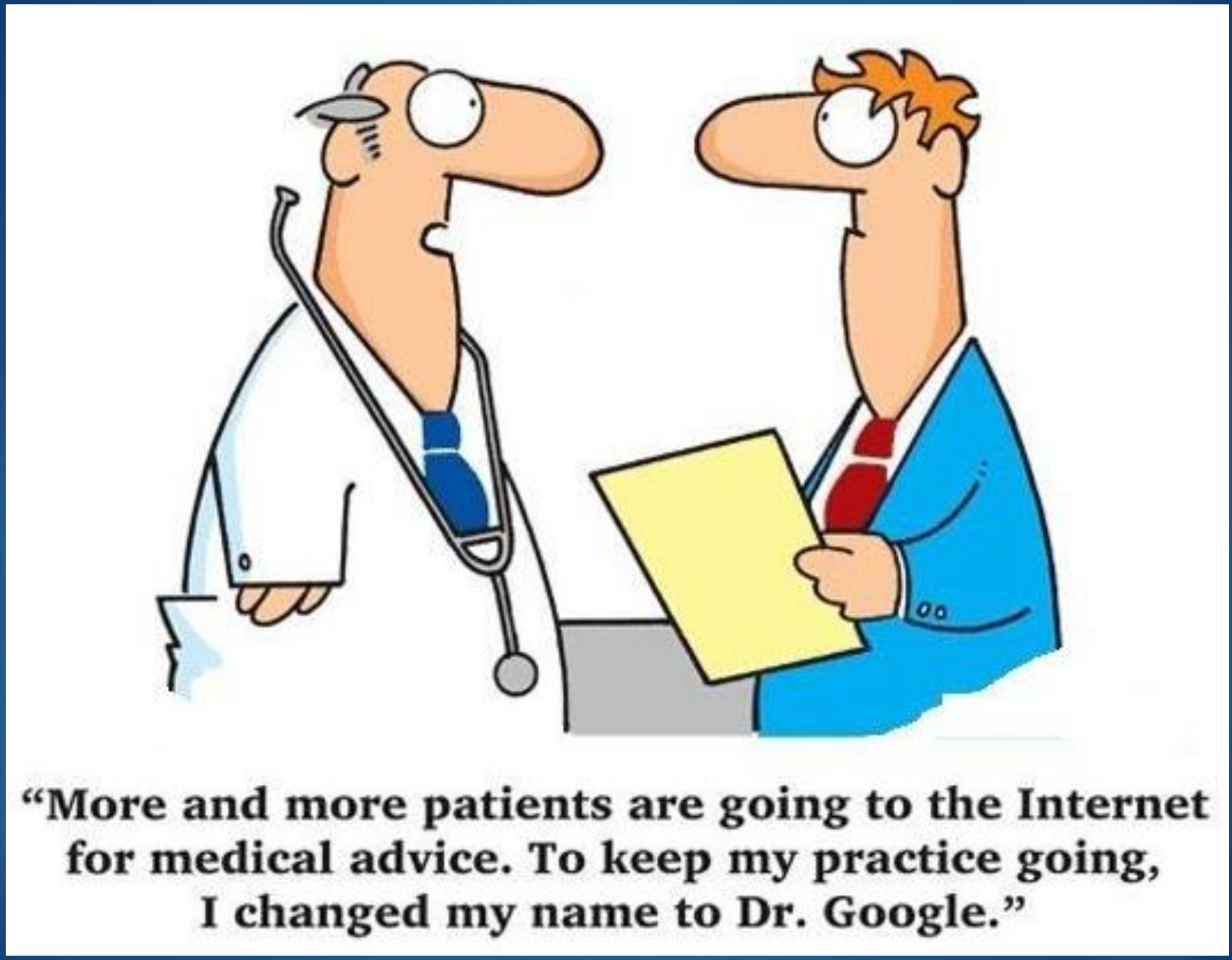


Image source: Google images

Increasing Rural Patient Centered Care Through Multi Digital Solutions

MINTO-MAPLETON

FAMILY HEALTH TEAM

Faculty/Presenter Disclosure

- Dr. Christine Peterkin, MD, CCFP
- Jodi Colwill BScN, PHC-NP,
- Pam Turton RN, BN,
- Shirley Borges ED MMFHT, MSN

- Relationships with financial sponsors:
  - **Grants/Research Support:** None
  - **Speakers Bureau/Honoraria:** None
  - **Consulting Fees:** None
  - **Patents**: None
  - **Other:** None

Disclosure of Financial Support

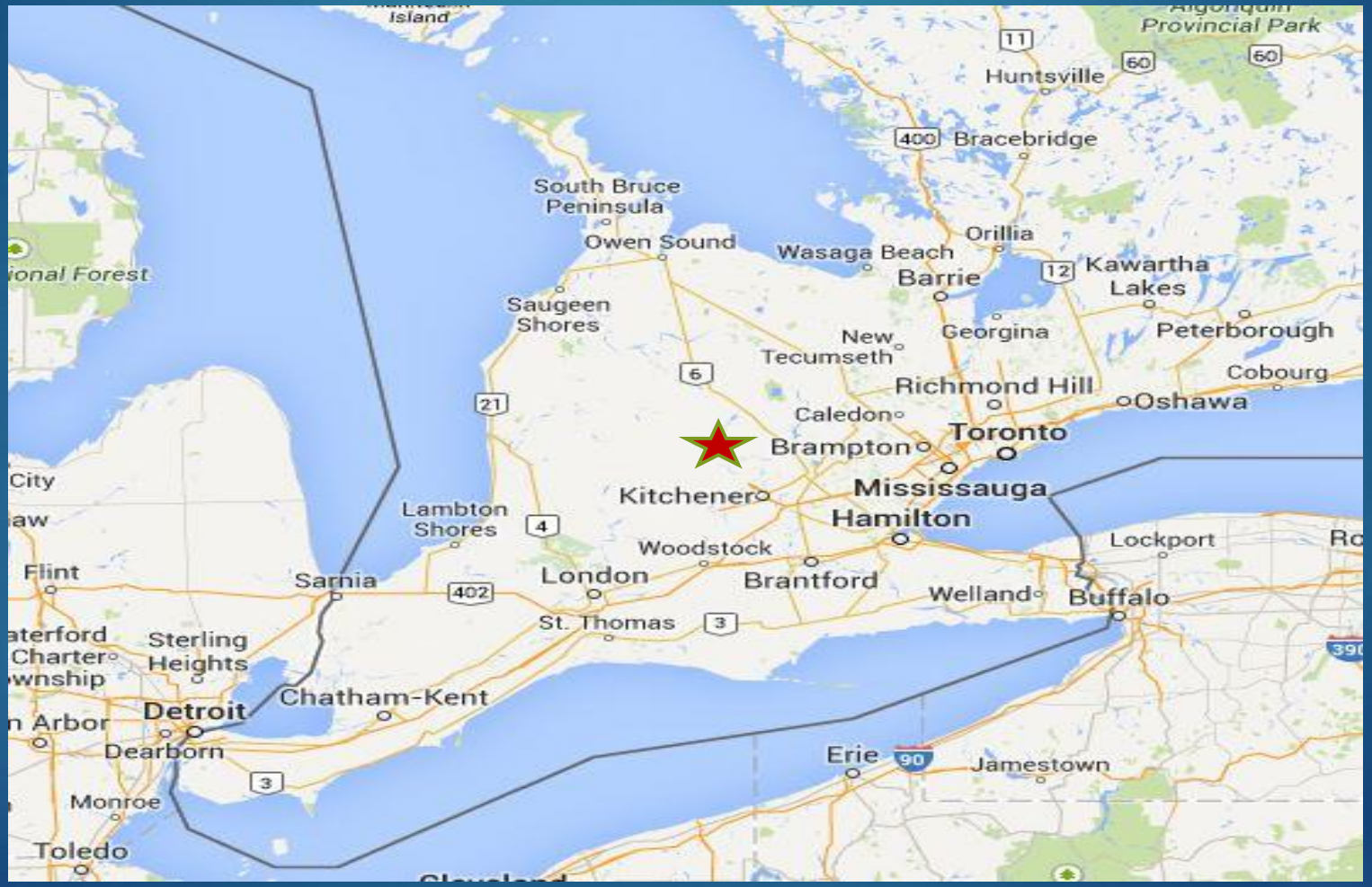
- This program has NOT received financial support or in – kind donation
- Potential for conflict(s) of interest: NONE

Mitigating Potential Bias - None

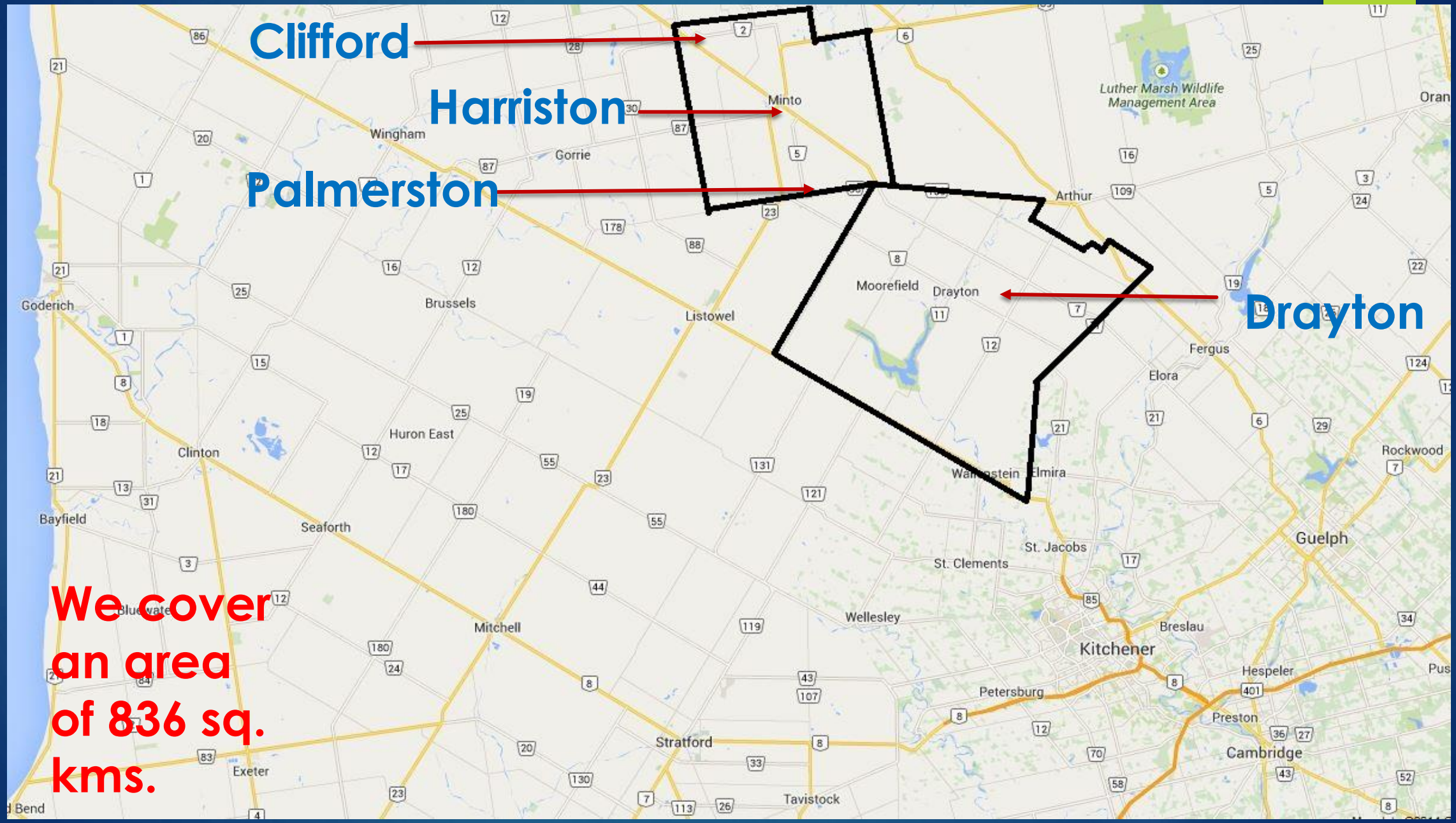
Objectives – Attendees will:

1. Understand how incorporating small digital solutions in their workflow can equal big change
2. Become familiarized with the various digital health options available to facilitate timely access to patient-centered care.
3. Increase their knowledge of how digital health options can be adapted to accommodate various different digital literacy levels.

Where We Are


Provincial Park
Huntsville
Bracebridge
South Bruce Peninsula
Owen Sound
Wasaga Beach
Orillia
Barrie
Kawartha Lakes
Saugeen Shores
Georgina
Peterborough
New Tecumseth
Cobourg
Richmond Hill
Oshawa
Caledon
Toronto
Brampton
Mississauga
Kitchener
Hamilton
Lambton Shores
Woodstock
Lockport
Flint
Sarnia
London
Brantford
Welland
Buffalo
St. Thomas
Sterling Heights
Chatham-Kent
Detroit
Dearborn
Erie
Jamestown
Monroe
Toledo

Minto-Mapleton Family Health Team Locations



Who We Are

Minto Mapleton Family Health Team

- 9 MDs
- 4 NPs (3 FTEs), 1 PA (0.6 FTE)
- 3 Telemedicine nurses (1 FTEs)
- 3 SWs, 2 RDs (1 FTE), 1 Chronic Disease Nurse,
  1 Pharmacist (0.2 FTE), and 1 Health Promoter

- 14,573 Patients Rostered (+ 1865 non-rostered) = 16,438 patients
- ~17% are seniors (65+ yrs.)
- We have a large Low German - Mexican Mennonite population

Image source: google images

Types of Digital Health We Use

Increasing Office Efficiency	Ontario Telemedicine Network	E-health Centre for Excellence
❖E faxing ❖Emailing ❖EMR–Health Report Manager (HRM Ontario MD), Ontario Lab Information System (OLIS), Ocean Tablets ❖Telus app	❖Telederm ❖eConsult ❖eVisit - OTNinvite, pcvc, room based video	❖Virtual Care

Ontario Telemedicine Network (OTN)

1. Telederm
2. eConsult
3. eVisit –OTNinvite, PCVC, room based video

otn.
Care. Connected.

Telederm

- **Average response 1.7 days**
- Leads to quicker treatment
- **72 percent** in person referral avoidance rate

otn.
Care. Connected.

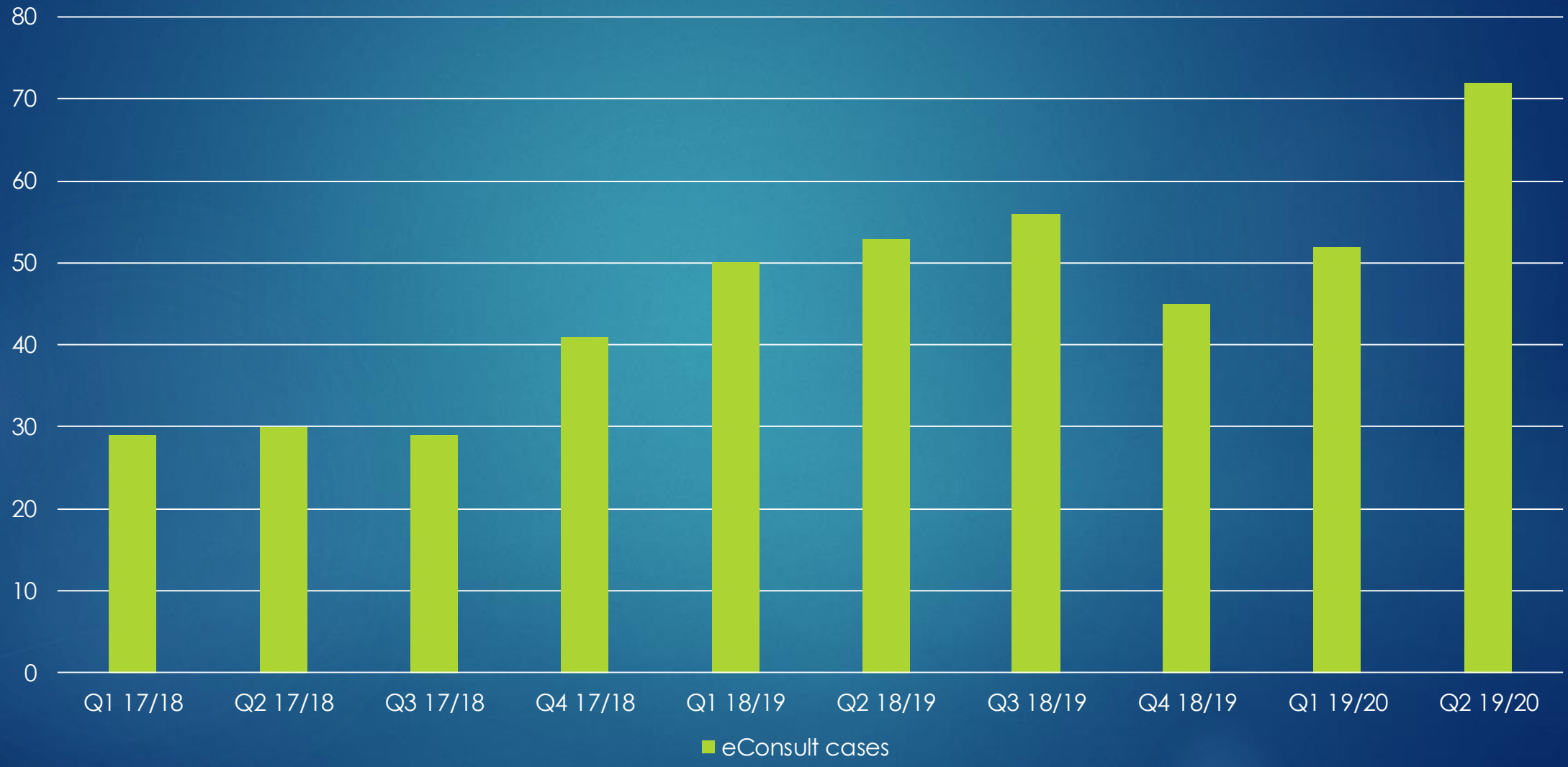
eConsult

- secure web-based tool
- clinical advice when an in-person visit to a specialist may not be necessary
- Reduces unnecessary testing and increases best practice guidelines
- Increases provider capacity
- OHIP billable

- Responses average 2 days

MMFHT eConsult cases per Quarter

Apr 2017-Sept 2019



eVISIT

Room Based

Personal Video Conference (PCVC)

OTNinvite

21,498

Video visits served to a patient's home

eVisits in Family Health Teams In LHIN3

Clinical, Administrative, & Educational Events
Apr 1, 2017 – June 30, 2019

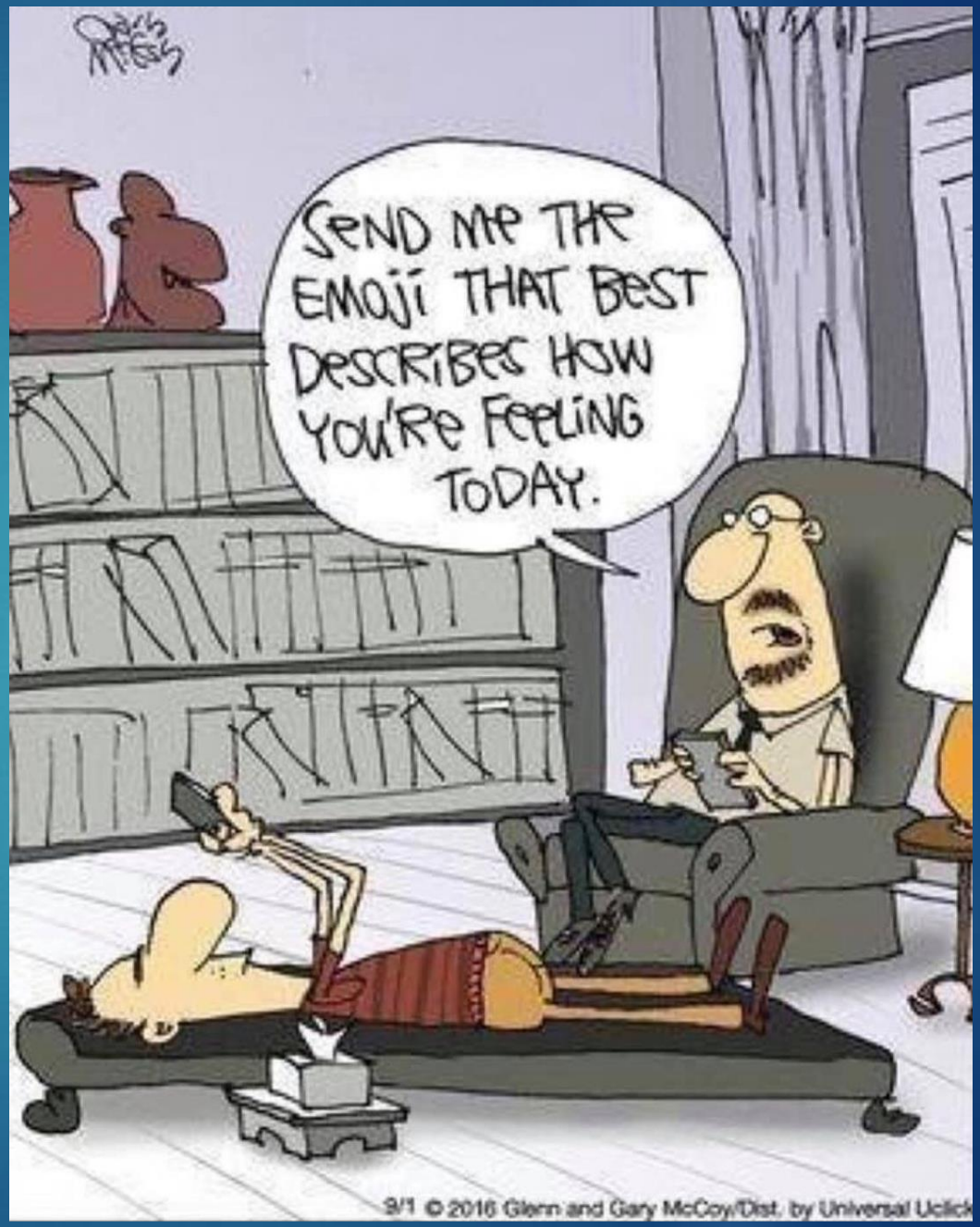
ORGANIZATION NAME	Sum of TOTAL
Minto-Mapleton Family Health Team	3,155
A_Family Health Team	1,416
B_Family Health Team	1,278
C_Family Health Team	857
D_Family Health Team	729
E_Family Health Team	258
F_Family Health Team	15
Total	**7708**

Community Partner Sees Value in eVISIT

Virtual Care in the age of the "Digital Doc"

Do You Dare To…

Virtual Care



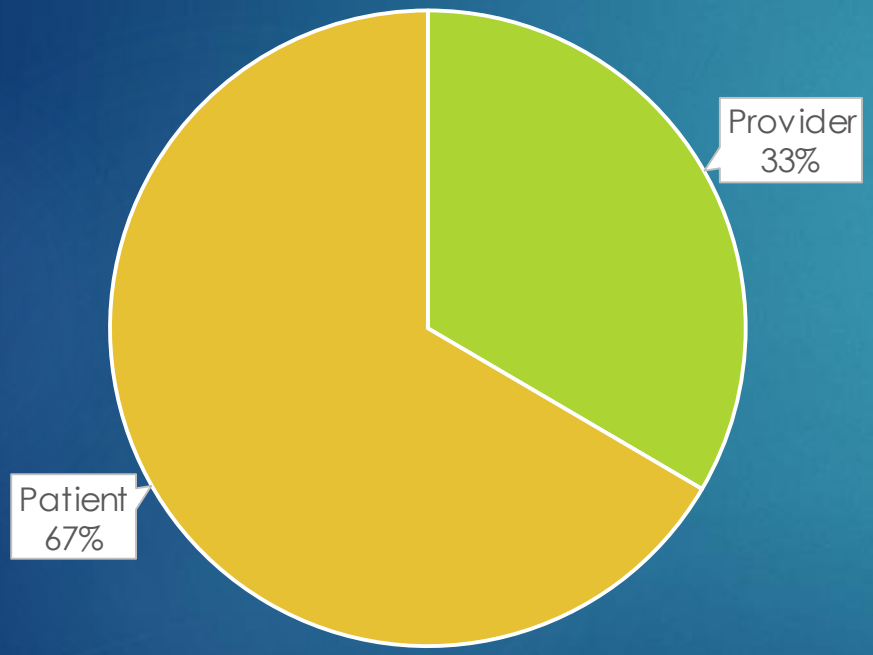
Virtual Care

Image source: google image

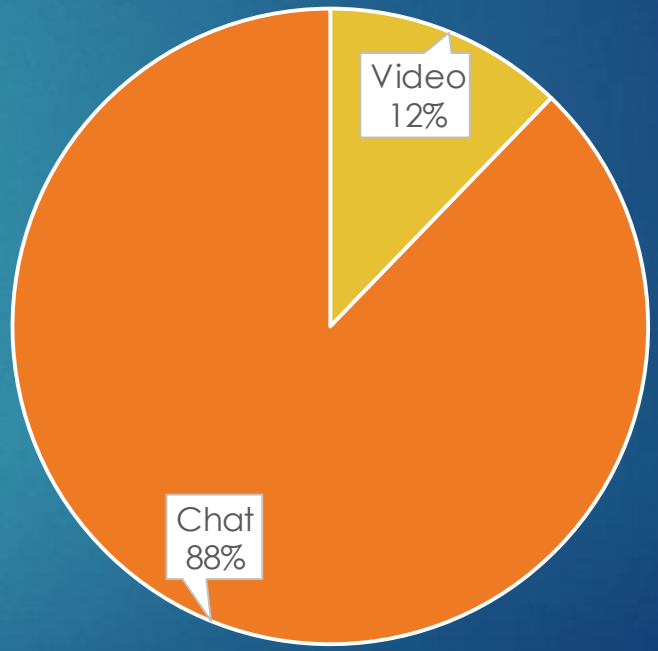
- patient app or browser based
- website portal outside of EMR
  - text chat, face to face video, or audio
  - interchangeable modalities with one click
- Online appointment between patient and practitioner – initiated by either
- E- mail is port of entry
- Consumers are increasingly seeking convenient and effective ways to engage in their care delivery

Virtual Care Visits ~ 603 visits

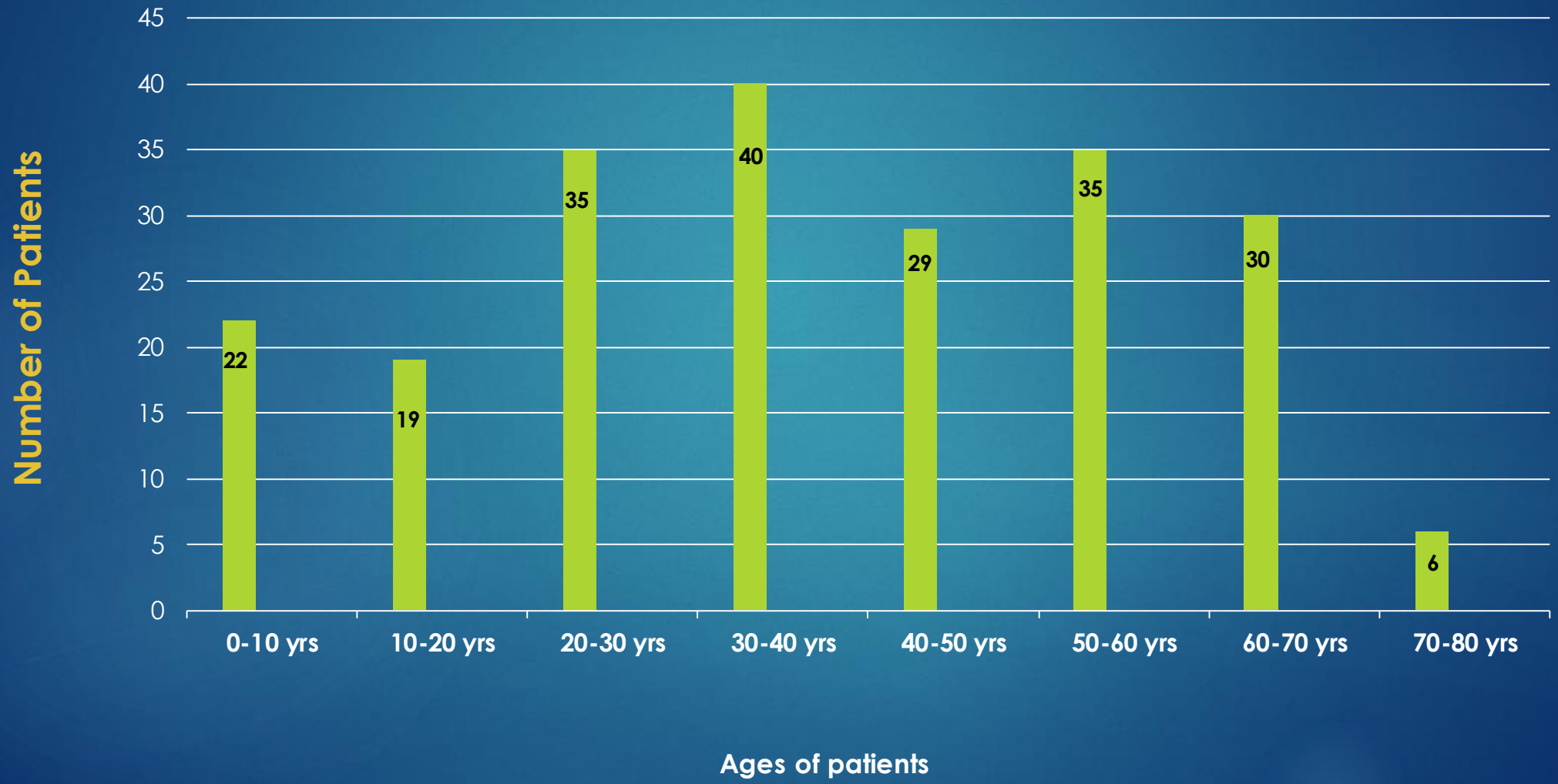
Visit Request Breakdown



Preferred Modality

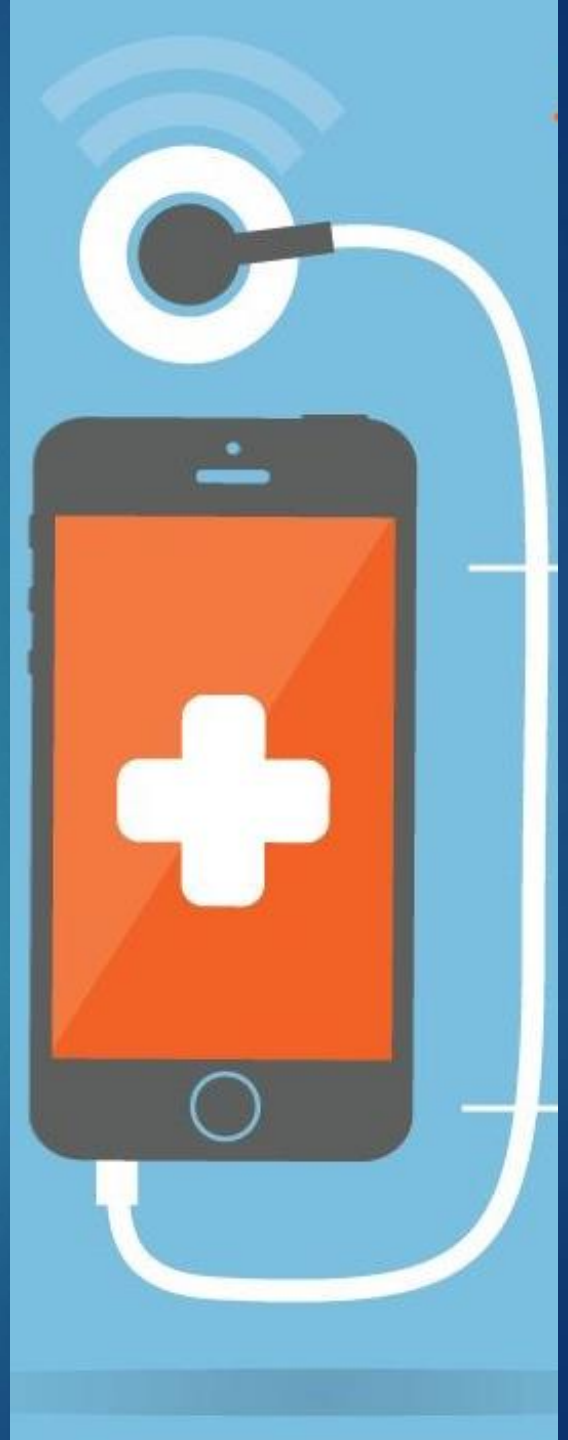


Virtual Care: Patient Age Class



FOR THE SCEPTICS:

BUT I'M NOT A "TECHIE" AND NEITHER ARE MOST OF MY PATIENTS



- **Jodi Colwill (me)**
- ok so I am going to list out the discussions. 1. OTN nurse has left a message for Xolaire nurse about coverage but it is dose based on weight and not sure you will qualify. She will let me know when she hears back. 2. She is awaiting a response from the respirologist as to whether he will see you in person in another location. 3. Sunnybrook does bariatric sleep studies so I have made the referral there for reassessment 4. bipap should be reassessed every 6 months by the company so please contact them to reassess the machine (ie vital air, medigas, whoever you have) 5. I looked into the Ontario bariatric network and there is the shake program. Another provider had a patient do it on ODSP but it would require me referring you and you reviewing it with them. Let me know if you would like a referral. 6. I also had a colleague who went to the Wharton clinic and it was OHIP covered. I believe this is the one you mentioned. I could alternatively make this referral as well which when I look at it looks like a more comprehensive program?
- let me know your thoughts on these interventions and I will keep you posted when I hear anything else back from the OTN nurse.
- **Patient**
- Well! Somebody's been busy. ☺ To your points; 1: Xolaire... 1st time I'm hearing of this. What is it, what does it do for me? Regarding respiratory; I'm set up now for oxygen at night, with my bipap, and the lady from Medina's has been out to hook me up with a full-time oximeter (for one night) while I'm sleeping, and from that info has me raising the litter/ min. From 2 to 5. I have a cordless oximeter myself, and check myself when ever I wake up through the night. So far, my oxy level is reading above 90 at night, with the machine set at 5. This lady has also adjusted my bipap machine pressure up by 2 points. That's all Medias May adjust it. Beyond that, The respirologist would need to prescribe a higher setting. 2: thumbs up emoji 3: Ok. I'll hear from somebody, some time, then. 4: covered above, in 1. 5: I tried a self - administered liquid diet years ago, on my first serious weight loss attempt. While it is a viable option, from what I learned then, I think we hold off on that one. 6: Yes, my take - from a distance, just as yourself - Wharton seems to be the more comprehensive approach. Also, my feeling is they would sort of take up where the CMHA has brought me, with the binge-eating disorder education. However, my OT from the Low Back Pain program, and I had a lengthy discussion about food programs and how to administer them, in our last appointment. I'm assuming you have received from CMHA the notice that they have closed my file, for now. I had a joint appointment with (councillor) and (dietician). After our conversation, they suggested that in order to not cause undue stress, etc, my file be closed with them, while pursue more focused weight loss options. This was a mutually agreed upon decision, and I am quite comfortable with it. I can still touch base with them if I feel the need, etc. What we are thinking at this point, after those two appointments, is that between my wife and I, we have the education and the knowledge, equipped with MyFitnessPal, to set up and maintain the actual diet. I would continue to see Karen for accountability and guidance, both for pain management and weight loss. AND last but not least, I would want to continue to see yourself, and have you closely monitor my bloodwork, etc. to make sure I'm doing okay through the graduated steps into a seriously calorie restricted diet. Does this work for you?
- **Jodi Colwill (me)**
- Thanks for the reply.
- 1. Xolair is a treatment for asthma that has an allergic component that is resistant to inhaled corticosteroids. I believe it is in an injection. Perhaps they were seeing if you would be covered by the drug company prior to getting into it more with you? I will still let you know that they say.
- Great to hear that the O2 and Bipap are being titrated. it will be great to see how those levels affect your sleep study and I will pass this info onto the OTN nurse and respirologist.
- I have not received anything from CMHA at this time but it sounds like it was an informed choice and a mutual one at that. Glad you are still being supported by OT.
- So to summarize you are working on diet and feel equipped to do so. You are not feeling the OBN for shakes is a good option. Do you want me to refer you to the wharton clinic at this time?

Issues Addressed

1. Asthma management
2. Appropriate Respirology follow up
3. Specialty sleep study clinic
4. Bi pap Titration
5. Weight Management strategies
6. Specialty Obesity clinic
7. Ongoing diabetes management

PATIENT DIGITAL LITERACY LEVELS
~WHY TO USE ONE MODALITY OVER ANOTHER~

Do patients have a cell phone or tablet?

Have they used Skype before?

Is nur*sing* support required?

Does patient have hearing difficulties?

Do they need an in-person referral?

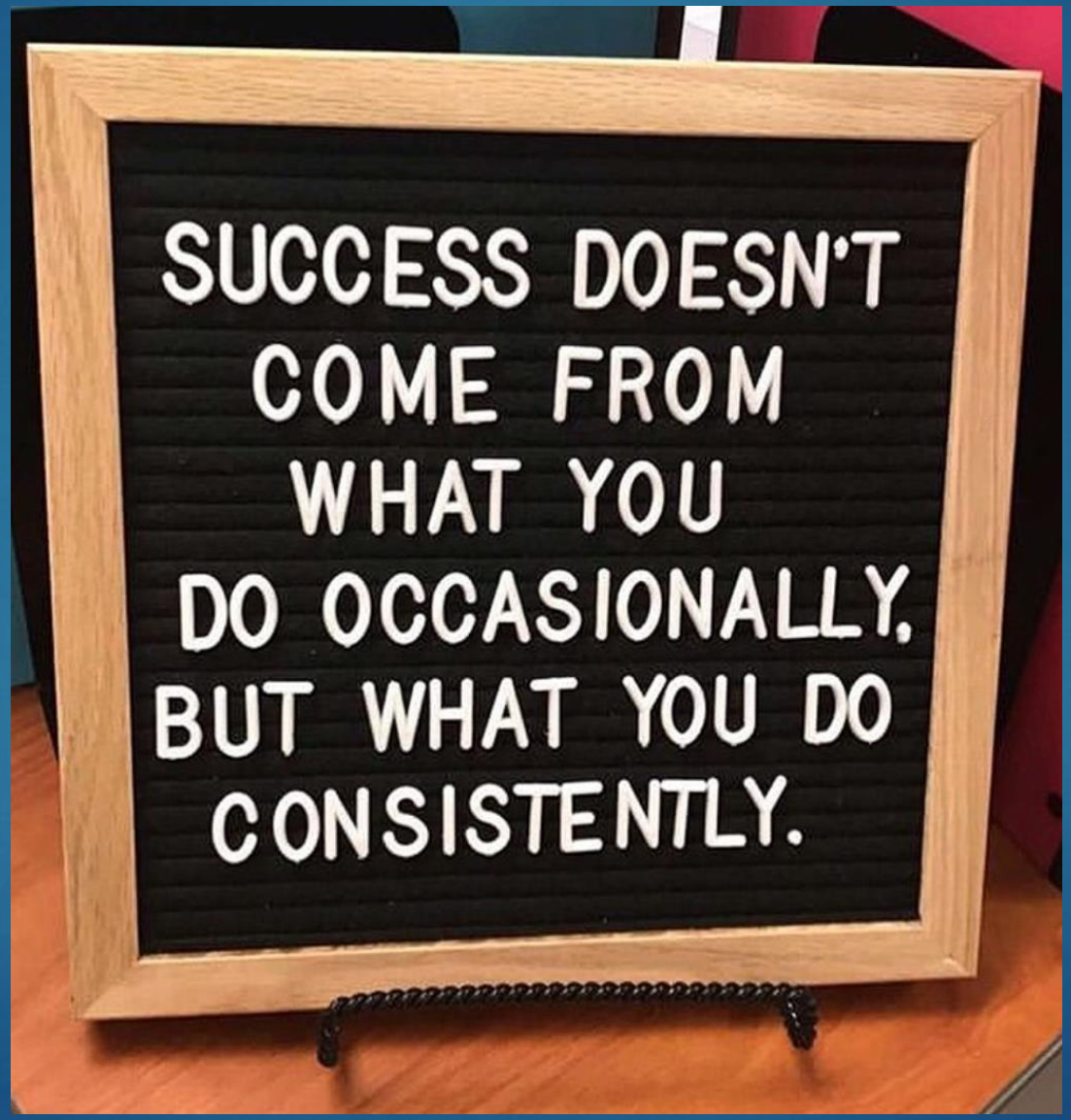
Is video access an issue?

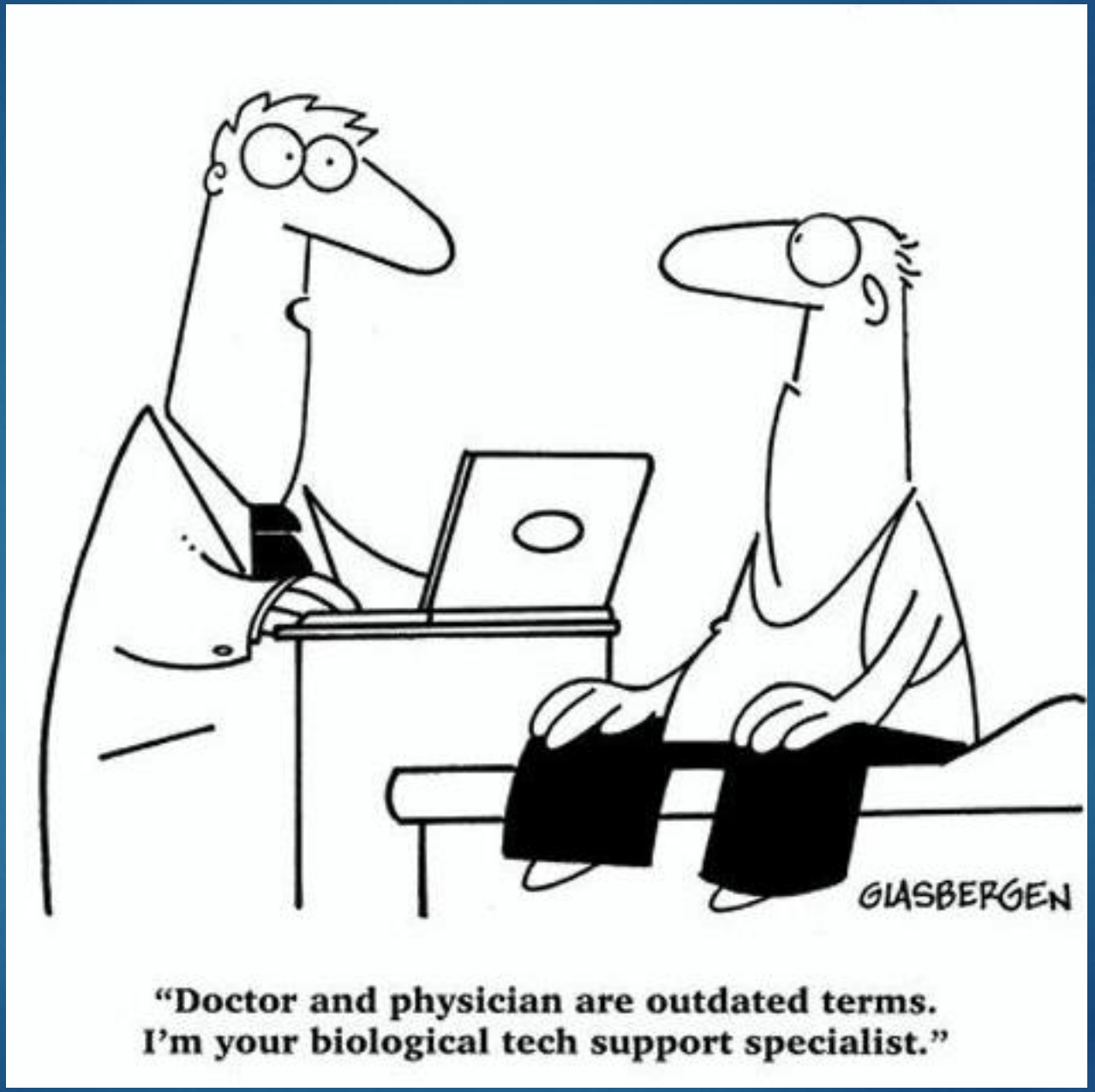
Do they have internet available at home?

How Other Team Members Are Using Digital Health

- Social Workers using eVisit for counselling
- Health Promoter using eVisit for smoking cessation and health promotion visits
- Pharmacist, Dietitian, Nursing and Social Worker hosting group classes
- Outreach worker – Ocean Tablet signing consent direct to EMR

Integration and Hurdles





"Doctor and physician are outdated terms.
I'm your biological tech support specialist."

Thank You

Dr. Christine Peterkin

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Pam Turton

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Peterborough
FAMILY HEALTH TEAM

An Integrated Model of Comprehensive Primary Care for Unattached Patients

Lori Richey

Executive Director, Peterborough Family Health Team

Disclosure of Commercial Support

- Financial support from the Central East Local Health Integration Network (LHIN) via the Sub Region Planning Table
  - Priority Project and the City of Peterborough with a one time contribution of $40k
- No MoH money to date
- Partnership with the Virtual Family Physician Network
- In-kind support from the Peterborough Family Health Team
- Current funding expires March 31, 2020 – clinic is at risk of closure

Peterborough Family Health Team

- Catchment area is Peterborough County – population of 134,000
- 116,891 rostered patients
- 106 family physicians (full time and part time) in 5 FHOs
- Large majority of physicians are at capacity and not accepting new patients
- Health human resource study conducted in 2016 indicated that PFHT primary care physicians were doing the equivalent of 14 FTEs in additional work annually
- 110 FHT employees
- 20 locations across the city and county
- Partners in Pregnancy Clinic (PIPC)

Why this Partnership?

Board and 2016-2019 strategic plan alignment:

Work to understand the diverse needs (existing and emerging) of the residents of the region, and design and deliver programs and services to meet them.

Develop an approach to caring for those who have difficulty accessing mainstream primary care, with a focus on addressing the social determinants of health.

Why this Partnership?

Unattached patients were deemed a priority for our community through the work of the CE LHIN Sub Region Planning Table.

Needed to understand the health and social support needs of the unattached population.

Unattached Patients

- Peterborough City and many of our townships are deemed “Underserviced” allowing us to continue to add MDs to the FHT
- Approximately 8,000 residents in our community without access to comprehensive primary care
- PFHT is contracted by the City and County of Peterborough for primary care recruitment
- Numerous annual retirements impact the ability to recruit a physician for our unattached population
- Population growth is greater than the ability to recruit physicians

What does it look like?

How Does it Work?

- Location: heart of downtown Peterborough at the PFHT main office
- Full scope RPN in the room with the patient and is the hands of the physician
- Clinic provides comprehensive care, and when possible patients return to the same physician for follow-up
  - This builds a therapeutic relationship with the patient and physician

How Does it Work?

- Physician is contracted with Virtual Physician Network to provide service via the OTN network
- All physicians are from the Toronto area as non of our local physicians had capacity
- Patients of the clinic are placed on a PFHT managed wait list and transferred with their chart to physicians seeking patients

Data Collection

- Sample of what we collect:
  - Demographics: age and postal code
  - Day of week/time of day patients visit the clinic
  - Where patient would have gone for care had the VCC not been available
  - Connections and referrals to community partners, services and specialty care
  - Data re health equity barriers
  - Local wait list: people seeking a local primary care provider

- Importance of data collection:
  - Learn about our unattached population and their healthcare needs
  - Tailor clinic hours to patient need
  - Lobby efforts to secure permanent on-going funding

After 15 months of service …

After 15 months of service …

Linkages and Referrals

156
Cancer Screening

119
PFHT Programs and Services

516
Specialty Care

334
Diagnostic Imaging/ Ultrasound

97
Community Mental Health Supports

841
Lab Services

After 15 months of service …

=

867

potential **ER diversions**†

$202,878

estimated **savings** to the health system*

† At each encounter patient is asked where they would have gone for care if this clinic wasn't available
* Based on $234.00 per ER visit (only includes nursing, diagnostic and therapeutic services, administration, and overhead costs)

After 15 months of service …

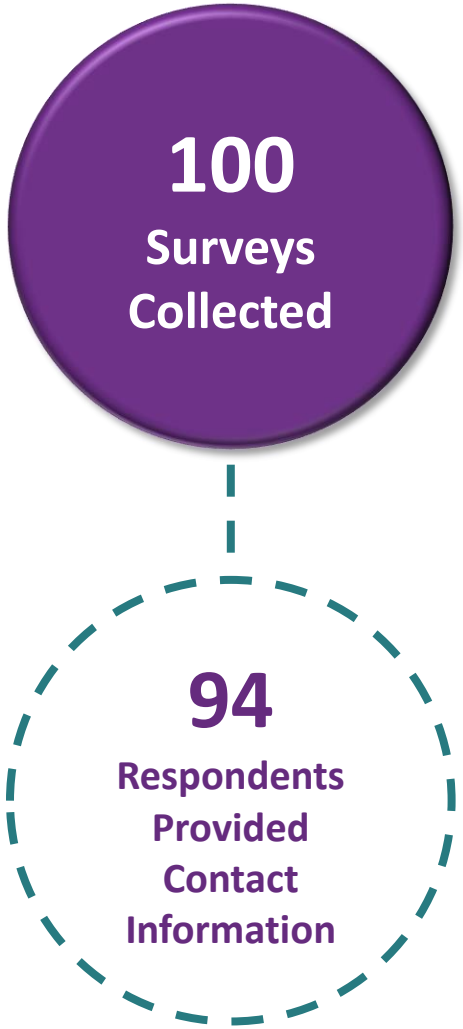
$165,000

Staffing cost of VCC including full-time RPN, part-time receptionist and part-time nurse navigator

$37,878

Overall **savings** to the health system with the care being delivered by the right person at the right place

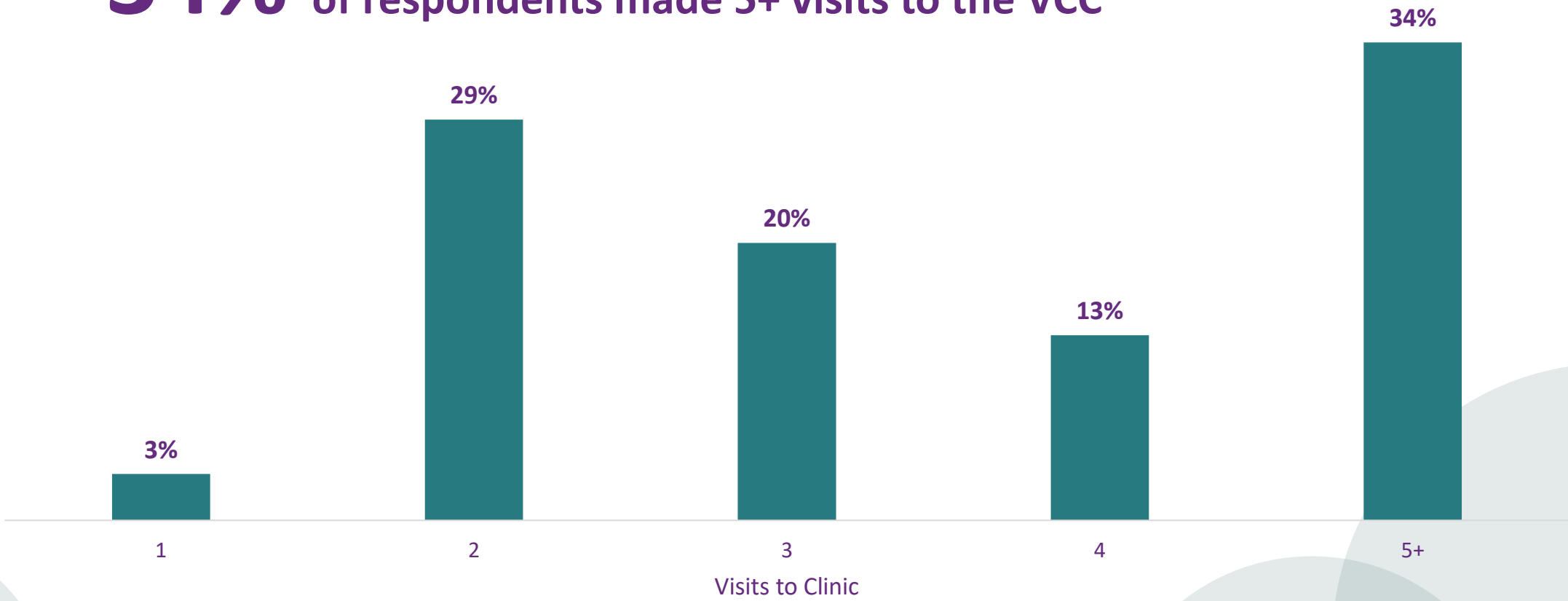
Patient Experience



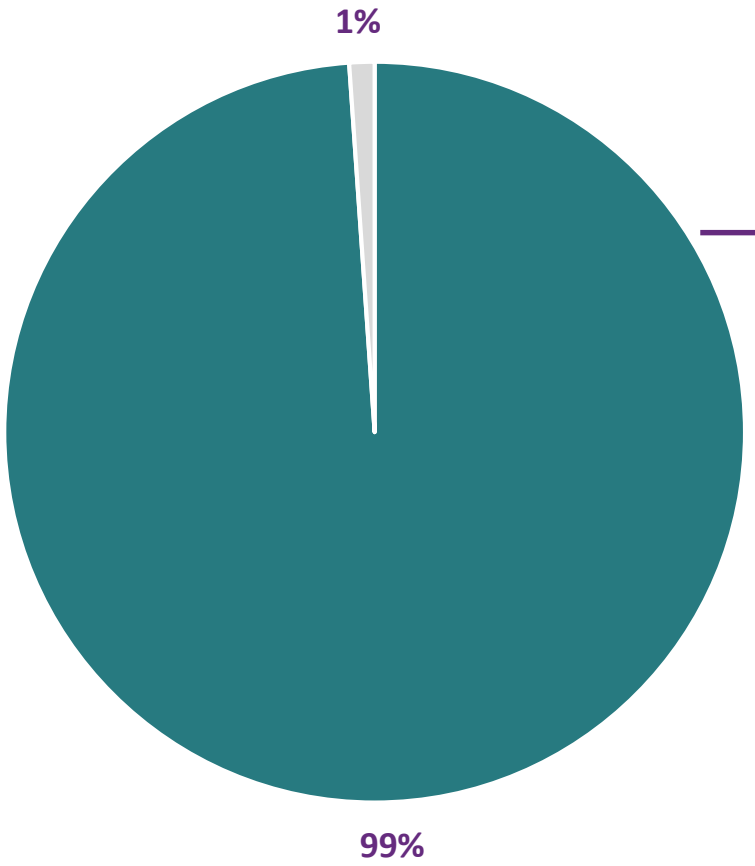
94% **of respondents agreed to be contacted to provide further information about their VCC experience**

Patient Experience

34% **of respondents made 5+ visits to the VCC**

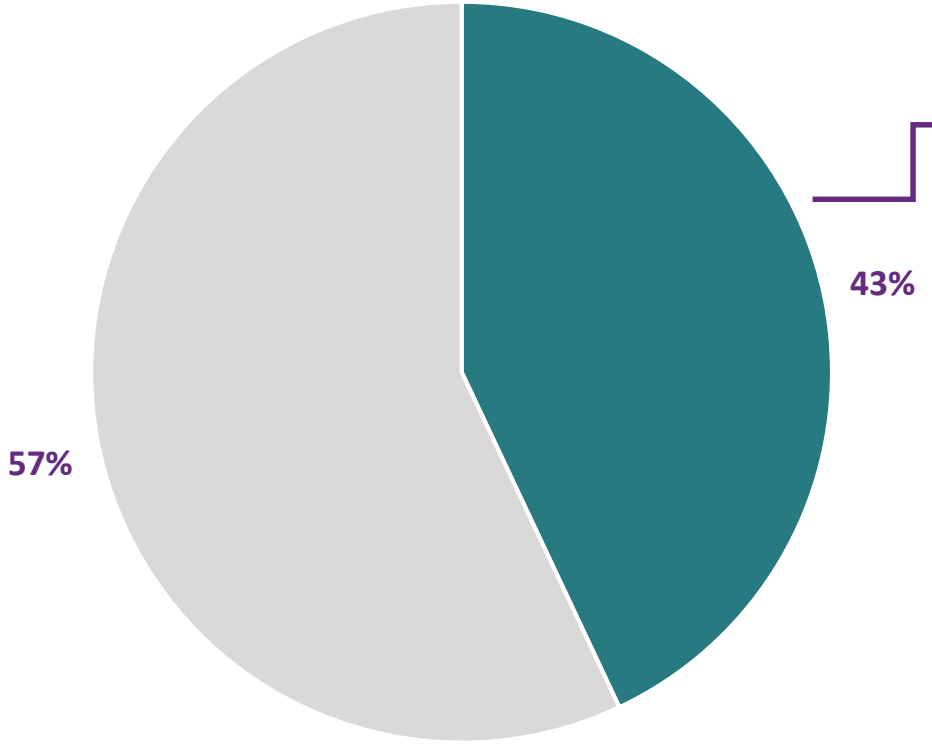


Patient Experience



99% **of respondents felt their care needs were met at their VCC appointment**

Patient Experience



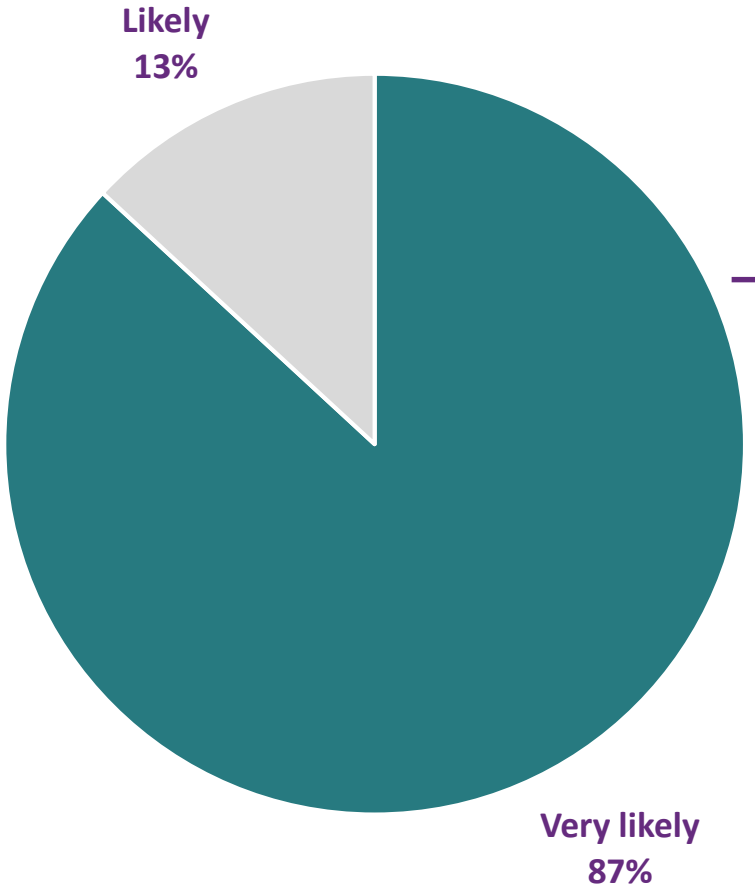
43% **of respondents indicated that the VCC diagnosed a healthcare issue that, had they not visited the clinic may have gone undetected**

Patient Experience

Healthcare issues identified:

- Scoliosis, degenerative disc disease
- Diabetes
- Pregnancy
- Irregular heart beat
- High blood pressure
- Abdominal hernia
- Anxiety
- Depression
- Bi-Polar, PTSD
- Hypomania or Bipolar
- Arthritis
- Possible lymph node condition
- Bronchitis

Patient Experience



100% of respondents indicated that they are very likely/likely to recommend the VCC to family or friends who do not have a family doctor

Patient Testimonials

“The VCC has been a god send for me personally. Moving to PTBO 2yrs ago I and my family have been unsuccessful in securing a family doctor. Without this service I would be burdening the ER at PRHC for unnecessary purposes.”

“I have never had a faster/better clinic experience at a walk-in center. Fast, efficient and they make it easy to get my prescriptions refilled. In PTBO it seems impossible to get a family Dr. but with the VCC I never have to worry about long wait times, or going without my much needed medication. Thank you for this service, it is a life saver!”

Patient Testimonials

“The PFHT VCC is a necessary resource for the community of PTBO. Having access to a Dr is a basic need, and the VCC bridges the gap between the limitations of family Dr's and patients who require non-emergency care.”

“As a young professional who has recently moved to the PTBO area, the virtual clinic was one of my very limited options in seeking healthcare. I've been blown away with the quality and depth of service and feel that this clinic offers an invaluable service to the community.”

Applying the Health Equity Lens …

Of the **563** health equity screens completed between February and November 2019:

39.0% of respondents have **difficulty making ends meet** at the end of the month

21.3% of respondents have eaten less than they felt they should because they **can't afford food**

11.6% of respondents **may not have stable housing** in the next 2 months

11.8% of respondents have issues with bug infestations, mould, inadequate heat or **safety concerns in their place of residence**

Lessons Learned

- Excellent opportunity to provide comprehensive care to unattached patients on an interim or “staging house” basis
- Can be used as a springboard for physician recruitment
- Great opportunity to build community partnerships
- Opening programs and services to the unattached population did not overburden our resources
- Need for creative options for care need to be continually explored

Lessons Learned

- Front-line staff training
- Additional resources required to serve higher mental health needs population
- Establishing clear boundaries to mitigate medico-legal risk (i.e. PFHT vs Virtual Family Physician Network)
- Back office in-kind support

Contact Info

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