The LTC Monitoring team.

Remote monitoring tool improve seniors' care

By Shahana Gaur

Humber River Health (Humber) has identified a core priority of delivering comprehensive, quality care closer to home for members of its community. This commitment is particularly relevant to caring for one of our most vulnerable populations – seniors.

In February 2021, Humber implemented a Long-Term Care (LTC) Remote Monitoring initiative in partnership with seven LTC Homes in Northwestern Toronto, scaled to two more LTCs in January 2022, and continues to grow. This program uses Practical Routine Elder Variants Indicate Early Warning for Emergency Department (PREVIEW-ED©), an observation-based clinical deterioration tool, and LTC+, an integrated team of healthcare professionals, to detect early signs of health deterioration in LTC residents and facilitate early intervention.

This initiative promotes an integrated, upstream approach to care through an innovative partnership between the hospital and LTC homes, reducing the number of Emergency Department (ED) visits and hospital admissions, which are key priorities for the Northwestern Toronto (NWT) Ontario Health Team (OHT).

On average, approximately 1,000 LTC residents per year visit the ED at Humber, with approximately 50 percent being admitted. By minimizing these occurrences, Humber's LTC Remote Monitoring initiative is improving resident care, optimizing patient outcomes, reducing healthcare system burden and costs, and boosting staff capacity.

CONNECTING CARE: HOW HUMBER, LTCS, AND COMMUNITY CARE WORK TOGETHER

LTC+ aims to re-imagine access to care and is committed to expediting the care of LTC residents close to or in their homes. The program focuses on putting the resident first by streamlining access to community and hospital services that previously would have required transfer to the ED.

LTC+ is operated by nurse navigators who offer general advice and assistance in navigating services at Humber and in the community. Nurse navigators also facilitate urgent virtual consults between LTC physicians and a General Internal Medicine (GIM) Physician or Geriatrician to support timely access to care. To further ensure residents receive the care they need when needed, a Nurse Led Outreach Team (NLOT) is involved to provide urgent mobile care.

The program creates efficiencies through pathways that support linkage to common health services needed among LTC residents. Pathways include streamlined access to diagnostic and medical imaging, fracture clinics, and lower limb preservation. This creates a seamless transition to and from the LTC home, supporting equitable access to care and services, helping reduce ED visits, and positively contributing to LTC residents' quality of life.

The program uses technology to deliver these services and creates stronger integration between LTC homes and the health care system more broadly. An electronic version of the PREVIEW-ED tool can be embedded within Point Click Care and includes

tracking and reports. The tools and digital components ensure appropriate actions are completed in a timely manner at the LTC to avoid ED visits.

IMPROVED OUTCOMES AND SUCCESSES

Humber has seen significant outcomes and successes with this program. In March 2023, we expanded the program and launched new pathways in diagnostic imaging (DI) and transportation support for LTC residents, both supported by new funding from the Government of Ontario.

As a result of these expansions, between March and August 2023 Humber successfully diverted 139 ED visits from LTC homes and 99 patients were transferred to and from Humber via non-urgent transport. Furthermore, 154 consultations with nurse navigators were performed for DI needs.

LTC Remote Monitoring has also facilitated improved care coordination and increased knowledge and awareness of available resources among LTC staff. A provider experience survey revealed that 85.7 per cent of LTC staff who interact with the program indicated improved ability to identify early health decline, 85 per cent noted it has fostered their assessment skills, and 85 percent said that it has enhanced team communication related to changes in residents' health status.

These successes are the result of the collaborative approach among our partners in the LTC sector and our Humber team. The leadership of Beatrise Edelstein in establishing, operating and evaluating this initiative has ensured that it is sustainable and meets the needs of both LTC residents and care providers. Kathleen Kirk, Clinical Manager, has been instrumental in leading and supporting collaboration with LTC homes and physicians, as well as overseeing the program's execution and evaluation. Humber's team of knowledgeable nurse navigators help bring the program to life and ensures its ongoing success.

EXPANDING ACCESSIBILITY AND EQUITABLE CARE

The program is guided by an overarching philosophy of supporting LTC residents in their homes and increasing access to equitable care. Many factors influence patient access to equitable care, and those variables are often compounded and more complex for seniors.

Two common barriers to care for seniors in LTC are cost and transportation. A standardized, free-to-access service is not currently in place to provide non-emergency transportation for LTC residents. In response to this, Humber, alongside our program partners and with the support of the Government of Ontario, are piloting a service that provides free transportation to residents that need to receive care outside of their LTC home.

Downsview LTC Facility is among our partners where the pilot program is active. They share that "residents and family members have been lamenting how difficult and expensive it can be to get to and from the hospital or doctor's appointments. The LTC + free transportation services for non-emergency visits piloted by Humber can make a massive difference to the residents at Downsview LTC Facility, who may otherwise find it stressful and tiring to access hospital services when they need them the most." It is anticipated that feedback like this will help shape and inform similar programs and services across Ontario.

Humber is the only acute hospital in the Greater Toronto Area that has a robust LTC+ hub that integrates a clinical deterioration tool (PREVIEW-ED) with LTC+ and its numerous pathways, and that is supported by NLOT and in-hospital nurse navigators. As we look ahead, our focus is on continuing to expand and build upon the program, delivering care where it matters most – closer to home. We are eager to share our insights with other hospitals and health care providers as we continue to light new ways in healthcare. H

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