Integrated LTC: An Innovative Initiative to Reduce Potentially Avoidable Hospitalizations for Seniors Living in East Toronto Long-term Care Homes

AFHTO Conference
October 29, 2017

Candy Lipton MA, RN, CHE
VP Operations, Long Term Care
Sienna Senior Living

Irene Ying MD CCFP
Palliative Care Consultant
Sunnybrook Health Sciences Centre
Assistant Professor, DFCM
University of Toronto

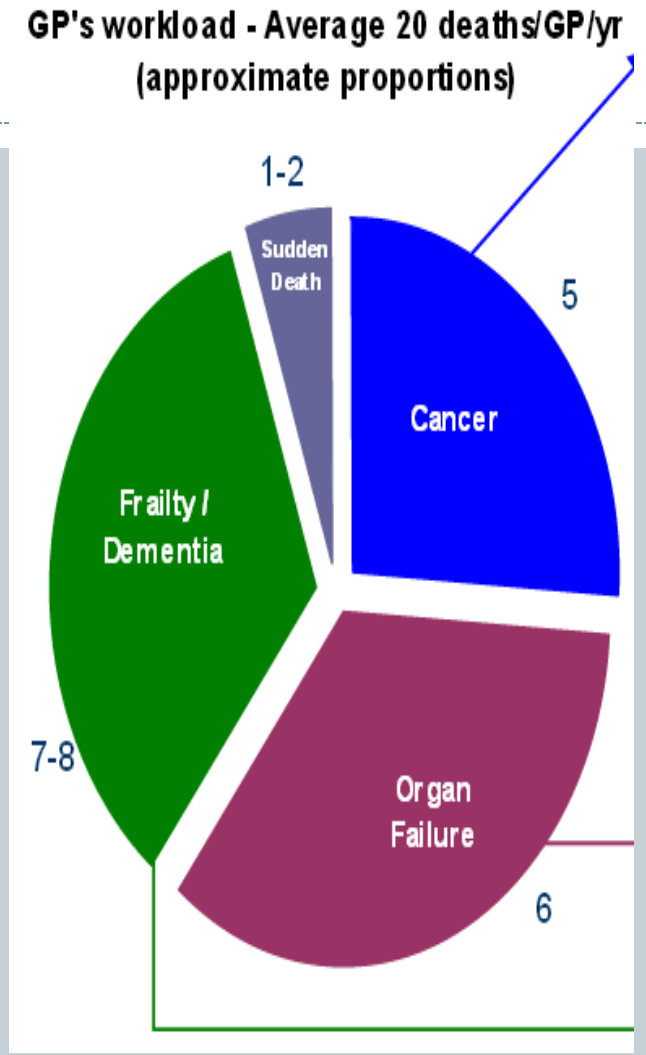
Objectives

- Present current state of palliative/EOLC in Toronto's LTCHs
- Identify facilitators and barriers for providing enhanced palliative care in Toronto's LTC homes
- Present the Integrated Long-Term Care Program team's work to develop a model for better quality of care and healthcare integration for Toronto's seniors living in LTC

Mr. R

Days 1-6

Days 7-10



Frailty kills!

Gold Standards Framework Prognostic Indicator http://www.gpscbc.ca/system/files 11_EOL_PSP_GSF_Prognostic_Indicator_0.pdf

Are elders safer in hospital?

http://image.slidesharecdn.com/goalsofclinicalnursingeducation-130707230624-phpapp01/95/goals-of-clinical-nursing-education-33-638.jpg?cb=1373238176

Benefits of treating elders in the community

- Patient outcomes and satisfaction
  - ↓iatrogenic complications (infxns, 75%↓ delirium)
  - ↓functional decline, LTC admission, mortality
  - ↑ patient and caregiver satisfaction

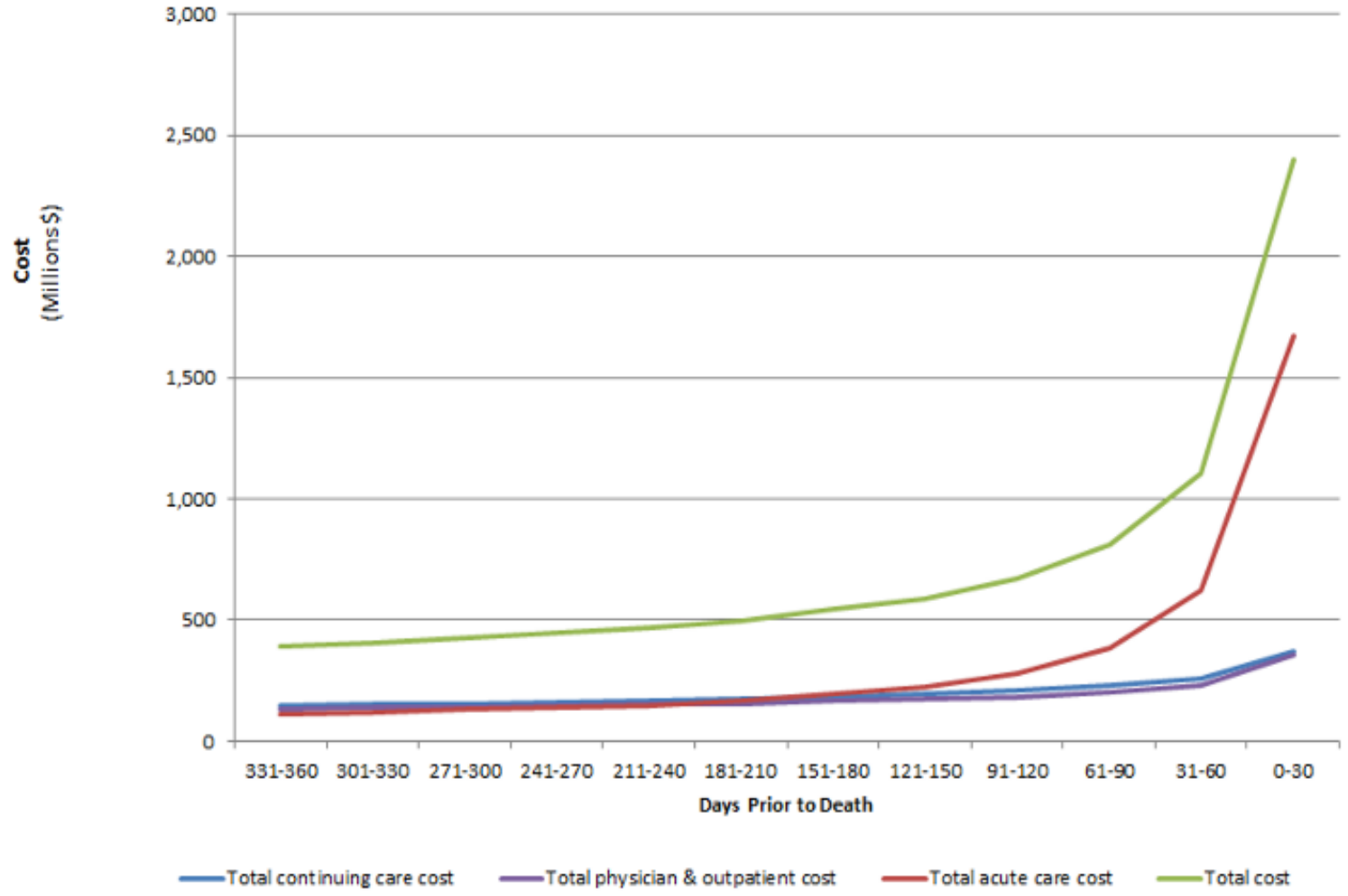
1. Leff B, et al. Improving Patient Care Hospital at Home: Feasibility and Outcomes of a Program To Provide Hospital-Level Care at Home for Acutely Ill Older Patients. Annals of Internal Medicine. Ann Intern Med. 2005. 143: 798-808.

2. Shepperd S, et al. Hospital at home admission avoidance. Cochrane Database of Systematic Reviews 2008, Issue 4. Art. No.: CD007491. DOI: 10.1002/1461858. CD007491.


TORONTO
Emergency Medical Services
EMS

Health care cost in 30-day increments prior to death

Fiscal Year 2010/11 to 2012/13



Continuing Care = Long Term Care + Complex Continuing Care + Home Care + Rehabilitation
Acute Care = Hospitalizations + Emergency room visits
Physician & Outpatient = Physician & non-physician visits + Laboratory + Drugs & Devices + Outpatient Visits

Tanuseputro et. al. 2015

Integrated Long-term Care

Inter-organizational

Inter-professional

Innovation

Agents of change

http://www.orangeobjects.de/entwicklung/integration

Choosing an LTCH partner

1. Expressed commitment for change and leadership from LTCH senior management team with a geography in TC LHIN
2. Current participation in the ILTC program or relationships with NLOT / PPSMC that are amenable for developing a partnership with the ILTC team.
3. LTCHs that have a capacity to sustain and scale the ILTC program including adapting appropriate policies, etc
4. High level of acuity (CMI) correlated with high number of ER transfers based on TC LHIN data

Sienna SENIOR LIVING

Business Overview

Canada's 5th largest owner and operator of seniors housing

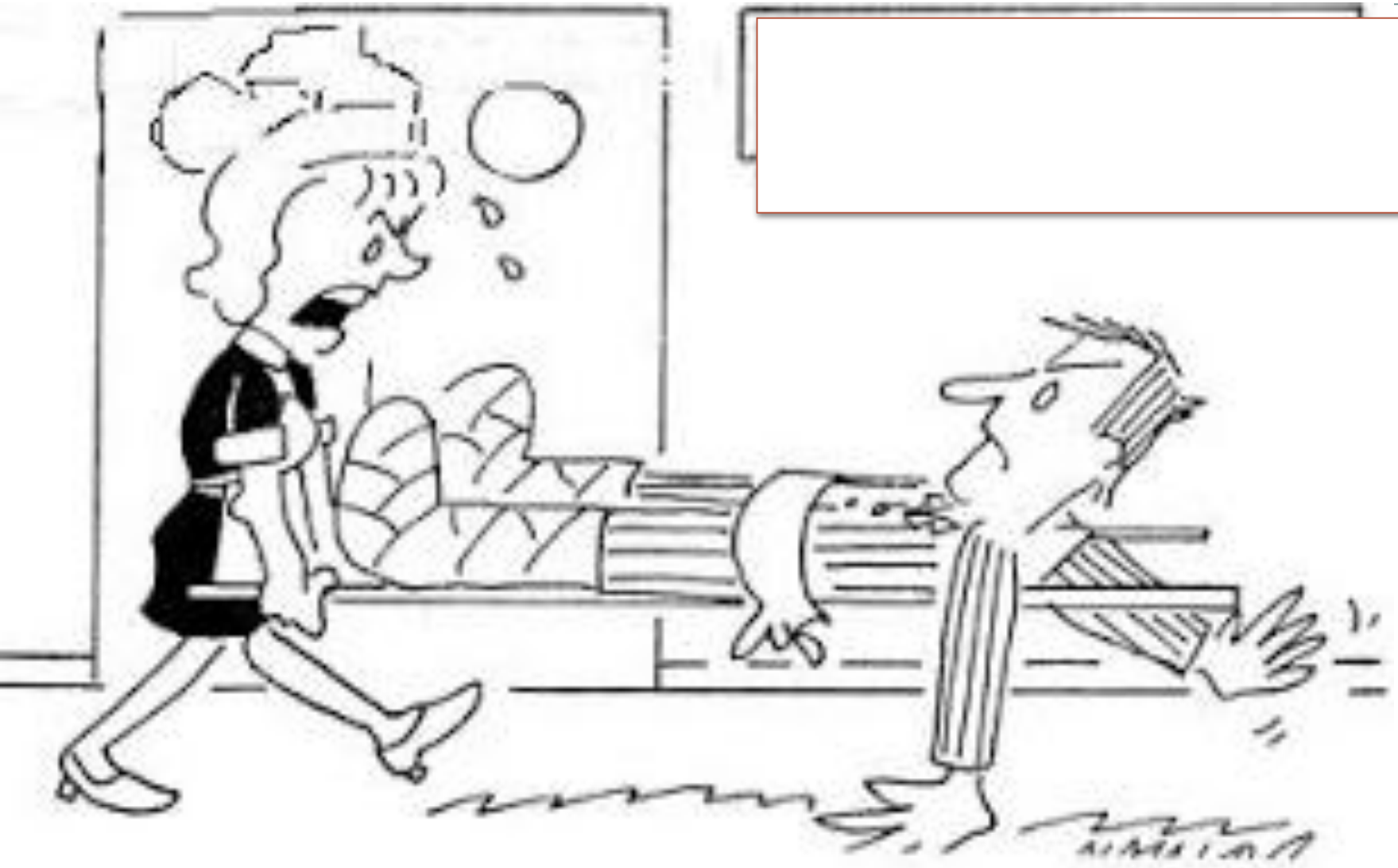
- TSX: SIA , TSX: SIA.DB
- Shares outstanding: **36.4 million**
- Market capitalization: **~$565 million**
- IPO: March, 2010
- Recent close: **$15.61** (May 21, 2015)
- 52-week low/high: $12.24 – $16.16
- Ent. Value **~1.1 billion**
- Dividend: $0.90/year
- Yield: ~**5.8%**

Long-Term Care	Largest owner & operator in Ontario with **35** homes & **5,733** beds
Retirement	**10** Retirement homes with **1,066** suites
Home Care	Delivering an average of **10,000** hours of service per week to seniors in their homes
Management Services	Managing 1,400 LTC & Retirement beds for NFP and small owners

Process Mapping and Fishbone diagram

Facilitators/Barriers for EOLC in East Toronto LTCHs

- REB: Approved by TEGH and Providence Healthcare
- 7 Focus groups at 3 LTCHs
- Transcribed → Coded → Thematic Analysis



"Sorry but we are shorthanded today . . ."

“Sometimes, when I have a resident that is dying, I feel rather guilty at times because I don’t have that time, that quality time that I can spend with the resident [...] I have to be runnin’ because [...] I have 30 others to think about.”

http://seapointcenter.com/why-good-teams-make-bad-decisions/

“We always go with whatever the family decides… if the family says hospital, even if the doctor says no, we will do that.”

STAFF

- Fear litigation
- Lack formal assessment skills particularly for end of life

<u>Frontline Staff:</u>
lack empowerment

<u>Physicians:</u>
⬇ trust in frontline staff

May be off-site for urgent issues

https://encrypted-tbn2.gstatic.com/images?q=tbn:ANd9GcQIBZyC8G1qX9--nWBbgOPFN4_FqQDSuNqa5x3NmB4dIFqZZVpjTA

ACP / GOC not done proactively

Level of Care forms problematic

“A lot of people are not aware that this person is palliative, or end of life, and might overlook that and call family […]

There’s a nurse calling ‘Your loved one breathing is laboured, do want us to send him or her out to hospital?’

They’re thinking “okay, well the nurse is calling and asking this, well obviously they must want my loved one sent to the hospital.”

Facilitators for in-house palliative care

- **Highly motivated** to provide compassionate EOLC
  - Believe with appropriate resources, residents better served in-house

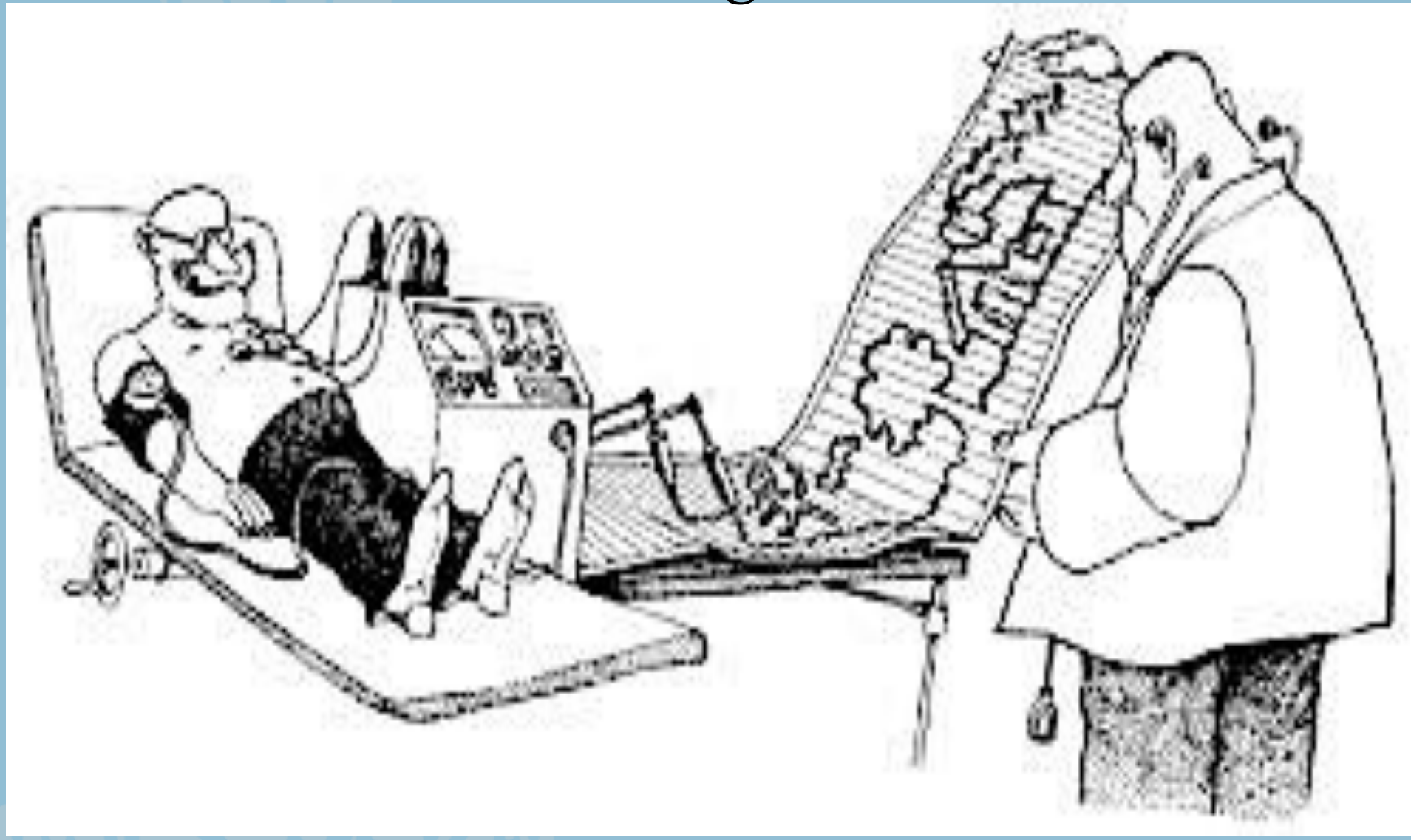
Continuity of care

  - Frontline staff know residents very well (“like family”) and are able to identify changes in health status

- **Group communication**
  - Comfortable communicating changes in health status to superiors

“We are the front liners, we are the caregivers. These things should initiate from us: compassion, understanding, lots of patience when dealing with this. Because after all we are dealing with end of life, it’s gonna come to pass.”

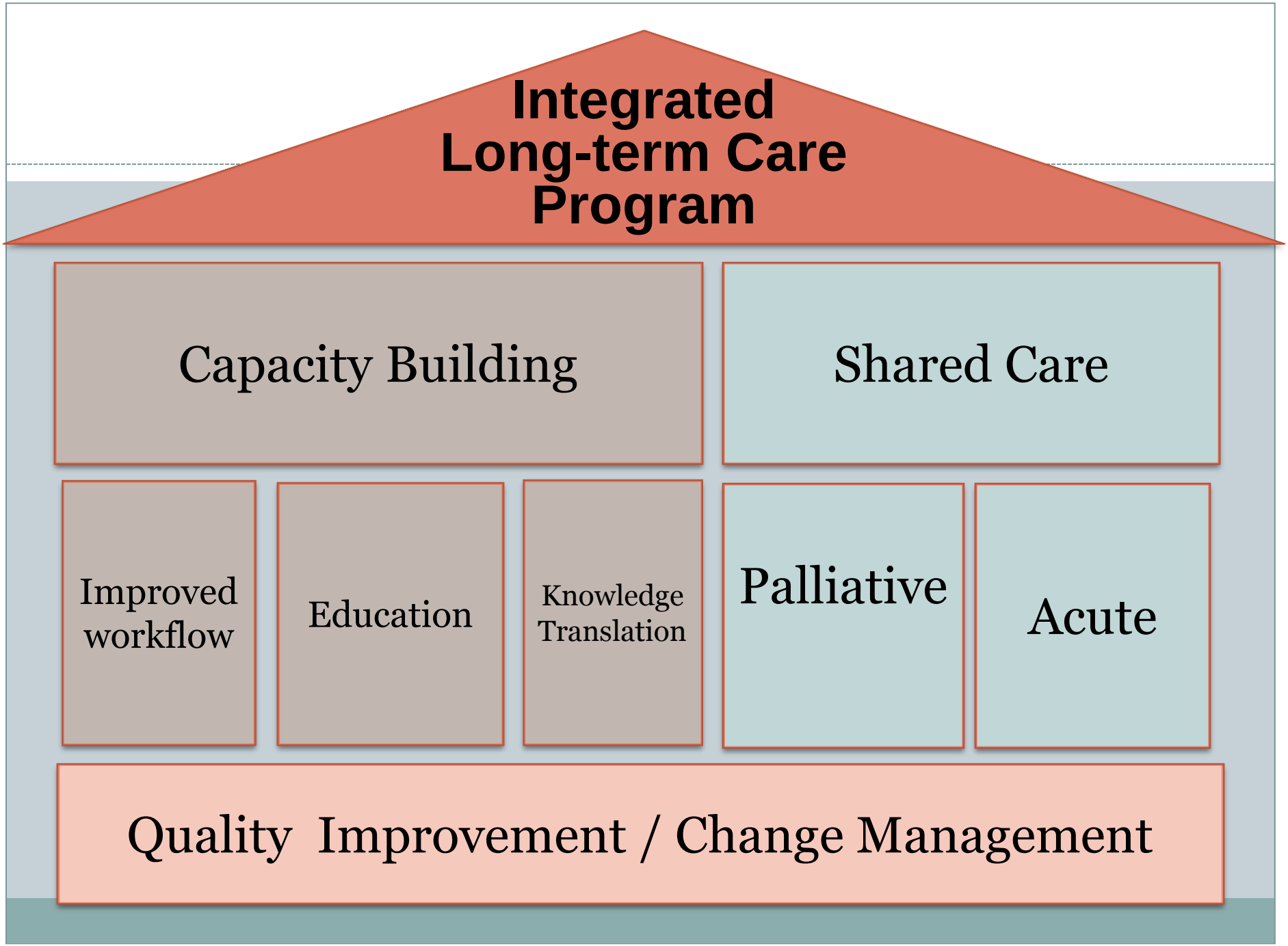
PILOT 1: NP performs proactive GOC discussions for high risk residents



Joaquin Quino

Mrs. W

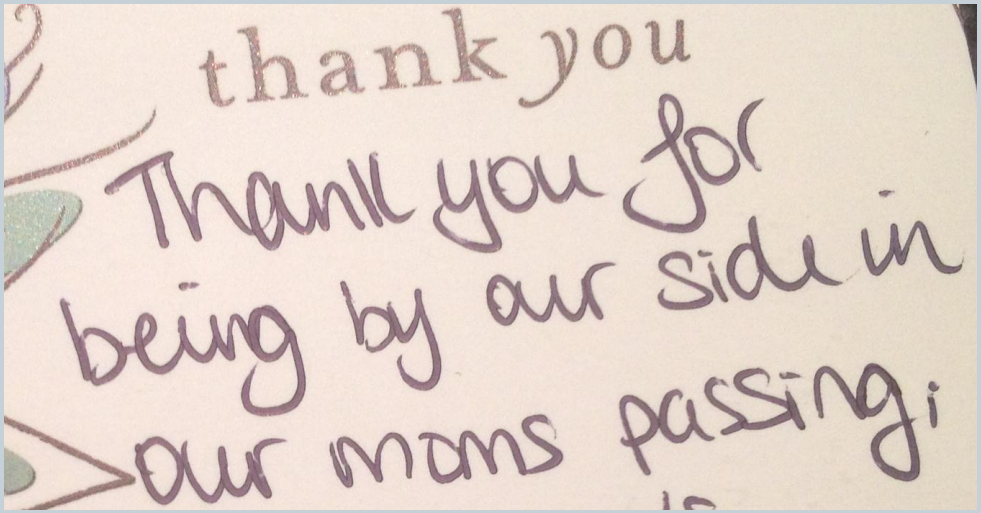
- 86 F with CVA in 2012 (previously well – gardening)
  - total care & bedbound, G-tube fed 24 hr per day
  - Level 2 - 2 ED visits in past year
- **Assessment revealed:**
  - Moderate to severe pain
  - Copious secretions & feeds leaking from nose
  - Unwanted G-tube (when discussed with POA)
- **Collaboration between ITLC team, LTCF MD, dietician, nursing to control pain, reduce secretions and plan for future (do not replace G-tube)**


Integrated
Long-term Care
Program
Capacity Building
Shared Care
Improved workflow
Education
Knowledge Translation
Palliative
Acute
Quality Improvement / Change Management

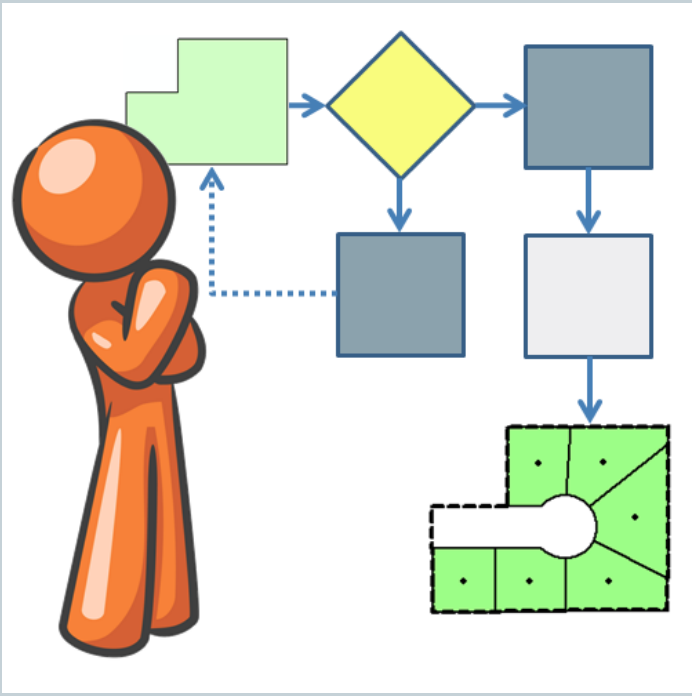
Capacity-Building

www.nursetogether.com/future-nursing-education-clinical-simulation-labs

Supporting Families…



Capacity-building



https://allenstalvey.wordpress.com/
http://www.sidwellco.com/gis-services/gis-implementation/workflow-analysis/

Shared Care

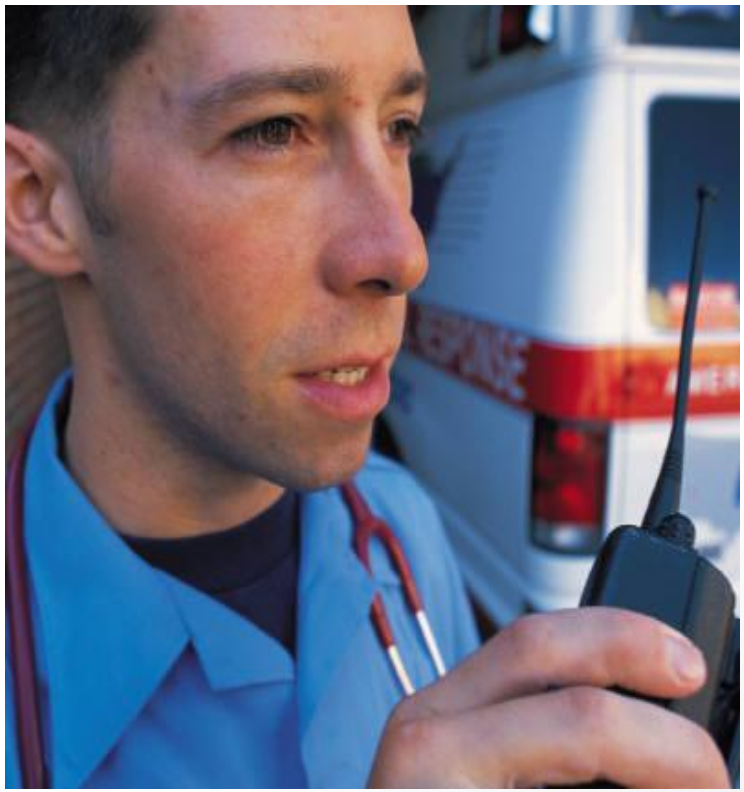
Bringing specialists to LTC homes via telemedicine

http://healthwise-everythinghealth.blogspot.ca/2012/05/sharing-blog-posts.html

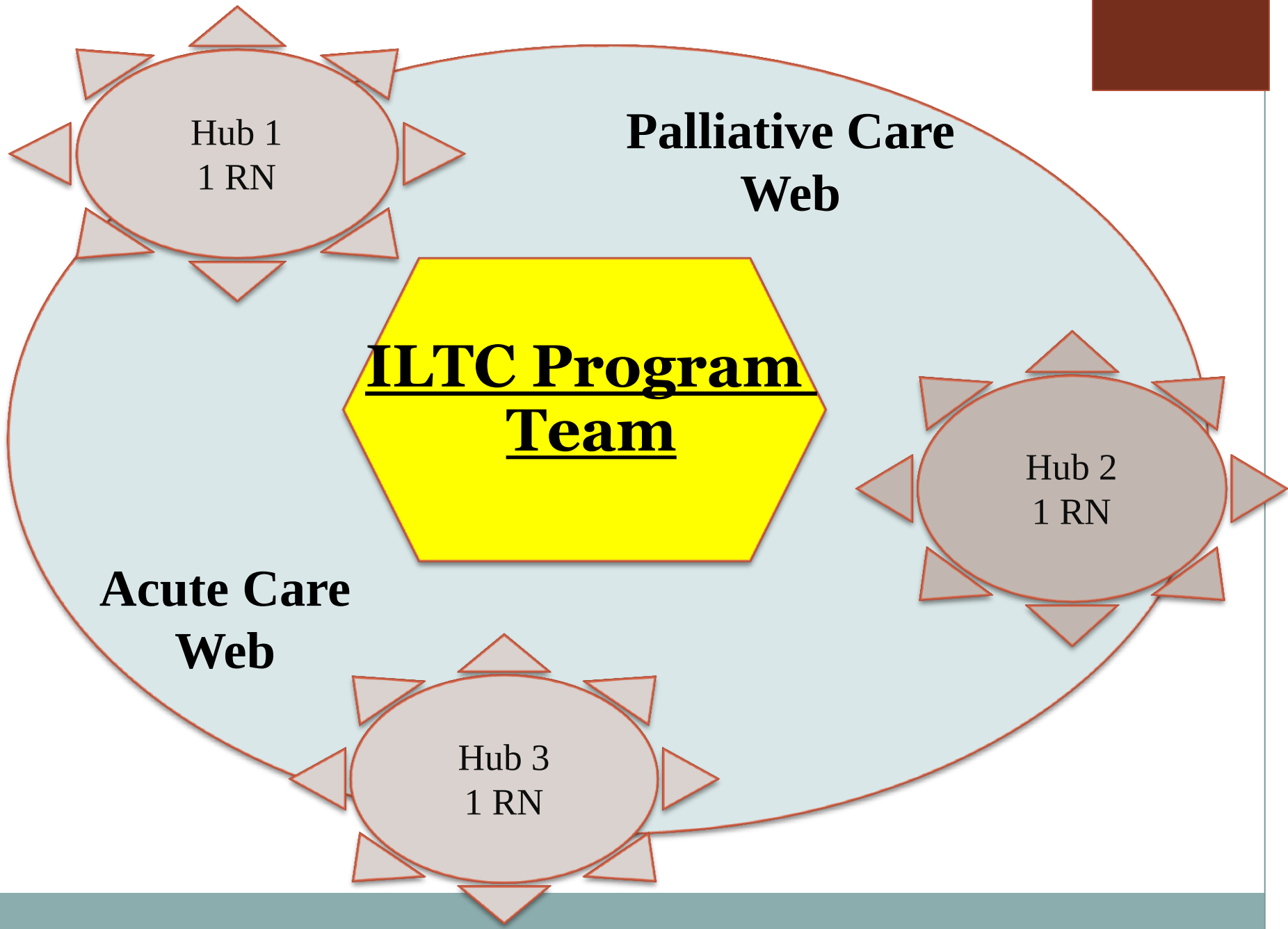
Ad hoc consults

Monthly case conferences

Palliative Care Web



Acute Care Web: TPS, TEGH, Providence, LTCHs


Hub 1
1 RN
Palliative Care
Web
ILTC Program
Team
Hub 2
1 RN
Acute Care
Web
Hub 3
1 RN

Questions / Discussion?

Many thanks to Dr. Michelle Grinman and the ILTC team!