The Win-Win of Nurses in Telemedicine

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Objectives

- Describe how nurses are supporting new models of care leveraging virtual technologies
- Discuss Critical Success Factors (CSFs) for an effective Telemedicine (TM) Nurse Program
- Profile an Ontario Virtual Critical Care (VCC) program & how patients are being supported in an urban environment
About OTN

1,748
SITES

1,289
MEMBERS

390,906
PATIENTS SERVED
Ontario’s Telemedicine Nurse Investment

- In 2011, the Government of Ontario announced the creation of 9,000 nursing positions

- 191 net new TM Nurse roles dedicated to supporting patient care through virtual solutions

- TM Nurses conduct examinations and work with patients and virtual multidisciplinary teams to plan and support appropriate care
OTN’s Role

- Partnered with regional authorities (Local Health Integration Networks) for:

  1. Business Case Development
  2. Program planning and implementation
  3. Training
  4. Reporting
  5. Collaborative three year review
Variety of TM Nurse Models are supporting patients

Specialty Care

Primary Care

Virtual Consultations

Care in the home
Critical Success Factors

- Effective Governance
- Diversification
- Accountability & Ownership
- Sustainability
Success Across the Province
Case Study – Health Sciences North and Virtual Critical Care

- Critical Care service ‘without walls’
- Increased access to same services available in large academic tertiary care centre
- Enhances assessment, diagnosis and subsequent treatment → goal improving patient outcomes
- Real-time education, knowledge translation of best-practices
- Collaborative care, second opinions
- Started as a pilot project in 2009 and phased in approach has enabled program expansion to 22 sites
Critical Success Factors

- Engaged all stakeholders early on
- Demonstrated how program goals aligned with Quality Improvement Plans and accreditation standards
- Supported by dedicated Staff
- Involved other sites early on in the process and provided opportunities for feedback
- Experienced tertiary critical care nurses were trained on the appropriate virtual tools and were empowered to run the program
Case Study –

Patient-Present, Primary Care Led Team Approach

Secure telemedicine video-conferencing technology connects primary care physicians and their complex patients with a local, inter-professional care team for consultation.
Model of Care

- TIP Care Plan yields:
  - a series of new recommendations to address the patient's priorities & goals, current barriers, and anticipatory needs
  - a coordinated care plan
  - the support of a dedicated TIP nurse for care coordination, care plan implementation, and follow-up care

- Follow-up TIP team consultations as appropriate: update care plan, assist with challenges in implementing the care plan

- TIP complex care clinics have been offered across Toronto since October 2013
The Story of Mr. A

Senior living alone in supportive housing with few social supports:

- **System perspective:**
  - 24 ED visits to one hospital over 8 months + multiple ED visits to other hospitals
  - Over 2000 lab tests, over 30 CT scans and multiple x-rays in past few years
  - Not receiving health care coordination services as not at home when services arrived

- **Patient perspective:**
  - Frustrated with the wait to get an appointment with family physician
  - Not getting the help he feel he needs – visits are disease focused
  - Hard to get to family physician

- **Family physician perspective:**
  - Patient frequently does not show up for appointments and does not follow through with instructions

- Identified as a high user at one of Toronto’s leading ED - offered a TIP nurse home visit
The Story of Mr. A (continued)

- At the TIP initial home visit:
  - coordinated care plan initiated
  - patient asked to use only one hospital
  - TIP Team visit planned to help him manage his symptoms

- Initial care plan shared with circle of care

- TIP home visit connected him with a geriatric inter professional team shortly after discharge:
  - Able to tailor the plans to meet the patient’s needs and ensure that the circle of care was aware of the care activities and communicating his progress
A person-centred, comprehensive, coordinated primary care model

1. **Go where the patient is**: Patient’s home, FP office
2. **Focus on patient’s personal perspective**:
   - Priorities and goals (short-term & long-term)
   - Barriers: Health literacy, social determinants of health
   - Historical perspective - *Avoid repeating what didn’t work*
3. **Centred in primary care**: Building capacity for comprehensive care in primary care setting
4. **Coordinated**: Integrated with Health Links: CCAC, hospital (including ED), CSAs, specialists, interprofessional teams
The ‘Win-Win’

- TM Nurses can support patients in a number of settings

- All health care providers and inter-professional teams can be equipped, obtain the core competencies and deliver virtual care

- Low cost/easy to use technology in combination with patients’ comfort and desire to receive care virtually supports the positive impact of the TM Nurses