

# Integrating Information for the Continuum of Care

## The SIMS Partnership

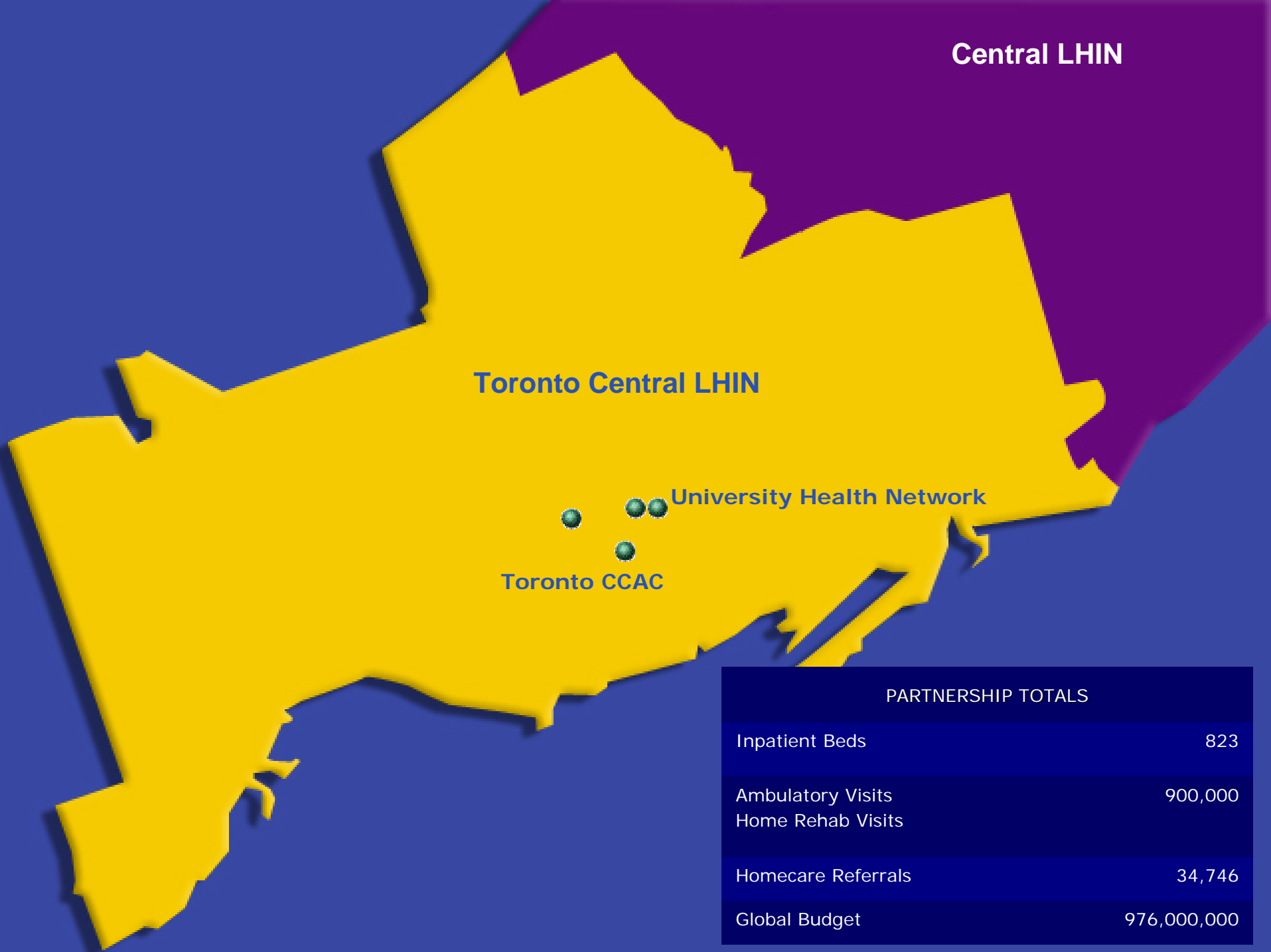
### Breakfast with Chiefs

May 9<sup>th</sup>, 2006

**Matthew Anderson**

**Vice-President, University Health Network**  
**Chief Information Officer, SIMS Partnership**  
**E-Health Lead, Toronto Central LHIN**





Central LHIN

Toronto Central LHIN

University Health Network

Toronto CCAC

PARTNERSHIP TOTALS

Inpatient Beds	823
Ambulatory Visits Home Rehab Visits	900,000
Homecare Referrals	34,746
Global Budget	976,000,000



St. John's Rehab  
Hospital

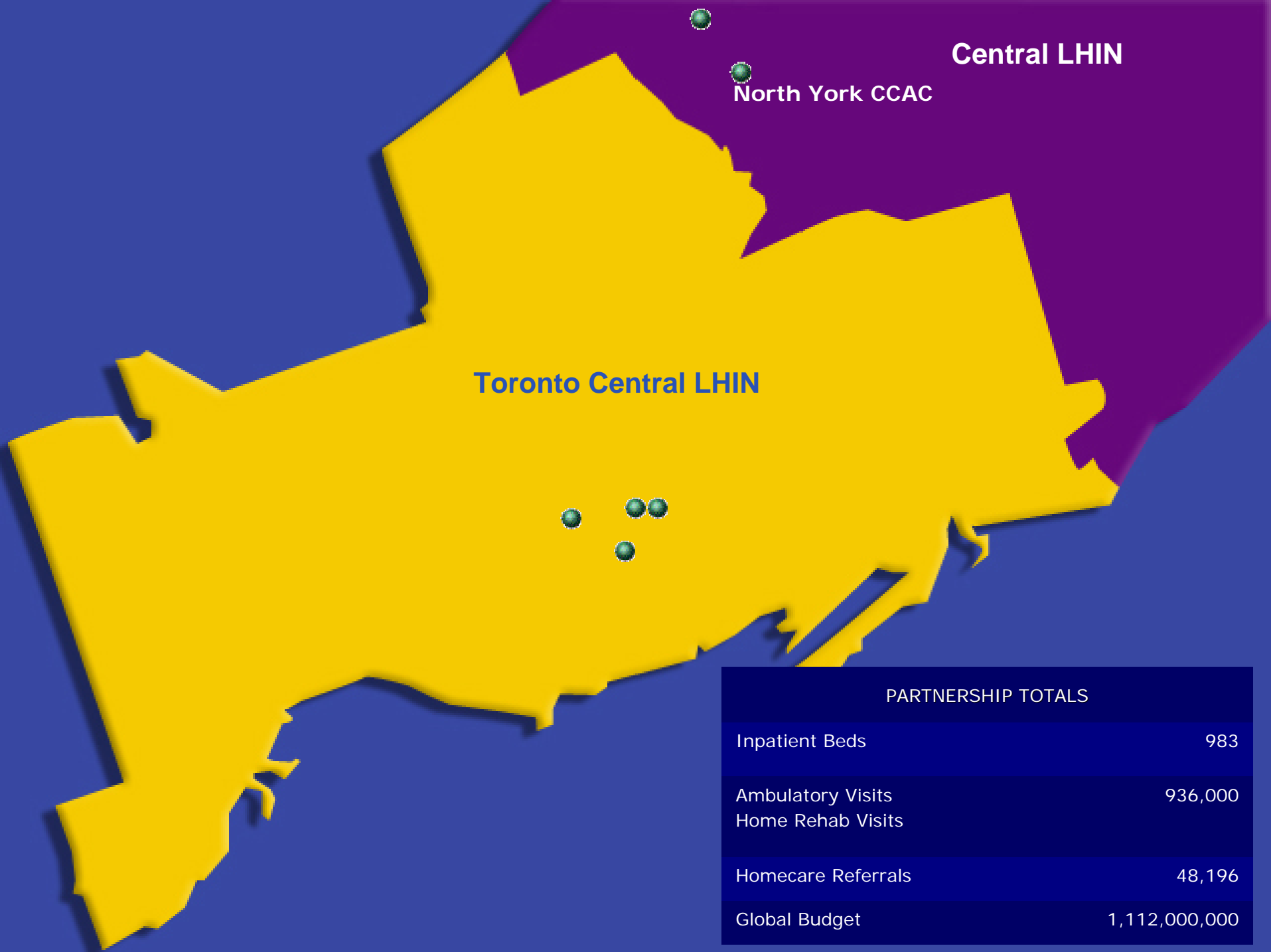
Central LHIN

Toronto Central LHIN



PARTNERSHIP TOTALS

Inpatient Beds	983
Ambulatory Visits Home Rehab Visits	900,000
Homecare Referrals	34,746
Global Budget	1,042,000,000

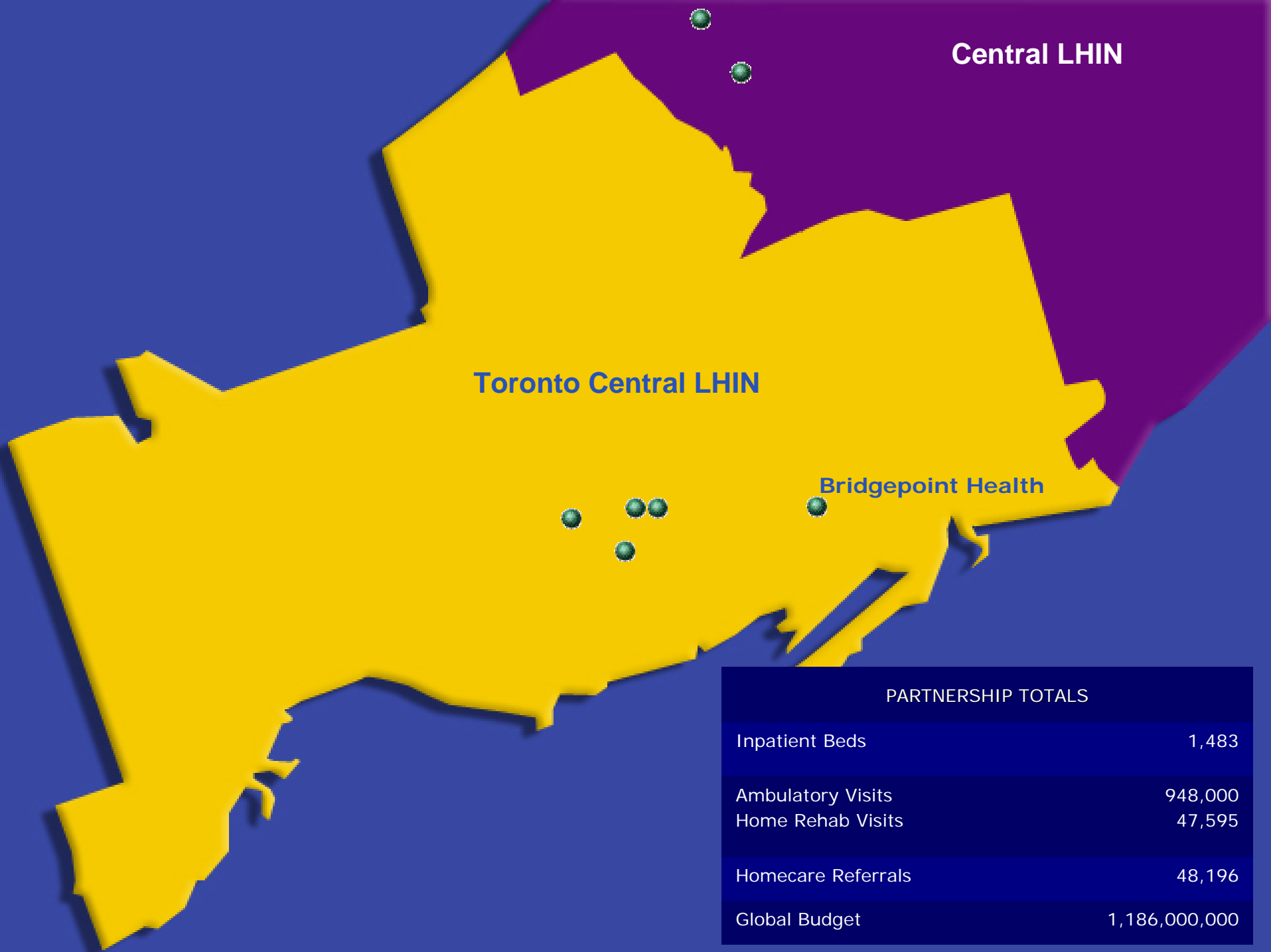


Central LHIN

North York CCAC

Toronto Central LHIN

PARTNERSHIP TOTALS	
Inpatient Beds	983
Ambulatory Visits Home Rehab Visits	936,000
Homecare Referrals	48,196
Global Budget	1,112,000,000

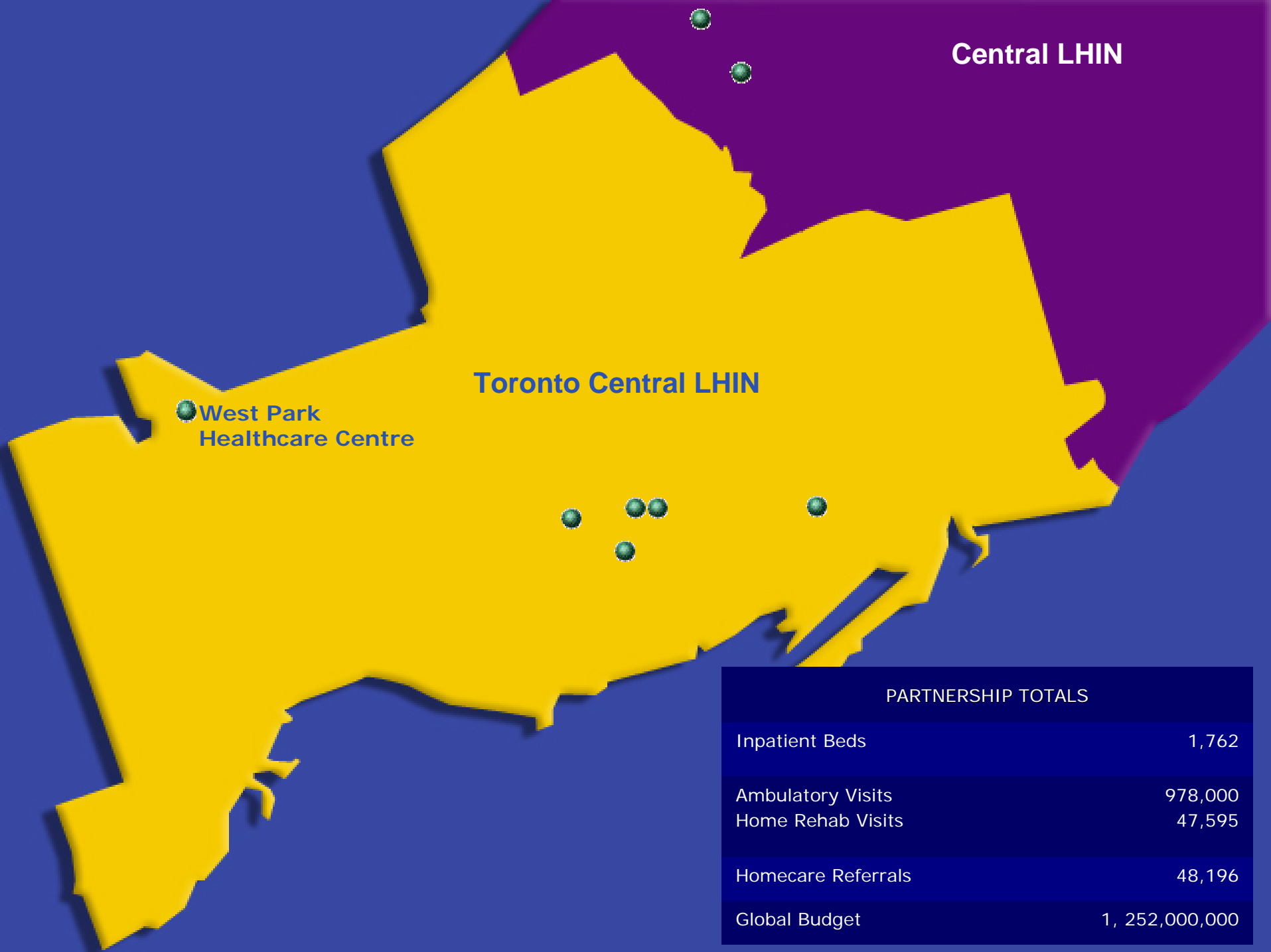


Central LHIN

Toronto Central LHIN

Bridgepoint Health

PARTNERSHIP TOTALS	
Inpatient Beds	1,483
Ambulatory Visits	948,000
Home Rehab Visits	47,595
Homecare Referrals	48,196
Global Budget	1,186,000,000



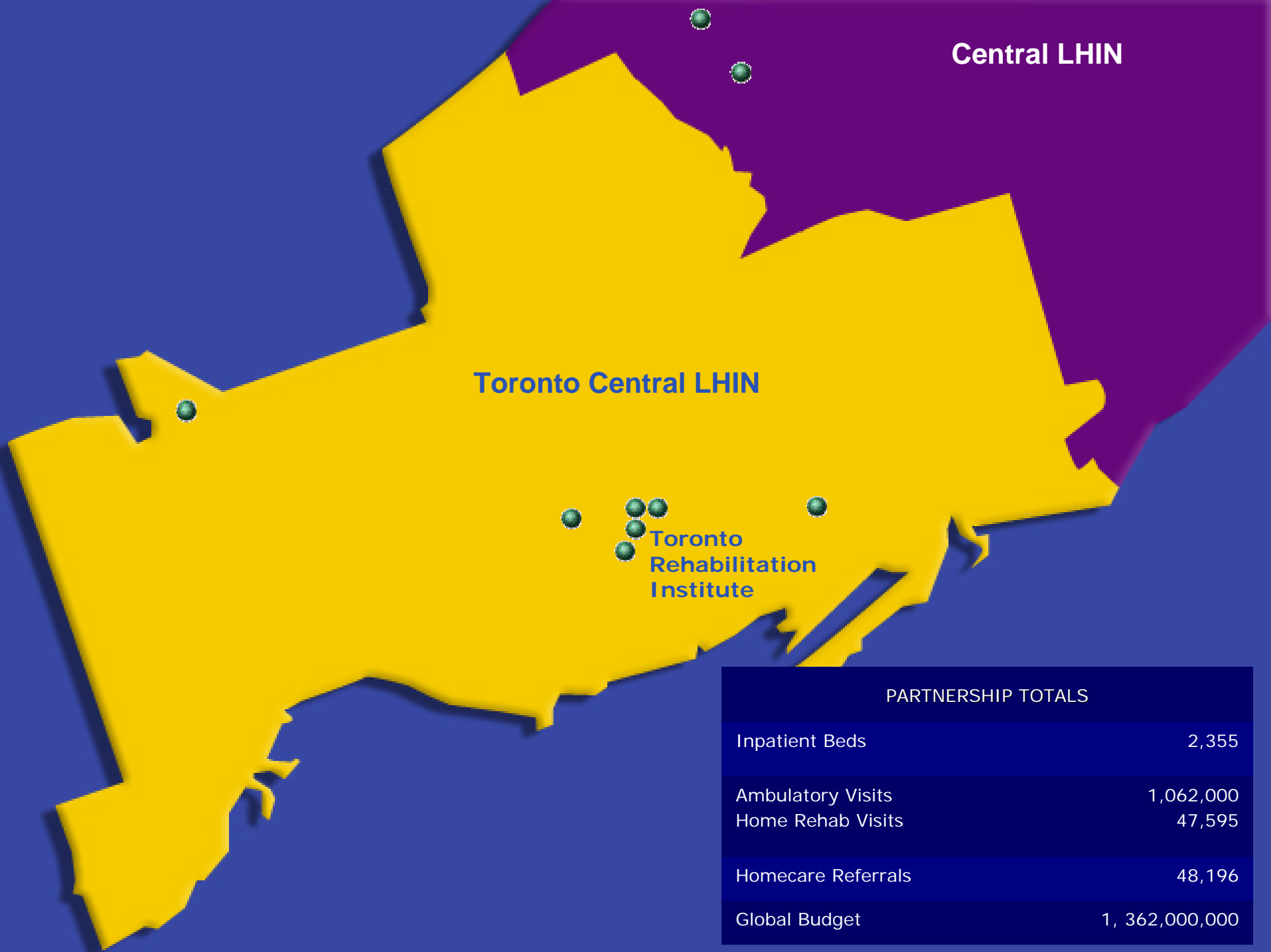
**Central LHIN**

**Toronto Central LHIN**

**West Park  
Healthcare Centre**

**PARTNERSHIP TOTALS**

Inpatient Beds	1,762
Ambulatory Visits	978,000
Home Rehab Visits	47,595
Homecare Referrals	48,196
Global Budget	1, 252,000,000



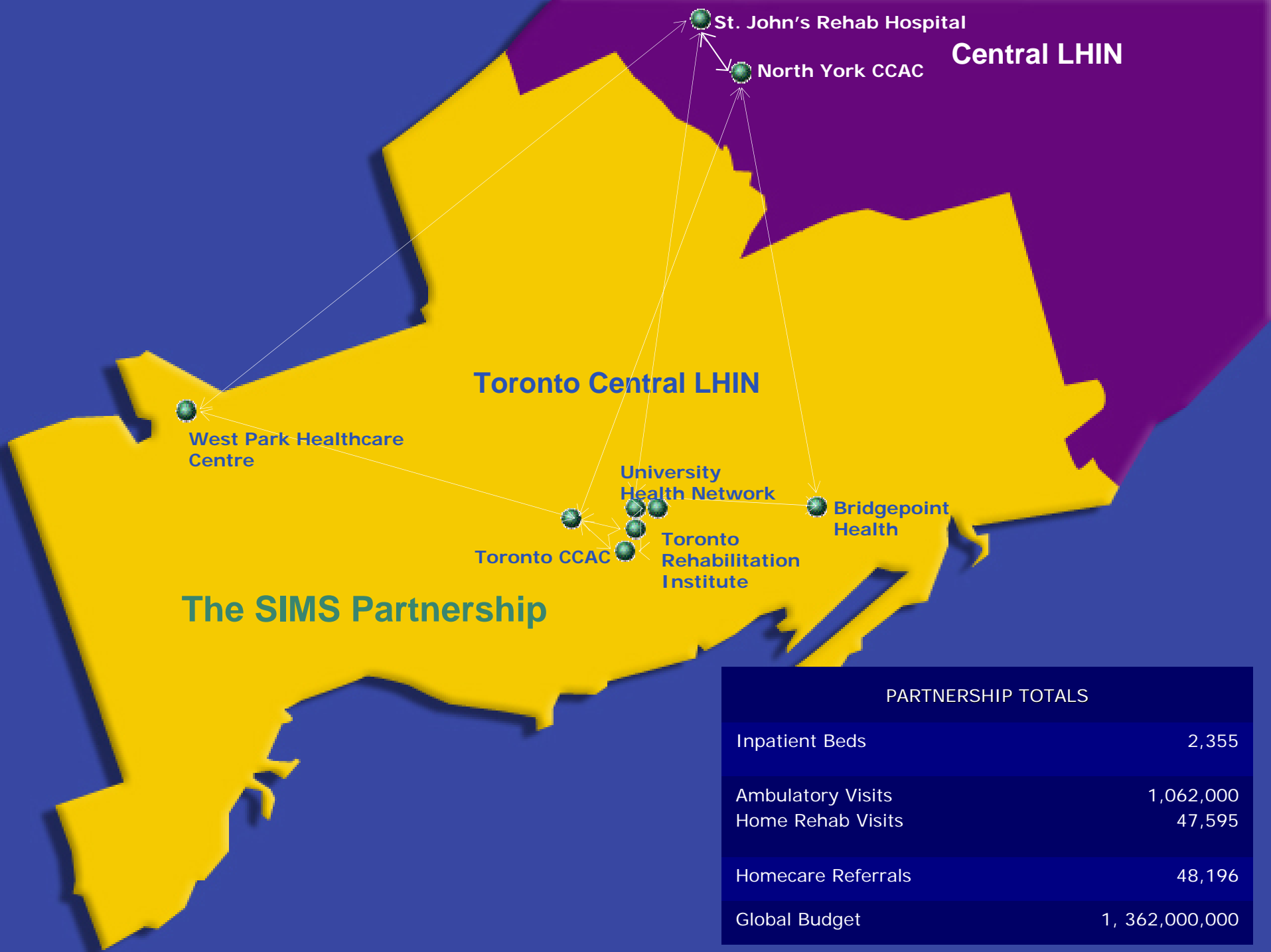
**Central LHIN**

**Toronto Central LHIN**

**Toronto  
Rehabilitation  
Institute**

**PARTNERSHIP TOTALS**

Inpatient Beds	2,355
Ambulatory Visits	1,062,000
Home Rehab Visits	47,595
Homecare Referrals	48,196
Global Budget	1, 362,000,000



**Central LHIN**

St. John's Rehab Hospital

North York CCAC

**Toronto Central LHIN**

West Park Healthcare Centre

University Health Network

Bridgepoint Health

Toronto CCAC

Toronto Rehabilitation Institute

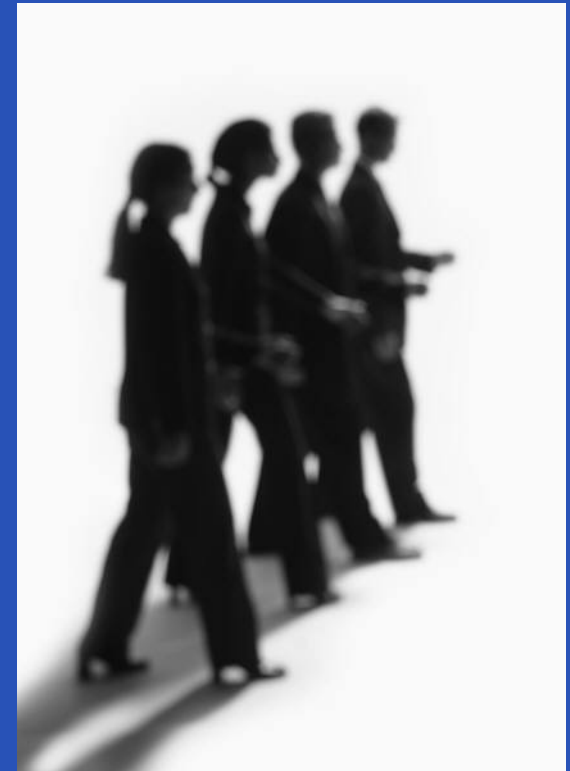
**The SIMS Partnership**

**PARTNERSHIP TOTALS**

Inpatient Beds	2,355
Ambulatory Visits	1,062,000
Home Rehab Visits	47,595
Homecare Referrals	48,196
Global Budget	1, 362,000,000

# How the Partnership Works

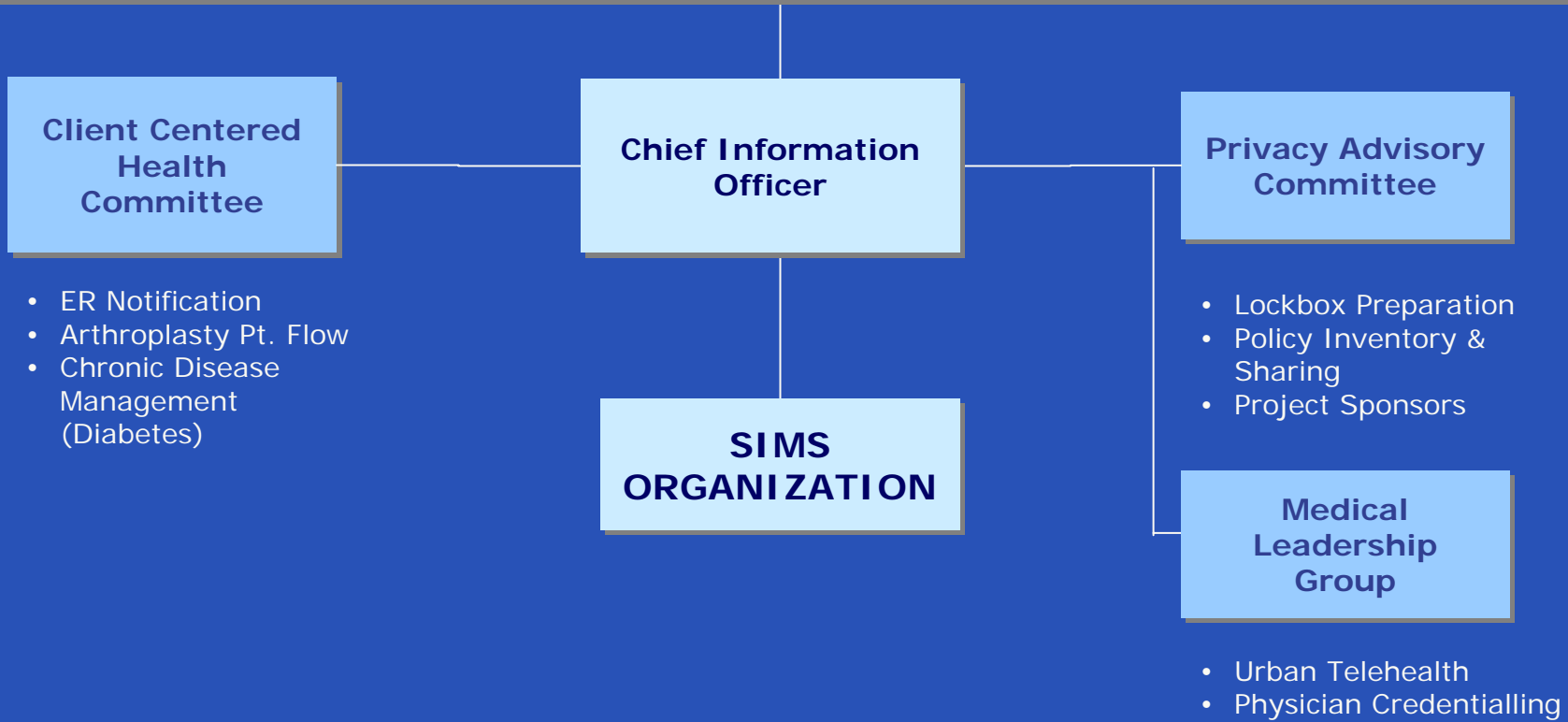
- Merge IT/IM departments (except Bridgepoint)
- Appoint Integrated CIO
- CIO works with CEOs to establish IM plan, goals and funding
- Execution of plan as per organizations' processes
- Respect for client privacy at every stage
- Partner organizations *may choose* to leverage each others existing IT infrastructure, shared software and employee skills set
- Partnership priorities: Our Clients, Our Clinicians and Health System Integration



# Governance Structures

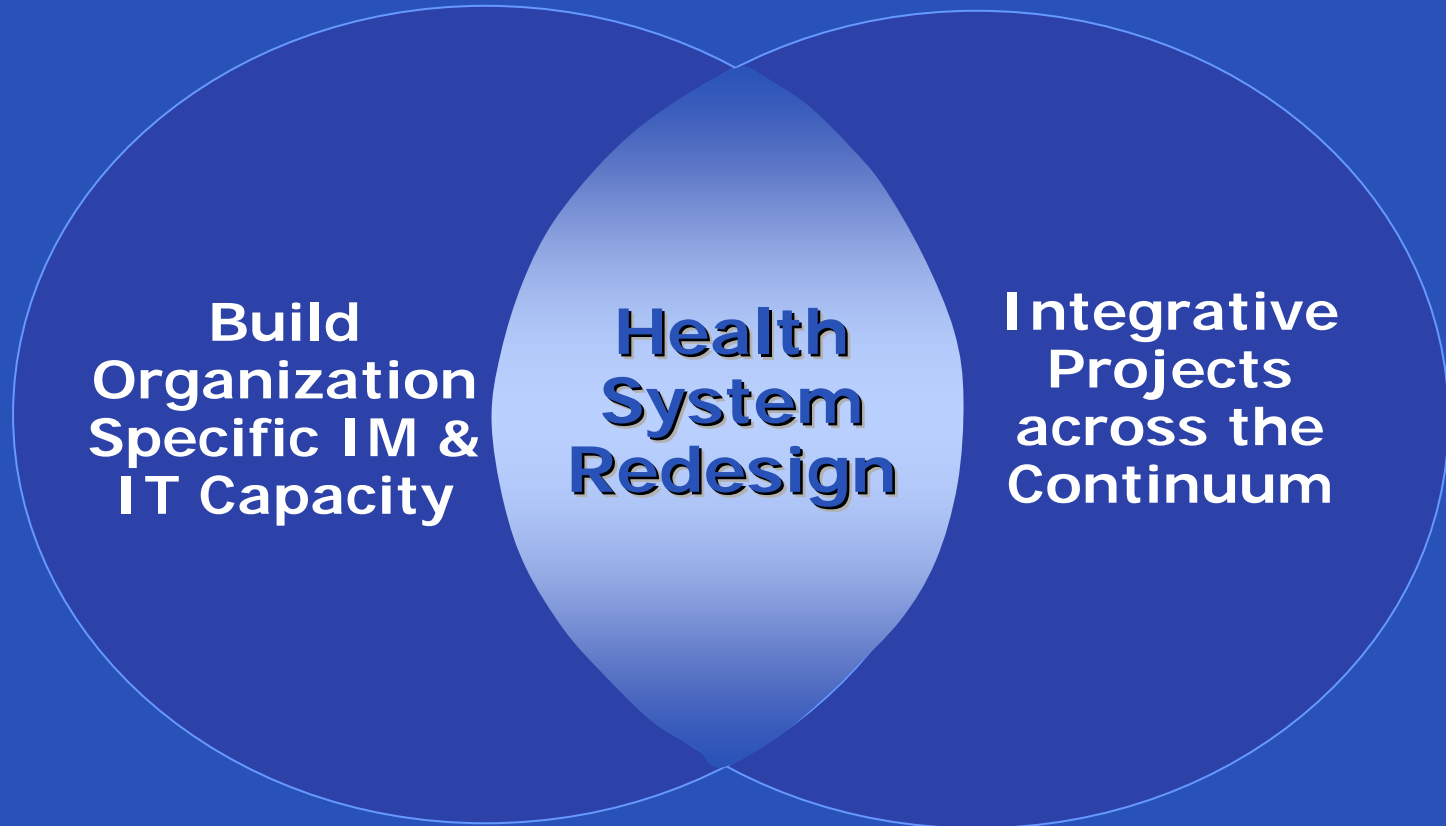
## SIMS PARTNERSHIP STEERING COMMITTEE

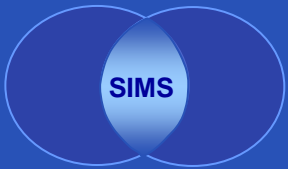
<b>Bridgepoint Health</b> Marian Walsh	<b>North York CCAC</b> Linda Stark	<b>St. John's Rehab</b> Malcolm Moffat	<b>Toronto CCAC</b> Camille Orridge	<b>Toronto Rehab Institute</b> Mark Rochon	<b>University Health Network</b> Robert Bell	<b>West Park</b> Anne-Marie Malek
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# Two Pronged Approach

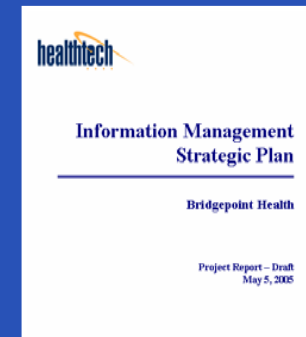
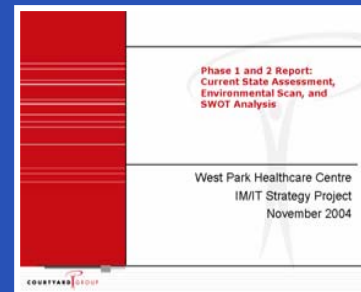
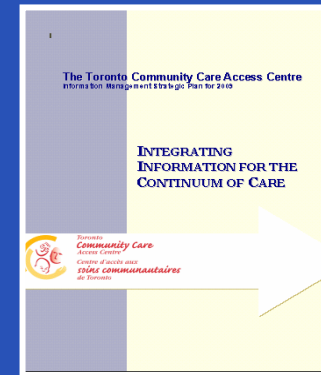
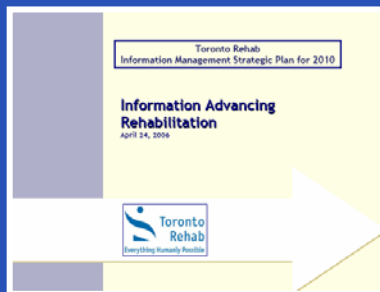
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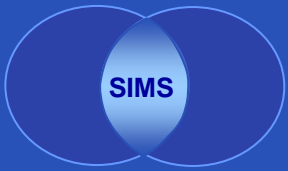




# Build Organization Specific IM & IT Capacity

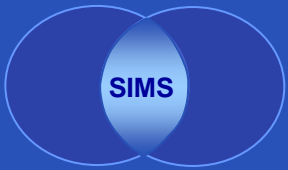
## Local IM/IT Strategic Plans





# Partnership Focus



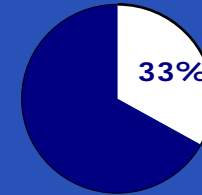


# Partnership Focus



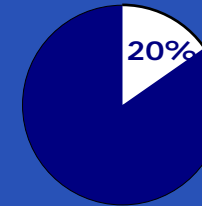
## Organization Specific

- Patient Scheduling
- Clinical Documentation
- Electronic Patient Record



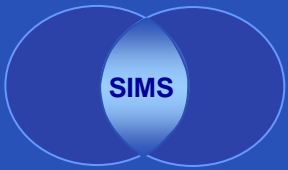
## Integrating Across the Continuum

- ER Notification
- E-Referrals –  
Arthroplasty, Surgical  
Discharge, Primary care
- Patient Portal



## Example Outcomes

- ↑ Client Satisfaction
- ↓ ALC Days
- ↑ Access to Services

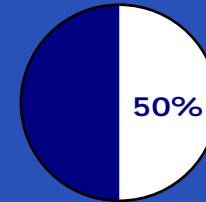


# Partnership Focus



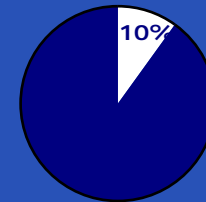
## Organization Specific

- Cancer Registry
- Data Warehouse/Repository
- Chronic Kidney Disease



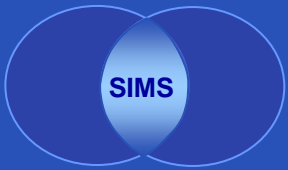
## Integrating Across the Continuum

- Registries
- Care Coordination Centre
- Complex Continuing Care
- Integrated to EPRs/Labs



## Example Outcomes

- ↑ control of Diabetes
- ↑ Inpatient Avoidance
- ↓ Wait Times

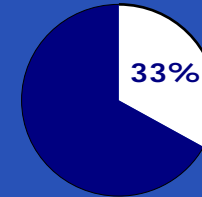


# Partnership Focus



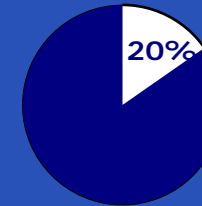
## Organization Specific

- Risk & Incident Management
- Computerized Physician Order Entry (CPOE)
- Clinical Alerting



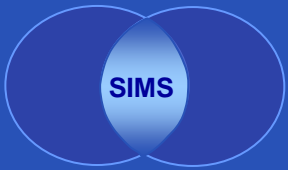
## Integrating Across the Continuum

- iEHR
- Common Rules Engine
- Clinical Rules Sets



## Example Outcomes

- ↓ Adverse Events
- ↑ Adherence to guidelines – multi-sector
- ↑ Medication Compliance

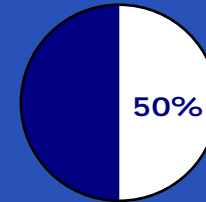


# Partnership Focus



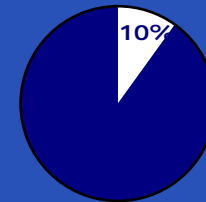
## Organization Specific

- Service Volume Management
- Corporate Dashboards/Scorecards
- Business Intelligence Tools
- Registration Re-Design



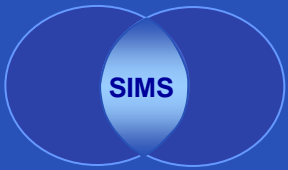
## Integrating Across the Continuum

- System-level Scorecard
- Single Data Repository
- Common Data Standards



## Example Outcomes

- ↓ Manual Data Collection
- ↓ Wait Times
- ↑ Financial Performance

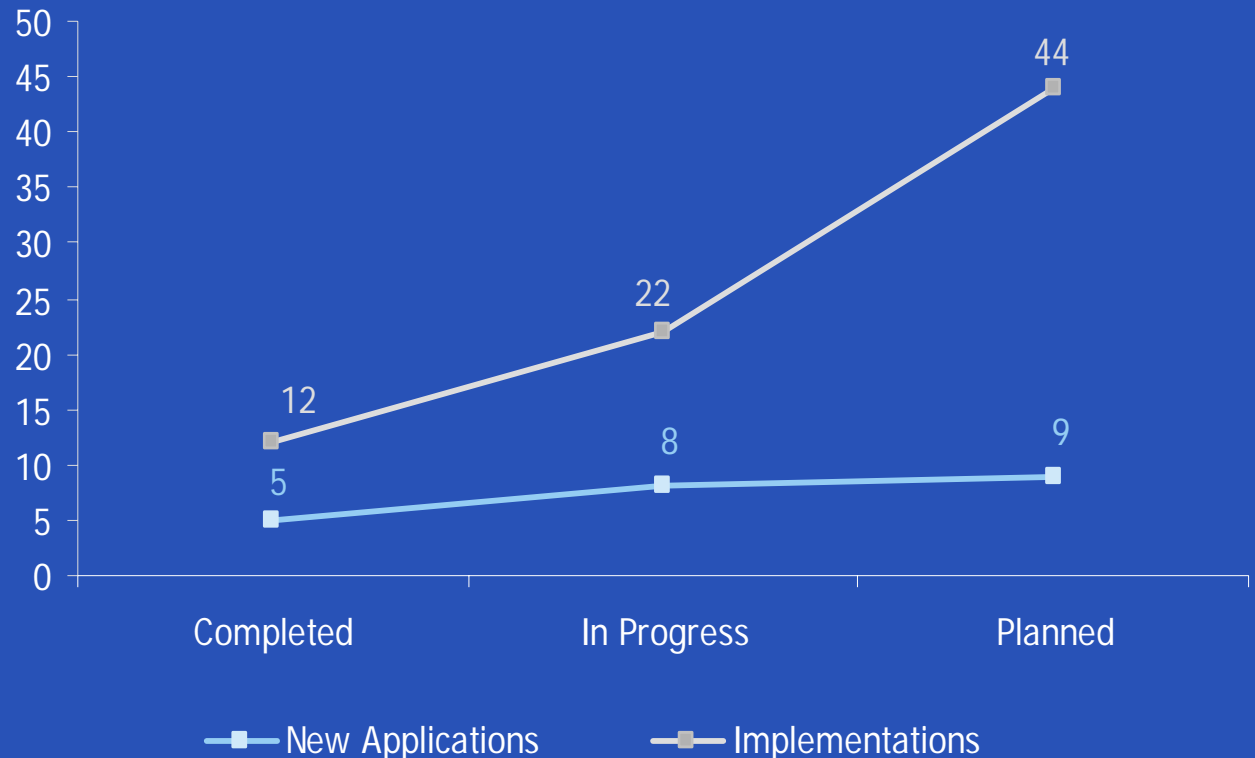


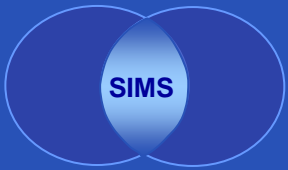
# Partnership Focus



## Leveraging Applications for Multiple Installs

- 44 Implementations over 3 years
- 9 Net New Applications over 3 years
- 7 FTEs Management Positions Eliminated

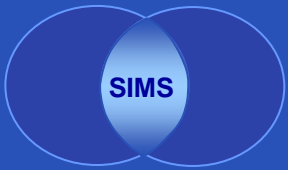




# Beyond the Partnership: Regional Integration

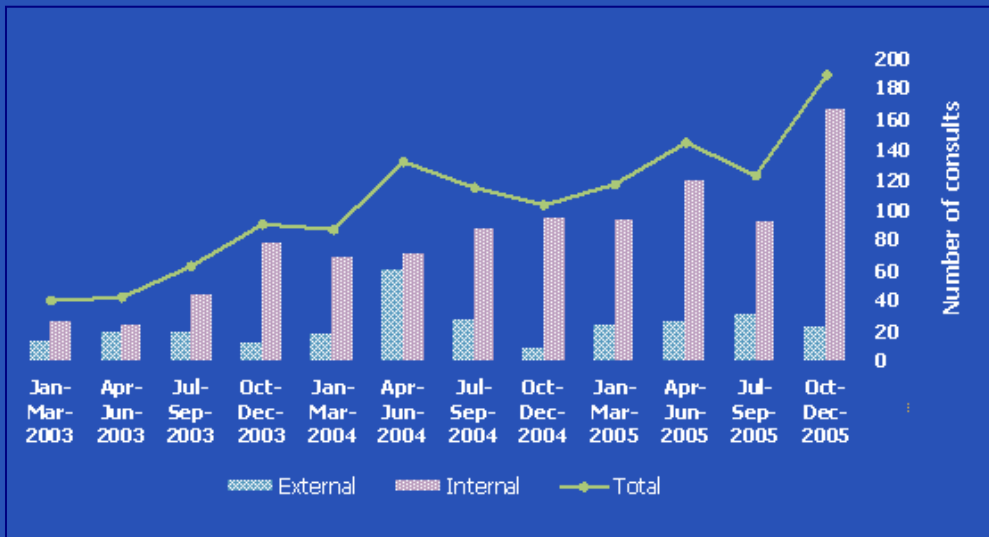
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- Anne Johnston Health Station
- Baycrest Centre
- Credit Valley
- East York CCAC
- MDS Labs
- Mount Sinai Hospital
- North Network
- Providence
- Queen West Community Health Centre
- Royal Victoria Hospital (Barrie)
- Seaton House
- St. Elizabeth Health Care
- St. Joseph's Health Centre
- Toronto Medical Labs

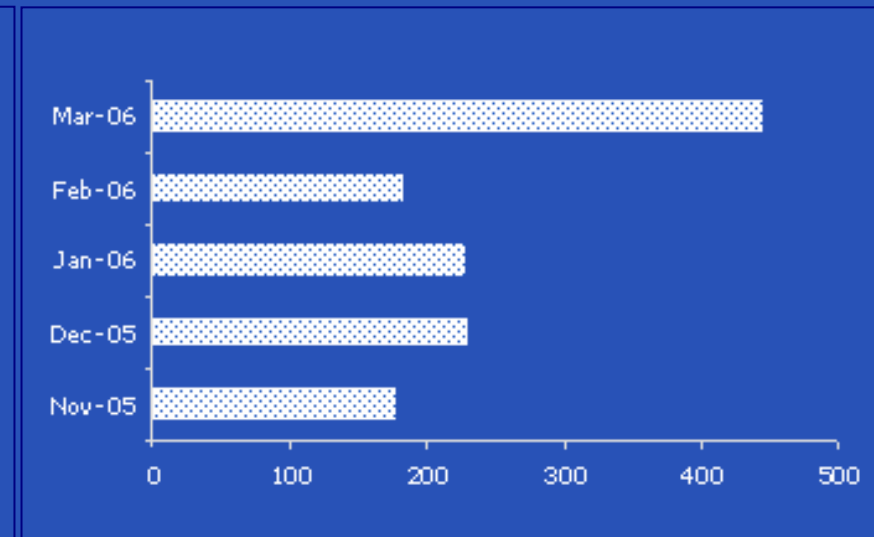


# Beyond the Partnership: Provincial Integration

## Telehealth



## ED Access to Drug History



## Ontario Lab Information System

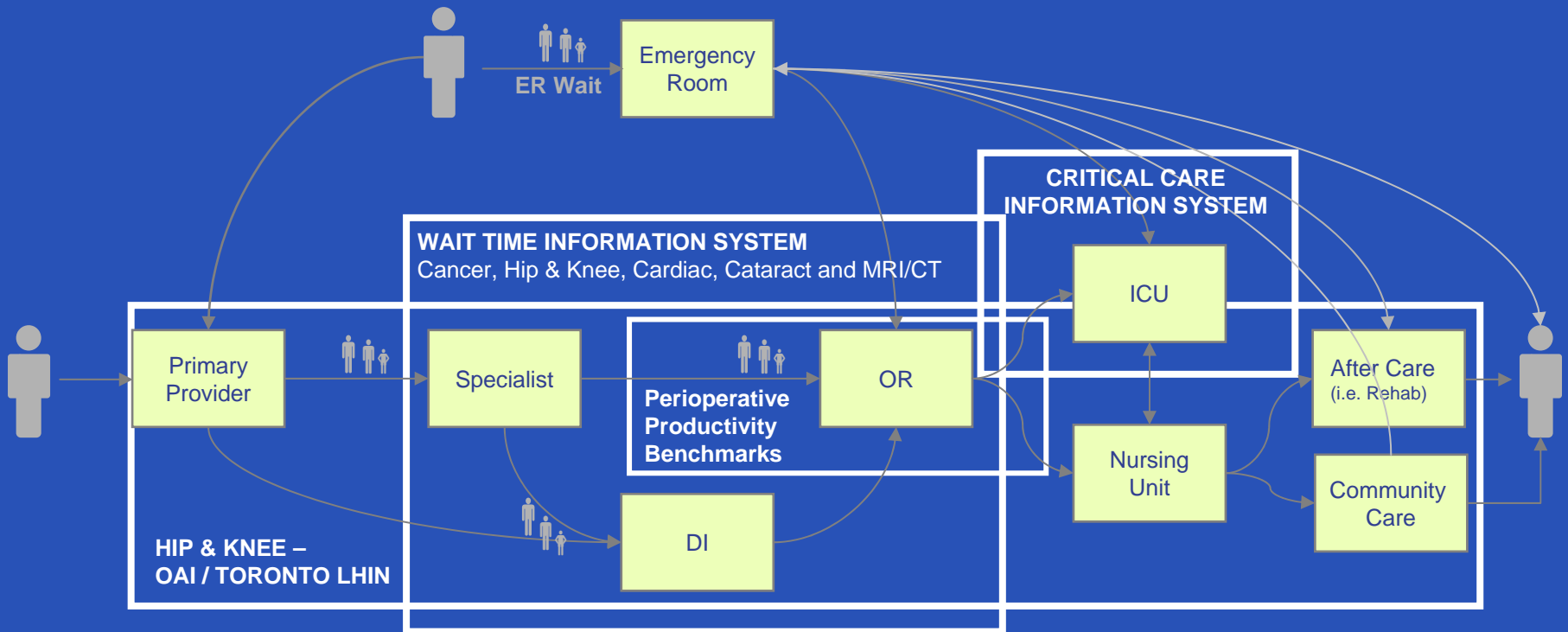
- Early Adopter

## Secure E-mail for Health

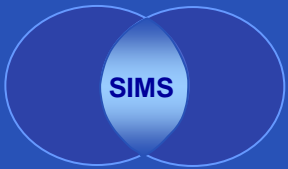
- Early Adopter

# Beyond the Partnership: Provincial Integration

## IT Strategy to support Access & Productivity Improvement

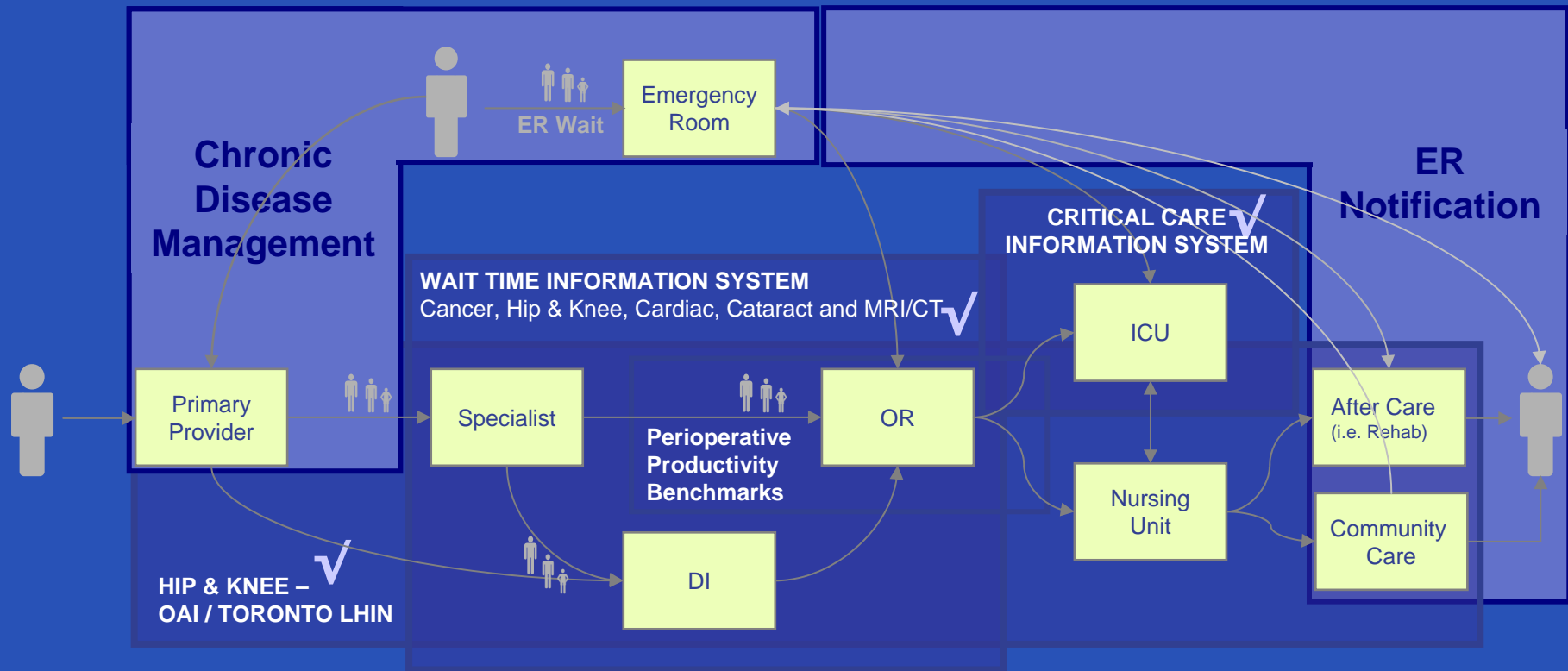


Provincial Client Registry (eMPI)



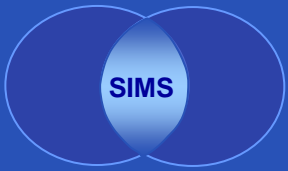
# Beyond the Partnership: Provincial Integration

## IT Strategy to support Access & Productivity Improvement



**Provincial Client Registry (eMPI) ✓**

**iEHR (Patient Results Online)**

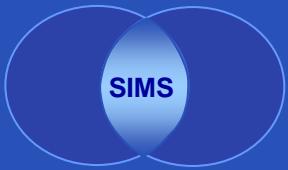


# An Integrated e-Health Strategy

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**The Partnership has a three-year e-Health agenda that will deliver the capability to:**

- ✓ **Share client/patient information electronically across the partners and beyond**
- ✓ **Electronically refer clients/patients between partners**
- ✓ **Redesign the patient transfer process for selected referral patterns**
- ✓ **Establish two-three chronic disease management programs**
- ✓ **Introduce common patient safety standards, processes and alerting infrastructure**
- ✓ **Standardize data collection and reporting at an organizational level**
- ✓ **Report on system level performance indicators to enable population-based planning**

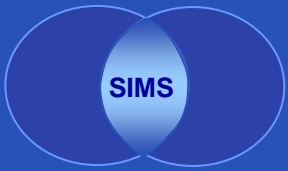


# An Integrated e-Health Strategy

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## Key Tactics/Enablers

- ✓ **Recruitment & Retention**
- ✓ **Innovative Service Delivery Models**
- ✓ **New business/market models – software**
- ✓ **Strong, reliable Provincial agenda and delivery mechanisms**
- ✓ **Additional investment sources and incentives**



# An Integrated e-Health Strategy

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## For the Partner Organizations (3 Yrs)

- ✓ Patient/Client satisfaction is higher
- ✓ Understand and improve our safety and quality measures
- ✓ Measure and monitor organizational performance
- ✓ Develop access management processes to streamline movement along the continuum of care
- ✓ Out-perform our respective accountability agreements

# Integrating Information for the Continuum of Care

## The SIMS Partnership

### Breakfast with Chiefs

May 9<sup>th</sup>, 2006

