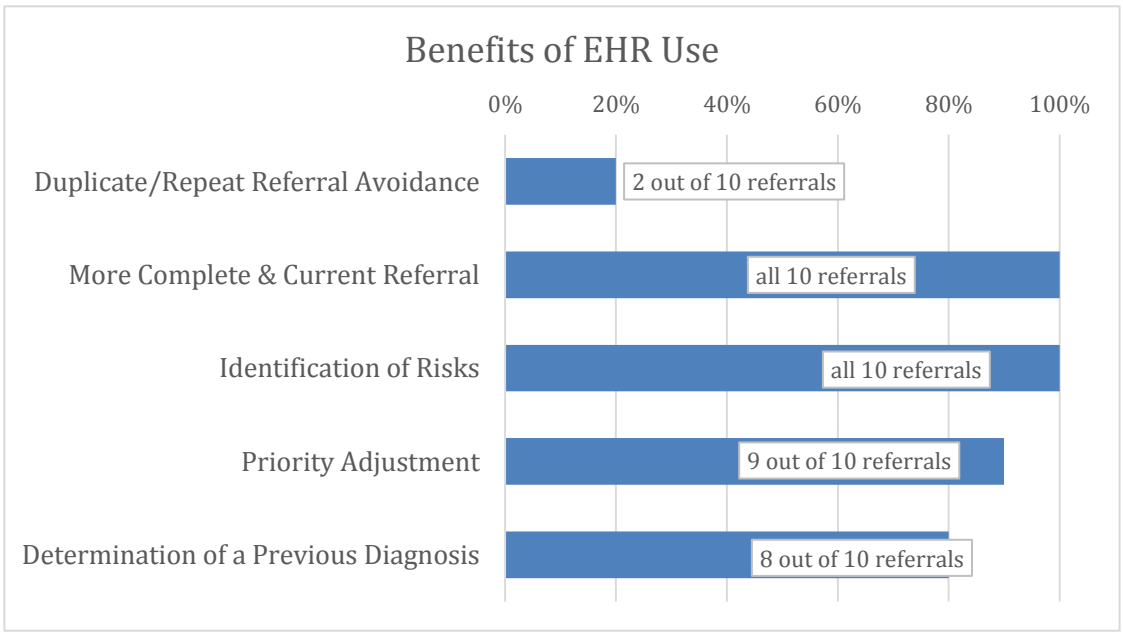


Figure 2: Charts summarizing the reasons for accessing ClinicalConnect and the associated benefits based on tracking of referrals for a month during the start-up of SGS Central Intake

Visit History showed hospital utilization outside of the Hamilton region (e.g. Brantford General), which otherwise would not have been known

Discharge Summary and Consult Notes available from Toronto area hospitals providing more complete medical history

No prior involvement with Home and Community Care was found so was suggested to the referring physician that the patient would benefit from a referral for HCC services

Recent CT Scan available which was not available at the time of the referral (i.e. just ordered)

LHIN Home and Community Care notes outlining responsive behaviours, therefore referral to BSO completed

Diagnostics (i.e. Head CT and ECG) only located in ClinicalConnect

Figure 2: Examples and further clarification on the referrals tracked over the past month

"Labs are very recent – even if the patient lives out of town/LHIN or has not visited HHS, we can access the information."
- Jena, Clinical Intake Coordinator, BSO/SGS CCI

"Pharmacy information very recent – uploaded from the patient's community pharmacy. Gives an idea of what the patient has been prescribed by their Primary Care Physician, if they are renewing their prescriptions or if the pharmacist has concerns about interactions."
- Jena, Clinical Intake Coordinator, BSO/SGS CCI

Figure 3: Other feedback from the Intake Coordinators on their use of ClinicalConnect

Questions

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Definition *

Frailty - "Individuals are defined as frail in this algorithm if they are a resident in a long- term care facility (identified using ODB prescription indicators for LTC in the current study); if they were receiving palliative care services11; or if they had two or more of the seven following conditions: cognitive impairment, incontinence, falls, nutritional difficulties, functional difficulties, targeted health service utilization, or functional difficulties"

Sources

[1] Kay, Kelly. (2019). Planning for Health Services for Older Adults Living with Frailty: Asset Mapping of Specialized Geriatric Services (SGS) in Ontario. Retrieved from https://www.rgps.on.ca/resources/planning-for-older-adults-living-with-frailty-sgs-asset-mapping-report/.

[2] McAiney, Carrie A. (2008). Priorities for Specialized Geriatric Services in the Hamilton Niagara Haldiman Brant Local Health Integration Network – Brief Report. Retrieved from SGS Priorities for the HNHB LHIN. Retrieved from http://www.hnhblhin.on.ca/Resources/ReferenceDocuments.aspx.

[3] RGP Central Annual Report. (2017-2018). Retrieved from https://rgpc.ca/annual-reports/.

[4] Comprehensive Geriatric Assessment Framework. (2018). Retrieved from https://www.rgps.on.ca/initiatives/cga/.

[5] RGPc Central Clinical Intake Overview. (2019). Retrieved from https://rgpc.ca/centralintake/

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Published: September 24, 2019

Funded by eHealth Ontario