CONNECTIONS

Continuing Care e-Health Projects Newsletter

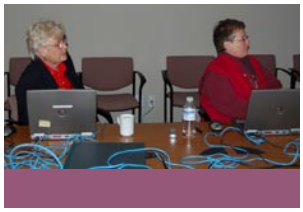
MARCH 2006

YOUR VOICE

Do you think we should continue producing the Connections newsletter?

Please click here and type **YES** or **NO** in the subject line of the e-mail.

> "I love this. It's so well thought through and there'll be no more bad hand-writing to deal with."
>
> Karen MacNeil-Giles
> Manager GTA Operations
> COMCARE Health Services



(From left) East York Access Centre Executive Director, Eileen Ryan and Service Operation Manager, Barb MacFarlane were amongst the first test users to preview the new Demonstration Model.

PARTNERSHIP NETWORK TESTS e-REFERRALS & ACCESS TRACKING DEMONSTRATION MODEL

After much anticipation, the e-Referrals & Access Tracking Partnership Network began training and testing the demonstration model in early January. Session participants were able to observe first hand what the future possibilities and capabilities a province-wide electronic referrals system would deliver for the Continuing Care sector and clients. Following one of the first sessions, Dan Hickey, Quality Manager at Care Plus, said, "What you're doing is important, and so is getting ideas from the users so they can provide detailed information on current needs and future requirements of an electronic referrals system."

For three consecutive weeks in February, testers were able to use the system in a protected environment by inputting fictitious data and scenarios. Participants from the Partnership Network were asked to create, revise, send and cancel a variety of referrals and service orders in order to simulate a real working environment.

> "I like that the system prompts you to fill in the required fields and won't let you continue until you do so."
>
> Karen Lilley
> Toronto East General Hospital Family Health Centre

Next Steps...

User testing feedback, including observations and future recommendations, will be incorporated into the e-Referrals & Access Tracking Business Case to outline the value, viability and investment required for a sustainable electronic referrals solution.

The testing of this model brings the Continuing Care sector another step closer to developing a more integrated health care system that will provide more effective and efficient care.

On the first day of user training, the e-Referrals & Access Tracking team was warmly welcomed by the East York Access Centre staff. (Okay...We weren't actually greeted by the staff en masse as this photo represents. We took this group shot during a practice fire drill!)

CONTACT US

If you have any questions or comments we'd love to hear from you! Please contact us at CCeHealthCommunications@moh.gov.on.ca.

EXPANDING e-HEALTH ACCROSS THE CONTINUUM OF CARE

COMMUNITY MENTAL HEALTH & ADDICTIONS MAKING e-HEALTH PROGRESS

The introduction of common approaches to collecting and reporting information is a shared objective between the Ministry and the Continuing Care health care providers. Building on existing resources and capabilities, the Continuing Care e-Health Council is working to rollout clinical and business standards across all our sub-sectors. The Common Data Set – Mental Health (CDS-MH) and Community Mental Health & Addiction Management Information System (CMH&A MIS) projects define reporting standards for community mental health and addictions that will provide consistent, reliable, and timely information for better decision making at all levels of the health care system.

Our successes so far

Benefits from CDS-MH and CMH&A MIS projects are being seen through early results:

- Building partnerships and capacity within and between the community mental health and addictions sub-sector and the Ministry of Health and Long-Term Care for successful implementation
- Using data to address questions about funding reach, resource utilization, and client outcomes
- CDS-MH implemented in 150 out of 350 CMH programs; and MIS implemented in 170 out of 400 CMH&A agencies
- Enhanced standards to address business information needs identified by stakeholders

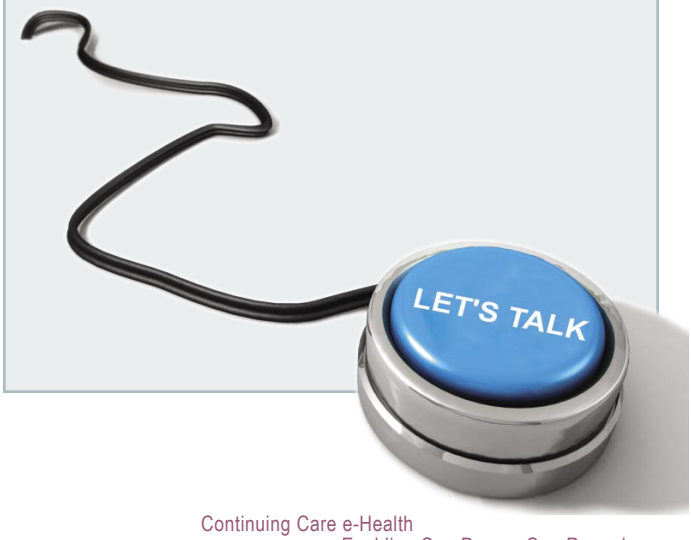
The **CDS-MH** project is underway to define and implement an administrative and clinical data standard for community mental health to meet mental health accountability requirements. The data will produce valuable indicators on access, service coordination, client demographics and outcomes. Use of CDS-MH data will lead to evidence-based system planning and program management decisions, development of best practices, and improved quality of care provision.

The **CMH&A MIS** project is committed to developing and implementing MIS financial and statistical reporting standards across all CMH&A agencies. Using these standards provide an integrated approach to managing financial accountability across our health care sectors. MIS data will help provide indicators around system capacity, resource utilization and financial planning.

With these projects, the CMH&A sub-sector can demonstrate use of diverse services in meeting community needs. We will continue to share our experiences in upcoming issues of *Connections*.

MAKE e-HEALTH WORK FOR YOU

- **SEND US YOUR STORIES** — whether it's successes or lessons learned, others can benefit from your experiences and we can help you share them
- **STAY UP-TO-DATE —** visit Continuing Care e-Health at **www.eHealthOntario.ca** and help keep you and your colleagues up-to-date
- **SHARE YOUR QUESTIONS OR CONCERNS —** let us know how we can better support you



CIAT PILOT SITES ARE ANNOUNCED AS CCACs FOCUS ON THE BUSINESS IMPACT OF TECHNOLOGY CHANGE

For the Home Care Client Assessment project (HC CAP), the New Year kicked off with numerous changes, reflecting ongoing activities in the Community Care Access Centre (CCAC) environment. With a number of activities underway, the project team continues to help CCACs prepare for the introduction of the Common Intake Assessment Tool (CIAT).

A call for pilot sites went out in early February and after a review of applications, Hamilton, Hastings and Prince Edward Counties, and York Region CCACs were selected to pilot the CIAT. The purpose of pilot testing is to gain a better understanding of how to implement CIAT within different CCAC environments. Concurrently, the Home Care Client Assessment Project (HC CAP) will also be supporting the implementation of the CIAT at the Scarborough CCAC as a part of a larger Continuing Care e-Health implementation. We will keep you updated as this particular stream progresses. Thank you to those CCACs who responded to the pilot call and to the three pilot sites for their dedication to help test out CIAT and integration to refine the process for future rollout.

The testing of the CIAT moves us closer to our vision of ***One Person One Record.*** This is an exciting milestone for CCACs and Continuing Care e-Health, as the ability to safely share client information between care providers will allow for fully informed and secure service provisions. Having this information will position the CIAT software to take advantage of the e-Referrals & Access Tracking capability once it is ready.

As a result, case managers can expect great efficiencies by reducing the number of forms to fill out and decreasing the amount of duplication; clients from across the province will benefit from a standardized research-based assessment. Of course, CCACs will benefit from the streamlined process created to transfer clients to other CCACs as well as receiving transferred clients! Say goodbye to faxes and hello to automation!

As we prepare for pilot testing, success will lie not only in what technology is implemented but how the technology will be used. That is why the HC CAP team has been helping to support CCACs as they identify and redesign business processes for implementation of the tool. CCACs have been planning activities to understand the impact the CIAT will have on their organizations. Together, the pilot experience combined with CCAC's business process preparation will provide valuable insight on how to successfully integrate the CIAT in different environments.

Here are a few key tips CCACs are using to develop their business plans:

Review the Business Process Toolkit

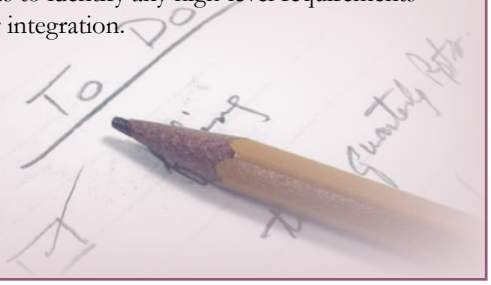
Helps CCACs identify what business process changes may be required to effectively integrate and sustain the CIAT at all intake points within a CCAC. The guide shows CCACs how to get plans started.

Plan early

CCACs needed to develop business process redesign plans early. Advance planning helps develop a strategy to address your needs and required business process changes with ample time for readjustments (if needed). Nobody likes unwanted surprises and the more prepared you are, the less amount of stress will be present when your implementation approaches.

Conduct a thorough gap analysis

To understand integration requirements, CCACs should be conducting a detailed gap analysis to determine what type of impact the integration will have on other areas of their business. This component will involve (but is not limited to) mapping out the 'As Is'/ and 'To Be' business processes e.g. knowing your laptop and technology requirements, as well as addressing privacy issues. A thorough examination of the business allows CCACs to identify any high-level requirements necessary for integration.



Stay tuned for news from our pilot sites. Based on pilot findings, other CCACs will benefit from the lessons learned and the best practices created for the CIAT rollout in all CCACs.

If you would like to receive an electronic copy of the **HC CAP Business Process Toolkit,** please send your request via e-mail to HCCAP@ccac-ont.ca.