Right Care, Right Place: Reducing ED Transfers from LTC at Newmarket Health Centre

- **Organization: Regional Municipality of York, Newmarket Health Centre (York Region Long-Term Care Homes)**
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Overview

Newmarket Health Centre launched Right Care, Right Place: Reducing ED Transfers from LTC to lower avoidable emergency department (ED) visits for ambulatory care-sensitive conditions. Baseline performance was 28.57 ED visits per 100 residents from October 1, 2022 to September 30, 2023. The 2024–2025 plan set an improvement target of 27.00, focusing on earlier detection of health changes, rapid in-home interventions, and stronger collaboration among clinicians, residents, families, and external partners. The approach blends proactive assessment, palliative and pain expertise, and structured communication so residents receive timely, person-centered care within the home whenever safe and appropriate.

Key Elements of Initiative

Change Ideas Tested or Implemented

- Early detection and intervention: Staff were trained to identify significant changes in residents' health early and consult with the Nurse-Led Outreach Team (NLOT), ET nurse, and physicians for timely interventions.
- Education and collaboration: Provided education and information sharing for residents, substitute decision-makers, and families. Collaborated with RNAO for staff education on pain management, accountability, and documentation.

Team Members Involved

- Internal: Director of Care, Assistant Director of Care, Social Worker, RAI Coordinator, Resident Council, Family Council, Nursing team, Personal Support Workers, IPAC Lead, Physicians, Continuous Quality Improvement and Compliance team.

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- External: Pain and palliative consultants, Nurse Practitioners from Southlake Regional Health Centre Nursing-led Outreach Team, ET Nurse, RNAO LTC experts.

Target Population

- Residents experiencing changes in health conditions (new diagnoses, decline, end-of-life progression, increased care needs), and their substitute decision-makers.

Objective of Change Ideas

- To honor residents' and substitute decision-makers' preferences while enhancing in-home care options and reducing avoidable hospital transfers.

Measurement of Progress

- Monthly process measures: Number of education sessions, referrals to Nurse Practitioners.
- Quarterly outcome measures: Rate of ED visits for ambulatory care-sensitive conditions per 100 residents, tracked and visualized using run charts in bi-monthly Continuous Quality Improvement Committee meetings.

Implementation Experience: Successes & Challenges

Successes

- Early outcomes show a reduction in unnecessary ED visits, with residents and families expressing appreciation for high-quality, in-home care.
- Improved communication and collaboration among NLOT, staff, and families helped support timely, respectful responses to health changes and prevent ED visits.
- Families shared gratitude through thank-you letters, recognizing compassionate end-of-life care that respects preferences and routines.

Enablers of Success

- Proactive engagement with palliative care consultants and NLOT manager, who provided targeted education and participated in council meetings.

- Empowerment of Palliative Resource Team champions to identify residents' status changes early, triggering coordinated responses (assessment tools, referrals, early conversations with POA, initiation of palliative care program, involvement in rituals and ceremonies) of the Palliative Care Program.
- Continued SDM involvement through the Dignity Walk, structured debriefs, and Celebration of Life practices that reinforce a resident and family-centred culture.
- Participation in CPLTC+ and Project AMPLIFI to support safe, appropriate care at home.
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Challenges & Solutions

- Staffing vacancies and leadership transitions among external partners disrupted workflows and communication, leading to delays and inconsistent care protocols.
- Solutions included standardizing internal processes, strengthening onboarding and orientation, enhancing team-wide training on early identification, fostering open communication, prioritizing continuity planning, building flexible communication frameworks, investing in proactive training, and reinforcing shared values with external partners.

Advice for Other Teams

- Engage internal and external service providers early.
- Consult subject matter experts (pharmacist, pain management consultant, ET nurse) for individual needs.
- Enhance the palliative care program through monthly meetings, integrated policies, data collection, and communication.
- Maintain a balanced scorecard aligned with priority areas.
- Keep family communication open, especially during acute changes.

Future Steps & Sustainability

Next Steps

- Continue targeting improvements on the ED transfer indicator in the 2025-2026 Quality Improvement Plan, focusing on education, access to diagnostic services, and intravenous care services within the home.

Embedding into Policy or Workflow

- Policy integration: Formalize clinical decision pathways into official LTC policies.
- Routine workflow alignment: Integrate resident status discussions and ED risk assessments into daily huddles; establish rapid response protocols (daily NP rounds, daily physician on-site) before considering ED transfer.
- Ongoing training and capacity building: Provide staff education on clinical assessment and communication, conduct monthly reviews of ED transfers with the MD or NP, hold debrief sessions, gather feedback from residents and families, and share written compliments with staff to reinforce culture and momentum.

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