HOW TELEHEALTH IS CHANGING THE WAY HEALTH CARE IS DELIVERED: ONE ORGANIZATION’S EXPERIENCE!

GTA Rehab Network Best Practices Day
May 1, 2015

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OBJECTIVES

1. To present critical success factors for implementing an effective Telehomecare program
2. To demonstrate how Telehomecare Nurses are supporting Ministry priorities
ONTARIO TELEMEDICINE NETWORK (OTN)

“A world leader in telemedicine, OTN helps Ontarians get more out of the health care system by bridging the distance of time and geography to bring more patients the care they need, where and when they need it.”

(www.ontariotelehomecarenetwork.on.ca)
WHAT IS TELEMEDICINE

Use of information technology to:

• Enable patients to access their health care providers and/or engage in their own health management
• Enables providers to collaborate with each other to improve care delivery

A.K.A. “Virtual Health Care”
OTN SERVICES

Telemedicine services that have been scaled province wide:

• Rural videoconferencing
• Distance Education
• Emergency/Urgent consultations
• Teledermatology and e-consult
• Telehomecare
The Central West LHIN Telehomecare Program was one of three original pilots

- Osler only hospital host
- Northwest LHIN, Toronto LHIN hosted by CCAC
- 5 FTE RNs, one FTE clerical, one FTE engagement lead

Telehomecare nurses are trained in:

- Motivational Coaching
- Disease Management Best practice
- Modifiable behaviours in chronic disease
- Telehomecare technology
- Medication Management
• Telehomecare supports patients and their families living with COPD and/or CHF through health coaching and remote monitoring and complements care provided by the primary care provider (PCP)
• Program launched January 28, 2013
• 6 month duration
• Target 500 patients per calendar year i.e. 1000 patients enrolled by December 31, 2014.
• Summer 2014 added diabetes monitoring if a co-morbid condition for a trial of 50 patients
• Effective May 2015 diabetes will be routinely monitored
• Nurses will provide education and support on topics such as medication management, knowing their numbers/targets, hyper and hypoglycemia management, mood management,
• Foot and eye care
THE PROGRAM

• Objective of the program is to reduce ER visits, readmission rates, LOS, and promote self management
• Referral sources include health care providers e.g. CCAC Rapid Response team, hospital, GP and patient self referral,
• GP or specialist asked to participate to provide patient support, medication or treatment revisions
• Easy-to-use equipment installed by technicians allows patients to measure and transmit weight and blood pressure with tablet technology
THE PROGRAM cont’d

- Specially-trained nurses monitor results and speak to patient asking simple questions about how they are feeling and alert the primary care provider if there are signs of an exacerbation or signs and symptoms are outside of preset parameters.
- Weekly telephone coaching educates patients about chronic disease self management.
- Liaise with community pharmacists.
- Ratio of RN:Patient approximately 1:60.
- Primary care providers receive regular reports from the Telehomecare nurses (standard template report).
- No cost to patients and families.
REFERRAL SOURCES

Source of All THC Referrals

- Osler: 58%
- Rapid Response Nurse: 11%
- CCAC: 3%
- MD office: 15%
- Headwaters: 10%
- Other: 3%

Legend:
- Osler
- Rapid Response Nurse
- CCAC
- MD office
- Headwaters
- Other
## Quick Summary

<table>
<thead>
<tr>
<th>Category</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Referrals to program to date</td>
<td>2368</td>
</tr>
<tr>
<td>COPD</td>
<td>580</td>
</tr>
<tr>
<td>Heart Failure</td>
<td>673</td>
</tr>
<tr>
<td>Total number of enrolments to date</td>
<td>1253</td>
</tr>
<tr>
<td>Total discharges to date</td>
<td>1004</td>
</tr>
<tr>
<td>Number of patients currently active in program</td>
<td>249</td>
</tr>
<tr>
<td>Number of patients currently being monitored</td>
<td>228</td>
</tr>
<tr>
<td>Number of patients currently awaiting equipment install</td>
<td>18</td>
</tr>
</tbody>
</table>
IMPLEMENTATION CHALLENGES

• Staffing model used “modified” workers
• “Sickest Patients” were enrolled at the beginning of the program
• Home Visits in early months were a benefit but too time consuming
• Privacy Laws prevent CCAC from sharing patient data with Telehomecare (THC)
• Diversity of LHIN population: Tablet only available in English and French but top 5 languages in CWLHIN are Punjabi, Urdu, Hindi, Gujarati and Tamil
• Documentation back to primary care was too long (feedback from PCP). Reports revised.
• Specialists felt out of the loop: now receive reports/updates
SUCCESS FACTORS

• Alignment with Primary Care Providers
• Building Community Partnerships including: Pharmacists, Heart and Stroke Foundation, Lung Association
• Order sets for CHF/COPD have an automatic referral to Telehomecare
• Capacity to accept referrals from outside of the CWLHIN – spreads the success
• Engagement role – required and critical to ongoing referral process
• Engagements with Emergency Departments, GEM nurses, Discharge Coordinators, Respiratory Clinics, Cardiac Rehab, COPD Clinic, Team Huddles, Center for Complex Diabetes Care
• THC marketing materials i.e. posters, pamphlets provided to each physician office with each Engagement Lead visit
SUCCESS FACTORS

• Roadshow with Physician Champion
• THC video in Doctor’s offices within the CWLHIN
• Auto Opt In
• Receive regular lists of COPD/HF patients who visited William Osler Health Care System
• Alignment and integration with other health system, such as Health Links and QBP's
• General program updates shared through lunch and learns
OUTCOMES

• Demonstrated decrease in ER visits
• Demonstrated decrease in re-admission rates
• Decreased inpatient length of stay (LOS)
• Patient/family satisfaction
• PCP’s highly engaged
OUTCOMES

Meet Dr. Sanjeev Goel and his patient Beatrice

To play Right click/Open hyperlink

https://www.youtube.com/watch?feature=player_embedded&v=p8fwF6Qnxsw
PATIENT TESTIMONIALS

• Loved the THC program because it made me more knowledgeable about BP and weight. I would highly recommend the program to who ever needs it.  
  PT:E8426891

• So grateful for the Telehomecare program. Allowed me to start taking more interest in my health.  
  PT: E8101963

• The program was a wake up call! Made me realize that my condition can get worse if not taken seriously. Felt safe knowing that someone else was keeping an eye on me.  
  PTE8429241
PROGRAM DEVELOPMENT

• CWLHIN commitment to continue program
• Telehomecare programs in Ontario have grown to 8
• Awaiting THETA Evaluation Report

Creating System linkages
• Identifying and referring patients to Health Links
• Advocating for the use of the Health Links provincial Coordinated Co-ordinated Care Plan as Telehomecare plan
TELEHOMECARE & HEALTH LINKS: Intake and Triage

**Identified by Telehomecare team:**
- During discharge from Telehomecare
- Mid-point into the program
- Upon admission and initial assessment
- Patients not eligible for enrollment into Telehomcare

**Consent:**
Telehomecare team members to obtain physician and patient consent to enroll into Health Links. Advise patient and physician that a Health Links care coordinator or patient navigator will contact them. If not able to obtain consent provide reason on Health Link referral form. Mark on the referral form patient and physician consent as appropriate.

**Referral:**
Complete referral and attach initial or most recent assessment. Fax or email referral to Evelyn.

**Intake & Triage:**
Referral received by Navigator. Referral to be forwarded to the appropriate Health Link. The referral to be dependant on CCAC attachment status, complexity and needs of the patient.

**Care Planning:**
Care Coordinator or Patient Navigator to connect with physician and patient to initiate enrollment and care planning activities. A home assessment or connection over the telephone might be completed based on the needs of the patient.

**Completion:**
The completed care plan will be approved by the PCP and shared with the patient and organizations or specialists the patient is attached to. Patients who require ongoing monitoring will be provided it. Patient who managing well will not be monitored on-going but will be caught if triggered in the system.
• Participating in pilot Telehomecare- Post Acute Transitional Model with **focus on Heart Failure** patients

• Partnering with Clinic/NP to facilitate assessment and treatment

• Partnering with McMaster in the PACT HF study (Patient-Centred Care Transitions in Heart Failure)

• Telehomecare success has encouraged Osler to look to other virtual care opportunities

  “**Patients becoming partners in their own care**” (OTN, 2014)
Telehomecare makes a difference to patients, their families and their doctors.