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# Improving Access to Specialty Care for Frail Homebound Older Adults in Toronto: Using a Nurse-Driven Comprehensive Telemedicine-Based Assessment Model of Care

Sinai Health System

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## Geriatrics Urban Telemedicine (TM) Program

- The Geriatrics Urban Telemedicine program was developed to enable frail homebound older adults receiving home-based primary care in Toronto to have increased access to specialist care when required.
- The program allows a telemedicine nurse with mobile access to facilitate face-to-face consultations between specialists, primary care providers and their homebound patients using the Ontario Telemedicine Network' s (OTN) mobile telemedicine technology.
- The goal of the initiative is to increase access to specialist health services as well as improve the quality and continuity of care for homebound older adults living within the Toronto Central Local Health Integration Network (LHIN) boundaries.

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## Catchment Area


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## TM CNS Role

- Pre-assessment versus TM Connection with Specialist
- Telemedicine Clinical Nurse Specialist Role
  - Triage
  - Coordinate a link among TM Specialists, PCP, and Client/Family/Caregivers
  - Collaborate with Hospital TM Coordinators
  - Create Consultation Appointment in Ncompass
  - Visit Client and Perform Comprehensive Health Assessment
  - Prepare a Medical/Nursing Summary (Sent to Specialist Prior to TM Visit)
  - Facilitate Consultation
  - Co-create and Review Plan of Care in Conjunction with Specialist
  - Documentation and Follow-up
  - Linking to other providers and services
  - Case Management as Needed
  - Other Inpatient Activities (Geriatric Consult Team)



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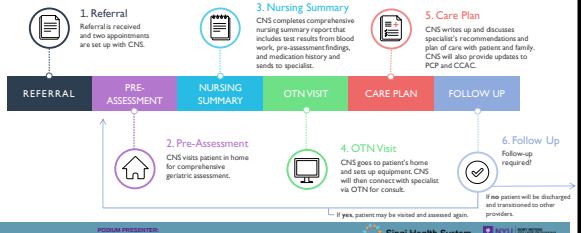
### Clinical Nurse Specialist Telemedicine Intervention



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## TM Program Patient Enrollment

- In the first 24-months, **79 unique clients** were referred to the program.
- A total of **119 telemedicine events** have been facilitated by the CNS.
- Patients referred to the program are usually:
  - 65 years and older
  - Frail and/or homebound
  - Live within the Toronto Central LHIN
  - Sometimes referred by the Consulting Specialist
  - May also be a registered patient with a Family Health Team in the City of Toronto Home-Based Primary Care Network

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## TM Program Patient Profile

| Characteristics | Proportions |
|---|---|
| Gender: Female<br>Male | 63%<br>37% |
| Age: < 65 years<br>Between 65 - 84 years<br>≥ 85 years | 2%<br>50%<br>47% |
| Living Alone | 36% |
| Connected to CCAC at time of engagement | 73% |
| ≥ 5 Medications | 93% |
| ≥ 3 or more chronic illnesses | 97% |
| Cognitive Impairments | 31% |

**N = 79**



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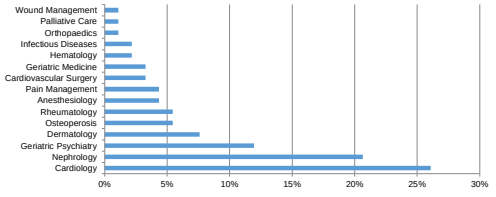
## TM Events by Specialties



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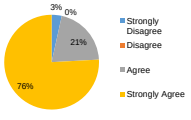
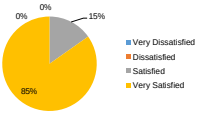
## Patient Satisfaction Survey Results

It would have been difficult to see a specialist without this telemedicine consultation option.




Overall, how satisfied are you with the services and care provided using telemedicine?




**N=59**

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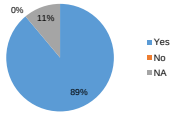
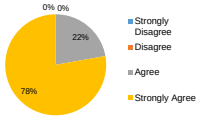
## Specialists Satisfaction Survey Results

Do you feel that this telemedicine consult enabled this patient to gain access to a specialist consultation that would have otherwise been hard to arrange in an office-based setting?




N=9

This telemedicine service has improved my ability to provide care and support.



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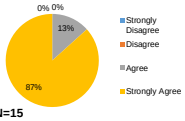
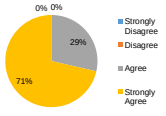
## Primary Care Provider Satisfaction Survey Results

The telemedicine consultation was an effective way for me to get advice and support for my homebound patient.

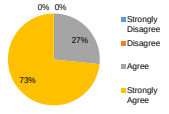



N=15

I believe that my patients' care and/or well-being will improve as a result of being able to access a specialist consultation using telemedicine.




Telemedicine technology supports the continuity of care for older homebound patients.



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## Case Example

- 73 yr. old referred to TM program was unable/unwilling to go to hospital heart failure clinic.
- Multiple factors discovered on visit:
  - Non-compliance with new meds (CNS discovered patient was illiterate)
  - Social issues with housing situation (unable to get out, landlords refusing to give food/access)
  - Worsening symptoms due to non-compliance
  - Distrust/understanding of the medical system

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## Case Example cont'd

- **Care Plan:**
  - Change in medications
  - Ordered blister packs, extra visit to teach use, once daily dosing
  - Referred to Social Work for housing dispute/other services
  - Meals on Wheels
  - Regular TM follow-up visits
- **Outcomes:**
  - Reduction of symptoms, able to get out of the house
  - Compliance with meds
  - Improved quality of life
  - Increased collaboration with the landlord



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## Final Thoughts

Contributors to Success:

- Availability of the specialist services from hospital settings to link with homebound patients
- Strong partnerships with primary and community care providers

Barriers and Challenges:

- Technical challenges with OTN technology
- Limited resources (e.g. admin support)
- Conflicts in scheduling appointments



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## Next Steps

- Complete formal evaluation of TM program to evaluate its impact on:
  - Health Services Utilization (ED Visits, Hospitalizations, etc.)
  - Patient Quality of Life
- Increase number of primary care providers currently on-boarded in program.
- Continue building specialist database to include more specialists in areas such as hematology, gastrointestinal and orthopedics.

## Acknowledgements

**Contributors**

- Nga Truong RN, MScN
- Dr. Samir Sinha MD, DPhil, FRCPC
- Nicoda Foster BPAPM, MPH
- Integrated Home Based Primary Care Network (Toronto)

**Collaborators**

- Toronto Central Local Health Integration Network (http://www.torontocentrallhin.on.ca/)
- Sinai Health System's Healthy Ageing and Geriatrics Program (https://sinaigeriatrics.ca/)
- Sinai Health System's Department of Nursing
- Ontario Telemedicine Network (https://otn.ca/)



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## Thank You!

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