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LTC Nurse-Led Outreach

Collaborative Care in Long-Term Care

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Disclosures

No conflicts of interest to declare

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Workshop Objectives

1. Describe collaborative care models where physicians and nurse practitioners work together.

2. Identify different roles for the NP (i.e. attending, Nurse Led Outreach (NLOT).

3. Present examples of collaborative care models.

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"Interprofessional care has the potential to increase the capacity of the Ontario health care system, improve patient care, and increase patient satisfaction"

(Hanna, 2016 in OMA Policy: Interprofessional Practice)

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Nurse Practitioner

- NPs are Registered Nurses who have met additional nursing education, experience and exam requirements set by the College
- Only those registered with the College in the Extended Class can call themselves “Nurse Practitioner” or “NP”
- NPs are authorized to diagnose, order and interpret diagnostic tests, and prescribe medications and other treatments for clients
- NP practice includes health promotion with the aim of optimizing the health of people, families, communities and populations
- NPs practice with diverse client populations in a variety of contexts and practice settings such as acute care, primary care, rehabilitative care, curative and supportive care, and palliative/end-of-life care.

College of Nurses of Ontario (CNO), 2019

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Nurse Practitioner

The College registers NPs with one or more of the following specialty certificates:

- Nurse Practitioner – Primary Health Care (NP-PHC)
- Nurse Practitioner – Pediatrics (NP-Pediatrics)
- Nurse Practitioner – Adult (NP-Adult)

College of Nurses of Ontario (CNO), 2019

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OMA's Principles on Inter-Professional Care

The OMA encourages collaborative, team-based delivery of health care.

To ensure the best care for patients, expanding scopes of practice are appropriate where they:

- Are consistent with the knowledge, skill and judgment of those involved;
- Are subject to a rigorous regulatory structure;
- Support a collaborative, team-based approach to care as opposed to parallel care;
- Do not raise patient safety concerns; and
- Are accompanied by system initiatives and supports to ensure that no health care provider is unreasonably burdened with complications arising from expanded scopes of practice from other professions

Ontario Medical Association (OMA).

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Collaborative Care Models in LTC

- Attending NP in LTC
- Nurse Led Outreach (NLOT) NP/Team

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NP Roles: Attending NP in LTC

- Ontario Government committed to funding 75 NP positions in LTC
- As of 2019, there are currently 60 funded attending NP positions in LTC
- Some LTCHs have hired NPs privately
- Some LTCHs have NP's supporting through primary care with the rostered physician

Ministry of Health & Long Term Care (MOHLTC), 2017

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NP Roles: Attending NP in LTC

Ministry of Health & Long Term Care Attending NP Position Summary:

- reports directly to the Director of Nursing and Personal Care or Administrator
- accountable to the Medical Director for meeting the long-term care home's (LTCH) policies, procedures, and protocols for medical services
- is a primary care provider to residents and works within her/his legislative scope of practice as described and outlined by the College of Nurses of Ontario
- collaborates with the resident and family/caregiver, and the health care team in the development, implementation and evaluation of the resident's plan of care;
- provides leadership and mentorship to LTCH staff that enhances their knowledge, assessment skills, and ability to care for residents in place;
- leads and collaborates in research, education, and evidence-based practice initiatives to optimize the resident, LTCH and health system outcomes.

Ministry of Health & Long Term Care (MOHLTC), 2017

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NP Roles: Attending NP in LTC

- Acute and episodic care
- Chronic disease management
- Provision of palliative care
- Staff mentoring and education
- Family education and counselling
- Program development & evaluation

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NP Roles: Nurse Led Outreach Team

- launched in 2008 as part of the Ontario government's plans to reduce ER wait times in Ontario
- Currently NLOT teams in each LHIN
- NLOT teams have different models; all RN, all NP or blended models
- WWLHIN is a blended model with RN's and NP

MOHLTC, 2010

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NP Roles: Nurse Led Outreach Team

The goals of the NLOT program include the following:

- Reduce transfers to the emergency department (ED) for conditions which can be treated in the long-term care setting.
- Reduce hospital admissions for conditions which can be treated in the long-term care setting.
- Reduce length of stay (LOS) for residents in acute care who can be safely transferred back to the long-term care setting with the appropriate supports provided by the NLOT.

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NP Roles: Nurse Led Outreach Team

- Acute and episodic care with some chronic disease management
- Focus on ED avoidance but also quality resident centred-care
- Provision of palliative care
- Staff mentoring and education; focus on capacity building with staff
- Family education and counselling as needed; often around discussion with acute episodic illness and goals of care
- Program development & evaluation including LHIN wide LTC Initiatives

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WWLHIN NLOT Roles

The NLOT has 3 full-time RNs referred to as Nurse Consultants and 1 full-time Nurse Practitioner. NLOT support is available from 0830 a.m. to 4:30 p.m. from Monday to Friday. Each LTCH has an assigned Nurse Consultant. The Nurse Practitioner is currently working with 2 LTCHs which have in excess of 350 residents. The NP is available to these homes 1-2 times per week for regular rounds as well as on an "as needed" basis. These roles are further described:

NLOT Roles	Nurse Practitioner	Nurse Consultant
Capacity Building & Prevention	• Identify acute change of resident condition • Support End-of-Life care initiatives • Participate in rounds • Support attending physicians	• Build staff confidence with complex clinical procedures • Provide educational and clinical support, guidance, and coaching to LTC staff to help increase capacity to manage complex resident health conditions • Build partnerships to meet resident needs (i.e. IV management) • Facilitate hospital-LTCH repatriation and ALC reduction • Provide education to meet home-specific needs (group or individual) • Collaborate with LTCHs regarding a repatriation upon hospital discharge and support the LTCH in meeting the needs of the resident (clinical or educational support) to facilitate transition back to the home • Promote the use of best practices
Emergency Transport Avoidance	• Rapid face-to-face response to emergencies • Telephone coaching • Tele-consult during Outbreaks	
Planned Ambulatory Access & Rapid Emergency Department Engagement	• Develop opportunities for access to clinics, (i.e. Interventional radiology) • Linkage with GEM Nurses • Facilitate inter-organizational information exchange	

Collaborative Care Models in LTC

- Attending NP/MD in LTC
- NLOT NP/MD in LTC

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Evaluations

Please complete your evaluations on our presentation!

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