Moving the Yardstick Toward a 'Patients First' Culture

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ClinicalConnect™ | CONNECTING SOUTH WEST ONTARIO
Hamilton Health Sciences
Funded by eHealth Ontario
Ontario eHealth Ontario

Learning Objectives

- ClinicalConnect is a secure, web-based portal that enables collaboration between acute and primary/community care providers through electronic information sharing.
- Learning objectives:

Depth/breath of regional EHR	Cross-continuum info sharing	Transformation of patient care
• Understand what data is aggregated from various healthcare organizations/ repositories in Ontario, and available for viewing by ~41,000 health service providers (HSPs) in South West Ontario	• Understand how accessing ClinicalConnect on desktop/mobile devices is allowing HSPs to deliver healthcare to patients in their preferred location, their home	• Understand how patients are benefitting from their health records being accessible to their health service providers, regardless of where they are or what stage they are at in their care

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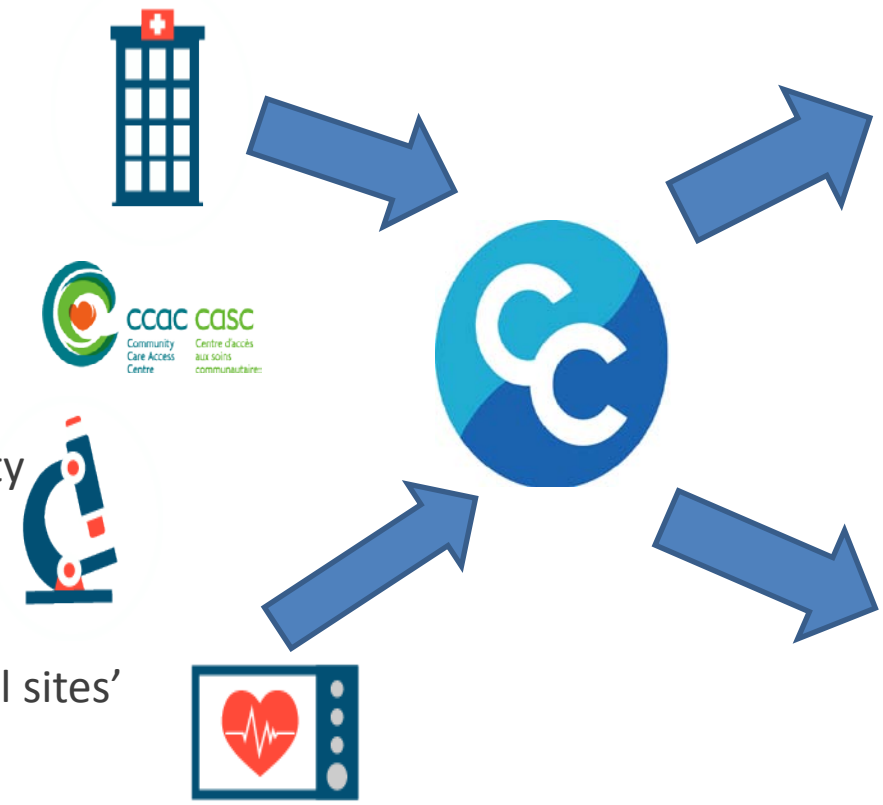
Data-Contributing Organizations

67 acute care hospitals

4 CCACs

Community Lab Reports

58 hospital sites' diagnostic images



HSPs Viewing Their Patients' Data

Hospital-based physicians and clinicians

CCAC care coordinators/nurses

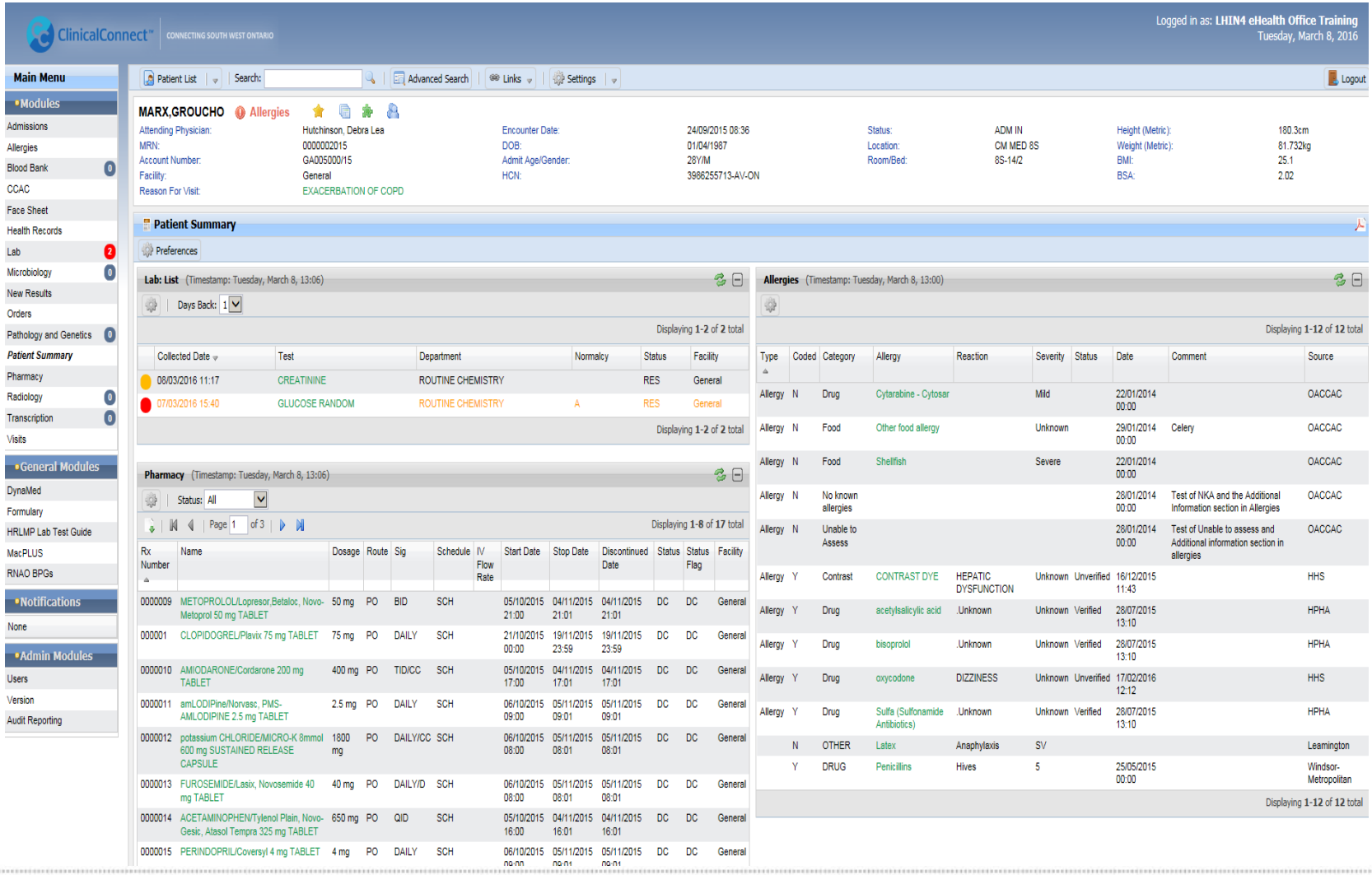
Regulated health service providers from:

- Long term care homes
- Public Health Units
- Mental Health & Addiction organizations
- Community Support Service Agencies
- Community/Solo Practices

About ClinicalConnect

- ClinicalConnect is the Regional Clinical Viewer for the connecting South West Ontario (cSWO) Program, funded by eHealth Ontario
- Hamilton Health Sciences is the solution provider deploying ClinicalConnect across the four South West Local Health Integration Networks
- The cSWO Program is foundational to eHealth Ontario's commitment to integrate electronic health information for all Ontarians
- ClinicalConnect is recognized by eHealth Ontario as a provincial strategic asset

What ClinicalConnect Looks Like



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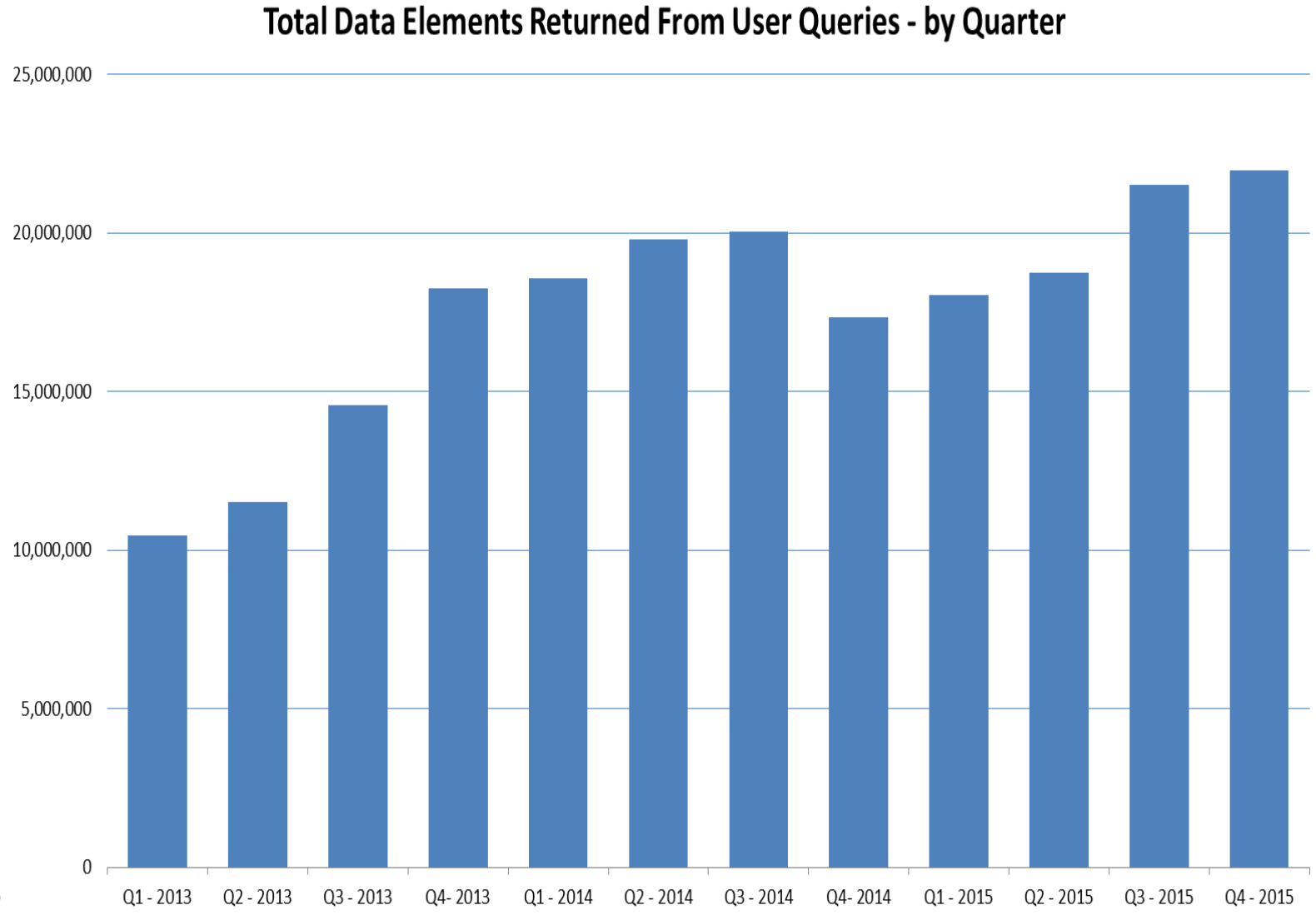
By The Numbers



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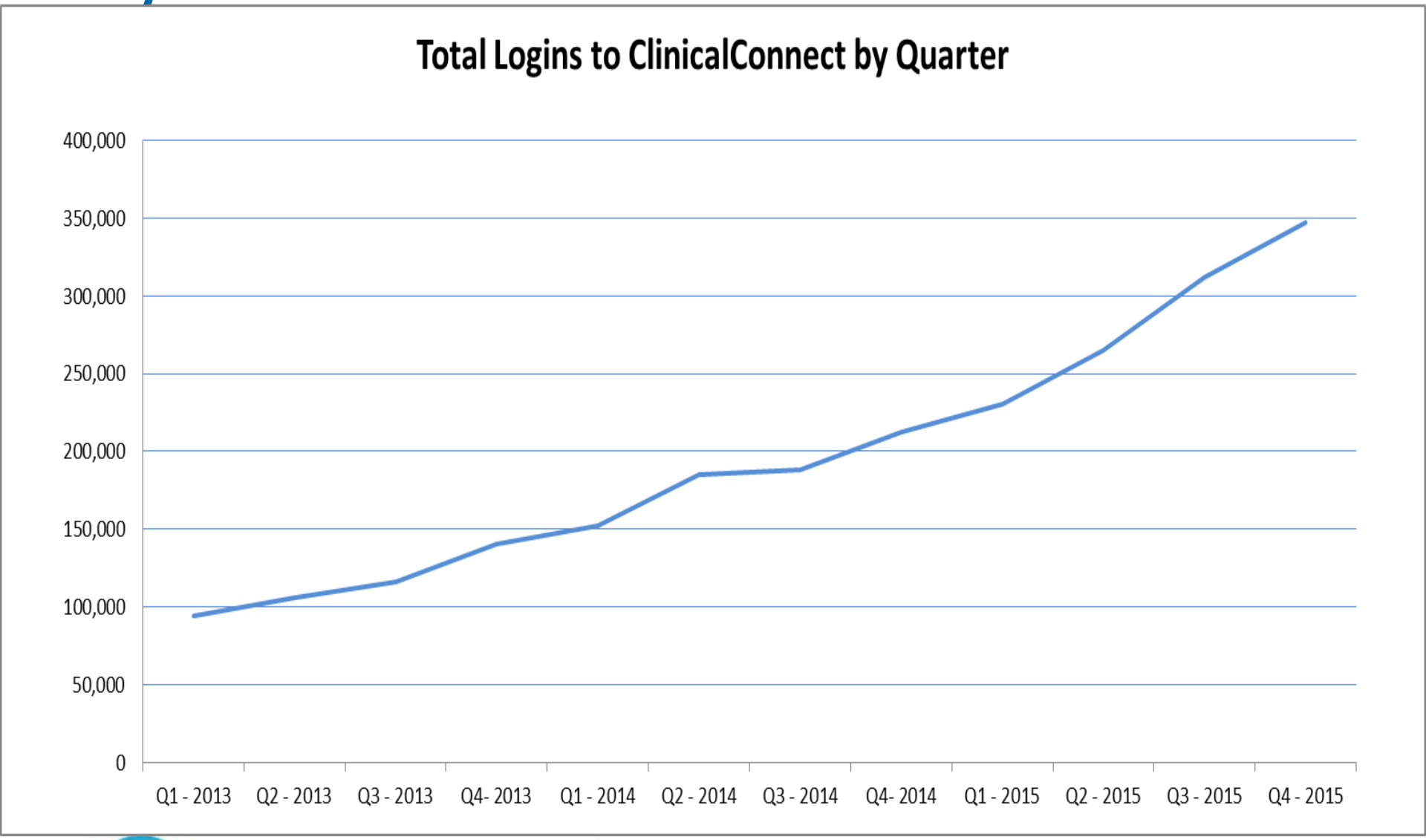

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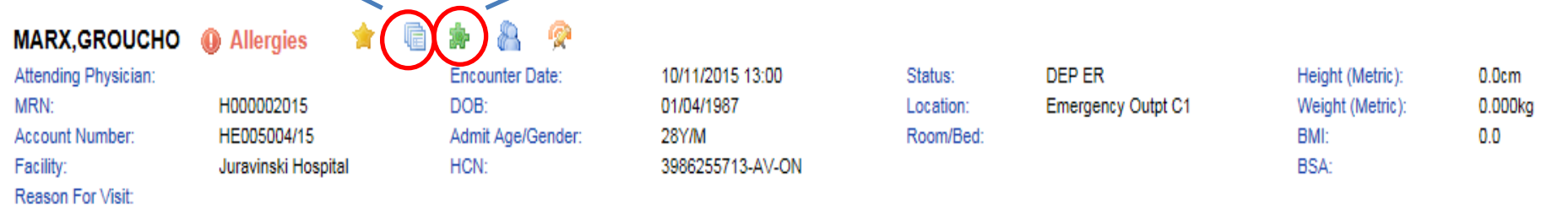
Cross-Continuum Information Sharing

- Flagging – helping providers quickly identify high users of healthcare system and enable better coordination of care
  - Frequent ED Visits flag: identifies patients with five or more visits to EDs at acute care facilities in southwest Ontario in the last 366 days
  - Health Links flag: identifies patients who have a Coordinated Care Plan initiated by a Health Link in the HNHB LHIN

Frequent ED Visits flag **Health Links flag**



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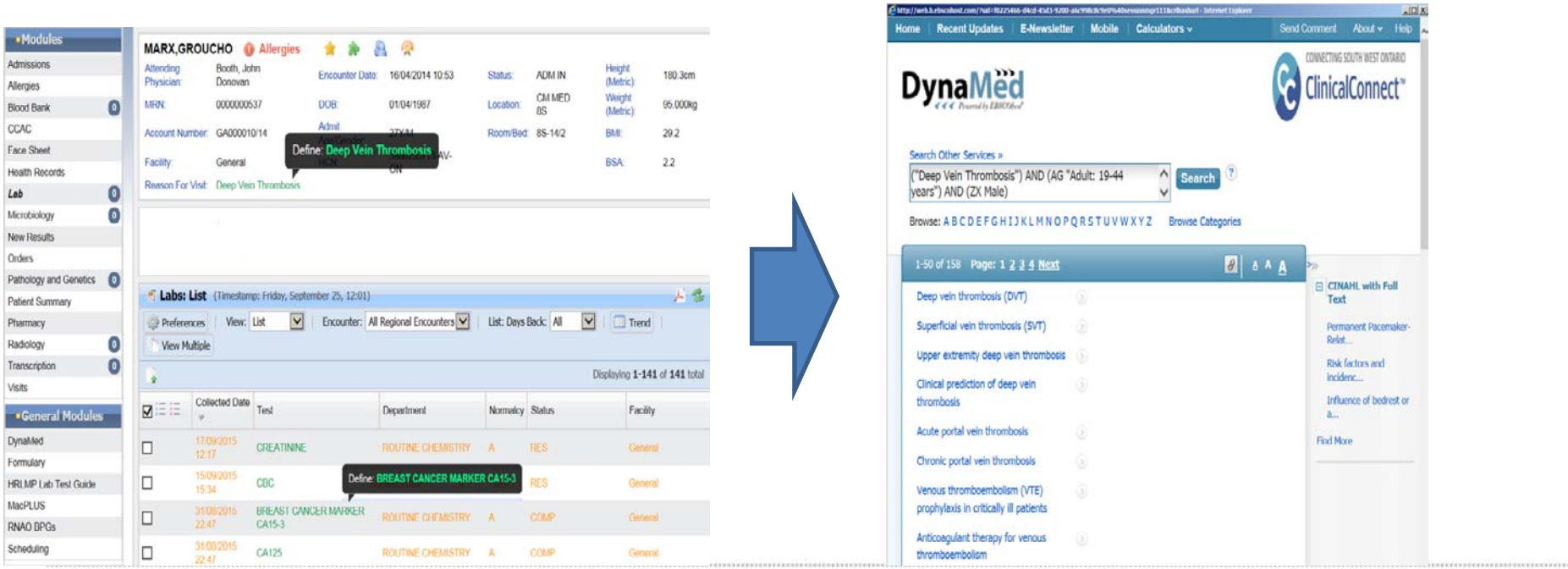
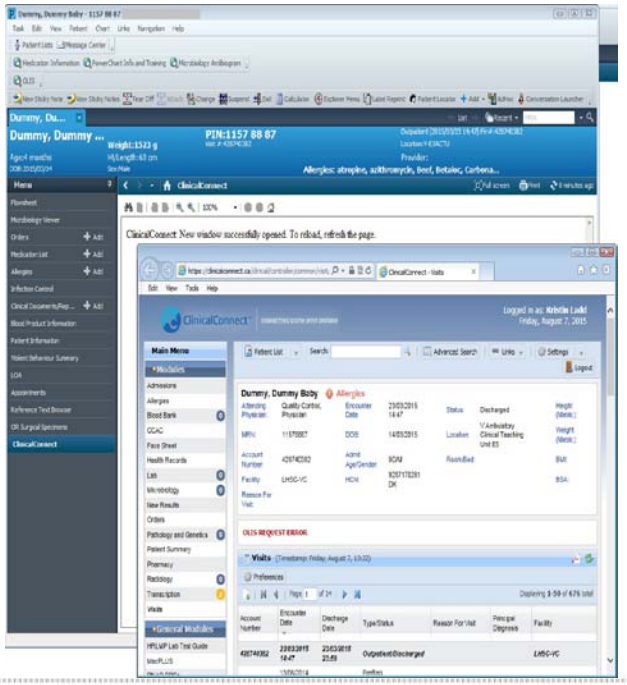
Cross-Continuum Information Sharing

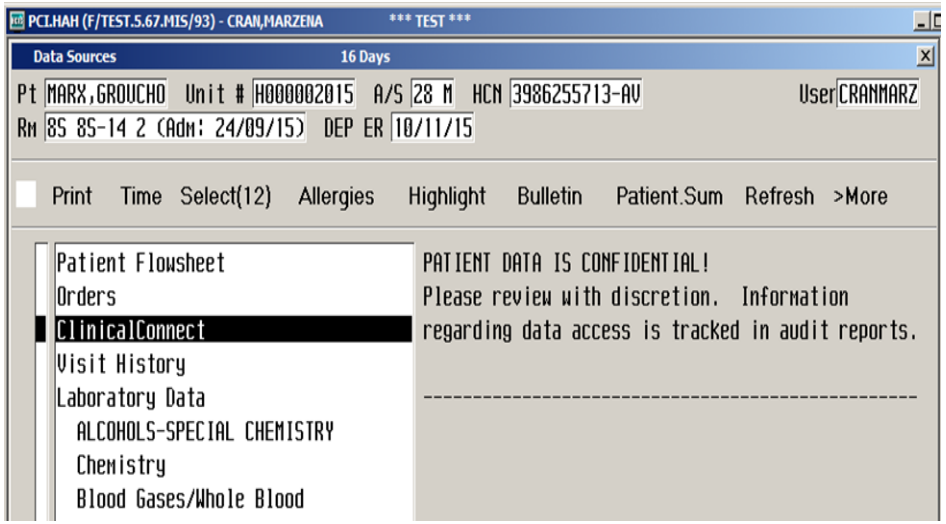
- DynaMed® – offering providers evidence-based, contextually-relevant clinical information about their patients' condition and prescribed medications



Cross-Continuum Information Sharing

- Contextual launch – offering providers the ability to launch additional records from source systems, outside of what's in their own information system, but from within their information system.





Cross-Continuum Information Sharing

- In addition to hospitals already in place, ClinicalConnect will soon launch directly from:
  - Client Health & Related Information System (CHRIS) – used by CCACs to input their clients' health information
  - eSHIFT – The Palliative Care eSHIFT (eSHIFT) program is a model of care that allows Personal Support Workers to be connected virtually to RNs through Smartphone technology to provide palliative clients with end of life care. Work underway to launch ClinicalConnect from eSHIFT.

Supporting Community-Based Physicians & Clinicians

- In the Province of Ontario:
  - There are 14 CCACs
  - Care provided is funded by the Government of Ontario through Local Health Integration Networks (LHINs)
  - Governed by provincial legislation and regulations
    - Sets parameters regarding eligibility criteria, service provision, etc., and requires the organization to operate within a balanced budget
  - Patient care plans may include community supports and services (adult day programs, assisted living programs, meal programs, volunteer visiting, etc.), which vary by community

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Connecting Individuals with Care in Their Community

- The HNHB CCAC helps people:
  - access home and community care resources (navigation)
  - remain at home
  - avoid hospital admission
  - access support upon discharge from hospital
  - receive information about care options including long-term care
- Last year, HNHB CCAC provided care to more than 82,000 individuals across the region
  - Individuals served vary in age and complexity of need
- Last year, HNHB served half of all seniors in the region aged 85+
- CCACs support secure information sharing with their partners using Health Partner Gateway (HPG)

CCACs: What We Do

- Provide **information and referral** to community health supports and services
- Help people remain at home, or return there more quickly from a hospital stay by providing **in-home health and personal support care**
- Provide **school health and support services**
- Provide **patient / system navigation** to a range of community and post-acute hospital programs
- Manage the **application and admissions process to long-term care homes**

Putting Patients First

CCACs Help Patients Access, Integrate and Coordinate Health Care

PRIMARY CARE

COMMUNITY SUPPORT AGENCIES

PATIENTS

CAREGIVERS

OTHER SUPPORTS (FAITH GROUPS, COMMUNITY SERVICES)

HOSPITALS/LONG-TERM CARE HOMES

LINK TO COMMUNITY SERVICES

SERVICE PROVIDER AGENCIES INCLUDING: NURSING, PERSONAL CARE, THERAPY, MEDICAL SUPPLIES, MEDICAL EQUIPMENT

CCAC CARE COORDINATION

TRANSITIONS TO LONG-TERM CARE

CCAC CARE COORDINATION & SYSTEM NAVIGATION

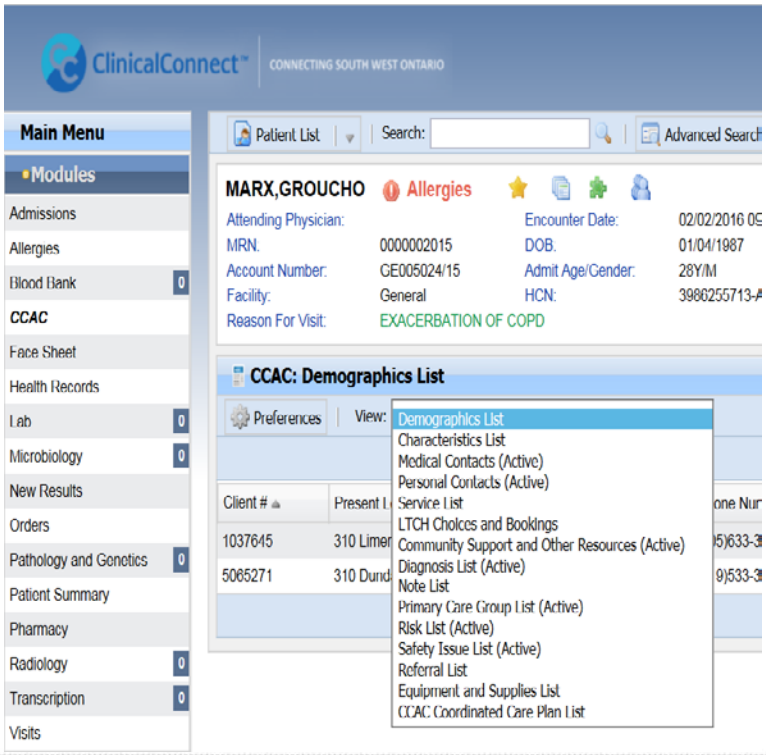
Homecare Providers View Acute/Provincial Repository Data

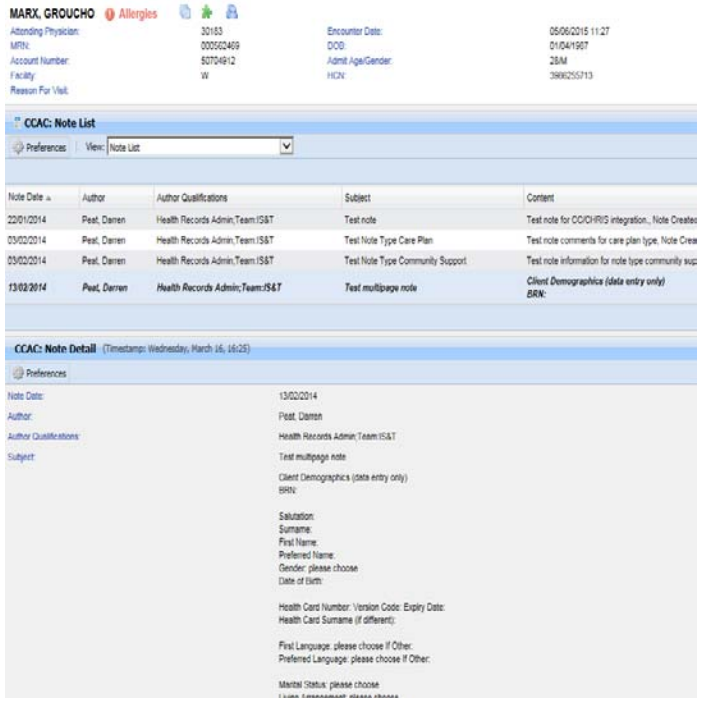
Modules	
Admissions	
Allergies	
Blood Bank	0
CCAC	
Face Sheet	
Health Records	
Lab	2
Microbiology	0
New Results	
Orders	
Pathology and Genetics	0
Patient Summary	
Pharmacy	
Radiology	0
Transcription	0
Visits	

Homecare Providers View Acute/Provincial Repository Data

Homecare Data Shared with Acute & Community Providers

- CCACs' client information available from CHRIS in ClinicalConnect, and a sample Client Note





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Putting Patients First

- How do patients benefit from electronic sharing of their information between their care providers? Through:
  - **Consistent support** from home to hospital, and back to home
  - **Complete advanced care planning**, including identifying early on palliative patients' wishes so all providers (acute or community) can act accordingly
  - **Sharing of complex care plans** amongst entire team provides continuity of care across the continuum
  - **Unnecessary duplicate testing and assessments** because results from previous tests are available electronically to patient's care team
  - **Two-way & collaborative communication**: change from hospital feeding data to community with community now feeding data to hospitals

ClinicalConnect™
Connect to your Patients

New From CHRIS:

Messaging between providers

Advanced care plans

Nursing notes, wound care, medication review

Physio/Occupational therapy

Dietician assessments

Mental health strategies

Care plans: transition, ED avoidance, palliative wishes, recent changes to care plan

In home supports: “eClinic, eSHIFT”

To Benefit:

Hospital-based physicians and clinicians

CCAC care coordinators/nurses

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New Standard of Care

- To truly build ‘patients first’ culture, we must:
  - Use ClinicalConnect before seeing any patient; **know their story** before arriving home visit
  - **Expand use of mobile devices** for community providers ‘on the go’
  - Use ClinicalConnect to **identify patients who are admitted to ER**, with view to fast-track their safe return back home
  - Ensure patient’s advanced care planning wishes/palliative measures are met – **unlock more information from CHRIS** so patient’s care providers in other healthcare settings have access

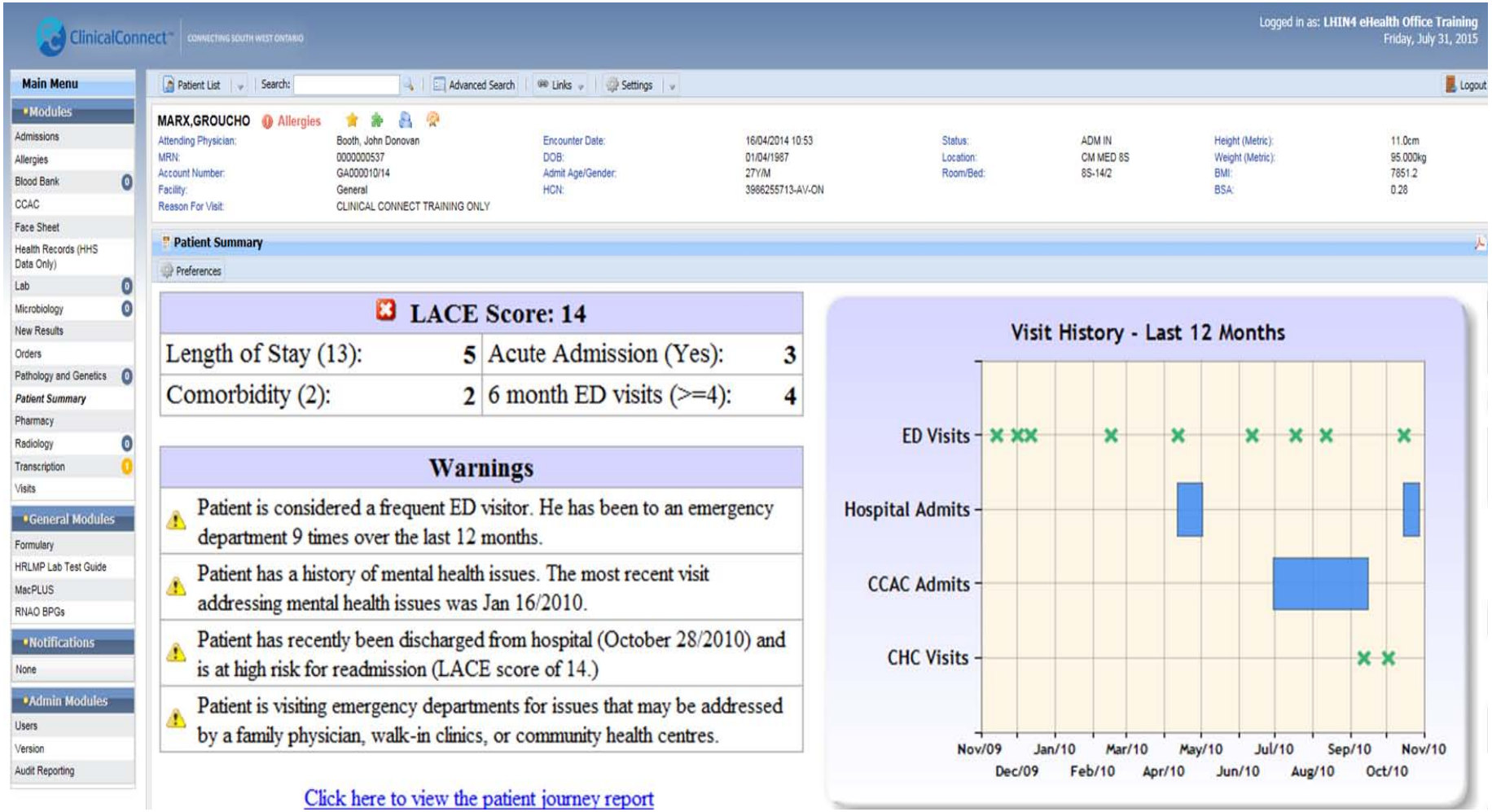
Future State of ClinicalConnect

- Secure messaging
  - Incorporate CONNECT's Provider to Provider messaging
- eReferrals
  - **Leverage ClinicalConnect, users at acute care facilities will be able to send referrals** electronically to CCACs; HNHB CCAC is pilot site. More advanced eReferral / Central Intake approaches to follow.
- eNotification
  - **Leverage ClinicalConnect to notify** CCACs and Primary Care Providers that their patient has had an ED or in-outpatient regional hospital encounter.

Future State of ClinicalConnect

- Primary care data integration
  - Make data from physicians' EMRs available in ClinicalConnect
- Expand use of data from Integrated Decision Support (IDS)
  - Integrate clinical groupings being developed through IDS with **ClinicalConnect to support population health** and better care for high user cohorts
  - Leverage decision support data and business intelligence tools to better support front line care

Patient LACE Score in Regional EHR



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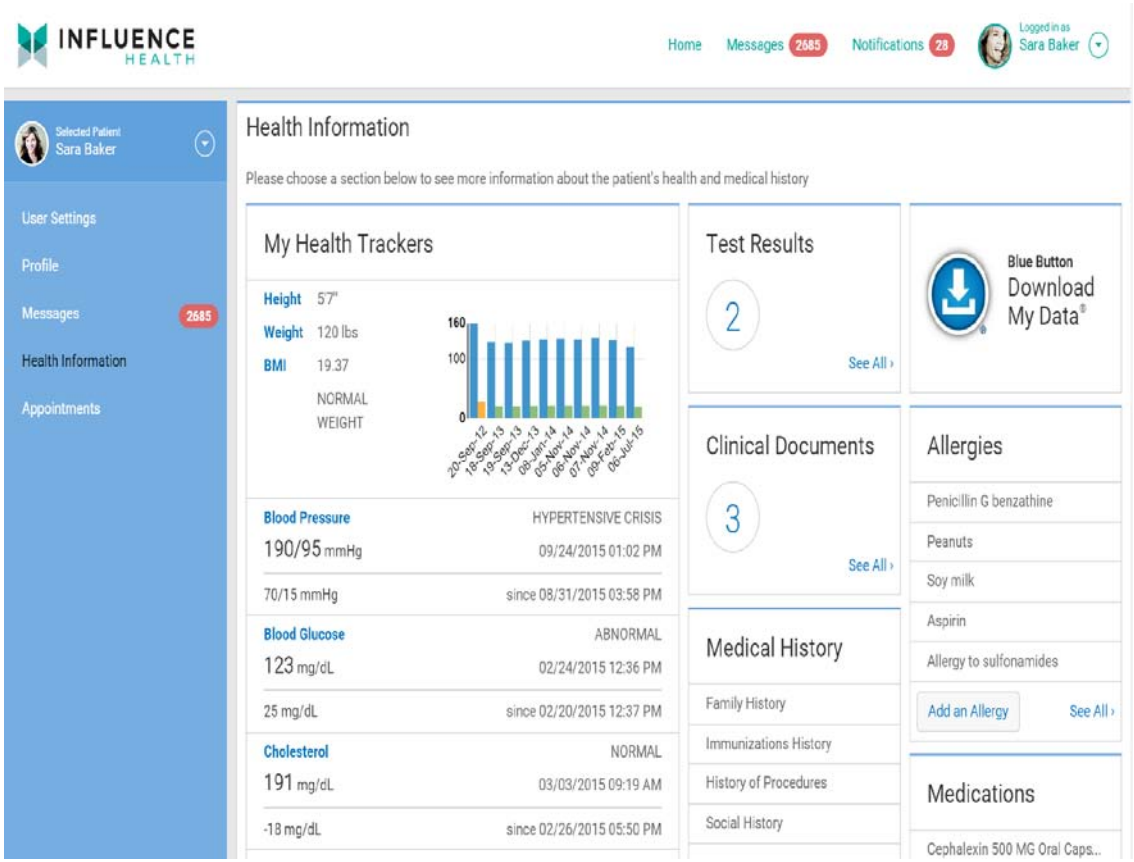
Patient Portal

- **Work underway to leverage existing integration to support a patient portal,** where patients have access to their health data, can manage appointments, have secure bi-directional messaging with providers, access educational information etc.



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Questions?

Thank You

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