Oscar Integrator

Evaluation Report

Fraser Northwest Division of Family Practice

2019

Table of Contents

About Us

The Fraser Northwest Division of Family Practice (FNW DoFP) encompasses family physicians in New Westminster, Coquitlam, Port Coquitlam, Port Moody, and parts of Burnaby, representing the traditional catchment area of the Royal Columbian and Eagle Ridge Hospitals. It lies within the ancestral, traditional and unceded territory of the Kʷikʷəƛ̓əm (Kwikwetlem), Qiqéyt (Key-Kayt) and Coast Salish Nations.

Together, members and division staff work to improve patient access to local primary care, increase local physicians' influence on health care delivery and policy, and provide professional support for physicians.

Background & Context

The OSCAR Integrator (Integrator) project emerged out of the initial work designed in 2016 to implement a unique Electronic Medical Record (EMR) tool which allowed for (near-real-time) real-time sharing of accurate health care information across multiple clinics participating in the Sunshiner Frailty Network (SFN), a program sponsored through the Fraser Northwest Division of Family Practice (FNW DoFP) and funded by GPSC through the GP for Me program. The project was directed towards providing support for full-service family physicians, and to assist family practices to evolve towards providing optimized, comprehensive primary care services in response to the needs of patients in their communities. Funding through the GP for Me, made it possible for this project to implement coordinated, timely access to patient health information, and team-based care including GP, NP, RN and Social Worker. Specifically, the project was designed to enhance the effective use of physician EMRs by allowing appropriate information collected by clinicians to be shared, following patient consent, across teams of GP networks supporting clinical practice with Fraser Health Authority (FHA) Primary Community Care Registered Nurses (PCCRNs) (Appendix A) (formerly known as "Nurse Debbie"). Individual PCCRNs work in conjunction with the assigned family practices across the FNW to support avoidance of acute care admissions to home bound patients (Appendix B).

The current Integrator project is a joint project between the Fraser Northwest Division of Family Practice and the Fraser Health Authority. This 2-year pilot project is designed to integrate and implement a sharing tool that supports real-time communication between different EMRs, providing family physicians and PCCRNs access to shared patient clinical information. Since implementation, the integrator servers have been used to store and share appropriate clinical information across practices. The project's overall goal is:

1. to support innovation;
2. promote provider working relationships; and

3. obtain Oscar Integrator pilot expansion learnings to be applied to a long term solution for all EMR to EMR operability (Appendix C).

Evaluation

The purpose of this evaluation is to have the opportunity to gauge the current landscape of provider-provider communication and how the addition of an EMR integrator would affect – and potentially strengthen – this communication and relationships across the health systems. Reporting metrics have been put in place to facilitate feedback loops between physicians, service providers, the FNW division and FHA leadership. This is an opportunity to measure the current state, in addition to measuring how the integration of EMRs would impact the health system.

Evaluation Objectives, Goals & Questions

The overall evaluation objectives for this project are as follows:

- To identify and document the current state and to provide evidence on a roadmap in how integrating EMRs can be done.
- To measure the effect on the communication between service providers in the communities and what kind of outcome this has on provider-provider relationships
- To measure any unintended consequences of the EMR integration
- To determine how the Oscar Integrator aligns with the following Division objectives and how those objectives are met:
    - Triple Aim
    - Community engagement
    - Team-based care
    - Resource for family physicians
    - PCN attributes
    - SCSP attributes
    - PMH Attributes

The evaluation has two main goals:

1. To evaluate the **effectiveness** of the Oscar Integrator in the Fraser Northwest community
    a. How effective was the program at optimizing practice efficiency for family physicians and the impact of the primary care nurses?
    b. To what extent did the program contribute to improved patient care?
    c. To what extent did the program impact the working relationship and communication between physicians and allied health?

   d. To what extent did the program contribute to a change in health care utilization and what effect did it have on system costs?
2. To evaluate the overall **delivery** of the Oscar Integrator to the Fraser Northwest community
   a. To what extent was the program delivered as intended?
   b. What were the unintended consequences and what impact did these have on the overall program?

Methodology

As part of the purpose of this project is to gauge the current context and how an integrated EMR would affect the current state of communication and relationships between service providers, this project will utilize a developmental evaluation lens. Data was collected from physician cohort feedback, provider feedback and program documentation data. Due to available program data, the methodology for data collection shifted to mainly utilize impact stories given the high level of involvement of physicians, Primary Community Care Registered Nurses (PCCRNs) - and subsequently the patients - in this project.

Results

Goal 1: To evaluate the effectiveness of the Oscar Integrator in the Fraser Northwest community

1a. How effective was the program at optimizing practice efficiency for family physicians and the impact of the primary care nurses?

Impact stories collected from community physicians strongly suggest that due to the integrated EMR with Health Authority (HA) PCCRNs, practice optimization was improved through leveraging the technology to support and strengthen the team-based care provided to the desired patient population (complex, frail and homebound). One physician describes how the process of implementing the Integrator with a patient is like,

> *"So how did it all begin? So the day that I think a patient needs a primary home care nurse who knows me and my patient over time, they're frail, they're homebound, it's difficult for them to get to the office and I need to know the nurse who is taking care of them overtime. So, I decide this patient needs to become a Sunshiner patient. This is their basic demographic, the index card for the patient. So I talked to the family first and they think "great" so I click the opt in button and now that patients charts forevermore, unless they decide they don't want it anymore, they'll know anything I chart and anything that is charted on the other side, our chart notes show up for each other. There's nothing else to do, it's a one-off and then we're working together from now on. No more faxes, no more you know, all kinds of [other] stuff."* – *community physician*

Through automating communication and charting between providers, one physician identified that the technology enabled seamless communication and improved workflow for the whole practice, *"So all [messages are identified as] coming from the integrated facility [PCCRN]. Each message maybe saved 10 minutes, maybe even 15 minutes."* The physician also identified that the Integrator allowed for photograph sharing which allows for the PCCRN to visually communicate patients' physical status to the physician. Having photographic evidence of a patient's status *"sometimes meant I didn't actually have to go do a visit because there's a picture."*

In regards to team-based patient care, a physician identified that, *"the coordination of care is much better and I think the relationship [with the PCCRN] allows us to connect with each other better and then we also are able to develop a better relationship with the patient."* They identified that having the Integrator supports a seamless communication flow between themselves, the PCCRNs, and their patients: "*I think that we get much more timely service just by having the integrator compared to the old fashioned way."* With the support of the Integrator technology to enable and strengthen the physician to

nurse relationship, *"we would just work together as if we were working in the same office. Not another thing in my inbox, nothing for the [practice] staff to print, to fax, to find [in the EMR]."*

Another physician's experience focusing on the original set up of the Integrator noting that "*getting onto the system initially was quite hectic. For the average physician, it could be seen as a deterrent. My experience with the OSP was not positive in getting started on the integrator."* Despite this obstacle, the clinic did complete the onboarding process and has been engaged in the Integrator project throughout the project's duration. A separate physician expressed that *"technology is an enabler. It's never a solution"* to improving relationships and workflow.

Feedback from two PCCRN's verified the efficiency of the Integrator as "*an effective tool for documentation and communication.*" Utilizing the Integrator allowed for increased "*efficiency [between the nurses] and doctors as it's very little [or no] faxing or calling. This tool was helpful because I didn't have to fax. It saved a lot of time.*"

1b. <u>To what extent did the program contribute to improved patient care?</u>

A clear theme that emerged through the data collection process was that relationship centered care is integral in providing coordinated and comprehensive care. A community physician identified that *"the health system will work better if we work on making sure that there's small teams of people that know each other and the patients."* In this model, the relationship between the physician and PCCRN support the continuity of care – *"[the nurse] gets to know the doctors and the doctors get to know [the nurse]. The nurse gets to know the home-bound frail patients of each practice and the nurse is available to do rapid response."*

> *"I haven't taken new patients for years, but once I had [the integrator], I actually said yes, I'll take on new frail homebound patients and do house calls on them because this [system] is such a joy."* – *community physician*

Another physician emphasized "*that understanding what's happening to [the patients], these are the small things, it's not even medical, it's just communication*." In describing the nuanced complexities with this patient population and how they've seen a change in giving care to their patients,

> *"When the patients come in and they tell me – first of all having the PCCRN has been great, the second thing that makes them feel good is that they know that I'm involved and aware of what's happening to them. So that's been huge. From my standpoint it's been big as well, not having a shared chart, it was difficult to keep up with the patient, unless the patient told me directly, but now I can look up and see what the conversation was. So say a patient calls me and says 'well we*

have these issues and the nurse saw me yesterday' I don't have to fish around or ask for faxes, I can instantly see in my EMR chart what the nurse said – what the [conversation] was like, and what treatment is happening."– community physician

A physician expressed the change they see with their patients as "*patients actually feel like someone cares about what's going on [with them]."*

One PCCRN described an occurrence where the Integrator supported seamless communication between themselves, a doctor, and a patient,

> *"I had a client who I was working quite closely with, and going out and seeing every couple days at first and then every week. The Doctor and myself were watching weight and INRs and all of these things with this very fragile client. The Interator was a very good way for us to kind of track and trade off [information about the] patient. So it was a really good way for us to go back and forth without having to do faxes or phone calls." - community PCCRN*

Another PCCRN detailed a story that a physician shared,

> *"I was talking to a doctor and he shared a story where he has some communication back and forth with his PCCRN and a client had come into the clinic and received a flu shot which was then documented in the EMR. It just so happened that the PCCRN was going out to do a home visit with this client and there was a question in there as the patient was feeling quite unwell, so there was a question around since you get the flu shot he's been feeling quite unwell is this because of the flu shot or something else going on. And then the doctor was able to respond back and clarify - this whole exchange was within minutes. So the whole conversation was within an hour and so the nurse was able to go out and chart and then the doctor was able to respond to her questions and clarify what was what was needed. The nurse can phone back the clients and say I've communicated with the doctor and share that it's nothing to worry about." - community PCCRN*

1c. <u>To what extent did the program impact the working relationship and communication between physicians and allied health?</u>

Feedback from a community physician noted, *"if you take a relationship centered approach to building the teams and then build the technology in support of the relationship, you come up with things that actually cost a fraction, don't jeopardize people's privacy and [have] much more efficient workflows and are cost-effective not only in terms of IT systems and their maintenance, but also cost-effective in terms of not [wasting clinical time] of high priced experts on doing menial tasks of filing and labelling documents."*

Reflecting back on how the Integrator enables co-charting between a physician and PCCRN, the physician noted that the level of detail in communication may not happen had the Integrator not been present and on a larger scale, the impact on sustainability for physicians. In regards to the use of email, faxes and telephone as forms of communicating patient information between providers, the physician reflected that, *"The truth is, the nurse probably wouldn't have sent all of [those notes] ... Apart from time savings and efficiencies of it, the frustration factor. When we see physician burnout, and it's becoming more and more serious. And we talk about paperwork, it's not doing things this way [with the Integrator] that's leading to burnout. Nobody is going to want to come do the work if they have to do it the other way."*

For a patient without the Integrator, the physician expressed their experiences and frustrations with redundancies in communication between different allied health professionals because of the disconnect of chart sharing. The physician said, *"Sometimes the nurses are asking the same thing again and again because it's a different [nurse]*" when treating the same patient. With the Integrator, the physician and the assigned nurse have a shared understanding of the patient and has all the chart notes available for reference. The physician noted that the Integrator technology *"is doing all it can to support [communication]*" but identified that the working relationship with the PCCRN could be further improved outside of the scope of the Integrator.

Additional feedback shared from a PCCRN Manager noted that the RNs found the note sharing between EMRs "*helpful and positive."*

Another community physician expressed *"that the most important thing is the relationship that we have with our team members and our patients and the current way of doing things without the integrator or shared information, it doesn't engender the relationship between providers and even with their patients so having something like the Integrator, actually does help foster personal relationships with the people you're working with. This is the most important thing of all, or one of the most important things. When we know the people that we're working with and what to expect, that makes a huge difference."*

Feedback from a PCCRN confirmed the increased ability to communicate supports a strengthened relationship between the physician and the PCCRN. "*It feels more personal and is a really good comparison because I have clinics that use [the Integrator] and those that don't. For me, I am in much closer communication with those doctors that have it - hands down."* Both PCCRNs that were interviewed confirmed that there has been much more communication with the physicians who have the Integrator "*the part that I can say, is that you develop a better working relationship [with the] physicians."*

1d. <u>To what extent did the program contribute to a change in health care utilization and what effect did it have on system costs?</u>

Quantitative data related to system costs was not available at the time of the report writing; however, qualitative feedback from community family physicians alludes to the healthcare utilization and potential effect on system costs due to the Integrator.

> *"The success is to have [system changes] be community driven, where users are actively involved in creating the system." – community physician*

The size of the users utilizing this Integrator *"is clear and definable – a manageable team connected to one another. In our pilot hub, we've got 5 practices to an Integrator and that Integrator also connects to the health authority Oscar instance."* Working within multiple systems despite having separate privacy legislation was a theme that also emerged:

> *"You've got the nurses charting in their FOIPPA controlled environment, you've got the doctors charting in their PIPA controlled environment and the chart notes are being integrated so that it feels like everyone is charting in one chart…the notes are seamlessly integrated so that you can actually all work together like a team."- community physician*

A doctor noted an instance where they received a call from a homebound patient's family observing a change in the patient's status as relayed by a nurse. Prior to the PCCRN, the doctor had to decide whether to send the patient to the emergency where there could be an increased risk of complications or make a home visit which wouldn't occur until the end of day. With the addition of the PCCRN, office staff were able to contact the clinic's assigned PCCRN directly who was then able to visit the patient in a much shorter period of time. The PCCRN communicated back with the doctor letting them know that they had visited the patient and to review the patient's chart. The doctor was able to review the PCCRN's chart notes through the Integrator which included the patient's vitals as well as a picture, thus allowing the doctor to make a stronger assessment. *"It makes taking care of patients like that a joy. It means that you have the information you need at the moment you need it."*

A physician reflected on the importance of having sustainable support from HA partners as the Integrator *"is something that can really be helpful and reducing errors with patient care, saving costs because of reduced back and forth and miscommunication...[but] at the end of the day, [it's the] health authorities scope, they have to buy in."*

A PCCRN ascertained that "*on our end we want to do everything possible to make the communication more efficient and right now with the fax and phone calls it's not efficient. This Integrator supports the efficiency."*

Goal 2: To evaluate the overall delivery of the Oscar Integrator to the Fraser Northwest community

2a. To what extent was the program delivered as intended?

The pilot project had two main deliverable objectives: to improve the information exchange and coordination of care between providers; and to collect ongoing project learnings. Based on physician feedback, both objectives were met.

There are currently 4 family practices (10+ physicians) connected to the Integrator with an additional small cohort of physicians still utilizing the original Sunshiner instance of Oscar. The project's software team has implemented instant messaging between a PCCRN and a physician's EMR in at least two of these clinics. One of these physicians noted that more recently, *"we're just implementing messaging – not instant, but messaging directly across the integrator...Before, at least, the nurse would have to notify me by email or text that they've seen the patient, and for me to go and take a look. But now, they can message me [using the messenger]."*

2b. What were the unintended consequences and what impact did these have on the overall program?

In one instance, the coordination of care for frail and homebound patients was not only initiated by the physician, but a PCCRN connected to the physician's clinic had reached out and "*asked me to take on a couple of home-bound patients because she [the nurse] knew that I was doing it this way [Integrated co-charting] and she knew it'd be easier to follow along with me with the patients who are at home. That seems like the complete change...We have the best of both worlds because we have the platform that works now."*

Physicians noted that in accessing the Integrator, they are able to have a more instantaneous understanding of their patients status, ensuring that patients needs are being met in a timely manner. *"The reassurance that I get knowing that I, at any time, can refer to what's been happening to the patient when they come in, or when they come in, I feel more secure and much more confident in this 'oh yeah this is exactly what's happening' which in some circumstances, I would have had to say 'I don't know what's going on, you have to come back because I have to figure this out later'. That's the level of difference it is, me knowing then and there at point in care and being able to address it right away versus them potentially them having to come back for another visit, and they're already having difficulties."*

Feedback from a program administrator noted the difference in risk that the FNW Division may carry compared to the FHA with regards to the data ownership and the

overall sustainability of this work. As the data includes individual patient information, the Division, as a non-profit, cannot hold the record of this information. As a short term solution, to support innovation, the Division may be able to provide this support; however, there is significant liability associated with the long term data ownership and the Division cannot provide this support.

Lessons Learned

1. Shared EMR access is pivotal for physicians to seamlessly chart with team members. This is valued by community physicians and team members that do not work directly in the same organization.
    a. The impact of not having a sustainable shared EMR system on physician, allied health and patient experience is not known at this time; however, physician feedback suggests that the efficiency in communication between providers can be negatively impacted thus potentially contributing to increased workload and potential burnout.
2. Physician and PCCRN feedback collected alludes to increased provider satisfaction. Further work is needed to measure whether this increase in satisfaction contributes to improved quality and coordination of care between providers and their patients.
3. Quantitative data (such as increase in panel size, measuring the length of time between EMRs for provider communication) was difficult to access and measure. Feedback from physicians working with this project identified this obstacle and suggested the move to more qualitative focused data.
4. Technology enables the relationships, but the relationships between providers are what can sustain the technology.
5. Onboarding onto this technology takes time for physicians and PCCRNs and additional support may be required during this onboarding process in order to successfully engage physicians and their teams to utilize this technology moving forward.
6. This is a solution seen by community physicians and PCCRNs that allows streamlined access and communication between team members and patients. The Integrator is an opportunity to continue to develop strengthened partnerships within the Patient Medical Home, but also for the larger Primary Care Networks within the communities.

Limitations of Evaluation

Limitations are evident in any evaluation, below are a few areas of improvement for future evaluation work done as it relates to shared EMRs:

Available Data

Due to the multiple systems of care and related privacy constraints that exist in the health system, coupled with the limited resources, ongoing quantitative data collection is a key method that needs to be highlighted further in future evaluations. Qualitative data was available to measure the impact of this pilot project; however, with qualitative

data, there is a higher risk of bias given a smaller sample size and makes the data more difficult to generalize for system comparisons. Additionally, feedback from PCCRNs and practice staff was limited due to available resources and project timelines.

Measuring Patient Satisfaction

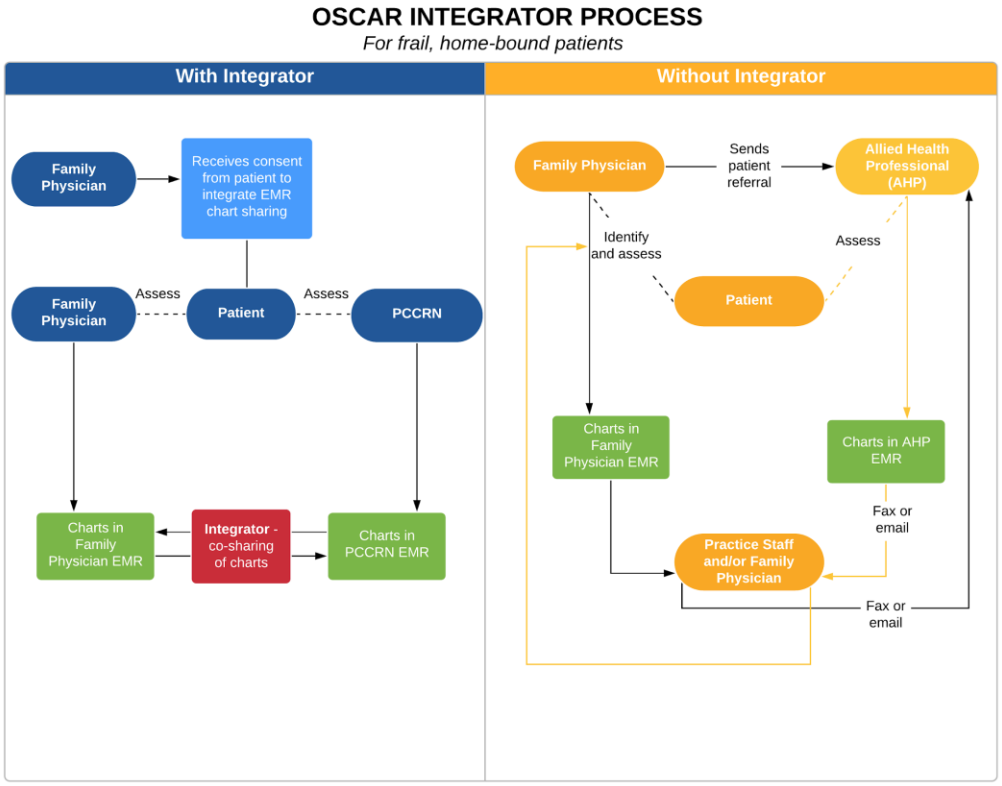
Due to limited resources available, patient satisfaction was measured through limited qualitative data from physicians. The Integrator worked to support frail and homebound patients which may contribute to the difficulty in collecting feedback directly from patients and/or their caregivers in future work.

Discussion

The program's main deliverable objectives were centred around:

1. Improving information exchange and coordination of care between FNW primary care providers
2. Collect ongoing learning around the pilot expansion project

Figure 1 below demonstrates the information sharing between a provider and PCCRN using the Integrator to support frail home-bound patients versus information sharing between a provider and an allied health provider (not limited to a nurse).



Based on feedback from community physicians utilizing the Integrator to support their frail homebound patients, the objectives behind the technology prove both useful and successful for supporting this specialized patient population. As mentioned throughout this report, the technology cannot be successful if the relationship between providers to provide continuity and coordination of care to this population is broken.

Ongoing learnings from this pilot project suggest that data sharing and co-charting between EMRs and providers improves patient care through access to primary care providers when needed. Additionally, the technology of the Integrator has supported physician's to take on unattached patients who are frail and homebound as increased physician satisfaction is directly related to what the Integrator enables. Further supports and resources are paramount to continuing this information exchange and to engage physicians and their team members to provide primary care services to their patients. This project has supported and invested resources in attaining the following Patient Medical Home (PMH) service attributes:

- Commitment
- Contact (timely access)
- Continuity of Care
- Coordination of Care

In addition to meeting the PMHs service attributes, this project supports the overall goal of the PMH which is providing patient-centred, whole persons care. Investing in this technology provides clear support to not only meeting, but maintaining a team-based PMH across multiple organizations and stakeholders to provide patient-centred primary care services to the communities within the FNW.

Conclusion

Further investment in the development of a shared EMR or co-charting is paramount to fully understand its scope and capacity to support family physicians and specialized populations such as the frail, complex and homebound patient population.

The impact that the Integrator project has had between physicians, nurses, patients and patients' families clearly supports and enhances access to care, coordination of care and overall efficient healthcare utilization within and across multiple systems of care. Moreover, physician burnout is real, and leveraging technology that supports physician's access to patients and awareness of health status are key factors in reducing the risk of physician burnout.

Appendices

Appendix A: Sunshiner/Truly Frail Home Bound Patient Panel: *Business Case*

Fraser Northwest Division of Family Practice
A GPSC initiative

fraserhealth
Better health. Best in health care.

Sunshiner/ Truly Frail Home-Bound Patient Panel
Business Case

Situation:

Four GPs currently chart in an instance of Oscar EMR which allows them to co-chart with PCCRNs. In order to comply with FIPPA & PIPPA legislation requirements, GPs and health authority employed PCCRNs will no longer be able to chart in this shared system. This project will address the needs of a network of physicians and PCCRNs working together in a shared EMR to enable a collaborative care approach for the most vulnerable patients.

Background:

For the past 4 years, these doctors have worked with PCCRNs closely in a team based care model. There are currently 4 GPs that do home visits in a fee for service model for truly home-bound patients, and each currently have a panel of 10-20 patients. They currently work in a joint EMR (OSCAR) to facilitate patient record sharing and a collaborative team-based approach to care. With the required repatriation of non-health authority data these physicians are now looking at charting separately from the PCCRNs and each other.

Recommendation:

The ideal state is for GPs to chart alongside the PCCRNs in PARIS. This would allow for a collaborative care platform and the ability to share chart notes with the PCCRNs, while enabling the GPs to continue working in a network model with their physician colleagues.

Assessment:

Benefits:

- 5 days per week/ 52 weeks per year physician coverage
- Access to integrated allied health support & a shared EMR record
- Used the OSCAR EMR outside FH and its worked for 4 years
- Still be fee for service
- GPs data would be secure

Risks:

- Needs to be fee for service but we don't know if there is a way for the GPs to bill in PARIS
- Risk of violating FIPPA & PIPPA

Desired timeline to begin:
As soon as possible

Appendix B - Story of 463 patients: the nurse debbie experience

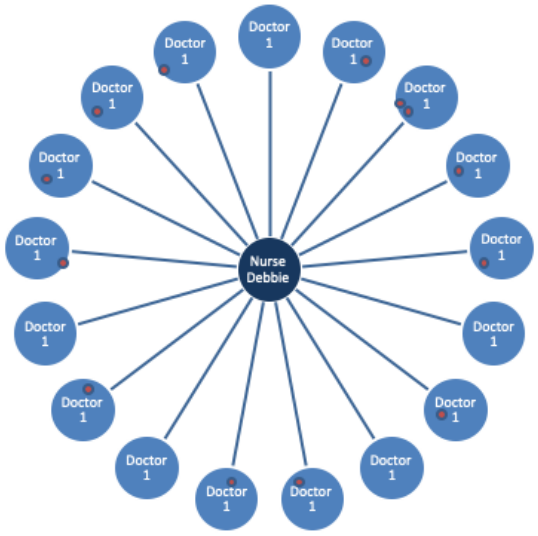
The story of 463 Patients
The Nurse Debbie Experience

Dr. Tracy Monk Family Physician, Fraser North West Division of Family Practice
Lisa Zetes-Zanatta, Executive Director, New Westminster Health Services, Fraser Health

fraserhealth

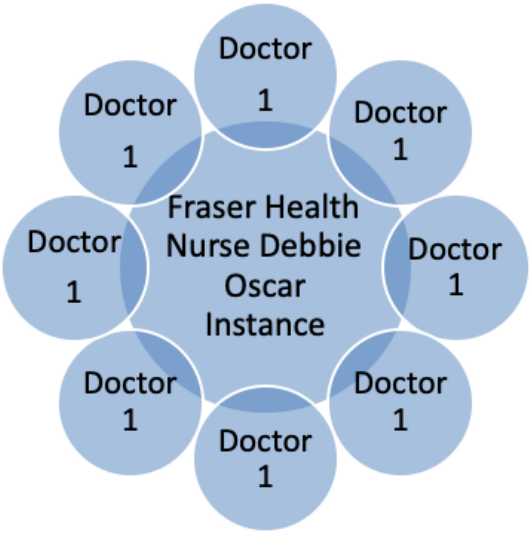
Fraser Northwest
Division of Family Practice
A GPSC Initiative

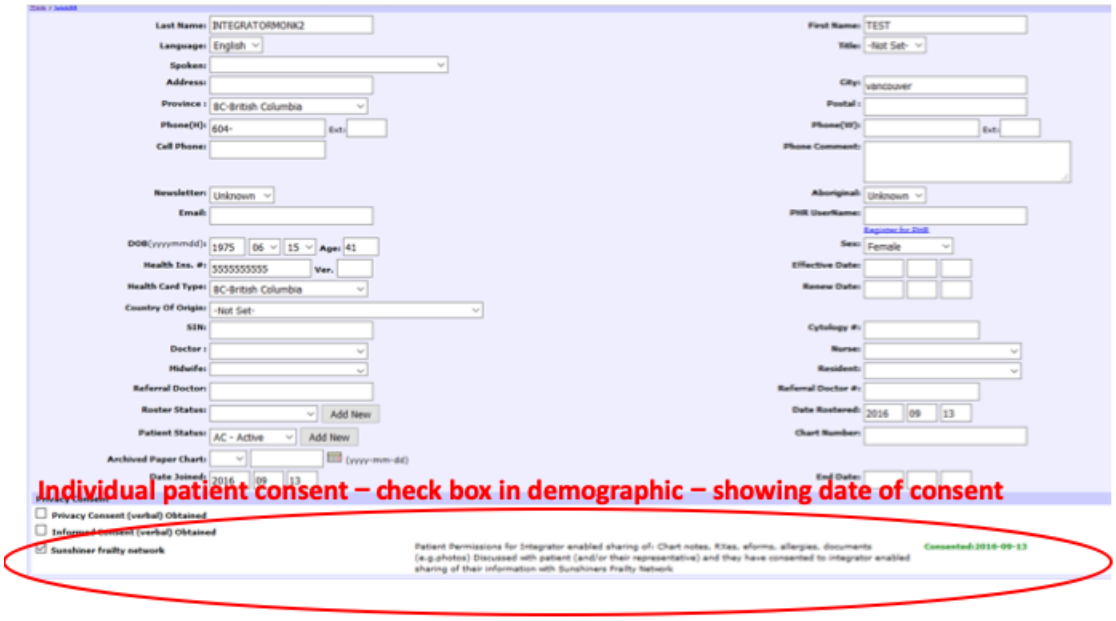
Sunshiners Frail Seniors Project FNW



Technology infrastructure

Fraser Health Home Health Staff Charting in an OSCAR Instance





Individual patient consent – check box in demographic – showing date of consent

Close up of consent wording

☑ **Sunshiner frailty network**

Patient Permissions for Integrator enabled sharing of: Chart notes, RXes, eforms, allergies, documents (e.g.photos) Discussed with patient (and/or their representative) and they have consented to integrator enabled sharing of their information with Sunshiners Frailty Network

Consented:2016-09-13

Chart View in Sunshiner EMR
Sunshiner EMR is the Oscar instance in which the allied health provider team are charting.
Pink stripe signifies that chart elements were created in another facility (i.e GP Office)
See how the chart notes created in GP office are now visible inside the allied health team's EMR

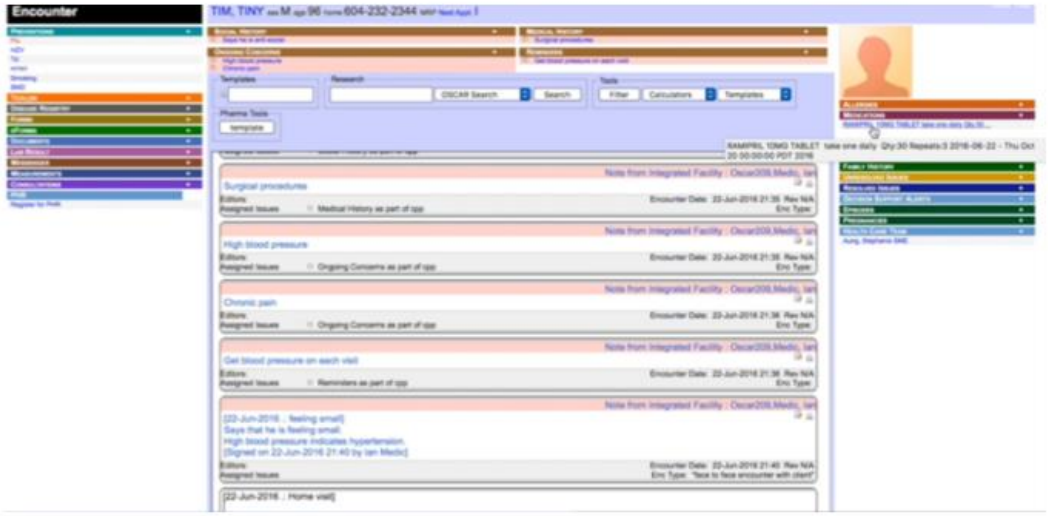
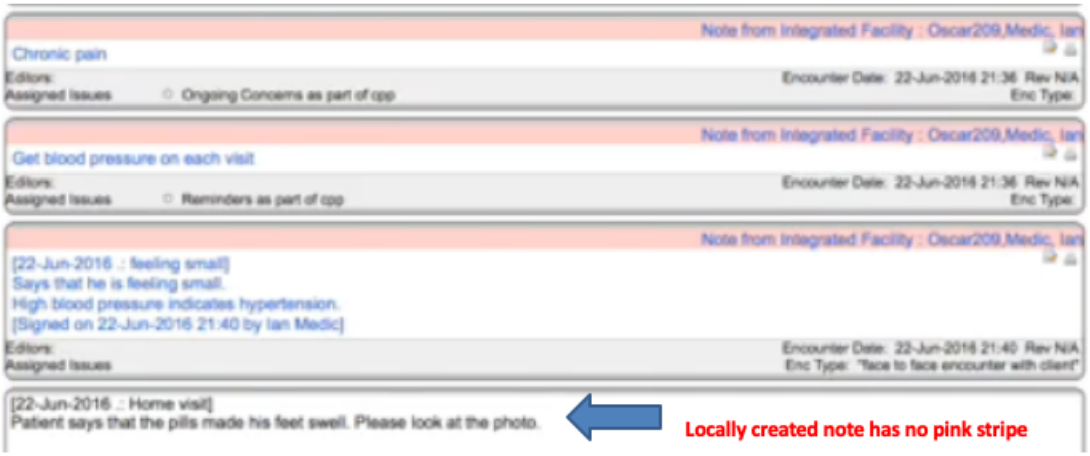
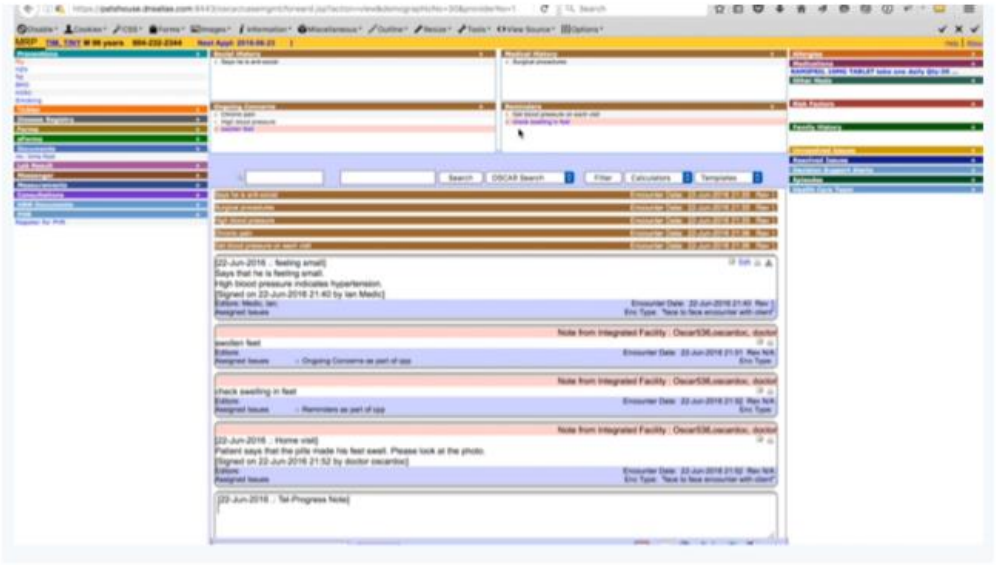


Chart view in Sunshiner EMR – RN makes chart note
New RN chart Note re foot swelling. Because it is a "local" note – no pink stripe.
RN has charted that she would like GP to look at photo of foot she has uploaded.



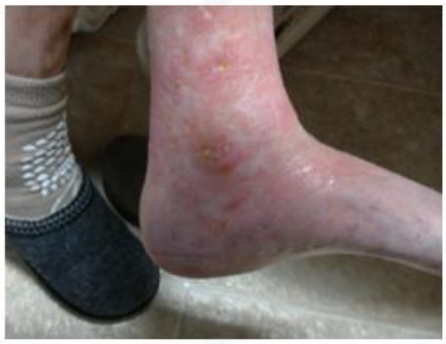
GP EMR View

RN's Notes that were created in Sunshiner EMR, are now Integrated into GP's EMR.
Pink stripes signify that the note or chart element was created at an integrated facility .

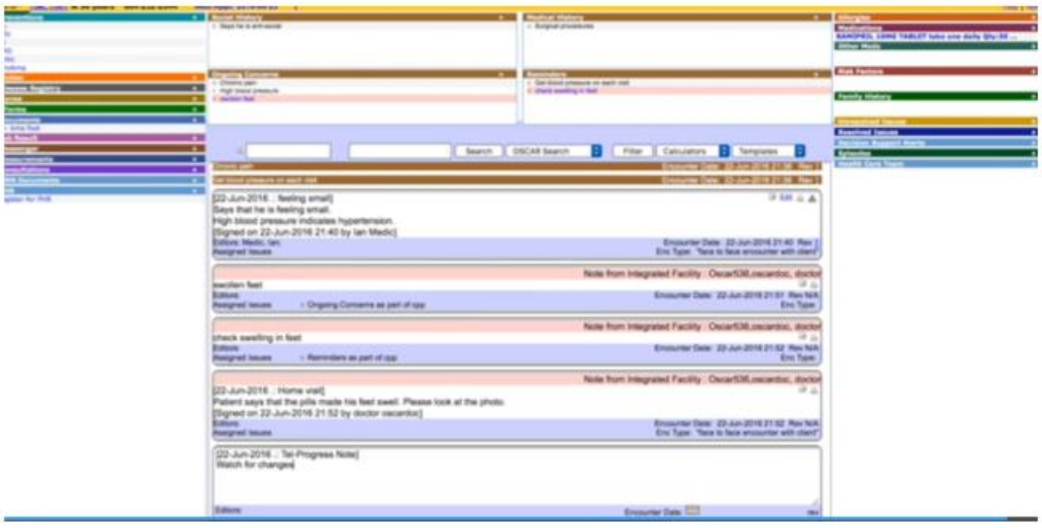


Note about the swollen foot now showing up in GP's EMR with a pink stripe stating: "Note from integrated facility"

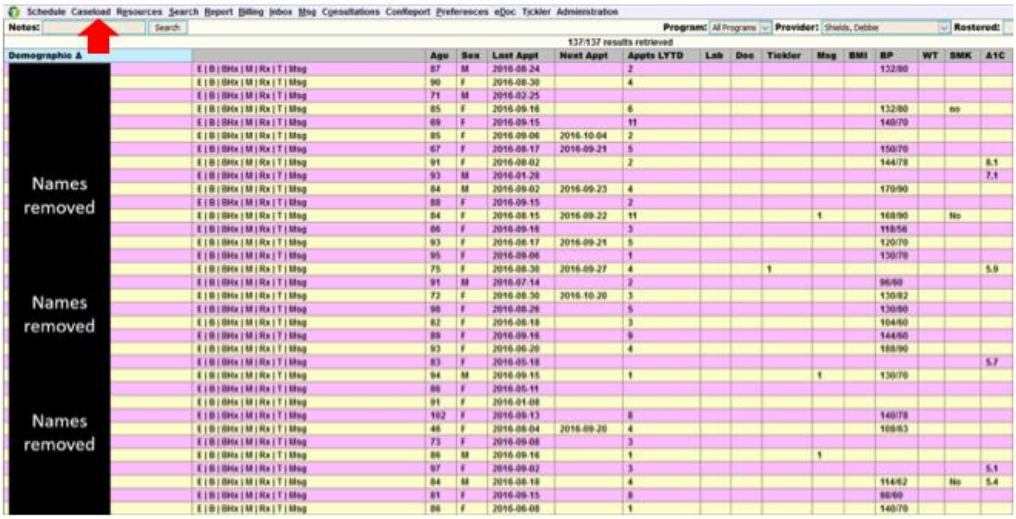
GP views photo inside his/her office EMR. Photo was uploaded by RN in remote EMR, and now appears in GP's EMR via integrator



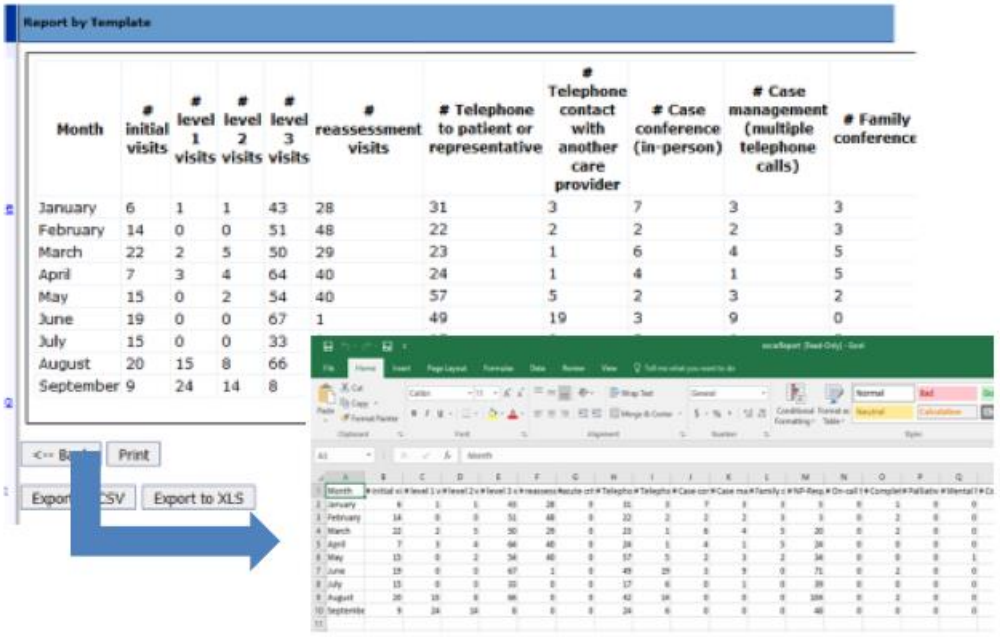
GP writes a chart note in response after viewing photo.



Nurse Debbie caseload view includes: active patient list (137 patients active), last appt, next appt, appts YTD, age, gender, BP, GFR, quick access to e-chart, Rxes, demographic etc.



Reporting functions: RN encounters by type



Month	# initial visits	# level 1 visits	# level 2 visits	# level 3 visits	# reassessment visits	# Telephone to patient or representative	# Telephone contact with another care provider	# Case conference (in-person)	# Case management (multiple telephone calls)	# Family conference
January	6	1	1	43	28	31	3	7	3	3
February	14	0	0	51	48	22	2	2	2	3
March	22	2	5	50	29	23	1	6	4	5
April	7	3	4	64	40	24	1	4	1	5
May	15	0	2	54	40	57	5	2	3	2
June	19	0	0	67	1	49	19	3	9	0
July	15	0	0	33						
August	20	15	8	66						
September	9	24	14	8						

Who are the patients

- At this time 469 patients have been enrolled into the Sunshiners network
- They are a combination of homebound or quite frail seniors that needed additional care to remain safely in the community

How has this small change impacted the patients and families

- Patients can safely remain in the community longer
- They can avoid hospital stays that are not necessary
- They can receive services without ED visits
- They can be assessed sooner and emergent care provided
- The physician can have real time access to service provision

How will this model Transform Health Care in the NW Region

- Fraser Health is training nurse Debbie in the community case management functions
- Cohorts of patients that would benefit from this type of care will be identified together with the division and replications of this model will be put into place.

How do we know that this works

- Administrative data was used to define the pre-Nurse Debbie patient baseline for 365 days

- Post intervention data was collected for the next 365 days

Acute Care Utilization Data

- Year two data was astounding
- 500 Emergency Department visits averted
- 17000 inpatient days saved
- And that was just 469 patients

Next Phase – Streamlining RAI Assessment through use of integrator and team based care

- By using the integrator to autopopulate data from physician EMRs into the home health nurse's RAI, time to complete the form could be significantly reduced
- By using the integrator for real time communication of patient status, it will be possible to respond in real time to meet patient needs at home, instead of sending them to the hospital

Physician Experience
Quote from FNW Member

"I can attest to the enormous impact that Debbie has had to my practice with respect to my elders that we serve together. She and I have a great rapport and communication. My patients feels safer knowing that she may be more available to take a call during the day than I can be, and that she will make sure that their concerns reach me in a timely manner. I also am comforted by her vast knowledge, experience and abilities to triage concerns as needed. She helps me keep my frail elders safer at home and out of the hospital as best as we can. She is an invaluable resource."

-Dr. Taki Galanopolous

Patient Perspective

Geraldine, a Burquitlam senior whose mobility challenges prevent her from leaving home unassisted.

Geraldine is able to stay in her own home, thanks to the Sunshiners Network.

"Whoever came up with this deserves a gold star. One phone call and Nurse Debbie is right here. She makes sure I get everything I need."

Oscar Integrator Pilot Expansion Project

February 25, 2019 – v1.0

Fraser Northwest Division of Family Practice
A GPSC initiative
fraserhealth

Mini- Project Charter

Overview

Fraser Health (FH) Integrated Primary & Community Care - New West & Tri-Cities is a virtual, full-service, primary care, team based practice located at Queen's Park Care Centre. The PCHS team consists of multi-disciplinary FH staff members (clinicians and allied health staff) who work collaboratively with Fraser North West family physicians to deliver primary care service at the clients' home. The FH PCC staff (RN & SW) document FH client information primarily into the Fraser North West Division of Family Practice (FNWDFP) owned Oscar EMR (formerly known as Sunshiner Frailty Network), and secondarily in PARIS, GoldCare and other FH systems).

Problem Statement

Lack of seamless transmission of patient information. Initial FNWDFP owned Oscar Integrator proof of concept project enabled real time sharing of patient information across two Oscar clinics. The model has since changed, and business area requested FH to purchase/ support (internal or external hosting) an instance of Oscar EMR and Integrator. A FH technical review was completed and concluded the solution does not align with many of FH's Enterprise Architecture Principles, and FH ownership of and hosting of the solution is not endorsed. Long term sustainment of the solution is also not desired by the FNWDFP, as it is not well positioned to manage the risks associated with holding the patient's clinical information.

Goals / Objectives/ Deliverables

Goal: To support innovation, promote provider working relationships and obtain Oscar Integrator pilot expansion learnings to be applied to a long term solution for all EMR to EMR interoperability.

Objectives:

1. Improve information exchange and coordination of care by expanding the Oscar Integrator pilot to enable real time information sharing and timely access to clinical information between FNW community Oscar physicians and FH providers.
2. Obtain Oscar Integrator pilot expansion learnings (i.e. to better understand EMR integration, how to connect additional clinics via the integrator, the impact on integrator performance, impact on provider relationships, etc.).

Deliverables:

- Repatriation of PIPA data (data removal from Division Oscar EMR used by FH)
- FH Security Threat Risk Assessment
- 1x funding agreement, Memorandum of Understanding
- Implementation of pilot expansion to five additional FNW physician Oscar EMRs v15 via the Integrator.
- Implementation of Oscar calculations required for interRAI forms (Home Care data set), and Oscar inter-clinic messaging
- Documented pilot expansion evaluation plan and evaluation summary
- Documented monthly status to FH.

Approach

- FH will lease space or borrow FNWDFP Oscar EMR and Integrator for FH clients until Dec 2019.
- FH IMIT will provide expertise and 1x funding dollars to a max of $60,701 to Mar 2019, and FH business area will provide funding to a max of $36,803 to Dec 2019.

Reporting

- Integrated Primary & Community Care Steering Committee
- Primary & Community Care Health Informatics Enablement Clinical Advisory Committee
- NW Primary Care Home Steering Committee

Project Sponsors

- **Kristan Ash**, Executive Director, FNW DoFP
- **Scott Brolin**, Executive Director, Tri-Cities & New Westminster Health Services, QPCC

In-Scope

- Expansion of five additional Oscar EMRs v15, using FireFox v45, to New West Primary Community Home Service via the Integrator.
- Oscar calculations required for interRAI forms (Home Care data set).
- Oscar inter-clinic messaging.
- Pilot expansion evaluation (FNW DoFP).
- FH PCC RN & SW

Out-of-Scope

- Oscar EMR versions prior to v15.
- Integration with community physician Oscar EMRs outside of Fraser Northwest regional area.
- Oscar Consent module improvements.
- FHIR data transport for multi-platform EMR support.
- FH PT & OT

Benefits

- Increased information exchange and access to clinical information, enabling enable continuity of care.
- Increased operational efficiency, as previous manual methods include mailing or faxing medical reports.
- Improved communications and relationships between FH and community – easier to be better community partners.
- Supports collaboration with FNW community and further opportunity to learn from expansion (i.e. capture performance data and impacts of adding more clinics to Integrator).
- Infrastructure already in place will allow for more timely expansion within FNW community, supporting team based sharing and learnings between selected and independent Oscar EMR v15 instances.

Timelines

Oct 2018	• FH Exec decision on path forward re Privacy Impact Assessment (PIA) options	Feb 2019	• Planning for repatriation of PIPA data (data removal from FNWDFP Oscar EMR used by FH as required) • Finalize mini-charter & evaluation plan • Initiate MOU
Nov 2018	• FH VP signoff of FH PIA • FNWDFP prepare draft evaluation plan • FNWDFP obtain research license from inter-RAI for use of RAI to study collaborative workflow in doing assessments	Mar 2019	• Develop and implement Oscar calculations for interRAI forms (Home Care data set). • Implement Oscar inter-clinic messaging • Expansion of five additional Oscar EMRs v15, using FireFox v45, to New West Primary Community Home Service via the Integrator • Complete FH STRA • Complete and signoff MOU
Dec 2018	• Revise one-time funding agreement, clarify indemnification • Update draft mini-charter • Secure resource for FH Security Threat Risk Assessment (STRA) • Review current state clinical workflows	May 2019	• Complete repatriation of PIPA data (data removal from FNWDFP Oscar EMR used by FH as required) • Stakeholder check-in
Jan 2019	• Review draft mini-charter & evaluation plan • Update current state workflows • Review current state clinical documentation workflow processes with Professional Practice & Legal • Signoff funding agreement • Initiate STRA	Dec 2019	• Complete FNWDFP evaluation documentation • Complete FH project closeout documentation • FH Exec decision on path forward