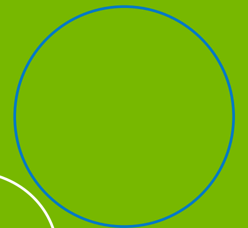
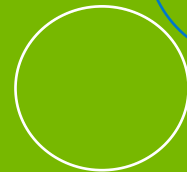
Rethinking Telemedicine Strategic Design



June 6, 2016



Topics

- OTN
- Rationale for evolving Telemedicine Strategic Design
- New approach and model
- William Osler Health System - Case Study
- Questions & Answers

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Disclaimer

The views expressed in this presentation do not necessarily reflect those of the Government of Ontario.

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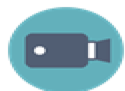
About OTN

A not-for-profit organization funded by the Ministry of Health and Long-Term Care.

- We help Ontario build a sustainable and responsive virtual care system.
- We assess healthcare innovations for their efficacy and alignment with Ontario's needs.
- We make tools that are proven, private, secure, and safe to use and are available in OTNhub.

The benefits to patients and the system drive everything we do.

OTN has built a robust and widespread telemedicine network

Integrated, secure provincial network	One-stop shop for products and services	Focused on patient access
4,324 ACTIVE CONSULTANTS	**23,052** OTNHUB USERS	**$56 Million** ESTIMATED ANNUAL SAVINGS FROM NHTG DIVERSION
 **519,287** CINICAL EVENTS	**304,713** PARTICIPANTS ATTENDING LEARNING EVENTS	**8,462** PATIENTS ENROLLED IN IN-HOME MONITORING (cumulative)

FY 2015/16 Year-end projections

Equitable access to care

Networks of connected care

Improved health outcomes

Efficiencies

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OTN Services that are scaling across Ontario

- Clinical Videoconferencing
- Emergency/Urgent
- Teledermatology and eConsult
- Learning
- Telehomecare

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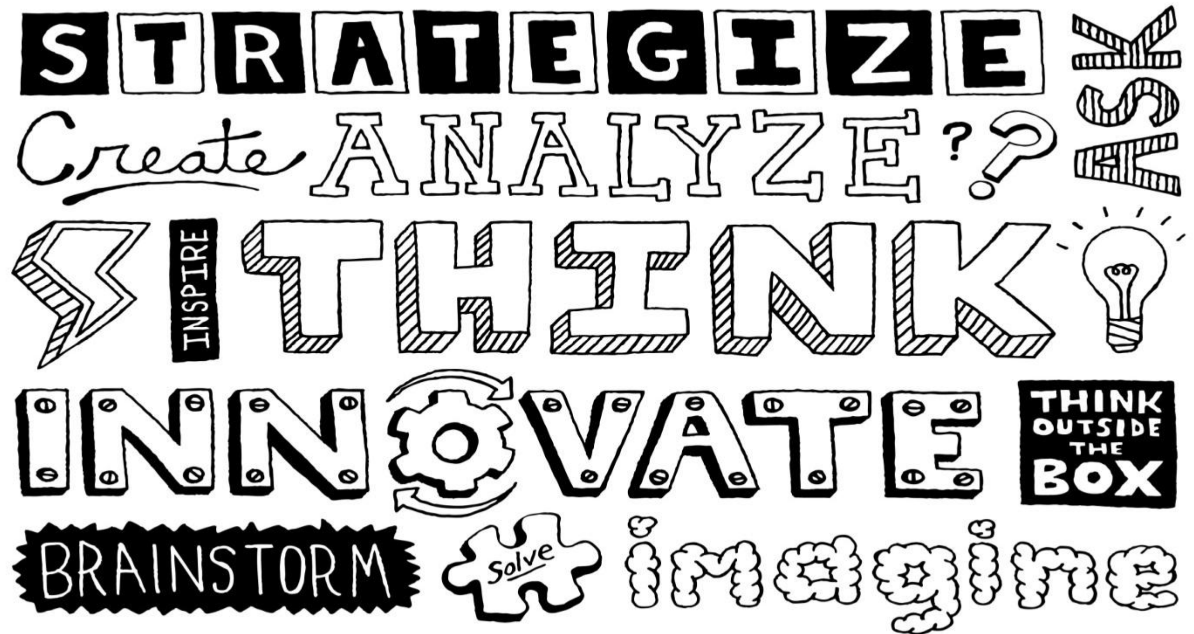
Rationale for a Rethink

Must
Evolve
as an

Starting from the top

- Top-down approach to embedding virtual care solutions into health care organizations' strategic plans



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The Approach

- Identify opportunities where virtual care tools can help meet strategic goals and objectives
- Prioritize the highest-value opportunities for virtual solutions to enhance the delivery of care
- Provide expertise and best practices for defining and articulating virtual care plans

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Partnership Model

OTN

- Virtual care thought leadership and planning expertise
- On-the-ground presence for account management
- BE and analytical expertise
- Clinical process design
- Operational process design (virtual care)
- Technical expertise/support

Health care organization

- Commitment to joint planning dialogue
- Designated Senior resource to coordinate internal teams
- Access to relevant clinical leads
- Commitment to optimizing current TM practice
- Access to data for decision-making and scorecard development

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Execution

Proposed engagement approach & timelines

KICK-OFF WORKSHOP

-Two-to-three hour session to delve deeper into the organization's pressing issues, prioritize, and select areas of focus

-Leadership participation from administration and clinical areas critical

IDENTIFY EARLY WINS

-Identify org's project team and data requirements

-Preliminary analysis and planning

-Quick win opportunities and longer term initiatives identified

WORKPLAN DEVELOPMENT

-Close collaboration with org's clinical teams to develop, refine and finalize virtual care opportunities

-Document clinical pathways, technical solutions and anticipated impacts

OUTCOME

Virtual Care Plans integrated into an org's Strategic Plan

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Readiness is Key

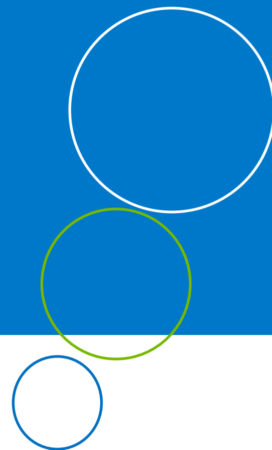
Senior Leader available to act as champion and quarterback engagement

Organization has regional vision and/or system approach

Virtual care identified in their strategic plan and/or Scorecard

Willingness to share key priorities, clinical programs and data for validating virtual opportunities

Case Study
William Osler Health System



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William Osler
Health System

Osler Overview

OSLER'S VISION
PATIENT-INSPIRED HEALTH CARE WITHOUT BOUNDARIES

The Community Osler Serves

LHIN #5: Central West LHIN

William Osler Health System

About William Osler Health System

2015-16 FY	
Beds	**854**
Births	**7,865**
Inpatient surgeries *(discharges w/intervention in surgical room)*	**13,597**
Outpatient surgeries	**45,646**
Emergency visits	**214,058**
Outpatient visits	**473,229**
Staff	**5,205**
Physicians	**850**
Volunteers	**1,100**

William Osler Health System

Brampton Civic Hospital

1.3 Million Square Foot Hospital Opened in 2007

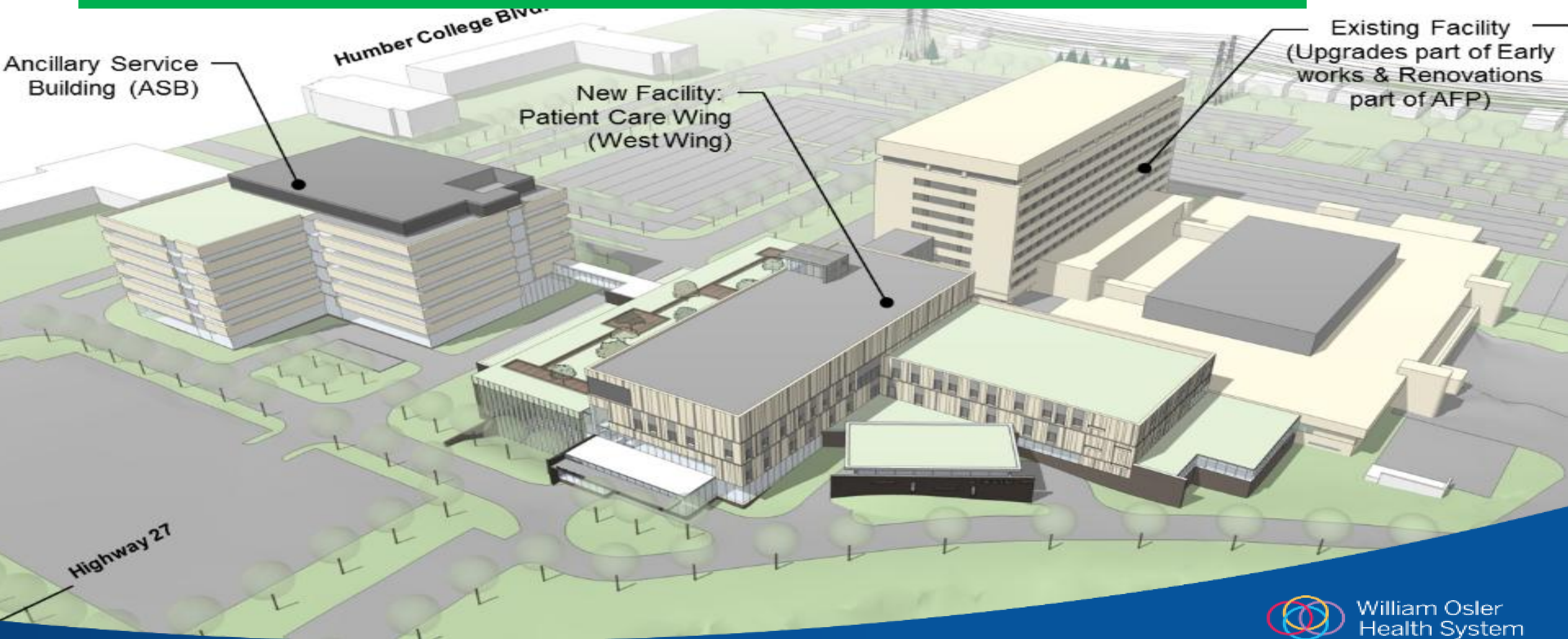
William Osler Health System

Peel Memorial Centre for Integrated Health & Wellness

Brand new ambulatory care facility – opening winter 2017

Etobicoke General Hospital

Originally opened in 1972; major redevelopment underway



William Osler Health System

Enabling Health System Transformation

Ambulatory Care

Increase scheduled outpatient activity, and **reduce** unscheduled / avoidable Emergency visits and inpatient admissions.

Access, Flow and Chronic Disease Management

Support timely access to appropriate care across the continuum while preventing onset or exacerbation of chronic diseases.

Virtual Care

Connecting patients and providers in new ways to improve access and the patient experience.

How it all began…

- William Osler an early adopter of Ontario's remote patient monitoring program
- Identified an opportunity to '*kick it up a notch*' to meet/exceed its corporate scorecard metric tracking # of eVisits (virtual care)
- Joint Senior Leadership with mutual support to engage in a partnership February 2015

Why do this?

- Strategic Direction #1: Create health services with an unwavering commitment to patient-inspired care
- Enable the 3 Year Clinical Priorities Plan to create a unified health system that meets the needs of patients and families
- Build off the learnings & success of Telehomecare
- Support a post acute integrated funding (bundled) care model

Workshop started with this…

Blue sky vision of Patient Inspired Health Care without Boundaries

Follow the patient through the health care 'journey' eliminating the patient's feeling of being left alone

There is no wrong door and/or distinct organization to care for a patient

No boundaries means not letting traditional barriers get in the way, policy, processes, funding etc.

Global Thinking

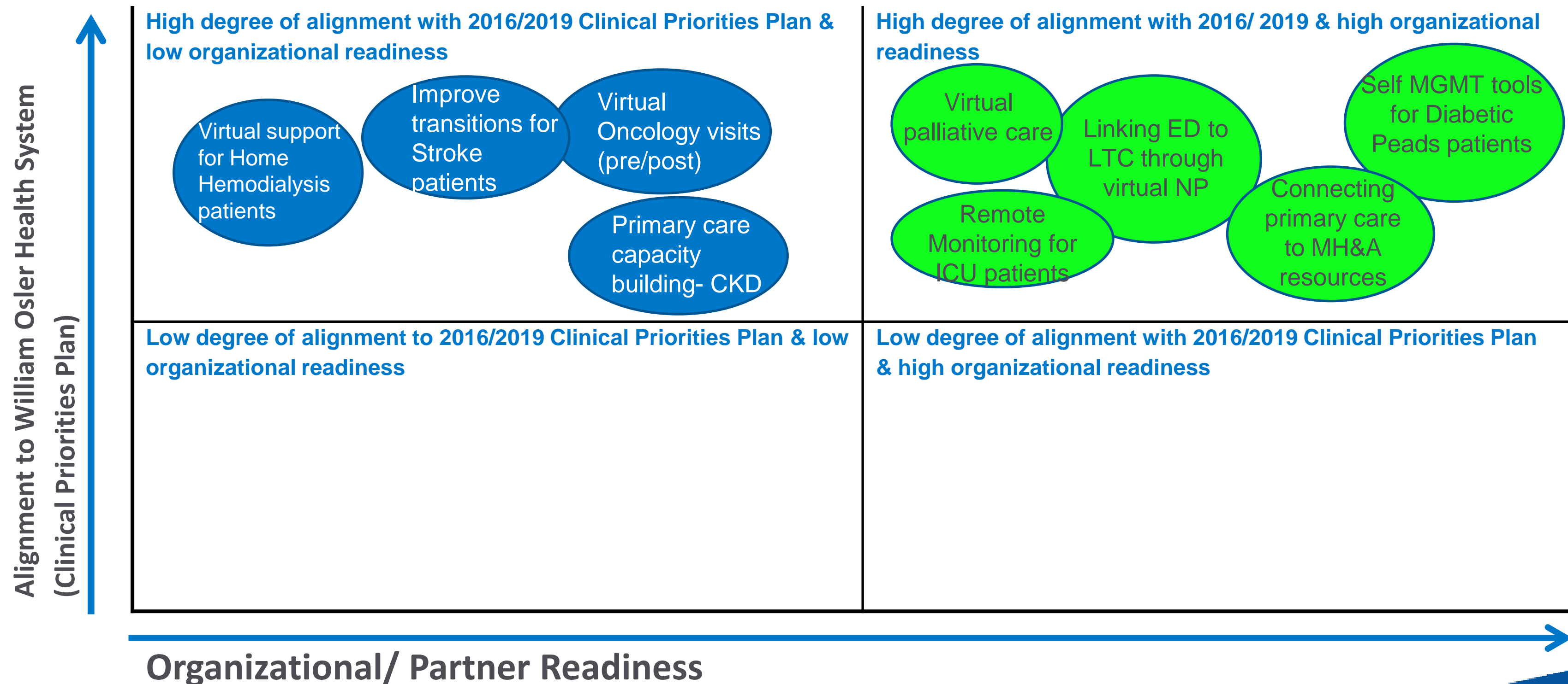
Let patient choice, in terms of how they access the system, become a focus

Think BIG

ACT small

Start NOW

Preliminary Prioritization



William Osler Health System

Year One Priority

Facilitating Access to Appropriate Care

Year 1 Strategic Focus

1. **Access to Sub-Specialties**
    - Between Sites (BCH to EGH/Peel)
    - With Partnering Hospitals
2. **Access to Primary Care**
    - Provider(s) to Provider
    - Provider(s) to Patient
3. **Access to Long Term Care (LTC)**
    - ED Physician to LTC
    - Senior's Clinic to LTC

Area of Focus

Urgent Care

Mental Health

Health Links

Oncology & Renal

ED

Seniors

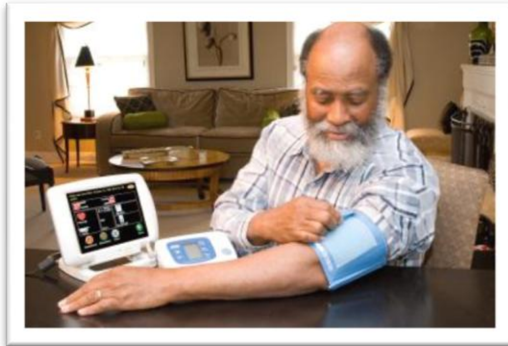
Impacts

Enhanced System Integration	• Increased continuity of care and collaboration across care settings as virtual care identified in Osler's 2016-19 Clinical Priorities Plan as a way to deliver care
Expanded Capacity and Reach	• Access to care providers is not limited by physical boundaries (e.g. virtual specialty consults within the Urgent Care Centre)
Culture of change fostered amongst clinicians	• Clinicians open and passionate to delivering new models of care e.g. palliative care in the home
Embracing of innovation with the vision towards sustained practice	• Transition from 'pilots' to new standard of care e.g. diabetic remote patient monitoring (adult and peads)

Telehomecare

Patient

Telehomecare Nurse



Remote monitoring and coaching for people with chronic disease

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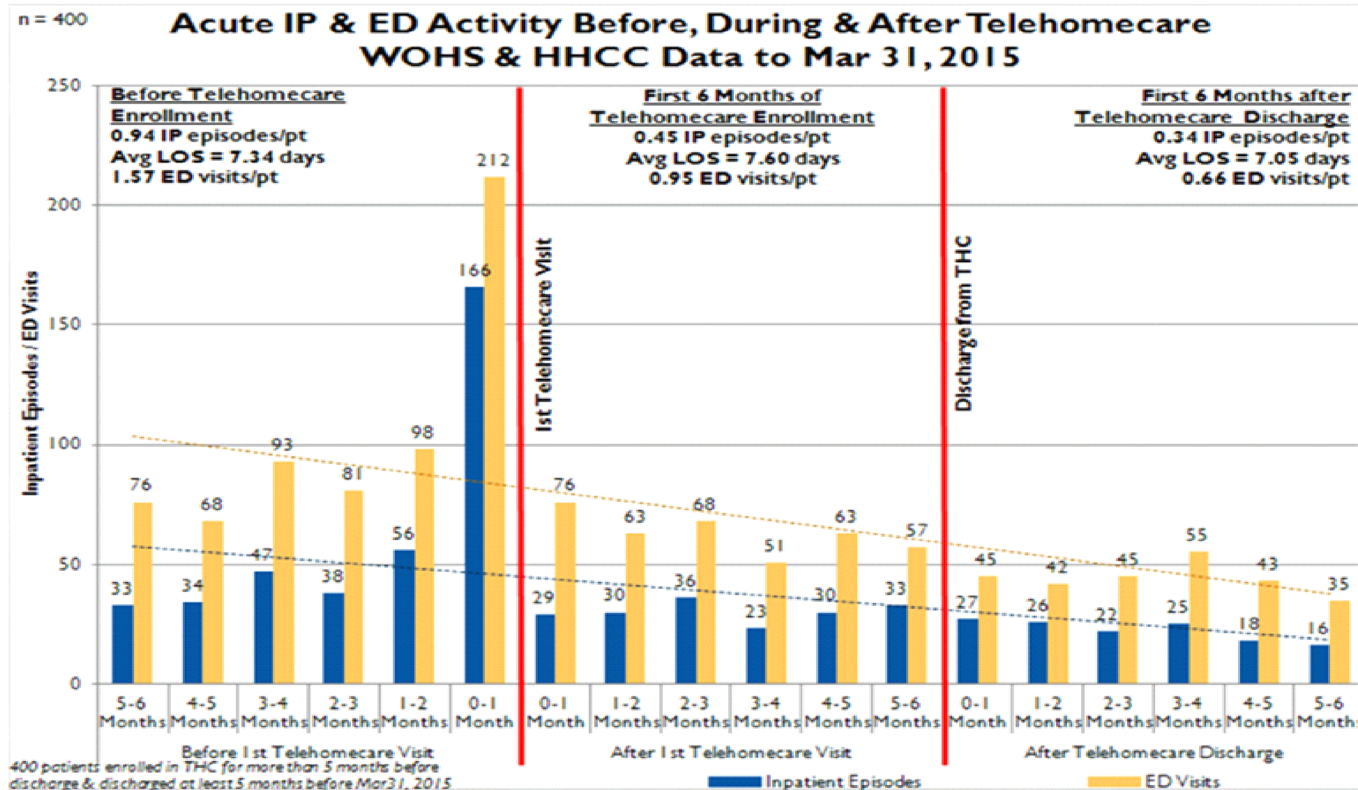
Central West LHIN - Outcomes

Acute In-patient and ED Activity Before, During, and After Telehomecare

58% decrease in ER visits and a **64% decrease in inpatient admissions**



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VIRTUAL-TECHNOLOGY INNOVATION
HOSPITAL-2-HOME EQUITY
PARTNERSHIPS
TRANSPARENCY
CONTINUITY
EFFICIENT PATIENT-INSPIRED
IMPROVED-COMMUNICATION INTEGRATED
LEADERSHIP
SYSTEM
CO-DESIGNED BEYOND-BOUNDARIES
PATIENT-EXPERIENCE COLLABORATION
PATIENT-CENTRED 24/7 SEAMLESS
ONE-TEAM SHARED-ACCOUNTABILITY
SYSTEM-LEADERSHIP

Hospital to Home

Unique opportunity to shift to a new approach of care continuity

- Collaborating with patients to improve the experience and navigate the journey utilizing a 24/7 Model
- Bundle care to facilitate seamless transitions from acute care to home
- Use existing OTN partnerships to enable nurses to connect with patients and deliver care virtually
  - Nurses can connect with newly enrolled patients more easily
  - Improved care management and convenience
  - Increased patient satisfaction with earlier access to their H2H care team

William Osler Health System

Central West LHIN

William Osler Health System

Underdevelopment for a controlled population aka IN PILOT

Diabetes

- 1.3 M patients with Type 2 Diabetes
- >50% are at the recommended A1C target
- The higher the HbA1c, the higher the risk of complications
  - Test Self Management tool
  - Mobile technology
  - In partnership with DECs & CCDCs

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