CONNECTING SOUTH WEST ONTARIO

Benefits Realization: Addressing health inequities through outreach

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

The clinicians at the Working Centre in Kitchener use the information and data in the Regional Clinical Viewer, ClinicalConnect™ to develop care plans to address the needs of clients who are homeless, at risk of homelessness.

Practice that addresses both health and the determinants of health

The Psychiatric Outreach Program (POP) at the Working Centre provides a patient-centred, community-based approach to mental health care to residents who face the challenges of poverty. The population receiving care are homeless, at risk of homelessness, or are involved with issues related to mental health, addictions or concurrent diagnoses (http://www.theworkingcentre.org/psychiatric-outreach/147).

The program integrates care from outreach workers, psychiatric nurses, physicians and other community resources to address patient needs. Those medical needs are often acute and rooted in social determinants of health as has been documented by Canadian researchers and advocates over the past decade (Frankish, et al., 2007). While important debate is needed to address structural health inequities through policy change, practical action is required to reduce disparity needs that occur in health programs (Reutter & Kushner, 2010).

POP is a practical program that does just that, first by health care providers developing trusting relationships with people who are vulnerable and often feel discarded by society. In POP, outreach workers, social workers and psychiatric nurses serve as the first point of contact between clients and the health system, where they function as trusted brokers and advocates, and form relationships with those living on the street. These relationships shepherd or transition the client into community-based care. POP clinicians treat immediate needs, refer to a wide variety of specialists, and advocate on behalf of patients to gain access to resources. This advocacy often involves trying to piece together a complicated medical history, as patients who are homeless and are mobile, traditionally have health records scattered across different health information systems in south west Ontario. In many instances, these records may not be accessible when patients cannot recall who or when they were seen previously.

ClinicalConnect enables POP clinicians to access reports to see a more complete history, and enables them to develop plans that access the right care, without redundancy, which leads to better care as well as cost savings for the system. ClinicalConnect also enables clinicians to assist in providing care to their clients by completing housing and disability applications, as both require accessing previous consults and studies to verify disabilities and psychiatric conditions (Figure 1).

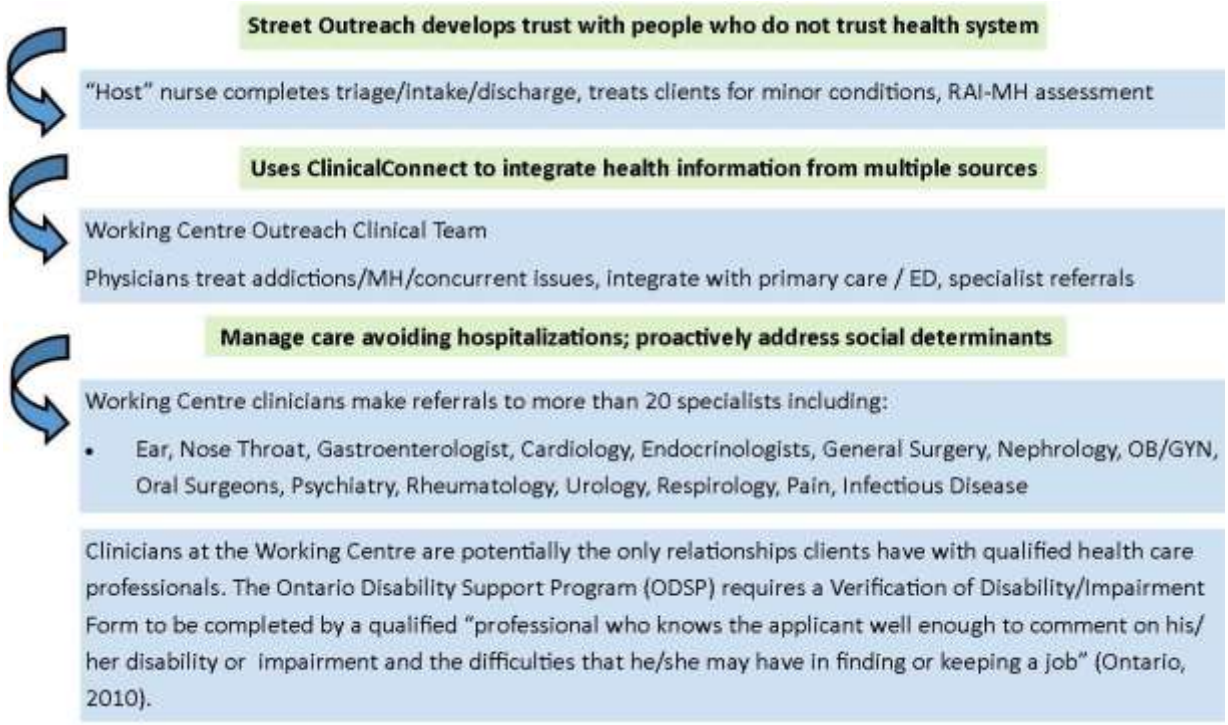
Testimonial

I use ClinicalConnect as an advocacy tool for both the patient and the health care system. At my homeless outreach site, I see patients whose lives are unstable, and often cannot remember where they were last hospitalized, what was done, or what diagnoses they carry. Often profoundly ill, both physically and mentally, these patients carry the wounds of prior abuse, are cognitively disorganized, and move from place to place.

This is where ClinicalConnect comes in. I can access records that span decades. For example, from when a patient lived in Hamilton as a teenager and was serviced by adolescent psychiatry, to when they moved to a place like Kitchener and spent some time in an adult patient ward. I can find out what medications helped them have a stable experience; what the psychiatrist thought when they were last hospitalized; and what the X-rays and MRIs showed after yet another violent encounter with an abusive partner. For many patients who have few options and to assist them in the provision of care, I will weave this narrative into a disability application to help a patient achieve stable housing and leave the streets, which is often the first step in stabilizing mental illness and addictions. Without access to ClinicalConnect, I would have to start over, ask for new consults and new studies, which would add at least 12-18 months onto the disability application process and cost the system much more in redundant consults/tests.

Dr. Rebecca Lubitz, Physician, Working Centre Psychiatric Outreach Program (POP)

Figure 1: Outreach and the use of ClinicalConnect to provide care to homeless residents



Questions

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

Sources

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