Ontario Health Team in Mississauga

Co-Design Session Outputs

September 12, 2019

Our approach

We took a user-centred design approach to develop our Mississauga OHT care model

1. Developed patient personas based on our Year 1 priority populations:
    - People who would benefit from a palliative approach to care
    - People with minor acute gastrointestinal (GI) / genitourinary (GU) issues
2. Created maps of the patient journey to identify pain points / challenges to improve upon in the future patient experience
3. Mapped the patient journeys onto a service blueprint to identify the various health care service touchpoints that needed improvement
4. Held a co-design session on Tuesday, August 27th with many diverse stakeholders, including patients and family / caregivers, primary care, acute care, home care, and community partners, to:
    - Validate our understanding of the current-state patient experience and service challenges
    - Generate “Big Ideas” for improvement in the future OHT care model, according to the OHT guiding principles
    - Discuss how these ideas could be implemented and measured in the new OHT model by describing a “Road to Success”
5. Incorporated elements of the co-designed “Big Ideas” and “Road to Success” into our OHT care model described in the Full Application

Our co-design session

2
areas of focus for year 1

Our OHT year 1 populations are…
People with palliative care needs
People with acute GI/GU issues

75
participants

49 people focused on palliative care
26 people focused on acute GI/GU

Diverse stakeholders, including 8 patient and family reps

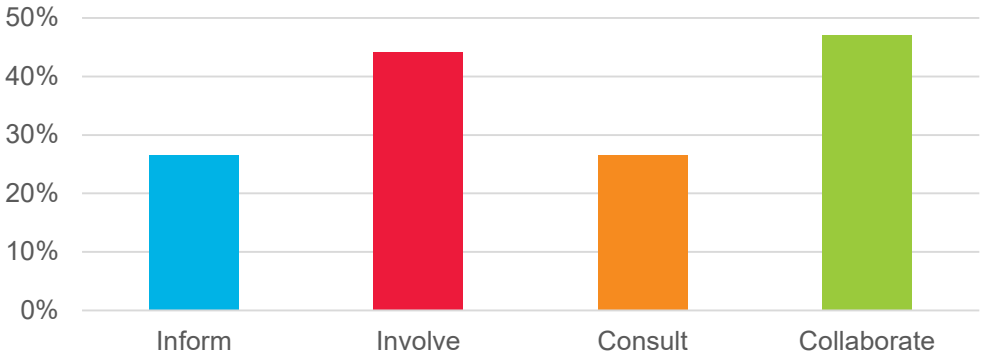
Group included patients and family / caregivers, primary care, home care, acute care, community partners, and others

12
big ideas

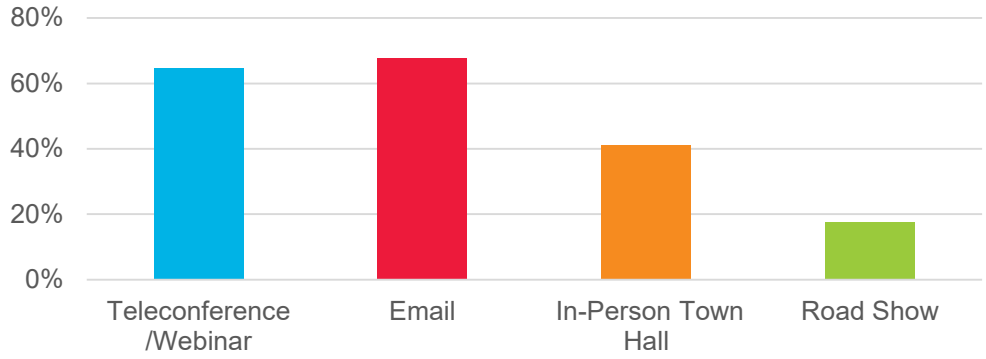
We came up with…
8 big ideas for palliative care
4 big ideas for acute GI/GU

We asked, "How do you want to be engaged after October 9?" (n=34)

Engagement level



Channel



Reflections on Ontario Health Team development so far

Selections from feedback provided

I love…

- The opportunity to be involved
- Group activity / discussions; Team work
- Working in small groups with variety of stakeholders (different perspectives)
- That all of these disciplines were invited to collaborate / discuss / learn about / co-design this exciting change
- Interactions and collaboration, lots of great ideas
- New ways to think about things; many people on board
- Openness in collaboration
- Idea of a digital system for all to access
- The human-centred design approach, starting with pain points / journeys of participants but considering all users
- Creative solutions to problems
- The concept; The idea of creating a system that is easier for patients, families to understand and be connected to the right care for them
- Sharing network, talking about the future
- Collaborative workshop, big picture system thinking opportunity with partners
- The vast information being shared, collaborative approach in relationship and trust building

I wish…

- For more of these meetings; More engagement events like this to help design the OHT
- It was happening at a slower pace; We all had more time available to work on things
- We were further ahead
- More $ to support big ideas that will improve care
- We could integrate electronic systems easier, and have less privacy hurdles for virtual care
- Clarification on 24 / 7 care for solo practitioners
- Rehab were involved in palliative care journey
- Inclusion of community providers of lab and imaging services
- To remain involved and a part of the work; to continue to provide feedback
- For more knowledge on how OHT is formed
- Have the meetings during the day
- Use of OHT resources to improve patient education

I wonder…

- What the future entails
- How things will progress post-October
- How can we be involved?
- If it will turn out great – hope so
- If we will be able to create one big electronic platform for information
- How the Ministry will work though the funding methodology to actually enable all this
- Why was this not done earlier?
- About focusing more on preventative care
- How palliative patients feel about palliative care
- How we can better manage at a population level

How to stay connected with the M-OHT

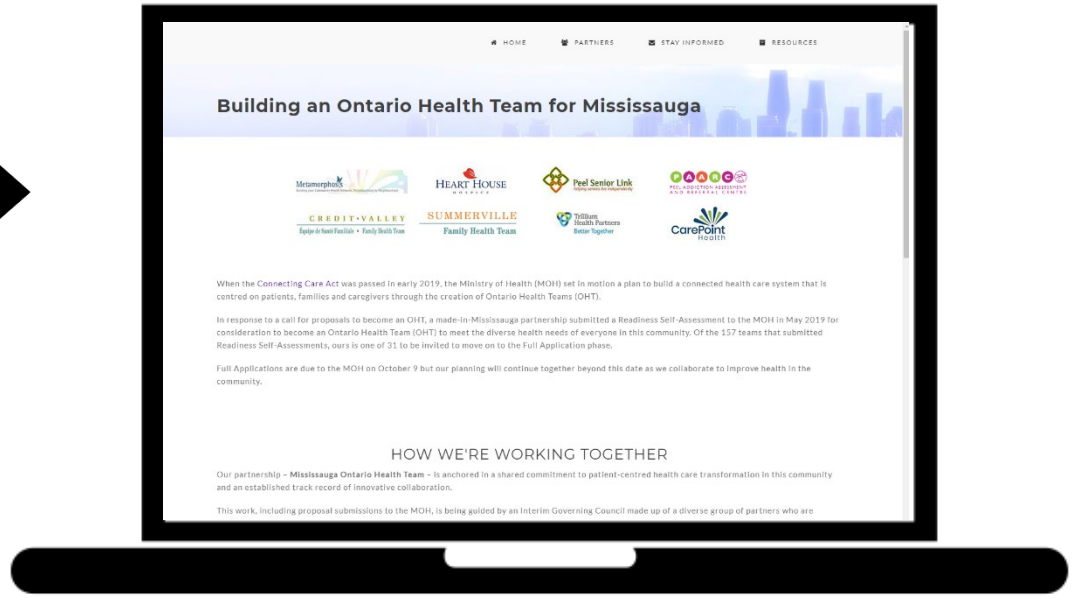
Thank you again for your ongoing support in the development of the Mississauga OHT!

If you have any questions, please contact info@moht.ca.

For updates and events, you can also check out our website at www.moht.ca

The next info session will be held the week of September 23rd.

Please stay tuned for details!



Outputs from the co-design session

Our big ideas + Road to success

PALLIATIVE CARE:

TABLE 1: OHT-Coordinators

TABLE 2: **“**Start Early and Do It Right”

TABLE 3: Quarterback with Clinical Skills

TABLE 4: Multi-Lingual and Multi-Channel Navigation and Resource Directory

TABLE 5: Palliative Care Hubs

TABLE 6: The “Always Experience” – Automated Trigger for Early ID

TABLE 7: Secure Information Access in Real-Time (Blockchain)

TABLE 8: Palliative Access and Rapid Response Team

ACUTE GI/GU:

TABLE 1: Advance Practice in Diagnostic Imaging

TABLE 2: One-Stop-Shop for Suite of Digital Services

TABLE 3: Rapid Access Diagnostic Center

TABLE 4: Advancing to a Digital Health Care Future

TABLE FACILITATOR: Bonnie Scott

TABLE 1: OHT-Coordinators

WHAT IS THE CHALLENGE?

How might we… allow patients to access one number (care team) who knows them and can trigger the right care (for planned and unplanned care)?

WHAT IS YOUR BIG IDEA FOR THE FUTURE?

- Embed care coordination into the primary care team – this enhanced role is the **OHT-C** (Ontario Health Team Coordinator)
- Step 0: Teach patients who to call in times of crisis (one number / website)
- Step 1: Patient contacts OHT-C via phone / video / text (someone is on call any time of day / night). OHT-C is part of a care team, knows the patient (has followed the patient throughout their journey), and has access to patient's health record
- Step 2: OHT-C has a clinical background and triages patient to appropriate resources, such as primary care, specialist, ED (triaging may be supported by AI); no referrals
- Rapid response can be provided by paramedics, who can be leveraged to provide palliative care in the home

WHAT IS THE DESIRED IMPACT?

- Patients are educated about alternatives to ED / hospital care
- Patients feel more confident that they are 'on the right path'
- Reduces physician concerns of not having enough time for care coordination with patients and building trust – OHT-C is the trusted point-of-contact for navigation and coordination

RISKS / BARRIERS?

- Currently, care coordination function not standardized into primary practice; large change management activity
- Limitations exist for paramedics to provide palliative care in the home (e.g., medication administration)

DRIVERS / ENABLERS?

- CarePoint's primary care model embeds care coordination into the team
- "Paramedics providing palliative care" program (NS/AB) currently being scaled and spread in pockets across ON and Canada (incl. by OPCN)

PROVOCATIVE THOUGHT STARTER

How can we leverage people at the right time and place to provide much-needed palliative care in times of crisis? (e.g., family / caregivers, mobile nurse teams, paramedics)

WHAT ACTIVITIES COULD YOU DO TO GET THERE?

Year 1

- Identify early champions
- Create OHT coordinator function
- Set up governance and accountability structures
- Establish clear goals and metrics

Year 2

- Evaluation of Year 1 performance and implementation of changes

Year 3

WHO NEEDS TO BE INVOLVED?

Year 1:

- Palliative Care Physicians
- Primary Care Physicians (starting with initial primary care groups)
- OHT-C
- Community Paramedics
- Home Care
- Community Care
- Hospice
- Hospital

Year 2:

- Organized Health Teams

Year 3:

- Expand to solo PCPs
- AI technologies?

TABLE FACILITATOR: Laila Peerbhoy

TABLE 2: "Start Early and Do It Right"

WHAT IS THE CHALLENGE?

How might we… address emotional, psychological and spiritual care, as well as practical and social supports, with patients early on rather than focusing at end of life?

PROVOCATIVE THOUGHT STARTER

Many emotional, psychological, and spiritual supports already exist for patients in our community. How do we get more people to use and benefit from them?

WHAT IS YOUR BIG IDEA FOR THE FUTURE?

- Early identification and discussion: **"Start Early & Do It Right"** approach that integrates assessment of emotional, psychological, spiritual care and social support needs along with palliative care discussions from the start; early on rather than introducing them suddenly at the end of life
- Flexible navigator / coordinator (non-clinical background ok) within interdisciplinary team to manage the patient's holistic care; one point of contact who gets to know the patient and family well to develop best palliative care approach
- Currently LHIN services are connected with checkboxes that patients might not fit into. Educate providers to assess needs for emotional and spiritual care early on along with ID of palliative needs; can be digitally enabled (e.g., digital reminder / trigger for completion)
- Educate patients on available community and cultural resources.

WHAT IS THE DESIRED IMPACT?

- Patients feels part of the decision-making process; if you take care of social (e.g., emotional) needs, then the health care needs are often reduced
- Provider satisfaction, coordination, communication and empowerment
- Appropriate system utilization; less resources needed if address issues earlier (e.g., stress)

RISKS / BARRIERS?

- Digital systems not currently integrated
- Privacy concerns; stigma around early Palliative Care discussions
- Too many assessments
- Billing code for family support but only while the patient is alive
- Cultural shift = doctor's obligation is not just for the patient but for the family around that patient

DRIVERS / ENABLERS?

- Education / training to have difficult conversations and eliminate fear
- Bundled care
- Good systems / teams / services but not necessarily added at the right time

WHAT ACTIVITIES COULD YOU DO TO GET THERE?

Year 1

- Educate (PCPs, specialists, and allied health) about early ID and discussion, as well as Palliative Framework
- Create team and care pathways
- Develop navigator role

Year 2

- Identify patients of one specific illness and navigate them
- Continue provider education and support through flexible team-based approach (digitally-enabled team communication); specialists/PCPs to start the conversation
- Monitor for patient's changing care needs to provide right service at right time

Year 3

- PDSA and repeat
- Expand to other illnesses
- Introduce virtual care / services

WHO NEEDS TO BE INVOLVED?

- Patients and families involved in decision-making of their emotional needs and support systems.
- Interdisciplinary Primary Care Teams (MDs, allied health)
- Specialists
- Hospices
- Home Care
- Vendors

TABLE FACILITATOR: Jessica Katul

TABLE 3: Quarterback with Clinical Skills

WHAT IS THE CHALLENGE?

How might we… help patients know who to go 24/7 to coordinate and provide care?

PROVOCATIVE THOUGHT STARTER

Your health care quarterback can be anyone on the primary care team with clinical skills. How does this role get assigned and by whom?

WHAT IS YOUR BIG IDEA FOR THE FUTURE?

- Introduce a **"quarterback with clinical skills"** – any provider (physician, pharmacist, care coordinator, etc.) who is responsible for developing a patient-and-family-informed dynamic care plan that is digitally accessible by all stakeholders (includes spiritual care, rehab, etc.)
- Leverage eVisits as incentive for 24/7 care to prevent unnecessary ER visits
- Off ramp patients from ER to care coordinator instead of to hospital
- Educate and train providers around early ID framework (all providers have role in starting end of life care)
- Create public awareness campaign on Advance Care Planning

WHAT IS THE DESIRED IMPACT?

- Reduced use of ER by patients
- Decreased patient and family anxiety
- Better coordination of primary care
- Better understanding of options at end of life and plan adhered to
- Better chance of patient dying in place of choice
- Overall improved patient experience
- Reduced stress with providers in ER and unnecessary admissions
- Reduced effort in coordinating care as everyone has access to the same plan
- Increased use of home care to meet patient desires

RISKS/BARRIERS?

- Culture change from "care provision" to "support provision" for primary care team
- Funding discrepancy between health care system employers for similar roles
- Advance Care Planning done up front
- Need technology to support full-access

DRIVERS/ENABLERS?

- Can leverage LEAP provider training
- Palliative Care Network

WHAT ACTIVITIES COULD YOU DO TO GET THERE?

Year 1

- Select a few quarterbacks (physician, nurse, or other) for coordination from initial primary care groups
- Address technology for digital care plan
- Establish new processes – off ramp at ER to redirect back to care coordination

Year 2

- Expand to include half of population (currently ~100,000 people with initial primary care groups)
- Add in community support services

Year 3

- Expand to remaining population

WHO NEEDS TO BE INVOLVED?

- Patient and families
- Interdisciplinary Primary Care Teams
- LHIN
- ER
- Specialists
- Palliative care specialists
- Long Term Care
- Home Care (PSWs)
- Hospices
- Community services
- IT teams
- LEAP program
- Palliative Care Network
- Adult day programs
- Public Health (public awareness campaign)

TABLE FACILITATOR: Elizabeth Molinaro

TABLE 4: Multi-Lingual and Multi-Channel Navigation and Resource Directory

WHAT IS THE CHALLENGE?

How might we… improve patient self-management, health literacy and education in a culturally, linguistically, and age-appropriate manner?

WHAT IS YOUR BIG IDEA FOR THE FUTURE?

- **Multi-lingual and multi-channel navigation and resource directory:** 24/7 access to written (e.g. website) and oral (e.g. real-time conversation with navigator via 1-800 number, virtual care) information that suits patient's needs (based on culture, language, age, etc.)
- Navigator and resources are available in patient's language of choice; navigator can view patient's health information (with consent) and connect with primary care team; conversations / information consider cultural nuances; can provide regular check-ins on patient and family wellbeing; can link providers to translation services for sensitive conversations
- Navigator and resources can provide support for self-management, medication compliance, and empowerment

WHAT IS THE DESIRED IMPACT?

- Patients and families have improved experiences due to access to appropriate resources (based on culture, language, age, etc.)
- Patients and families are better equipped to die in place of choice
- Families have greater access to appropriate bereavement supports
- Providers are supported in having sensitive palliative conversations, increasing number of patients ID early
- Greater health equity and coordinated care across providers

RISKS/BARRIERS?

- Burden on providers to do regular check-ins with patients and families
- Shift from convenient to quality conversations: Providers can call a translator line today, but family are often relied on for translation

DRIVERS/ENABLERS?

In the future…

- Central 1-800 team to follow up with family doctor
- Virtual hospice care

PROVOCATIVE THOUGHT STARTER

How does the primary care team stay up-to-date on local community palliative resources that are available?

WHAT ACTIVITIES COULD YOU DO TO GET THERE?

Year 1

- Information collection to identify resources, translation options, and technology requirements (planning) to create a Resource Directory
- Identification of partners and responsibilities.

Year 2

- IT implementation and testing
- Begin translation process
- Identify and train navigators
- Educate health care providers

Year 3

- Implement and test translation services
- Conduct pilot to test idea in diverse areas
- Ongoing PDSA

WHO NEEDS TO BE INVOLVED?

- Primary care providers
- Patients, families, caregivers
- Allied health professionals
- Service providers
- Palliative Care Network
- Faith Community
- Other community partners
- "Buddy" visitors
- Transportation services
- Hospices
- Home Care
- IT supports
- Translation team
- Cultural representatives

TABLE FACILITATOR: Elliot Archer

TABLE 5: Palliative Care Hubs

WHAT IS THE CHALLENGE?

How might we… help non-palliative specialists feel that palliative care is part of their role, feel more comfortable / competent, and feel supported when providing palliative care?

WHAT IS YOUR BIG IDEA FOR THE FUTURE?

- Create 3-5 Palliative Care Hubs across the geography of the OHT where palliative specialists can have regular touchpoints with primary care teams (in-person or virtually; e.g., conduct biweekly / monthly patient rounds)
- Palliative Care Hubs would reinvest in the core team (MDs, NPs, etc.) by:
  - Building trust with community partners / offer extended services / access to palliative specialists
  - Training staff in how to do early ID of palliative needs for patients in practice
  - Raise awareness of help that is accessible 24/7
- Ensure financial accountability and incentives for primary care and palliative specialists by including them in the single funding envelope (shared care and accountability)
- For model to be successful, need to address physician remuneration; services other than face-to-face patient visits need to be compensated

WHAT IS THE DESIRED IMPACT?

- Patients and families would experience a more seamless continuum of care
- Increase in education and confidence in primary care, resulting in more patients ID early for palliative care
- Patients receiving palliative care in primary care means that specialists are more available to focus on high needs / complex palliative patients; better use of system resources

RISKS/BARRIERS?

- Many solo practitioners in our region; need to address incentives and accountability for this model
- Funding model
- Adoption and shift in culture
- HR plan (how many patients per hub)
- Different documentation platforms

DRIVERS/ENABLERS?

- CarePoint's primary care model includes having a "Hub" or specialist touchdown space for these purposes
- LEAP training
- Leverage PCAs for capacity building (e.g., academic detailing)

PROVOCATIVE THOUGHT STARTER

Who on the primary care team might be best suited to carry out palliative care assessments with patients? What might be a factor (e.g., time, scope, compensation)?

WHAT ACTIVITIES COULD YOU DO TO GET THERE?

Year 1

- Leverage initial primary care groups and care coordinators. Involve HR teams to understand volumes
- Organize hubs at existing locations (Credit Valley FHT, Summerville FHT, CarePoint Health).
- Develop HR plan for future growth based on population projections

Year 2

- Expand to one additional site based on data

Year 3

- Neighborhood / religious / faith community survey to determine care team / needs specific to them

WHO NEEDS TO BE INVOLVED?

In each neighborhood / sub-region:

- Interdisciplinary Primary Care Teams (MDs, NPs; allied health – OT/PT/SW)
- Home Care (e.g., Care Coordinators)
- PSWs
- Palliative Care specialist teams, including Palliative MDs, NPs, nurses and care coordinators
- Existing Palliative Programs
- Non-medical support services including schools, shelters, housing facilities, spiritual care teams.
- Consulting services

PEOPLE WITH PALLIATIVE CARE NEEDS **TABLE FACILITATOR: Laura Harild**

TABLE 6: The "Always Experience" – Automated Trigger for Early ID

PROVOCATIVE THOUGHT STARTER

How can we increase participation of non-health care providers in palliative care? Where could they have the biggest impact on improving the patient and family / caregiver experience?

WHAT IS THE CHALLENGE?

How might we… better recognize sooner when someone has palliative needs?

WHAT IS YOUR BIG IDEA FOR THE FUTURE?

- Palliative care cannot be delivered unless someone is first identified with palliative care needs
- To standardize and simplify process for providers, leverage **automation of triggers for palliative ID** (e.g. HOMR, GSF); initial trigger for palliative approach to care is diagnosis of life-limiting illness
- Positive ID will trigger a comprehensive and holistic assessment, regardless of the sector (primary care, acute care, home care, long-term care), + connection to 24/7 interdisciplinary care team planning (if not connected already); first needs assessment should be done by a clinician
- Automated triggers help take the provider-specific dependency / variation out of the system; creates an "always experience"

WHAT IS THE DESIRED IMPACT?

- Patient and families benefit form earlier access to resources and services that enables them to make informed decisions. Holistic care reduces isolation and fear.
- Providers benefit from increased supports through team-based care coordination that reduce burden and burnout and fosters trust
- Optimal health resource utilization helps reduce overall costs
- Creating and "always" experiences improves health equity

RISKS/BARRIERS?

- Funding for education; lack of education might mean under-treatment
- Stigma around "palliative care" designation
- Primary skillset in palliative care usually low
- Funding for time to build capacity (FFS specialist model)

DRIVERS/ENABLERS?

- Performance indicators
- Plan to build primary skillset in palliative care
- One chart across settings with coordinated care plan
- OHT planning = palliative care education
- OPCN Early ID report for best practices tools
- Palliative specialists (MD + NP), if funded

WHAT ACTIVITIES COULD YOU DO TO GET THERE?

Year 1

- Involve Primary care and Home Care in OHTs (be mindful of time and resources for MD partners)
- Engage, educate, some operational change
- Digital tools to make this easy (understand THP EPIC options)
- Create evaluation plan
- Collect baseline data

Year 2

- Operational change within acute care, ER, primary care (include paramedics to ID)
- Engage and educate non-health care partners

Year 3

- Operational change for non-health care partners

WHO NEEDS TO BE INVOLVED?

- Primary care
- Hospital / EDs
- Home Care
- Community leaders
- Disease site specialists
- CAPACITi QI project
- THP EPIC system for ID and to trigger action for coordination
- Hospices; Dorothy Ley Hospice for outreach in vulnerable communities
- TELUS Practice Solutions – Palliative EMR Toolkit
- Better Care Program – Sunnybrook (care coordination and care plan)
- PPSMCs, paramedics
- QI specialists, Primary Care Advisors
- Communications team
- Programmer / digital health experts

TABLE FACILITATOR: Sunita Kheterpal

TABLE 7: Secure Information Access in Real-Time (Blockchain)

PROVOCATIVE THOUGHT STARTER

Providers and patients have different information needs. What information might providers and patients not want to share with each other or documented in the medical record if it could be seen by both?

WHAT IS THE CHALLENGE?

How might we… ensure that information follows the patient, and all care providers and the patient have access to the same information?

WHAT IS YOUR BIG IDEA FOR THE FUTURE?

- Leverage **blockchain technology for the creation, live updating, and secure sharing of an integrated record through a real-time, interactive chain of information** (blue sky opportunity for sharing information securely)
- One point of contact and entry into the system; one source of truth
- Serves as a ledger for providers to see who is connected to the patient.
- Flags in the system enable physicians to be notified at appropriate times, e.g. when patient is moved to a hospital

WHAT IS THE DESIRED IMPACT?

- For patients: greater access to their own information, no need to repeat information, more seamless care
- For providers: automated processes and tracking, built-in notifications, communication with patients, can access right information at right time
- For other stakeholders: Enables measure of outcomes across system; fosters transparency and accountability

RISKS/BARRIERS?

- Consent management and privacy – what information do patients not want providers to know?
- Access management – what information do providers want to keep from patients to prevent Dr. Google?
- Multiple, siloed systems – you need one system or connect them all
- Legislative barriers around PHIPA
- Moving to new tech is challenging for users and may have low adoption (balance adoption with standardization)

DRIVERS/ENABLERS?

- OHT opportunity for change
- Patient demand (Caregiver Survey)
- Provider capacity

WHAT ACTIVITIES COULD YOU DO TO GET THERE?

Year 1

- Environmental scan to create inventory of all tech and digital assets
- Enhance current assets - borrow from best practices such as one-Link to have a single point of access to OHT (referral management, central intake)
- Data sharing / policies to exchange data - government can assist in breaking down silos by creating supportive legislation
- Engage stakeholders (patients, partners) to understand needs

Year 2

- Facilitate data exchange between stakeholders through data sharing policies
- Ensure Patient Coordinated Care Plan in CHRIS is accessible by all sectors (i.e., break barrier of direct access to CHRIS through HPG – HSSO Policy)

Year 3

- Real time access to one record by circle of care
- Evaluation

WHO NEEDS TO BE INVOLVED?

- Patients, physicians, other healthcare providers, etc.
- Government, regulators, funders
- Private sector, vendors

Systems / partners / projects that it would leverage:

- Connecting Ontario
- Connecting GTA
- Diagnostic Imaging repositories
- Care Coordination in CHRIS
- FHTs flagged for assessment
- TELUS early ID
- Revisiting scales on RAI for early ID
- Ontario MD
- OTN
- EADC
- one-Link

TABLE FACILITATOR: Kathy Davison

TABLE 8: Palliative Access and Rapid Response Team

WHAT IS THE CHALLENGE?

How might we… connect and share information, have one point person / team, and have one number to call?

PROVOCATIVE THOUGHT STARTER

What health care services do patients and families / caregivers need 24 hours, 7 days a week? Is care coordination needed only during day, while navigation and access to care needed throughout the day and night?

WHAT IS YOUR BIG IDEA FOR THE FUTURE?

- **Palliative Access and Rapid Response PARR team** – a rapid access mobile team (e.g., nurse team) that can be reached via a **central hotline** for on-the-phone or in-person, at-home consultation (multichannel: text, email, phone, video)
- The patient is directed to appropriate resources via an OHT navigator who has access to the patient's integrated EMR / health record (navigator can support virtual care visits with primary care, specialists)
- Advance Care Planning (ACP) and Palliative care education campaign (raising public awareness, normalizing the conversation); navigator included in education strategy
  - Link ACP to a non-medical trigger (e.g., age – over 35, reminders via mail / email); social medial campaign
  - Also use common health system touchpoints (hospital registration; check-in for primary care visit) to collect ACP information

WHAT IS THE DESIRED IMPACT?

- Patients and families get quick access to someone they can count on
- Providers benefit from shared information and clear accountabilities (who is doing what)

WHAT ACTIVITIES COULD YOU DO TO GET THERE?

Year 1

- Identify patients who will get access to PARR
- Environmental scan of similar programs
- Set up phone line (one number)
- Identify navigator + primary care duo
- Market PARR
- Conduct ACP education campaign

Year 2

- Set up virtual care systems to support integrated clinical visits
- Conduct ACP mail-out to public

Year 3

- EMR integration – identify and ensure all required providers have access

WHO NEEDS TO BE INVOLVED?

- Primary care providers
- Home care providers
- Specialists
- Navigator
- IT / Digital specialists
- Marketing / Communications

PEOPLE WITH ACUTE GI/GU ISSUES **TABLE FACILITATOR: Anjana Dattani**

TABLE 1: Advance Practice in Diagnostic Imaging

WHAT IS THE CHALLENGE?

How might we… have access to diagnostic imaging and results in a time-appropriate manner?

PROVOCATIVE THOUGHT STARTER

What would be needed to expand the scope of diagnostic technicians to communicate results directly to providers? What information would patient's want to have in the "layman's note" captured in the health record?

WHAT IS YOUR BIG IDEA FOR THE FUTURE?

- Using the Nurse Practitioner model, upgrade the skills of diagnostic technicians to have the authority to report negative results and obvious results directly to the physician
- Physician communicates results to the patient verbally along with a note in patient's health record written in layman's terms that explains meaning of result and reduces possibility of patient resorting to "Dr. Google"; requires patients having access to their health records
- Have diagnostic center focused only on GI/GU complaints

WHAT IS THE DESIRED IMPACT?

- Patients benefit from faster information and clearer understanding of issue and next steps, resulting in less stress
- Providers receive information faster, leading to better patient care and greater effectiveness (skills match need)
- System is leaner, better patient experience overall, at less cost with more patients served

RISKS/BARRIERS?

- Funding model with OHIP
- Radiologists allowing technicians to do this work
- Radiologist resentment to handling only complex cases

DRIVERS/ENABLERS?

- Primary care physicians: more effective patient visits by knowing the diagnostic results faster
- Patients: knowing eliminates fear of the unknown (anxiety reduction); enabled by access to health record

WHAT ACTIVITIES COULD YOU DO TO GET THERE?

Year 1

- Determine most common ordered test using Pareto analysis
- Determine training and competencies needed for GI/GU test
- Identify most experienced and teachable technicians for pilot test
- Work with legislators and college to draft regulations and policies
- Choose a diagnostic center to be a GI/GU focused location
- Conduct pilot in Year 1 and follow PDSA cycles

Year 2

- Find second location and prepare to launch

Year 3

WHO NEEDS TO BE INVOLVED?

- Primary care physicians
- Radiologists
- Private and Public Diagnostic Facilities
- Professional Colleges

PEOPLE WITH ACUTE GI/GU ISSUES **TABLE FACILITATOR: Sharon Gretzinger**

TABLE 2: One-Stop-Shop for Suite of Digital Services

WHAT IS THE CHALLENGE?

How might we… provide seamless access to health care information and providers in a timely fashion?

PROVOCATIVE THOUGHT STARTER

Some health care organizations use tablets for patient check-ins, feedback surveys, and short health assessments (e.g., ESAS-r, PHQ-9). How could patient input be used to improve health care across our OHT?

WHAT IS YOUR BIG IDEA FOR THE FUTURE?

- Integrated health records in a secure digital location, accessible by all providers in continuum of care
- Virtual care (phone, text, video, etc.) between primary care and specialists (specialists can be part of an ON-wide telehealth service to reduce wait times for primary care consults)
- Primary care access to language translation services that are approved for health care use and don't require data connectivity; preference in patient record; patient prompt "in what language do you want care today?
- Patient self-management and health literacy:
  - Phone hotline for advice (more than Telehealth; good for low income since don't need computer)
  - Access to digital health record; allows proactive management
  - Access to reputable health website
  - Virtual care services for patients

WHAT IS THE DESIRED IMPACT?

- Patients have access to their health records and can access to their physician / team 24/7 (i.e., virtual care), thereby reducing wait times and unnecessary system utilization (ER / primary care)
- More integrated and efficient system for providers: PCPs feel more supported, have full access to shared patient record and results, greater access to specialists, benefit from peer-to-peer education, and reduced admin work / paper trail
- Overall reduction in hallway medicine; frees up capacity of ER staff
- Employers benefit from more satisfied staff and less missed work

RISKS/BARRIERS?

- Privacy and confidentiality
- Risk of self-diagnosis

WHAT ACTIVITIES COULD YOU DO TO GET THERE?

Year 1

- Acquire digital platform
- Create one website and one phone number to replace existing resources; centralized service will contain reliable health information and a single point of contact for patients and providers
- Assess current state (needs and readiness) to determine implementation strategy

Year 2

- Expand virtual care to more providers

Year 3

- Develop integrated digital health record that links all patient's health information and is accessible by entire care team.
- Digital record identifies preferred language for care

WHO NEEDS TO BE INVOLVED?

- Patients and caregivers
- Primary care physicians
- Virtual care / Telehealth tools
- Specialists
- Labs / Diagnostic Imaging
- ER
- Digital health providers for tech tools e.g. eConsult
- Cultural agencies
- Translation services
- IT team to build website, SEO on search engine, Healthline
- Health system planners
- Legal teams

PEOPLE WITH ACUTE GI/GU ISSUES

TABLE FACILITATOR: Carie Gall

TABLE 3: Rapid Access Diagnostic Centre

WHAT IS THE CHALLENGE?

How might we… create rapid access for primary care to diagnostic imaging / testing?

PROVOCATIVE THOUGHT STARTER

What would a "Geek Squad" support team for health care look like? What types of services would they offer and how would providers access them?

WHAT IS YOUR BIG IDEA FOR THE FUTURE?

- Set up a **Rapid Access Diagnostic Center** (e.g., bloodwork, diagnostic imaging) for primary care patients, ideally outside of the hospital setting
  - Specialists available to interpret results
  - On-call access to specialists if that is what the testing indicates is needed
- Centre is fully accessible to providers, including Personal Support Workers (PSWs) that can transfer / support testing
- Supported by single electronic health record shared across all care providers (e.g., primary care, pharmacy, diagnostic imaging, acute care, specialists, and social services); single sign-on feature
- Health record is also accessible to patients

WHAT IS THE DESIRED IMPACT?

- For patients: less wait times in ED, quicker response time, more streamlined care, and increased patient satisfaction
- For providers: more balanced workload, less admin work, reduced burnout, more efficient communication and patient care
- Overall, decreased patient volumes in the ED and reduced hallway medicine

RISKS/BARRIERS?

- ED physicians do not want to lose patient volumes and income; buy-in
- Lack of one payment model for primary care; FFS transactional care delivery model
- Teaching needs to be included
- If patient is more acute than anticipated (need clear criteria)
- Transition of records

DRIVERS/ENABLERS?

- One payment model for providers in system to incentivize shared care
- Physician trust in new centre

WHAT ACTIVITIES COULD YOU DO TO GET THERE?

Year 1

- Identify early adopters / provider champions and patient advocates
- Develop new workflow for Rapid Access Diagnostic Centre and identify needed digital assets (on-call service, shared digital health records)
- Address funding, privacy, legislation for new workflow and shared digital health record
- Establish prototype for centre and shared record, test with early adopters and patient advocates, evaluate and iterate

Year 2

- Expand to other providers
- Establish a "Geek Squad" to support all providers onsite in transition and overall change management
- Continue evaluation and assess cost savings

Year 3

WHO NEEDS TO BE INVOLVED?

- Primary care providers
- Specialists
- Labs and Diagnostic Imaging
- Emergency Department
- PSWs
- SCOPE program (Rapid Diagnostic Imaging Access)
- eHealth Ontario
- IT / EMR vendor
- "Geek Squad" change management team

TABLE FACILITATOR: Mira Backo-Shannon

TABLE 4: Advancing to a Digital Health Care Future

WHAT IS THE CHALLENGE?

How might we… create more seamless transitions for patients across the health care system?

WHAT IS YOUR BIG IDEA FOR THE FUTURE?

- **One OHT digital platform** that allows all providers and information to be interconnected
  - Health record integration, including sharing of lab and diagnostic results
  - Clear accountability, directives, expectations, incentives, and reporting requirements for providers
  - eConsult – can prioritize based on urgency
- Clear billing codes for virtual consults (phone, video, text, email, etc.) with radiologist / specialists
- Health records shared with patients through patient portal
  - Managing interpretation - physician has to sign off on viewing results
  - Leverage Ocean platform to collect patient input – integrates into EMR
- Patients have access to virtual care 24/7; multichannel options – sometimes just need to talk to someone
- Better accreditation and quality of digital apps and peripheral devices used at home / outside of the clinic

WHAT IS THE DESIRED IMPACT?

- For patients: greater access to information; guide for interpretation
- For providers: greater access to information, improved communication across team, more seamless and efficient care for patients

RISKS/BARRIERS?

- Cost of digital platform, integration of information, and change management across providers

PROVOCATIVE THOUGHT STARTER

How could cutting-edge innovations outside of health care (e.g., drones, artificial intelligence) be used to improve the health care experience for providers and patients alike?

Additional photos from the co-design workshop