Patient Visits Reimagined by COVID-19

00:00
Dr. Guylaine Lefebvre:
(Off microphone) very much, Dr. Oetter. Our next panellist is Darren Larsen, who will speak to us on his perspective as a user of – of digital and virtual health in your – in your own practice, Darren, and also your – your leadership of OntarioMD.

00:21
Dr. Darren Larsen:
Thanks a lot, Guylaine. Can you hear me well? Awesome. Thank you. So it's a real pleasure to be here, like all of the other panellists in front of me and following behind me. It's – it's an exciting time to be talking about virtual care. And I'm always asked to discuss the on-the-ground sort of practice experience of what virtual looks like in our practices and what the future is probably going to look like, now that it came upon us so very quickly.

00:42
I work for a company called OntarioMD. We're owned by the Ontario Medical Association. We're funded by the – by the agency, Ontario Health. We have done for the last 15 years a lot of implementation of digital tools. And even though we don't own digital tools or – or actually control some of the – the rollout of these products, we think we have a – had a lot to do during the time of COVID at helping doctors implement and onboard products as quickly and efficiently as possible. I'm going to ask for the next slide, please.

01:11
So when COVID came long, we know there was a lot of stuff happening already. Doctors' practices were changing dramatically. We had digitization of medicine in ways that we'd never seen before, not just moving to EMRs but going well beyond that, with many other tools for patients, for providers at the health system level that were – that were digitized, so that we were able to access more information at the right time for the right patient and the right problem.

01:35
The health system is transforming in virtually every single province. In Ontario we have complete reorganizations of the structure of delivery of care from the highest level of government down to the organizations of family health teams. As new accountable care organizations, called Ontario Health Teams, were being contemplated and begun to be rolled out over the year prior to COVID happening, we also have seen, as we already know, an explosion of data, and the ability to use that data for care is actually one of the most paramount concerns that we had in medicine, just to know that we were offering, again, the care that was appropriate to the patient based on his or her own profile. That's the profile in their over time. That's the data that's being collected for them from the hospitals systems, from our – our own individual offices, and across the board. As

they move from care environment to care environment, that data needs to follow them. We were well down the path of beginning to organize that at the time that COVID hit us.

02:31
And of course patients are getting smarter. They're getting more active, they're getting more engaged in their health care. They're monitoring every single heartbeat, blood pressure, and respiratory rate, and that's coming to us on a daily basis in – especially in primary care, but across all the professions, to help them interpret. So as docs were trying to consume all of this and gradually change their practices over, something big happened. Next slide, please.

02:53
On March 12th, March 13th, we saw the shutdown of many of our hospitals, of many of our most paramount and deeply ingrained health care structures at a time that we didn't know what this pandemic would look like. We knew there was disease happening south of the border that looked horrible. We had looked across to Europe and had been a disaster in Italy and parts of Spain and – and areas in Germany. We could not let that happen here. So immediately the health care system transformed. I like to say we went from zero to 89 in about two weeks, meaning zero is not quite where we were in using virtual before – we were using about seven percent of our – of our time and our visits in the virtual space, including telephone calls; and we went to, according to a CFPC survey, around 89 percent of us using virtual care for – for 80 percent of our visits being virtual, in the space of about two weeks. So nothing was the same for us as doctors. Next slide, please.

03:50
But also important to remember that also nothing was the same for patients. Just as we were trying to figure this out, so were the people we were looking after. And as you know, and Dr. Oetter had already said, patients were afraid sometimes of coming to see us. Sometimes they weren't sure if they wanted to be in our offices at all for fear of coming in contact with other patients. So virtual exploded onto the scene. Next slide, please.

04:15
I had a really fun time in my job with OntarioMD to try to help doctors along. We rapidly created a new website called OntarioMD.news. It started to aggregate virtual care products in Ontario. We have over 25 of them available to us. We created webinars using our Peer Leader program to teach doctors how to use virtual more efficiently in their practices. We created, with the Ontario Medical Association and the Ontario Telemedicine Network, an Ontario virtual care clinic to get unattached patients to care. We worried particularly about 300,000 Ontarians returning home during COVID, either because they were ex—they were living away and had come back because they felt they were at risk at where they were, or they'd been travelling and came home during the time of the pandemic.

04:57
We also did a lot of work in releasing and moving data around, moving ol—COVID results through the Ontario lab information system directly to doctors in near-real time. We helped uptake – show doctors how to uptake many other digital tools, including the optimized use of their EMRs. We're getting to the certification of virtual care now with Ontario Telemedicine Network, and we're looking at the development of national standards as some of our people are involved in the task force and the – actually the multiple task forces being created right now via Health Canada and the CMA. Next slide, please.

05:30
But what does it look like to do virtual? What does a virtual visit look like? And we heard earlier then – that some of the doctors are using telephone for the majority of these cases. And – and I actually will be one of those propoments – proponents that says that's OK because what we really have to do during a time of a crisis like we've seen in the last four months is meet patients where they're at. We – we know that even a lot of homeless people, people on the street, have – may have one item in their possession that they own, and that's likely a telephone. It may or may not be a smart phone, but almost everybody in Canada now has access to a voice way of speaking to a clinician. So telephone for many in the north, where there is limited bandwidth for video is the first point of contact. And in a study that we did through OntarioMD, we saw about 90 percent of the calls that were – or the visits that were being done at the beginning were telephone, and, as the virtual care platform started to ramp up and be more integrated, video visits seemed to take on a greater and greater role.
06:26
I think that over time, as we find this new normal, we will find the appropriate mix of what can be done by phone, what can be done by e-mail or text message in a secure way, and what video has to offer. Video can be very secure, it can be private. At this point in time we still need to ask for consent using some of the platforms that are not medical grade. It can be very patient friendly if it's a click of a button and enter the system, and it can be clinician friendly. So we need to find the platforms that work in that domain. And more and more, we're understanding that the – the greater they're integrated into the point of care systems that doctors and nurses are using, the more robust they will be for the overall experience and reducing the burden, redurcin—reducing the newness of it, and hopefully leading to less of the burnout that we experience with rapid cycle change. New – next slide, please.

07:14
We also know there are a lot of items on the horizon, and – and going beyond the actual visit, as we contemplate that balance between in-person visits and what might happen on some kind of electronic or virtual space, we have to figure out how we start getting data into the systems, often by patients. Collaborative care records are probably the future of the actual integrated care record for patient, clinician, and other providers. Especially as patients move around the system from acute care to primary care to long-

term care, even into palliative, end-of-life care, we need to make sure that patients have the right or the ability to access their data and – and actually contribute to their data.

07:52
I know many clinics now doing record keeping or the – the history taking in the parking lot, and only moving the patient into the examining room at the moment that they need to be examined, so as to decrease their contact with other patients and health care providers, providing more temporal spacing and physical spacing for the average clinic. This is all new for us. Add on to that we have the evolution of contact tracing apps that have actually now brought patients into our office, say this is flagged red, what do I do next? We're seeing AI-based chatbots helping with triage and the sorting of patients from one – one type of care to another. And it could be you start with a telephone call or an e-mail, you move into a video visit, and sometimes you have to come in to be seen. So the ability to put the right person in the right visit environment for the right problem is – is paramount.

08:40
We're seeing more and more clinics evolving into online scheduling systems, which allows more flexibility to maybe temporally space patients. So you might do a few visits virtually, a few visits in person, which gives them time to clean the rooms and move that whole extra space in the care environment forward without having to run into yourself or run into new patients in the interim. So the efficiency of a practice actually improves.

09:04
We're seeing remote monitoring coming along. There are a lot of virtual products now out there for the home care environment, for looking after patients. My own hospital, Women's College, had a COVID at Home program where, when you were seen to be positive with the COVID results in our testing centre, you were automatically assigned to the COVID at Home program. You'd be shipped a pulse oximeter monitor. You'd be contacted by a nurse or a physician two times every day to ask about your breathing status, your temperature, etcetera. And with that program, we had zero admissions to hospital. So there's some evidence that doing this well decreases the burden of hospitalization and acute care environments. And I've already mentioned the need for data to follow the patients. This is what's coming in front of us in the very, very near future, if not already. Last slide, please. Next slide.

09:47
The new normal for in-person visits includes of course the – the need to protect ourselves with PPE. We're limiting time spent directly in front of patients, yet we're trying to make that time the highest quality. It's difficult to be behind a mask and a face shield, and sometimes cloaked in gowns and gloves, and examining a small child with a cough. It creates a barrier between us and our patient care. And it's quite appropriate, I think, for some of the visits that we would do to be all virtual. For instance, mental health does very well with a video visit, more so than connecting with a patient in an office behind a mask and a face shield, in terms of your ability to truly connect and deliver their care.

10:25
We are creating physical and temporal space, as I said before, and – and we're trying to figure out in practice as we go how to bring these virtual tools into that same environment so that perhaps we can blend them. It may be that you are doing a history from a parking lot, using a video conference, or it may be you're using the telephone, or it may be that in fact you're able to offer really innovative programs like, you know, flu shot clinics in – in environments where it's very low touch and very quick turnaround, at the same time trying to keep patients apart, especially if we get a wave two of respiratory illness.

11:00
So the entire world has changed for us in – in primary care and specialty care. I have been incredibly proud of my peers as they have moved forward in a way that I never thought possible, although it tells me we were really ready for it. It just took a little hook, and probably a big push, to move ahead in the realm of virtual. And frankly, as Seamus said, the genie's out of the bottle. I say always the horse is out of the barn. Coming from Alberta, it's an easier one for me to say. Horse is out of the barn. Corralling it is not what we want to do, but perhaps putting a bridle and a saddle on it is the next real move as we get into the balance between virtual and in-person care over time. So on that note, I'll stop and hand over to the next speaker. Thanks so much for your time.

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