Presentation to Ontario LTC Commission

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Overview

Contributors to the LTC Crisis

- Provider-level factors
- Facility-level factors
- System-level factors

Suggestions for future

- Integration of LTC with acute and primary care
- IPAC standards
- Standards/interventions for end-of-life care in LTC
- (Change staffing model for LTC)

Contributors– Provider-level factors

- Inconsistent MD presence on the LTCs
  - Pre-pandemic vs. during pandemic?
  - During pandemic- cross-covering multiple facilities
  - “Available by phone”
- Inconsistent knowledge/application of end-of-life practices

Contributors- Facility-level factors

- Management issues - overwhelmed by staffing shortages
  - Usually well-run, welcoming of help (initially unaware of help)
- Staffing issues – COVID, self-isolation, etc.
  - Unable to find staff- labour pool small, restricted from working at multiple sites
- IPAC practices/PPE Supplies
  - IPAC training needs to improve- inconsistent according to role
  - Cohorting was often not done quickly
    - Delays in swab results can make outbreak worse- residents are negative at the time of the swab, but become positive waiting for the result and get moved to the “negative” ward

Contributors- System-level factors

- LTC and acute care are interdependent – a crisis in one setting creates a crisis in the other
- LTC contains frail/fragile people- not enough reserve to manage when many deteriorate
- The only available source of staff and expertise to deal with surge in acute illness is the acute care sector
  - No simple mechanism to allow staff to support
  - Complexities- privileges, electronic medical records, etc.

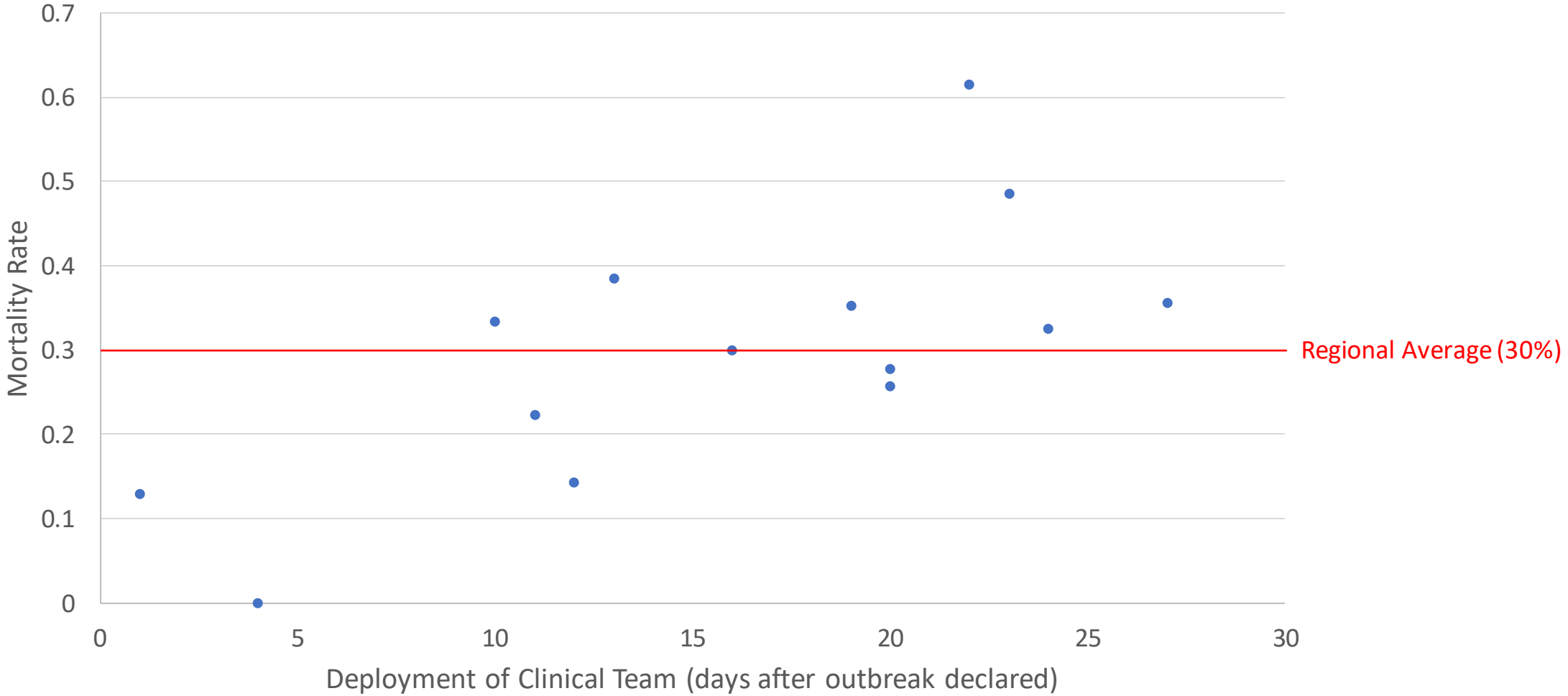
Suggestions for the future - Integration

- Formal links between LTC and local family health teams/OHTs, but especially to acute care facilities
  - Support for acute illness management, IPAC, staffing
  - Sending patients to acute care vs. sending acute care to patients
- Backup MD staffing for LTC from FHT/OHT
  - Risk to many LTC MDs due to age, comorbidities
- Non-physician staff?
  - Nurse-practitioners
  - Physician Assistants
- *Boots on the ground- present, not just available*
  - *Escalating presence with increasing case numbers*

Suggestions for the future - Integration

- LTC Support “Strike Teams”
  - MDs, NP/RNs – Acute + Palliative Care
  - Community Paramedics
  - Mass casualty response
    - Triage
    - Treat on site
    - Transfer if needed
    - Communicate with family members
  - Follow-up, slowly hand back to facility staff when able
  - Coordinate with IPAC, management support team

Mortality and Response Team Deployment



- Champlain region- 14 LTC/RHs, 719 COVID+ve residents, 243 Deaths
- Significant Correlation between time to deployment and mortality rate ($R=0.7$, $p<0.01$)

**preliminary analysis- do not circulate

Suggestions – IPAC training and practices

- Routine, with audits
- Strong focus on staff with greatest exposure to multiple residents
  - PSWs, Kitchen staff
  - Workflow analysis to reduce chances of exposure
    - Distribution of meals, picking up trays
- Cohorting- need three zones, not two

Suggestions – Clinical Care

- Timely, reliable identification for people nearing end of life
  - RESPECT tool- using RAI data
  - Early conversations about goals for patients identified- QUALITY METRIC?
- Improving EOL skill
  - Training for symptom management, insertion of subcutaneous lines
  - Standardized comfort medication forms
  - Audit and feedback about use- ongoing study- QUALITY METRIC?