All Together Series

Session 1: Reimagining a Hospice Model of Care

Wed, Feb 12th, 2025 (12pm-1pm)

	DISCUSSION
Introductions	Facilitator: **Lisa Clement,** Program Manager, Public Health Initiatives, BCCPC **Presenters:** • **Kara Lyons-Dietz**, Community Health Services and Hospice Manager, Island Health • **Katie Hennessy**, Clinical Nurse Specialist, Palliative & End of Life Care, Island Health **Learning Objectives**: • Share the approach used in transitioning Cowichan Hospice House from long-term care to community health services in the Cowichan Valley. • Discuss system challenges faced during the transition. • Encourage creative and collaborative thinking among various partners.
Background	**<u>Background of Cowichan Hospice House:</u>** • Recognition of the hard work that led to the establishment of Cowichan Hospice House, especially the contributions of the Hospice Society, Island Health, and other dedicated individuals. • A **10-bed hospice** (initially funded for 7 beds), opened during the pandemic. **Reason for Transition**: • High hospital deaths among palliative patients despite community support. • Staffing and operational challenges during COVID-19. • Need for a dedicated palliative care model within the community. • Findings from the Cowichan Health and Care Plan, which highlighted growing demand for palliative services. **Goals of the Transition:** • **Improve End-of-Life Care** – Provide a dedicated, well-staffed hospice for patients nearing the end of life. • **Reduce Hospital Deaths** – Many palliative patients were dying in acute care, which was often not aligned with their end-of-life wishes. • **Establish a Hybrid Model** – Support patients to remain at home when possible or transition to hospice if needed, avoiding hospital admissions. • **Enhance Interdisciplinary Collaboration** – Strengthen partnerships among hospice staff, community health services, and hospitals. • **Address Staffing Challenges** – Shift hospice staffing models to ensure adequate care levels while navigating the transition from long-term care to community care.

Transitioning Cowichan Hospice House to Community Health Services

- ❖ **Goal:** Create a hybrid nursing model supporting palliative care at home or in hospice, offering flexibility and preventing hospital admissions.
- ❖ **Challenges:**
- **System & Operational Barriers:** Transitioning from long-term care to community services meant dealing with conflicting systems and access to resources.
    - **Licensing & Policy Conflicts**: CHH was still categorized as a long-term care facility in many provincial systems, even though it was operating under community health services thereby complicating operational processes.
    - **Electronic Health Records (EHR) Complexity**: The electronic records system) had limitations in reflecting the new hospice model, causing documentation and access challenges.
- **Job Descriptions:** Difficulties in aligning job descriptions between community and long-term care roles, especially for LPNs.
- **Recruitment Issues**: CHH needed to expand staffing for the additional three beds while ensuring the new hospice-focused model aligned with community care standards.
- **Team Dynamics:** Introducing new staff and expanding the team led to adjustments and a shift in team dynamics.
    - Some staff initially resisted the change due to disruptions in routine and new leadership structures.
- **Transition Management & Communication Gaps**
    - **Multiple Stakeholders**: The transition required collaboration between hospice, community health services, hospitals, long-term care, pharmacy, dietary, and housekeeping teams.
    - **No Change Management Consultant**: The team did not have an external consultant to guide the transition; they had to navigate the process independently.

Successes & Outcomes

- Collaboration with community nurses and staff to fill staffing gaps.
- Reaching out to acute care and long-term care services for necessary support.
- Developed workarounds for system access, policies, and referrals to improve efficiency.

- ❖ **Outcomes:**
- **Improved Hospice Admissions & Faster Transitions**: Successful expansion of services and improved patient transitions.
- **Significant decrease in hospital deaths**: In early 2024, CHH reported several months with zero palliative deaths in hospital due to better hospice accessibility.
- **Strengthened Community & Hospice Integration**
    - Palliative home care nurses provide dedicated support for patients during their last 12 weeks of life, helping sustain home-based care and facilitating hospice transfers when necessary.
    - Closer partnerships with the Cowichan Hospice Society allow for expanded psychosocial support and community outreach programs.
- **Leadership & Staffing Model Improvements**
    - CHH now has a Clinical Nurse Leader (CNL) 7 days a week, which is unique compared to other Island Health sites.

	o RN and LPN staffing models improved team collaboration and responsiveness to patient needs **Key Lessons:** • Patience, creative problem-solving, and collaboration across teams. • Importance of communication and staying solution-focused. • Support for staff, leadership availability, and team buy-in were crucial. • Ongoing work with electronic health records (Eye Health) and aligning procedures across programs to meet the unique needs of the hospice population.
Questions, Reflections or Stories	**Q: What were the Learnings had in the change management process?** **<u>Response:</u>** • Transparency & Clear Communication were essential to counter rumors and fears. • Allowing staff to voice concerns helped manage resistance. • **Importance of the "Why" in Change Management**: Understanding and communicating the reasons behind the change was a key piece of managing the transition. **Q: Would hiring a change management consultant have helped?** **A:** A consultant could have been beneficial for the process, but the team did not have the budget for one and lack of funds meant they had to rely on internal resources. It was agreed it could have made the transition smoother. **Q: Hospice beds and long-term care provincial model – Is it transferable especially for communities in island health, where there often may be fewer beds?** **A:** The model can be replicated, but it requires community buy-in which depends on the local community's needs and existing infrastructure. o Some practices are working well in specific hospice societies, and these variations might influence how the model can be replicated elsewhere. o The model's success depends on the **specific needs** of each community, the type of long-term care sites available, and the involvement of local hospice societies. o While the model can work in different areas, it might not be suitable for every community due to varying resources and needs. o Communities must assess their unique needs, long-term care capabilities, and hospice society involvement before deciding on replicating the model. **Q: How Are Patients Who Outlive the 12-Week Prognosis Managed?** A: If a hospice patient stabilizes or outlives the 12-week marker, **transition to long-term care** may be considered, especially if the patient can no longer return home. o Close collaboration with the community team helps expedite the assessment process when patients need to transition to long-term care. o Long-term care waitlists are long, but efforts are made to expedite the process, especially when hospice beds are full.

- There are escalation pathways in place to address community needs, including working with different stakeholders to expedite care transitions.
- Ongoing conversations with families are crucial to keep them informed about potential changes in the patient's care plan.
- If there are empty beds in hospice, respite care can be provided for short-term stays or symptom management, which may allow patients to stabilize and return home.
- Respite care is valuable for sustaining caregivers, offering them breaks while managing their loved ones' care.
- Some patients stabilize and can return home for additional months before needing hospice care again.
- Due to high demand, it has been difficult to offer planned respite care in hospice clusters, though long-term care facilities have resumed facilitating planned respite stays for palliative patients.

Q: Do residents in long-term care die in those beds or do they transfer to the hospice?

A: Residents in long-term care do not generally transfer to hospice care. Long-term care homes provide excellent palliative care to support residents at the end of life.

- There is no routine transfer from long-term care to hospice once a resident is receiving end-of-life care in the long-term care facility.
- Long-term care facilities are equipped to manage palliative care and meet the needs of these residents without needing to move them.

Q: Could you please share what psychosocial support looks like?

A:

- Psychosocial support was already in place through the palliative end-of-life program and the Hospice Society before the transition to CHS.
- The regional palliative and end-of-life teams include a palliative care nurse consultant, psychosocial consultant, and palliative MD in each community.
- Local hospice societies, including Cowichan Hospice, play a key role in providing psychosocial supports, with Cowichan Hospice being especially robust in this area.

Q: Does your community also provide shift care nursing for people who want to die at home but are now needing 24/7 nursing care?

A: 24/7 home support is available if needed, but not specifically for palliative care. Community-based palliative care nurses provide increased visits in the last 12 weeks of life, but not continuous bedside nursing.

- The Cowichan Health and Care Plan has provided dedicated lines for palliative nursing during the last 12 weeks of life to support home deaths and caregivers.
- Increased visits in the final weeks of life are encouraged to support caregivers and facilitate home deaths.

	◦ The plan also includes resources for COPD patients in the Cowichan Valley, where the highest population of COPD patients in Island Health resides. **Q: With the availability of spiritual care and music therapy. Elaborate more into the psychosocial support.** A: **Psychosocial Supports:** • CHH benefits from palliative social workers and counselors through the Cowichan Hospice Society and Island Health. • Volunteers from the Hospice Society provide music therapy to patients, though it's not a dedicated service due to resource constraints. • Spiritual care is available on request, but there is no dedicated on-site spiritual care provider. • The need for dedicated spiritual care is recognized, but not yet fully integrated into the hospice model. **Hope for Future Integration:** ◦ There is a desire for greater expansion of psychosocial support across healthcare, especially in acute care and hospice settings.
Conclusion	• The transition of Cowichan Hospice House from long-term care to community health services was complex but ultimately successful. • Lessons learned include the need for clear communication, flexibility, and strong leadership support. • The model may be replicable in other communities but must be adapted to local needs.
Resources	• Session recording link • Stay tuned for registration info for upcoming sessions!