LTC+ Virtual Care Support for Long-Term Care Homes in Ontario

Orientation and On-boarding

LTC+ is a collaboration between Women's Virtual at Women's College Hospital, GEMINI at Unity Health Toronto, the Ontario General Medicine Quality Improvement Network, the Centre for Quality Improvement and Patient Safety and the Department of Medicine at the University of Toronto

Agenda

- Welcome and Introductions
- Current Situation
- Goal of LTC+
- Model of Care
- Collaboration Principles
- How to Get Started
- Discussion

Meet the Team – LTC Engagement

Dr. Andrea Moser
Long-Term Care Lead
Baycrest Centre
amoser@baycrest.org

Dr. Pauline Pariser
Clinical Lead
Women's College Hospital
pauline.pariser@uhn.ca

Laura Pus
Administrative Lead
Women's College Hospital
laura.pus@wchospital.ca

Dr. Tara O'Brien
Medical Lead
Women's College Hospital
tara.obrien@wchospital.ca

Ian Stanaitis
Project Manager
Women's College Hospital
ian.stanaitis@wchospital.ca

Kyle Liang
Project Coordinator
Women's College Hospital
kyle.liang@wchospital.ca

Meet the Team – Clinical

2 **Advanced Practice Virtual Care Nurses**
Women's College Hospital

12 **Hospital Resource Partners**
Baycrest
Humber River Hospital
Michael Garron Hospital
North York General Hospital
Scarborough Health Network
Sinai Health System
Sunnybrook Health Sciences
Trillium Health Partners
Unity Health – Toronto
University Health Network
West Park Healthcare Centre
Women's College Hospital

Toronto Paramedic Services

Centre for Quality Improvement and Patient Safety – C-QuIPS

Ontario General Medicine Quality Improvement Network – GeMQIN

LifeLabs

Dynacare

StL Diagnostic imaging

Medigas

Current Situation

- There is an urgent need to enhance the availability of services to support high quality medical care in LTC homes
- Over 70% of COVID-19-related deaths in Ontario have been LTC residents
- There is an opportunity to support and enhance non-COVID-19 and COVID-19 care for many LTC residents
- Providing LTC homes access to services is a rapid method of expanding the capacity to deliver urgent and acute medical care in the health care system

Goal of LTC+

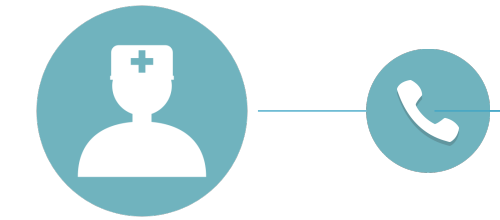
Our **goal** is to partner with all Long-Term Care Homes in the Toronto region providing access to enhanced care services.

Services are designed to enhance existing processes and protocols in place, with the local attending physician as the most responsible provider.

Roles & Responsibilities

When to connect with…	
Ontario Health Toronto	Planning, oversight, risk monitoring • Monitor and communicate emerging and rising risks • Collection of risk self-assessment data • Integrated, equitable and proactive PPE allocation
Hospital Resource Partner (HRP)	LTC Outreach, SWAT team in high risk homes • IPAC (risk assessment, recommendations, implementation) • PPE (short-term and emergent PPE support) • Staffing (critical staffing needs and access to necessary supports and training) • Testing (mobile assessment teams)
LTC+	Single point of access for medical supports and clinical services • Access to specialist consultation (GIM, Palliative, Geriatrics) • Direct nursing support • Enhanced behavioural supports (BSO and Baycrest)

- Some of your homes may have previously established communication channels with your HRP, including access to clinical services. To respect the processes already in place, we will best tailor LTC+ services to meet your needs.
- If you have not been contacted by your HRP, please email **LTCplus@wchospital.ca** or contact our Advanced Practice Nurse and we will make the connection for you.



Attending MD in LTC can access…

Press 1 to reach…

General Internal Medicine On-Call (24/7)

- Access to urgent medical consultations and advice

Press 2 to reach…

Advance Practice Virtual Care Nurse (9-5)

- Rapid needs assessment, advice, and linkage to services

- Geriatrics
- Palliative Care
- Behavioural Supports
- Wound Care
- GeriMedRisk
- Neurology

Enhanced Point of Care Services and Care Pathways

- Mobile Diagnostic Imaging (STL Imaging)
- Access to STAT labs through LifeLabs

LTC+ Program Overview

Case Example

- **85 year old man, resident at a LTC facility in Toronto, with a history of heart failure with reduced ejection fraction and stage III chronic kidney disease**
- Recent discharge from acute care -- admitted for hypercalcemia secondary to severe primary hyperparathyroidism
- Primary care physician (PCP) called by RN at the LTC because resident was less responsive, but with stable vital signs
- The PCP suspected recurrent hypercalcemia but needed advice on how to manage – so called the GIM consultant on call
- After discussing the case by phone, the GIM consultant made several recommendations – including initiating hypodermoclysis, holding the diuretics, and checking a capillary blood glucose level; the GIM consultant also confirmed that since IV pamidronate already given on the recent admission, no further treatment other than fluids would be helpful

Continued...

Case Example

- The PCP ordered STAT labs and confirmed that the calcium level was elevated, but that the renal function was stable
- The PCP spoke with the resident's daughter and explained that he is receiving the same care that he would receive in acute care, and that an internal medicine specialist had provided advice and would continue to be involved – his daughter agreed she would not want him transferred
- Two days later, the SC fluids lowered the calcium level, the resident was more responsive, and started eating and drinking again, and taking all of his medications – he continued to do well 1 week later
- The GIM specialist checked in by e-mail 1-2 additional times

Our Commitment

- Availability of the program (we are here to support you)
- Expansion of services where possible to better meet your needs
- Avenue for you to provide feedback and advice on how to better meet your needs

Collaboration Principles

Our Ask of You

- Engage and encourage your attending MDs/NPs to use the service
- Share ideas and feedback around services in need
- Participate in LTC+ team engagement (check-ins, reminders of available services)
- Help us with data collection to improve the services we offer, i.e. follow-up to ask about process/case (no PHI)

Collaboration Principles

How to Get Started

1. We will send the Medical Director, Home Administrator, and Director of Care an email with the **LTC+ one number to call** to access the **LTC+ Virtual Hub**, along with additional resources and information about the program.

2. Visit **https://ltcplus.ca** for access to fact sheets, guidelines and other clinical resources.

Our Partners

C-QuIPS
Centre for Quality Improvement and Patient Safety

MASSLBP

WOMEN'S VIRTUAL
AT WOMEN'S COLLEGE HOSPITAL

WHV
WOMEN'S COLLEGE HOSPITAL INSTITUTE FOR HEALTH SYSTEM SOLUTIONS AND VIRTUAL CARE

Ontario General Medicine Quality Improvement Network

GEMINI

Ontario Health

Medigas
Praxair Canada Inc.

Dynacare

LifeLabs

TORONTO PARAMEDIC SERVICES

DIAGNOSTIC StL IMAGING