Telemedicine IMPACT Plus

Interprofessional Complex Care Clinic

Patient Centred Care Planning for Medically Complex Patients using Videoconferencing and Multidisciplinary Teams to Support Primary Care Providers

Nursing Leadership Network of Ontario Conference

Toronto

March 23 2018

World Health Organization

Primary Health Care-Now more than ever

“United by the common challenge of primary health care, the time is ripe, now more than ever, to foster joint learning and sharing across nations to chart the most direct course towards health for all.”

Dr Margaret Chan Director – General, World Health Organization 2008

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WHO has identified 5 goals:

- Reducing exclusion and social disparities
- Organizing health services around people's needs and expectations
- Integrating health into all sectors
- Pursuing collaborative models of policy dialogue
- Increasing stakeholder participation.

We are making progress

- Much progress has been made in treatment for some diagnoses- e.g. cancer care, stroke, hip fracture.
- However, they tend to be focused on hospital care
- How can our health care system change to promote more effective primary health care?

What are the opportunities for primary care ?

Dr Barbara Starfield

- “In its most highly developed form, primary care is the point of entry into the health services system and the locus of responsibility for organising care for patients and populations over time. There is a universally held belief that the substance of primary care is essentially simple.

Nothing could be further from the truth.”

Starfeld B., Primary Care: Concept, Evaluation and Policy (Oxford University Press: Oxford) 1992

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Welcome to the world of the medically complex patient

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Where are the financial costs?

- Patients with complex co-morbidities represent 1-4% of the population but account for 30-60% of health care costs.

What are the emotional/social costs?

- Often they are staggering.

The trajectory of life limiting conditions: Care v.s. Disease Management

TRAJECTORY	RISK/ FLAGS
Diagnosis Initial tests Discussion Prognosis Education	Determinants of health not identified Comorbidities may exist and affect Disabilities Mental health disorders Education not 'absorbed' Access to care providers
TRANSITION Change in condition, Crisis and ED Other conditions Unrecognized determinants Broken communication	Multiple hospitals and specialists Moving target of suggestions Polypharmacy Transportation Missed appointments Anticipated burden on caregivers Complex family situation
TRANSITION Worsening of condition Moving into downward trajectory Possible problems anticipated End of life planning	Diagnosis focused Lack of pt/ family knowledge of disease process Lack of anticipating predictable events and readiness of resources Unclear direction of care 'Rescue treatment' -earlier interventions and better monitoring might have avoided Burden to caregiver

How do we influence change?

- Any impact on the acute care system must occur in the home **BEFORE** they reach the hospital
- There are gaps in our primary care system
- Barbara Starfield- primary care balancing health needs, services and technology

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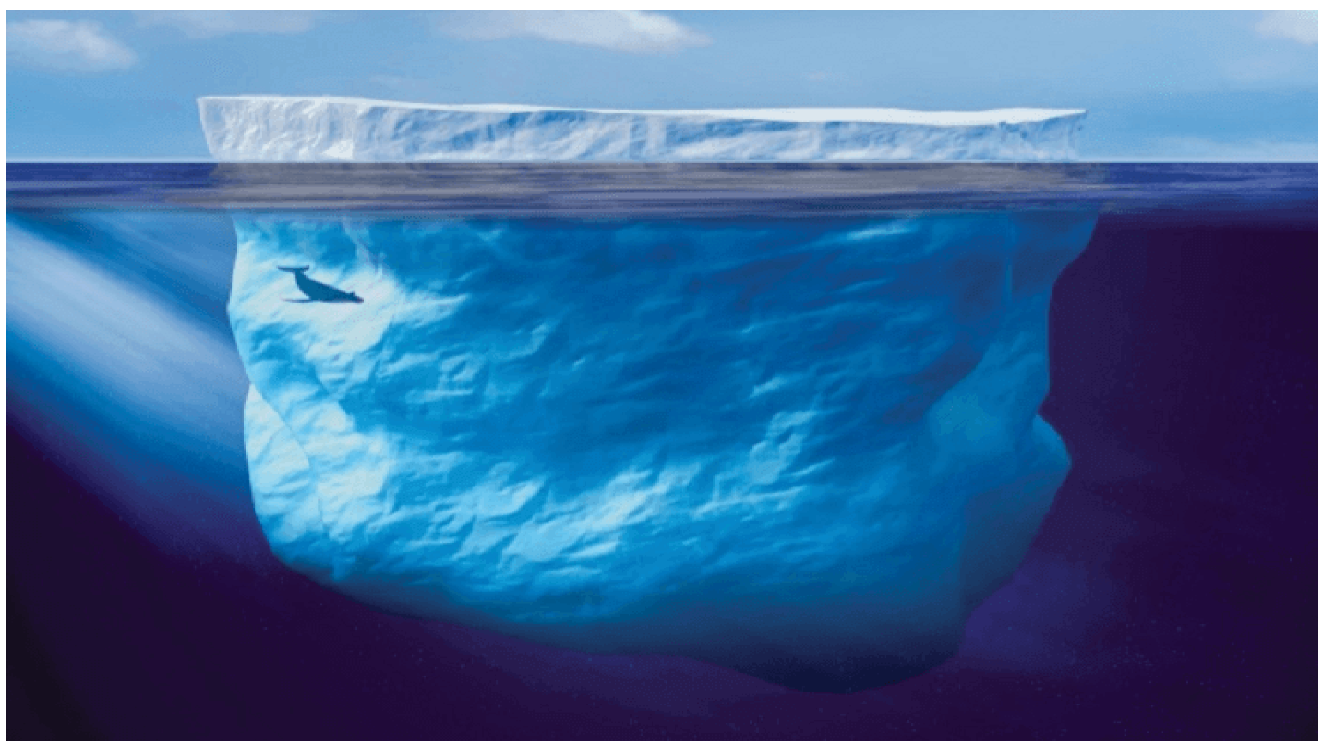
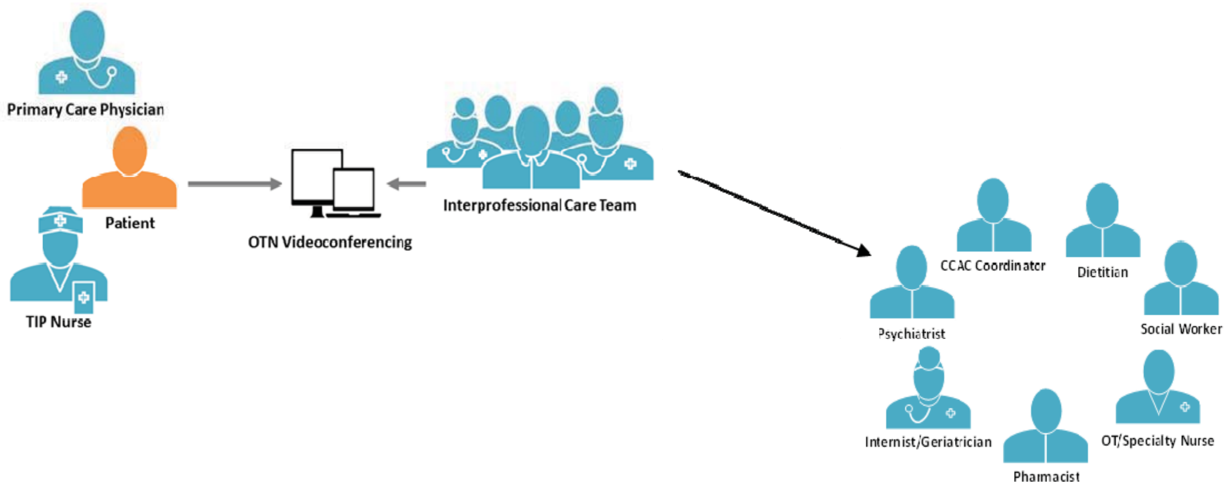
Reality



Telemedicine IMPACT Plus (TIP)

TIP utilizes secure telemedicine videoconferencing technology to connect primary care physicians and their patients with complex health needs to an inter-professional care team, including specialists, for a one-time consultation facilitated by a TIP RN



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TIP beginnings- 2013

- Part of Urban Telemedicine Initiative funded by Toronto Central LHIN
- Alignment a number of TC LHIN hospitals, community organizations and multiple stakeholders
- Community Nurses were recruited from Saint Elizabeth Health Care
- Ontario Telemedicine Network (OTN) important partner

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Building a model

- Process developed,
- Source of referrals was to be solo family doctors
- Access to patient information from multiple sites
- Consent and documentation tools developed and refined (PDSA)
- Interdisciplinary teams began to collaborate at multiple sites, assisted in refining tools to maximize effectiveness (eg. MMSE,MOCA, RUDAS frailty score, Depression tool)

Patient story - Pre tip

Physical health

•45 yr. old woman with constipation (abdo pain), nausea, missed periods

Social determinants:

- Lives with family. Has access to transportation; food and shelter situation stable; on ODSP

Relationships:

- Lives with parents, brother and sister. Her sister is her POA but patient still makes own decisions

Mental health:

- Diagnosed with schizophrenia; has delusions that she is pregnant. Sees psychiatrist every three weeks for Modecate injection

* Not connected with any mental health support. She sees a psychiatrist at local hospital but because patient is not within their catchment she was not accepted into their ACT program

•**Primary care connection-** would go to ED and not see GP

In 6 months:

•75+ ED visits (sometimes twice in a day)

•11 ultrasounds, 8 CT and 6 xrays, +++ lab tests.

Post TIP

Physical health:

- medication changes made, new regimen started, negotiated that pt would go to GP weekly, instead of ED

Financial:

- No change

Social determinants:

- She takes bus for transportation, with no issue

Relationships:

- Set up with health coach for support. Health coach available on a daily basis.
- She is also connected with the LINK program for case management

Mental health:

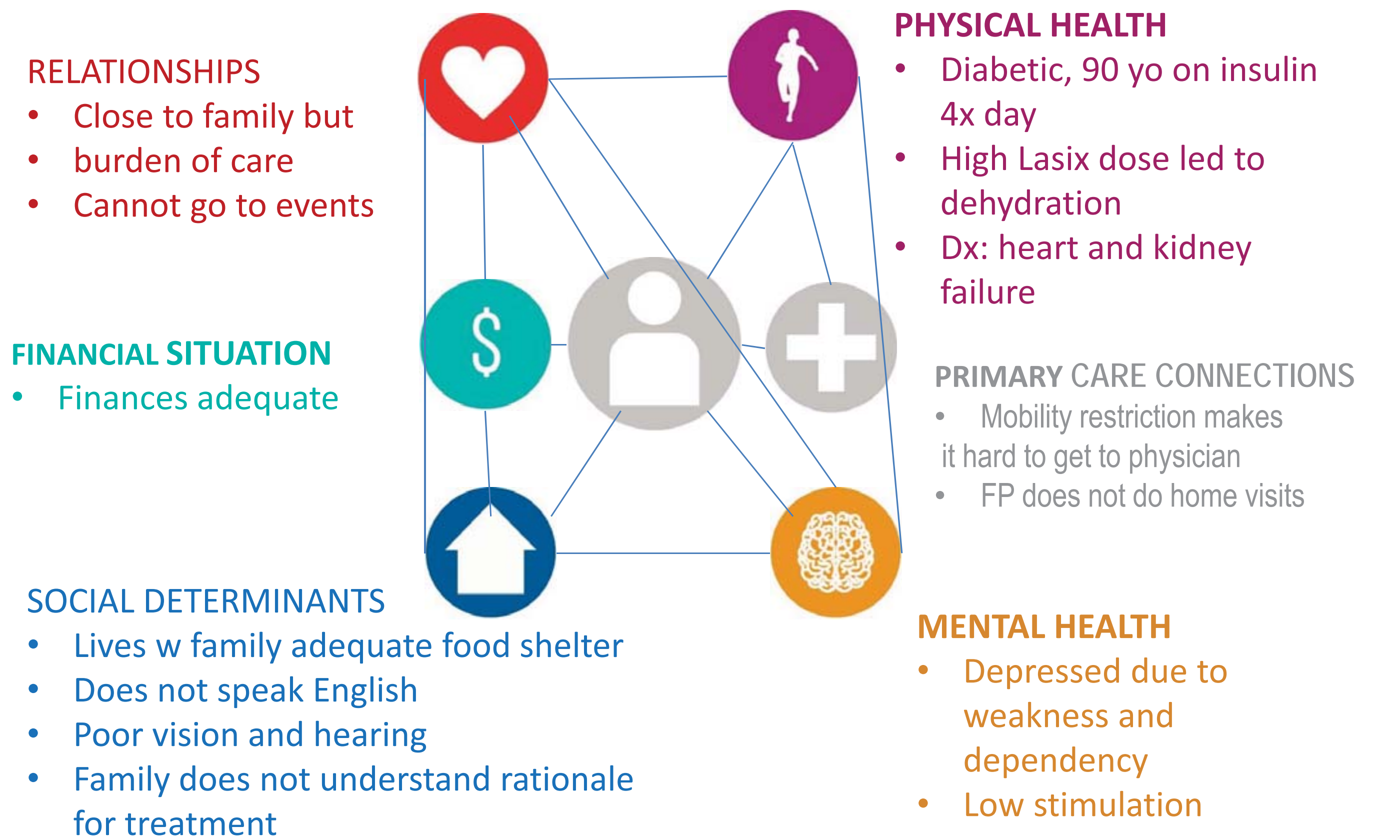
- patient has more active support from health coach

Primary care connection:

- Family physician now aware of behaviours, relationship improved and care less fragmented

Patient seeks assistance of FP rather than ED. Since TIP (6 months ago) 3 ED visits

Client #2 with High Medical Needs Frequent ED visits – Pre-TIP



Client 2 post TIP

RELATIONSHIPS

Day program identified in pt language to give family respite. Less strict diabetes management reduces burden of care

PHYSICAL HEALTH

- Insulin changed to 2 x a day long acting
- less strict control of blood sugar to reduce episodes of hypoglycemia. Lasix sliding scale if signs of fluid retention

2 meds discontinued due to risk of side effects. F/U pharmacist home visit

FINANCIAL SITUATION

POA confirmed

PRIMARY CARE CONNECTIONS

Physician for housebound patients identified in catchment areas Transfer of care facilitated by TIP pt. summary

SOCIAL DETERMINANTS

Link to day program for social needs. Transportation available at lower cost with volunteer if her mobility increases with more activity

MENTAL HEALTH

Feeling better and able to get our more often

Working the model

- Family physician engagement not always present.

- How do we identify patients who would benefit from the model

- We realized that we were on the road less travelled.

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Challenges

- Technology learning curve
- OTN
- Fax barrier
- Access to information
- Different consulting teams had different expectations
- Lack of a ‘home’
- Family physician engagement

Our experiences with Family Physician engagement

You might think it was easy….

But we proved it was not.

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How do we identify medically complex patients?

- High ED users
- Multiple diagnoses
- Mental health issues
- Missed appointments
- Unfilled prescriptions
- Patient /caregiver self reporting

Key indicator:

Ineffective use of the health care system

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How do we ensure that all caregivers are aware of the situation?

- A long list of diagnoses does not necessarily mean that the patient is not well managed.
- Even with a shared health record system, important information is not necessarily available to the clinician.
- **Patients who are more complex and at risk need to be identified earlier.**

Building relationships

- Opportunities for collaboration with developing Health Links Model
- Public health
- SPIDER program with EMS, police services, public housing, social services,
- Further understanding and exploration of Family Physician engagement

Patient-Centred Innovations for Persons with Multimorbidity (PACE in MM) Study

Funded by CIHR

P.I.: Dr M Stewart Western University and Dr M. Fortin Universite de Sherbrook

Goal of 5 year national study:

- To change primary health care and community-based chronic disease prevention and management programs to:
- Move from a single disease focus to a multiple disease focus;
- Centre on not only disease but also on the patient;
- Realign the health care system from separate silos to coordinated collaborations in care.

Encouraging early results from study , TIP effective in addressing complex concerns

GROWTH

- Patient identification was essential, but when Family physicians did not do this there were other ways –e.g. SCOPE (network of Family Physicians)
- Better Care (identification and screening of high ED users)
- Model getting recognition as a leading practice (OHA and College of Physicians)
- Advocating for the voice of the patient and their needs
- Expansion to larger area, centralized referrals, addition of new teams

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Benefits

NETWORKING!

- E.g. SPIDER program in Toronto, EMS, Police, ALS society, Pediatrics and developmental service support (Sick Kids, Surrey Place)
- Public health has an important role to play with this population
- High users are being tracked and understood
- Service providers are eager to work in a collaborative model, but would benefit from a comprehensive way to communicate with each other
- Gaps in the system are better understood when there are case studies that illustrate the issue

Setting a path

- Earlier identification of patients and resources is essential for maximum cost savings and enhanced quality of care.
- It is important that we have data and published articles to drive change and receive funding.
- Follow up and ongoing navigation for patients is still evolving.
- Technology will be a valuable tool in doing this.
- Health Links model is evolving to do a better job of managing complex patients and supporting primary care providers.
- Nursing has a key role in integrating and ongoing monitoring of patients in their chronic disease management.

Thank you!

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