CONNECTING SOUTH WEST ONTARIO

Benefits Realization: Improving community care through HealthLinks and community paramedicine

Benefits evaluation 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 an electronic health record (EHR). 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) ultimately, patients benefit from higher quality, better informed clinical decision-making.

The cSWO Benefits Realization program uses a research-based approach to identify areas of clinical best practice that are affected by the use of the EHR, and works collaboratively with clinicians to understand the value of the EHR. This formative evaluation process informs change management and adoption, and enables clinicians to use the EHR more effectively. This research does not include the use of any personal health information.

The document is one in a series of case studies which describe the clinical value of the EHR in different clinical settings and contexts, particularly with respect to clinical best practices. The work of the cSWO Benefits Realization program is ongoing; in some cases, these cases raise questions for further investigation, and clinicians are invited to participate in benefits evaluation to continue to develop these answers.

Value statement

Using the cSWO Regional Clinical Viewer, ClinicalConnect™, clinicians can provide more integrated, more proactive community care to historical high users of acute care services by accessing clinical data from a variety of sources in one portal. This ultimately improves patient care by facilitating a timely and efficient care intervention.

Information builds a better circle of care, and better home care from community paramedics

Several strategic investments have been made in Ontario over recent years with the goal of providing the care that residents need in their home, rather than in hospital Emergency Departments. In October 2014, the Ministry of Health and Long-Term Care announced an investment in community paramedicine programs to integrate with HealthLinks to:

- Provide home visits to seniors and high-needs patients, to help them with a range of services such as ensuring they are taking medication as prescribed.
- Increase assessment and referrals to local services in the community like Community Care Access Centres (CCACs) for follow-up care.
- Educate patients on managing their chronic diseases.

This added community-based resource is supported by preliminary research that has suggested paramedics “are capable of learning and applying additional medical competencies” and that research of community paramedicine is required to better understand the potential benefits and risks for health systems and patients alike (Bigham, et al., 2013).

EHR usage by a community organization, which is a lead for a HealthLink

ClinicalConnect provides real-time access to information from 100 per cent of the acute care hospital sites across south west Ontario, information from the CCACs, and from community laboratories via the Ontario laboratories information system (OLIS).A case manager at a community health centre (CHC), which is also a lead for a HealthLink, uses ClinicalConnect to support the care provided to their patients. A HealthLinks team in the Hamilton Niagara Haldimand Brant LHIN, led by the Centre de Santé Communautaire (CHC) retrieves detailed information from multiple organizations to inform how community paramedicine professionals can provide care for the HealthLink patients, creating the strengthened circle of care those patients need.

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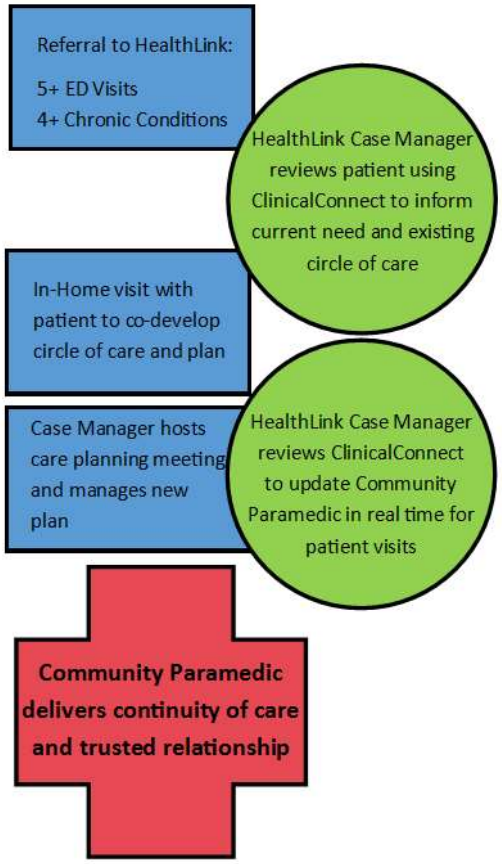
Improving continuity of care with informed, in-home care for high-users of the health system



This figure shows how the case manager's use of ClinicalConnect helps provide better care to patients in the HealthLink.

The HealthLinks case manager reviews the patient's health records from multiple care settings. The case manager works with the patient to co-develop a care plan that includes components of the circle of care that may have been missing historically.

Primary care clinicians are included in the care plan meeting to ensure continuity. Seventy-five per cent of primary care clinicians included in meetings practice in solo practices, so this HealthLinks case management and community paramedicine partnership offers well-informed, inter-professional community support to proactively manage chronic conditions.

Avoiding unnecessary hospital use

For HealthLink patients with care plans developed by the Centre de Santé Communautaire:

In 6 months prior to being treated by the HealthLink:	187 ED visits
In 6 months since having a plan:	91 ED visits (↓51.3%)
Admissions to hospital for the year prior to joining the HealthLink:	115 admits
Admissions YTD	23 admits
(avg tenure of HealthLinks support is 141 days)	
Projected Annualized Admits	59.5 admits (↓ 48.3%)

Testimonial

"ClinicalConnect allows us to expeditiously target, assess, and respond to patients who have the greatest health care needs in our society, thus allowing for timely and efficient access to care."

Anik Lambert-Bélanger, Case Manager

Questions

For questions, comments, or to participate in cSWO Program's Benefits Realization program, please contact:
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Sources

Bigham, B. L., Kennedy, S. M., Drennan, I., & Morrison, L. J. (2013). Expanding paramedic scope of practice in the community: a systematic review of the literature. Prehosp Emerg Care, 17(3), 361-372. doi:10.3109/10903127.2013.792890

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