LTC External Clinical Support Model:

Webinar for LTC Primary Care Practitioners

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Agenda

Time	Item	Discussion Lead
5:00-5:05pm	Welcome and Introductions	Rose Cook
5:05-5:20pm	Context Setting & New Model Overview	Victoria Heaslip
5:25-5:35pm	Clinical Services & Examples	Dr. Brian Wong/ Dr. Andrea Moser/ Victoria Zefkic
5:35-5:40pm	Transition Planning Timelines	Victoria Heaslip
5:40-5:55pm	Discussion/Q&A	Dr. Brian Wong/ Dr. Andrea Moser
5:55-6:00pm	Wrap Up	Rose Cook

Context

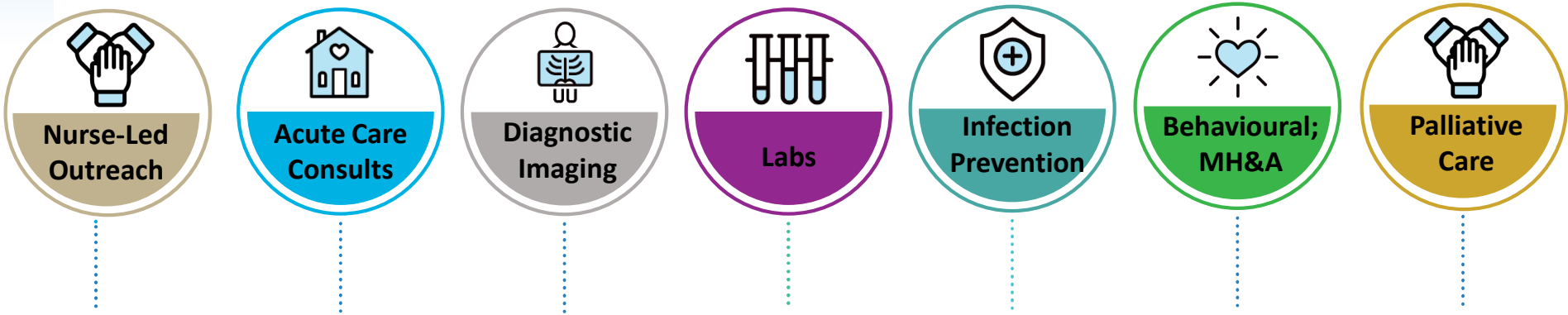
- The COVID-19 pandemic accelerated the development and expansion of external LTC supports; new relationships forged between acute care and LTC
- Surveying the current landscape, we see a wide variety of currently available external supports to LTCHs, however:
  - Variability in access and utilization
  - Inequitable access to certain supports
  - Limited program coordination, integration or geographical alignment
  - Opportunity for improved resource sharing, training and education within and across programs

Context (cont'd)

- In 2021, there were ~8000-9000 resident transfers from LTCHs located in the City of Toronto to hospitals within the city
- Studies estimate 25-40% of transfers are potentially avoidable, although highly dependent on several factors
- Where there is variation, there is opportunity for improvement:
  - Average rate of potentially avoidable LTC resident transfers to ED per 100 residents is **20.2**
  - Rate range of potentially avoidable LTC resident transfers to ED per 100 residents is **8.6 to 42.4** in the City of Toronto

Long-Term Care QIP Potentially Avoidable ED Visits Indicator, City of Toronto LTCHs, Q3 2021/22 – Q2 2022/23

Current State: External Supports to LTC



82 Long-Term Care Homes located in OH Toronto Region*

Challenges

- Inequitable Access
- Difficult to Navigate
- Limited Coordination
- Inconsistent Offerings

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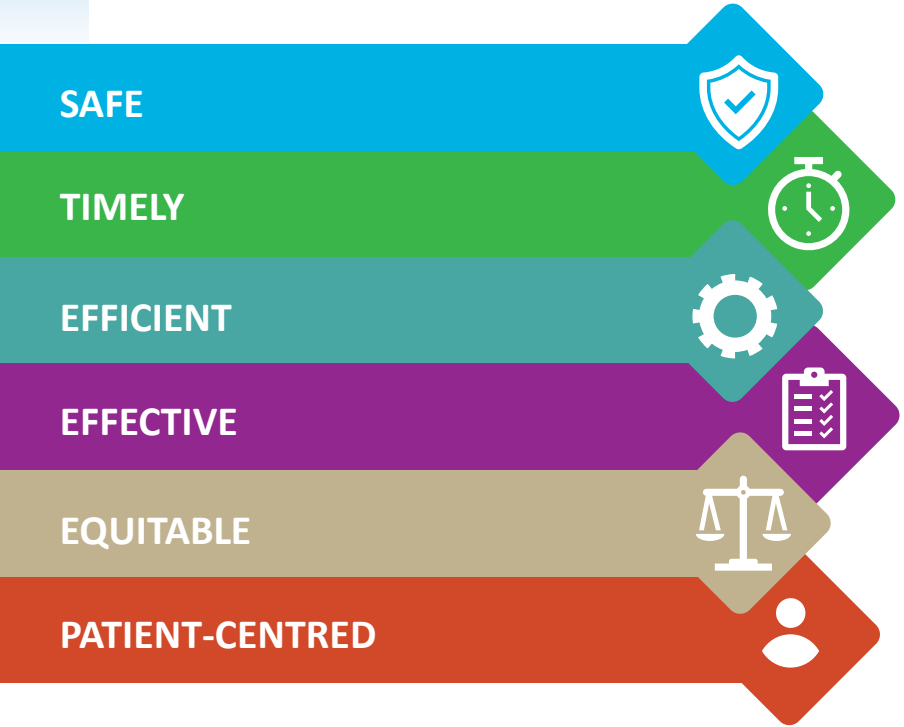
*Considering OH boundary realignment effective 2023-04-01

Guiding Principles to Drive Change

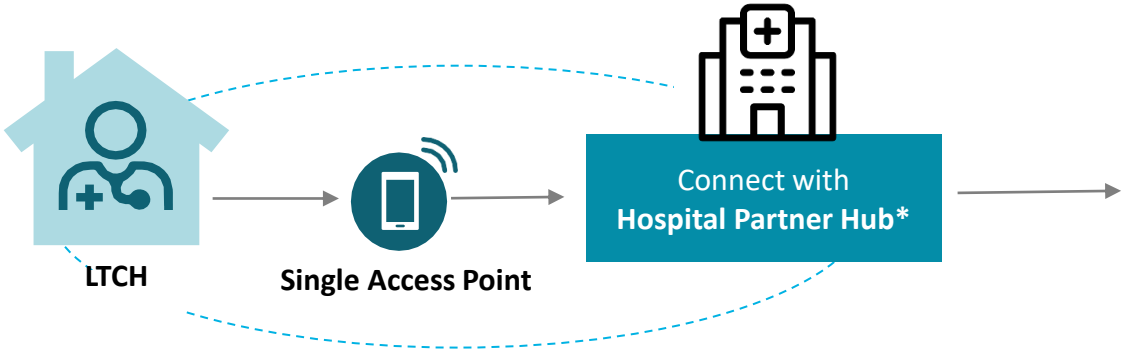


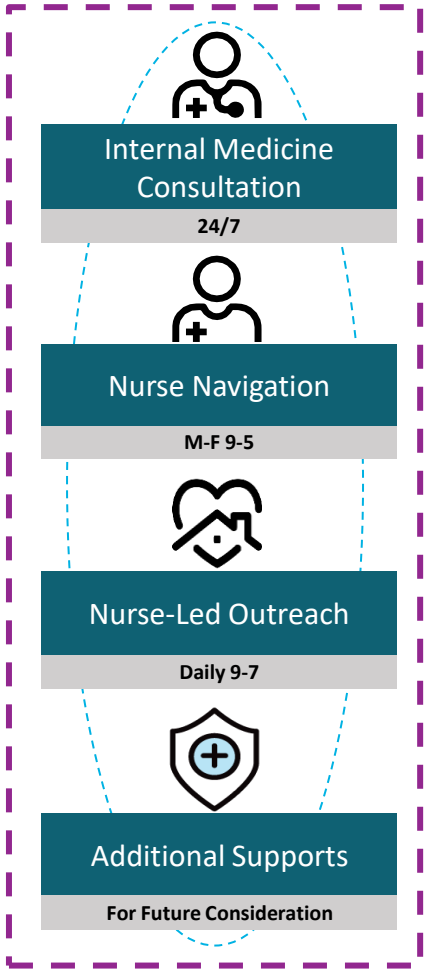
Objectives

- Enable integrated, high-quality clinical care for all LTCH residents
- Enhance internal clinical capacity via knowledge building
- Increase external capacity by leveraging, integrating & augmenting existing support structures and systems
- Improve system capacity and flow
- Drive sustainability via eventual OHT-driven accountabilities

New Model: OHT-Based Hospital Hubs

Each hospital hub, situated within an OHT, will form their own integrated care network with surrounding LTC homes. The hospital hub will provide LTCHs improved access to clinical services and system navigation to ensure high-quality, resident-centred care



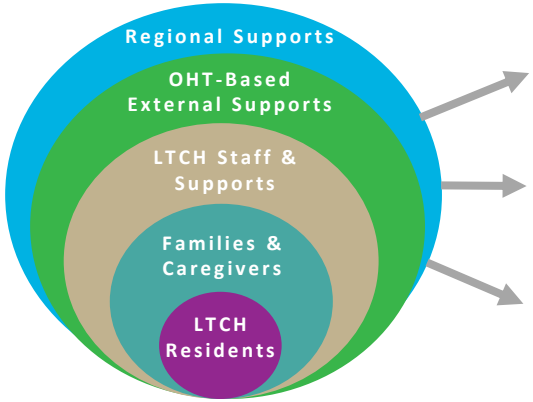


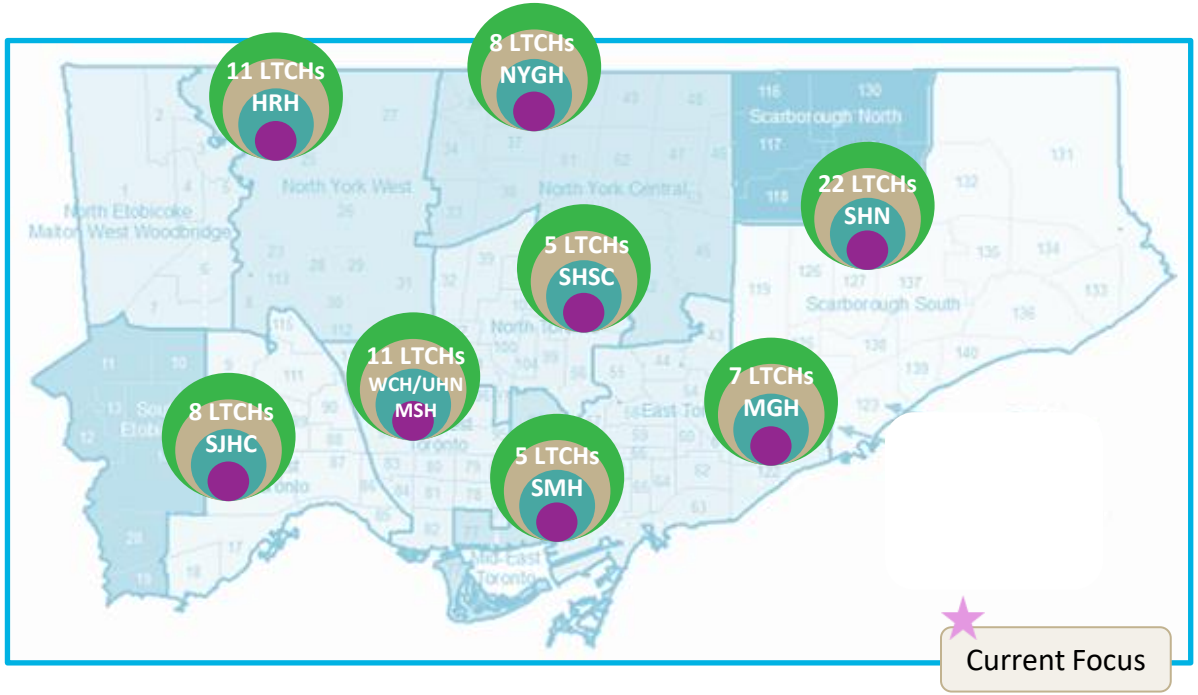
***OHT-Based Hospital Hubs**

1. Mid-West Toronto OHT | 2. North-Western Toronto OHT | 3. North York Toronto Health Partners | 4. Scarborough OHT | 5. Downtown East Toronto OHT | 6. West Toronto OHT | 7. East Toronto Health Partners OHT | 8. North Toronto OHT

New Model: OHT-Based Hospital Hubs

OHT-Based Hospital Hubs





Hub Supports

LTC+ ★ NLOT ★ Integrated Pathways IPAC Labs & DI Behavioural Supports Others

Regional Supports

★ Quality Improvement ★ Education ★ Data & Analytics ★ Evaluation Others

New Model: Core Components & Benefits

Strengthened Partnerships: between LTC PCPs, clinicians in acute care hospital and community service providers;

Centralized Access: a single point of access for a suite of services (e.g., internal medicine consults, nurse navigator, NLOT supports, etc.);

Direct and Consultative Specialized Service Provision: by clinical staff from acute care sites to LTCHs and their residents, within a defined OHT-based geography;

Engagement & Education: LTCH engagement and feedback; tailored education for staff; regional community of practice for shared learnings & advanced best practice dissemination; integrated clinical care pathway development;

Program Evaluation & Improvement: Via the Centre for Quality Improvement and Patient Safety (CQuIPS) and LTC+, collect and analyze data received from OHT-based hubs to identify program strengths, challenges, opportunities.

Direct and Consultative Services; Navigation

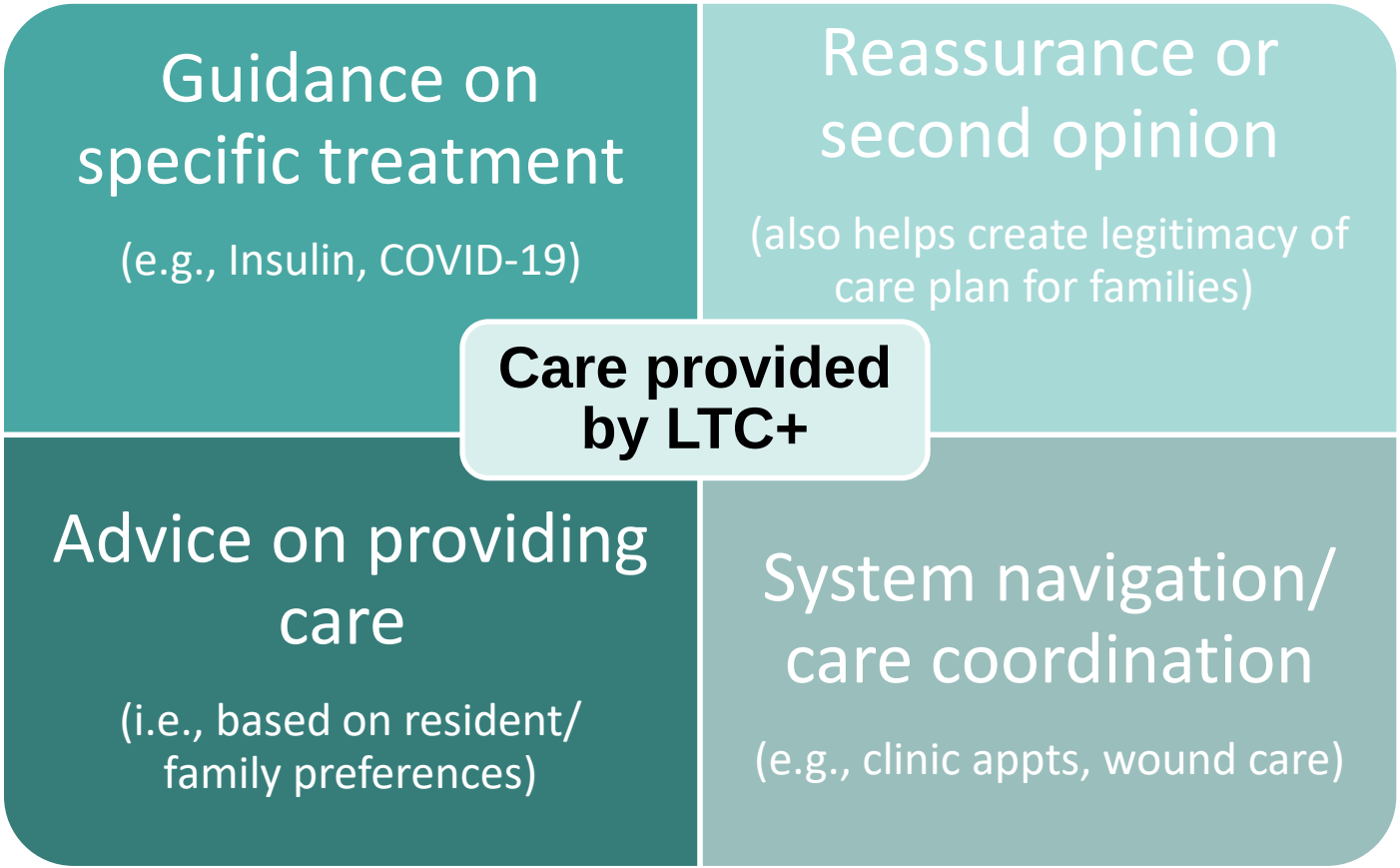
LTC+: Integrated Supports

1. Virtual specialist consultations
2. Nurse navigator support
3. Integrated fracture & wound care pathways (currently limited)
4. Capacity building educational webinars

J Am Med Dir Assoc. 2022 Feb;23(2):304-307.e3.

Information provided by LTC+

LTC+: Core Consultation Types



Information provided by LTC+

LTC+: Primary Reasons for Clinical Consultation

Reason for Consultation (n=354)
Abnormal lab values
Cardiac concerns (chest pain, heart failure)
Delirium
CoVID-19
Suspected infection
Renal failure
Shortness of breath
Medication management
Venous thromboembolism
Gastrointestinal concerns (vomiting, diarrhea, abdominal pain)
Neurologic concern (stroke, headache)
Skin condition (rash, wounds)
Other

Information provided by LTC+

LTC+: Primary Reasons for Service Coordination

Services coordinated (n=158)	n (%)
Specialist referral	51 (31)
Urgent Imaging/Lab work	27 (16)
Escalation to inpatient care	20 (12)
Wound care outreach	16 (10)
Orthopedics / fracture clinic referral	15 (9)
In-home support	9 (5)
Geriatric medicine outreach	7 (4)
Palliative care outreach	4 (2)
Behavioural Support Outreach Team	2 (1)
General advice	14 (8)

Information provided by LTC+

NLOT:

NLOT Core Activities

- Provide direct assessment and treatment of specialized nursing care needs to residents with increasingly complex medical care needs

- Provide capacity building for LTC staff and resident caregivers
- Participate in Regional Community of Practice - TBA

- Work with LTC+ to develop, support and implement integrated care pathways
- Facilitate rapid access to ambulatory care services

- Assist in reducing non-urgent transfers to the region's Emergency Departments
- Support transitions to and from hospital

- Contribute program data to support model evaluation
- Participate in iterative model design

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Integrated Clinical Service Exploration: Case Examples

Clinical Example: LTC+ GIM Consult

Background	• LTC MD caring for resident with a GI bleed – taking a blood thinner because of a life-threatening blood clot 10 years ago • Vital signs were stable and urgent lab work organized that day revealed that his hemoglobin level the same as one month ago
Action	• GIM consult through LTC+ obtained – GIM specialist advised that since blood clot was from 10 years ago, safe to stop blood thinner temporarily – bleeding stopped
Intervention	• General internist facilitated a virtual consultation with a thrombosis specialist from the hospital to provide guidance regarding the need for long-term anticoagulation.
Outcome	• Thrombosis specialist confirmed that the ongoing risk of DVT would necessitate ongoing treatment and recommended an alternate blood thinning agent to reduce the bleeding risk.

Example provided by LTC+

Clinical Example: NLOT, Navigator & IR access

Background	• Resident's g-tube had become displaced
Action	• Home called NLOT to change g-tube • Unfortunately, stoma had closed and NLOT unable to change g-tube
Intervention	• NLOT called LTC+ Nurse Navigator to facilitate urgent Interventional Radiology appointment to re-insert g-tube. • NLOT completed and sent all necessary documentation to support request • Nurse Navigator facilitated next-day IR appointment
Outcome	• Resident experienced timely access to care • Resident avoided emergency transfer and extended wait time in ED

Example provided by LTC+

Clinical Pathway Example: LTC+ Fracture Pathway Pilot

LTC+ Virtual Care Support for Long-Term Care Homes in Toronto Region

Orthopaedic Fracture Consult for an LTC Resident

Imaging services provided by **STL Diagnostic Imaging**
Orthopaedic Fracture Consult provided by LTC affiliated hospital Fracture Clinic

Services provided between Monday to Friday, 8:00 – 5:00pm

1 **Complete the "Look, Feel, Move" assessment if a fracture is suspected**

- If the resident has the following conditions, please transfer to ED if within goals of care
  1. Open fracture (exposed bone, wound over fracture site)
  2. Hip Fracture
  3. Shoulder dislocation
  4. Visible deformity of limb
  5. Neurologic compromise
  6. Ongoing pain not controlled by analgesia
  7. Compartment syndrome

2 **Fax the STL Requisition Form to 1-855-374-3497**

- Write **LTC+ URGENT** on the top left corner
- Include reason for imaging on the requisition
  - Rule/out fraction
  - Level of concern
- All exams marked as URGENT will be rapidly uploaded and read by the radiologist on the same day they are received

3 **Send Fracture Clinic Referral Form, if fracture found**

- The referral will be triaged by a Nurse Navigator and booked into consultation with an appropriate Orthopaedic surgeon

4 **Immobilize the fracture**

- NLOT or LTC staff will immobilize the fracture while awaiting for Orthopaedic consultation

5 **Orthopaedic Surgeon Consultation**

- The resident will be booked for an in-person Fracture Clinic appointment or virtual consult if appropriate

For more information, go to www.LTCplus.ca Virtual Orthopaedic Fracture Consults | v2.0

Suspected Fracture	Fracture appropriate for virtual consult	Virtual Ortho Consult	Stabilization
Complete "**Look, Feel, Move**" assessment. If fracture is suspected, select "X-ray LTC+ urgent" on STL imaging requisition. This will trigger rapid upload of imaging for assessment.	Long Term Care Physician will review x-ray results for appropriateness* and send a referral to the Sunnybrook Fracture Clinic	The Orthopedic Surgeon will review the images and determine whether the resident is appropriate for a virtual consult or require an in-person appointment	Stabilization will be done in the home if possible or during a scheduled Fracture clinic appointment (no need for ER transfer to access Fracture clinic)

Information provided by LTC+

LTC+ Fracture Pathway

Fracture Location	ED Transfer?	Fracture Clinic Transfer?	Management
Elbow	No	Yes	• Given Sling • Sent to # clinic
Metacarpal Phalange	No	Yes	• Sent to # clinic after one week • No need for immobilization
Wrist	No	No	• Left Velcro wrist splint applied • Fracture managed well
Ankle	No	No	• Aircast for 6 weeks. OT helped buy air cast as this was not available. • Follow up with x ray 6 weeks, ortho advised to discontinue boot
Shoulder	No	Yes	• Temporary left arm sling applied

Ng et al. JAMDA Published online: February 28, 2023

Transition Planning Roadmap

External Support Model: Timelines

SEPT-DEC ‘22

Pre-Launch Preparation

Understand current state of external supports & areas of need;

Secure funding for LTC+ and NLOT expansion

FEB-APR ‘23

Engagement

Provide LTCH Administrative and Medical Leadership with model overview;

Hospital partner alignment confirmations

We are here

APR-JUN ‘23

Engagement & Implementation

Collaboration with acute care hubs and LTCHs on planned **LTC+ and NLOT** program expansions/ transitions

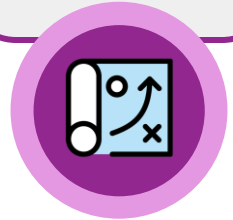
JUN ‘23-Onwards

Troubleshooting & Pathway Expansions

Engagement re: post-transition needs;

Education & CoPs

Clinical Pathway Spread & Scale



Alignment/Transition Planning: Key Messages

Current Objective:

- **Onboard all TR LTCHs to both LTC+ and NLOT programs, aligned to 8 OHT-based hospital hub(s)**

- LTCHs will receive communication from OH re: transitions/timelines in April
- Transitions will occur in a planned, phased approach through ~May-July
- Transition timelines are dependent on several factors:
  - The number of program alignment changes the home will experience
  - Resources available at hospital hubs to service additional/new LTCHs (e.g., GIM staff)
  - Hospital hub staff recruitment and onboarding (e.g., NLOT staff)
- We are committed to ensuring LTCHs do not experience any gaps in service and transitions are well supported

Discussion/Q&A

Considerations for Discussion

- How does this resonate with you and your practice?
- Do have any concerns about what is being proposed?
- Are there recurrent clinical gaps that you'd like to see considered in the future?
- Are there other opportunities you see?

Thank you for your time and support of this initiative!

Additional questions and comments can be submitted to:
victoria.heaslip@ontariohealth.ca