CONNECTING SOUTH WEST ONTARIO

Benefits Realization: Improving hospital readmission outcomes with better post-discharge visits

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™ in primary care can enhance the quality of seven-day post-discharge follow up visits and reduce hospital readmissions caused by medication conflicts.

Clinical best practice for primary care follow up

Certain chronic conditions (stroke, chronic obstructive pulmonary disorder, pneumonia, congestive heart failure, diabetes, cardiac conditions, gastrointestinal disorders) are measured in indicators because of their association with readmission to hospital (Grunier et al., 2011). In these cases, follow up by a primary care practitioner within seven days of discharge from hospital is recommended practice; however, the quality of these seven-day follow up visits can vary based on the hospital information available to the primary care practitioner.

Accreditation Canada, the Canadian Institute for Health Information, the Canadian Patient Safety Institute, and the Institute for Safe Medication Practices in Canada have conducted research which reports that two-thirds of readmissions for chronic conditions are caused by medication conflicts (Accreditation Canada et al., 2012). However, if the appropriate medication information from the hospital is available to the primary care practitioner, they can change the post-discharge visit from an attempt to gather information from the patient, to an opportunity to make an informed assessment and adjust patient care or medication based on facts from the hospital.

EHR usage for seven-day follow ups

Work to improve quality of care is taking place inside primary care organizations, and that work relies on a greater and more efficient sharing of information between hospital and primary care providers. ClinicalConnect facilitates this sharing. The New Vision Family Health Team, located in Kitchener, Ontario, is leveraging ClinicalConnect to improve the quality of the seven day post-discharge follow up meeting.

First, ClinicalConnect enables the Family Health Team's authorized users to view records of their patients who have been discharged from the hospital to book more post-discharge visits within the recommended seven day window. Second, a clinical pharmacist uses ClinicalConnect to gather information about what medications were ordered for the patient during the hospital stay. This enables the primary care provider to focus on medication information during the patient's post-discharge visit to proactively avoid adverse drug reactions.

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Identifying the value of the EHR in seven-day follow ups

ClinicalConnect enables proactive Primary Care organizations, like the New Vision Family Health Team, to pursue quality improvement projects (described on page one) that will improve the quality of seven-day follow-up meetings and readmission rates for their patients. Figure 1 shows the process being used to deliver more proactive medication reconciliation and patient follow up in primary care.

Testimonial

"I am able to use ClinicalConnect to learn about the patient's hospital stay prior to their visit with the physician, which allows much more effective use of time during the visit. You couldn't do this before because you didn't get reports in time."

Bridget Braceland, Pharmacist, New Vision Family Health Team

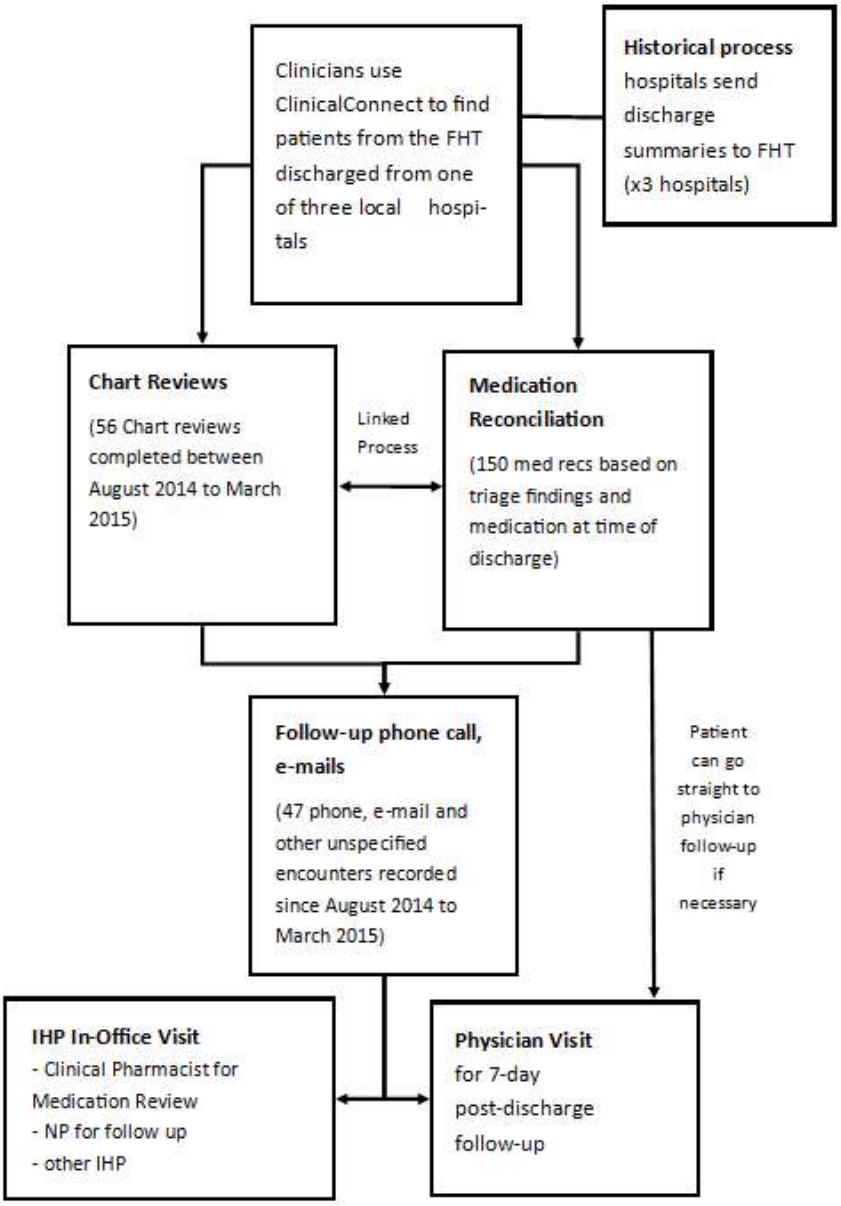

Figure 1 – Family Health Team process for integrating care post-discharge, New Vision Family Health Team

For questions, comments, or to participate in the cSWO Program's Benefits Realization program, please contact: Ted Alexander, Manager, Benefits Realization, cSWO Program: ted.alexander@lhsc.on.ca

Sources

Grunier, A., Dhalla, I. A., van Walraven, C., Fischer, H. D., Camacho, X., Rochon, P. A., & Anderson, G. M. (2011). Unplanned readmissions after hospital discharge among patients identified as being at high risk for readmission using a validated predictive algorithm. Open Medicine, 5(2), E102-E111.

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