HealthLink

Let's Make Healthy Change Happen

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Enabling Health Links with a Care Coordination Tool

February 2014

Ontario

Health Links highlighted the need for a care coordination tool

- Health Link business plans consistently highlight how technology could enable their objectives from patient identification to care coordination. They need tools to:
  - **Create, maintain, and share coordinated care plans**; and
  - **Send secure messages** about patient care to providers from different sectors and organizations.
- If these actions were easier to do consistently and securely,
  - **Patient goals** would be recorded and known to all members of the care team and clinicians would have more information, all recorded in the same place, to **plan and deliver care based on those goals**;
  - Duplications or gaps in care could be more easily spotted and fixed;
  - Clinicians could **communicate more quickly** about patient's care.

The Care Coordination Tool (CCT)

- The ministry's analysis showed there is no existing ehealth system that is provincially available that can meet all Health Link requirements.
- However, there are ehealth systems that, with some modifications and improvements, can be used to meet Health Link needs.
- The **Integrated Assessment Record**, which already has thousand of registered users and stores millions of clinical records, can be modified to create the CCT.
- The CCT would enable **secure messaging between providers** in a patient's care team and will allow members of the care team to **create, maintain and share coordinated care plans**.
- In time, the CCT will be more fully **integrated with patient Electronic Health Records and point of care systems** and provide different options for how patients can access their coordinated care plans.

Journey to a Care Coordination Tool

Step 1

Coordinated Care Plan (CCP)

Objective:
Establish a coordinated care plan template that can be used by providers for patients within a Health Link

Products:
- A paper version of the coordinated care plan
- Business requirements needed to begin development of an electronic version

Draft CCP Completed

Step 2

Secure Access

Objective:
Work with Health Links to setup key providers within Health Links with access to a dynamic, online coordinated care plan

Products:
- Dynamic web-enabled care plan
- Secure messaging within a Health Link
- Visibility of a patient's Circle of Care
- Business requirements needed to begin development of an electronic version

Care Coordination Tool

Step 3

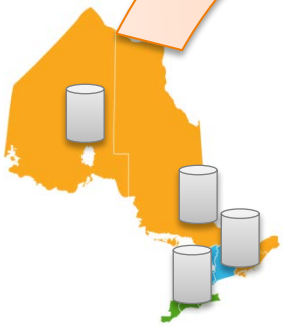
EMRs

Hospital Info. systems

Objective:
Integrate key ehealth solutions within Health Links into the CCT solution

Products :
- Bi-directional updates between CCT and local Point-of-Care systems (within HL)
- ED Notification and Discharge Summary
- Partial automatic update of Care Plan based off interface feeds

Step 4



Objective:
More robust integration with other provincial sources of data

Products (forecasted):
- Community assessments populating areas of the coordinated care plan
- EMR upload of visit summaries / cumulative patient profile
- Consumption of provincial cornerstone systems (Client/Provider Registry)

Health Links themselves defined the coordinated care plan (CCP)

From August to November 2013, 3 plenary and 7 breakout sessions were held in Toronto, Hamilton, and Ottawa to develop a CCP template.

HQO's literature review framed and guided the discussion

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Existing Health Link CCPs were used as the basis for a draft

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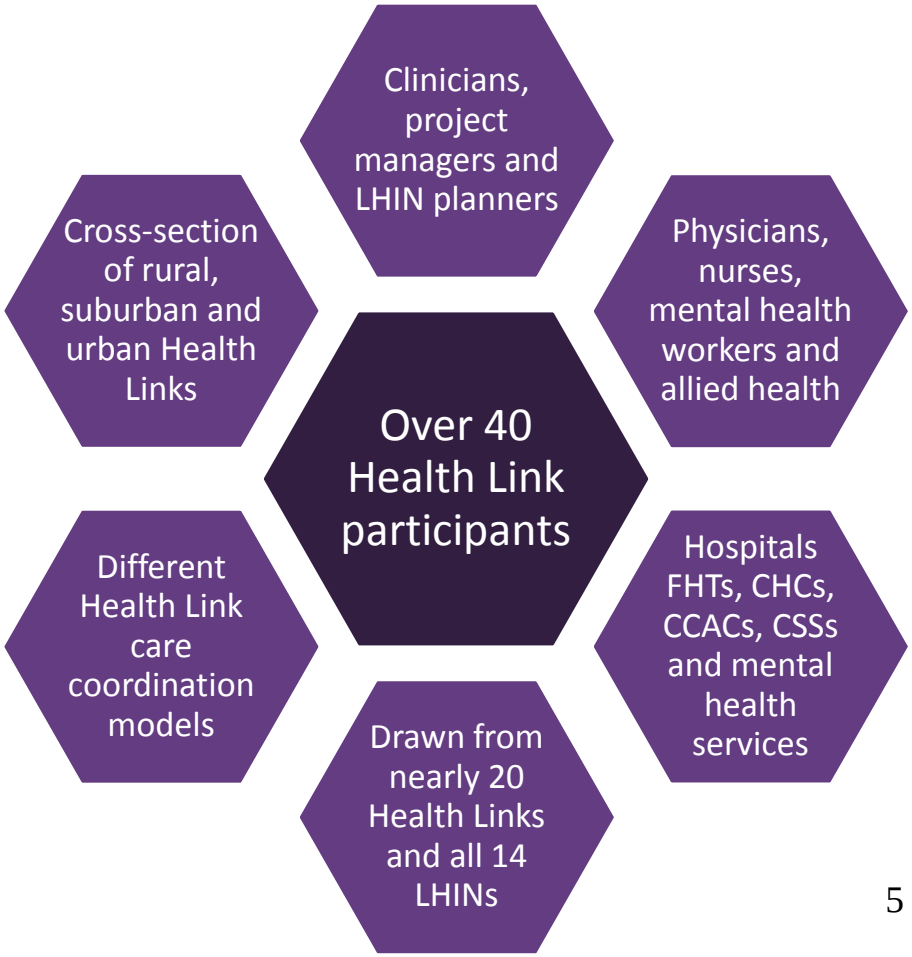
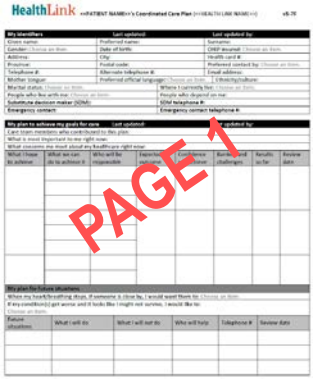
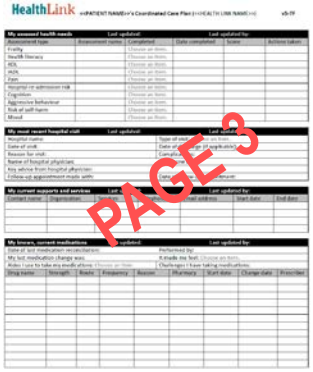
Participant discussion and experience shaped the draft into its current form



Snapshot of the coordinated care plan template

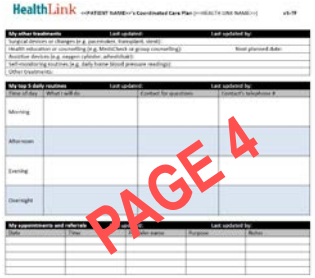
- Identifiers
- Patient goals and care plan
- Advanced care planning information





- Assessments
- Recent hospital visit
- Social supports
- Medications

- Care team members
- Health conditions and issues
- Social history



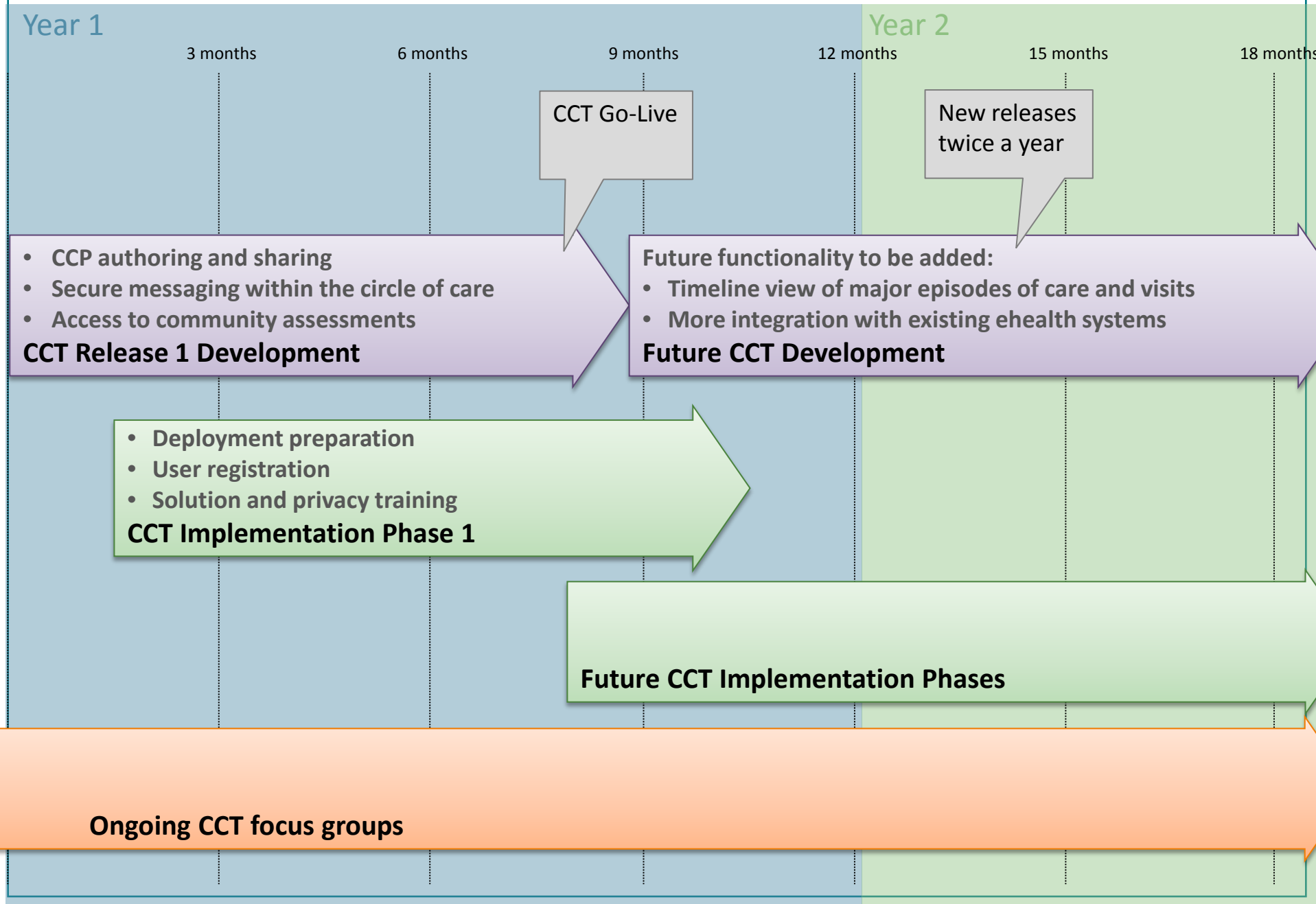
- Other treatments
- Key daily routines
- Upcoming appointments

Please contact evan.mills@ontario.ca to receive a copy of the most recent version of the Coordinated Care Plan template

Moving forward

- The ministry is again partnering with Health Quality Ontario to run a series of focus groups to continuously improve the tool and the coordinated care plan template based on experience.
- Two focus groups have already started:
  - One focus group is for Health Link clinicians and project managers, tasked with improving the **coordinated care plan template** specification;
  - The second focus group is for **patients and caregivers involved with Health Links** – to gather their insights and perspectives.
- Focus groups that address other topics, such as data integration and secure messaging, will be added when they are needed.

CCT rollout plan



Ministry commitments

Business requirements will continue to drive decisions on enabling technology

Health Links will be our partners throughout the life-cycle of this initiative

CCT will complement existing point-of-care systems and eHealth Ontario's regional connecting projects

We will strike a balance between taking the time to properly reflect Health Link requirements – and getting a tool into the hands of Health Links