Western York Region OHT

Palliative Education Enhancement in LTC Homes to Reduce Alternative Level of Care Days: Collaborative Quality Improvement Project with, Mackenzie Health, LTCHs and Stakeholders

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OLTCC Conference – October 2023

Western York Region ONTARIO HEALTH TEAM

Mackenzie Health

Objectives

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- Project Overview
- Development and Implementation of Curriculum
- Evaluation and Results
- Next Steps

Acknowledgment

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Project Leadership Team

- **Mary-Agnes Wilson**, Executive Vice President, Chief Operating Officer, Chief Nurse Executive
- **Kim Kohlberger,** AVP Mackenzie Health – WYR OHT Integrated Care Advisory Committee
- **Stefanie Richards**, WYR OHT Manager
- **Claudia Schauer**, Western York Region OHT, Mackenzie Health
- **Olga Shapiro, NP,** NLOT, Mackenzie Health
- **Bella Grunfeld**, NP, NLOT, Mackenzie Health
- **Lauren Ridge,** OHT Impact Fellow, WYR OHT

Working Group

- Bella Grunfeld, NP, NLOT, Mackenzie Health
- Clara, Nisan, Director of Care/Nurse Practitioner, Universal Care
- Claudia Schauer, Western York Region OHT, Mackenzie Health
- Fiona Neil, RN, Manager, Patient Navigation and Discharge Planning, Mackenzie Health
- Jonathan, Moore, Social Worker, Maple Health Centre
- Kim Kohlberger, AVP Mackenzie Health – WYR OHT Integrated Care Advisory Committee
- Lina Bavaro, Manager, Behavioural Supports Ontario, Mackenzie Health
- Maria, Cherbel, Vice President of Quality and Clinical Services, Universal Care
- Olga Shapiro, NP, NLOT, Mackenzie Health
- Stefanie Richards, WYR OHT Manager
- Agnes Colonna, ADOC/IPAC, Sherwood Court
- Pierre Geoffroy, MD, Palliative
- Manjit Gill, RN, NLOT, Mackenzie Health
- Lauren Ridge, Impact Fellow, WYR OHT/Mackenzie Health

Ontario Health and Western York Region (WYR) OHT Priorities

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The Ontario government is building a connected health care system centred around patients, families and care partners to:

1 **Strengthen Local Services**

2 **Improve the Navigation Experience for Patients**

3 **Create Seamless Transitions between Providers**

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Alterative Level of Care Days 2020/21

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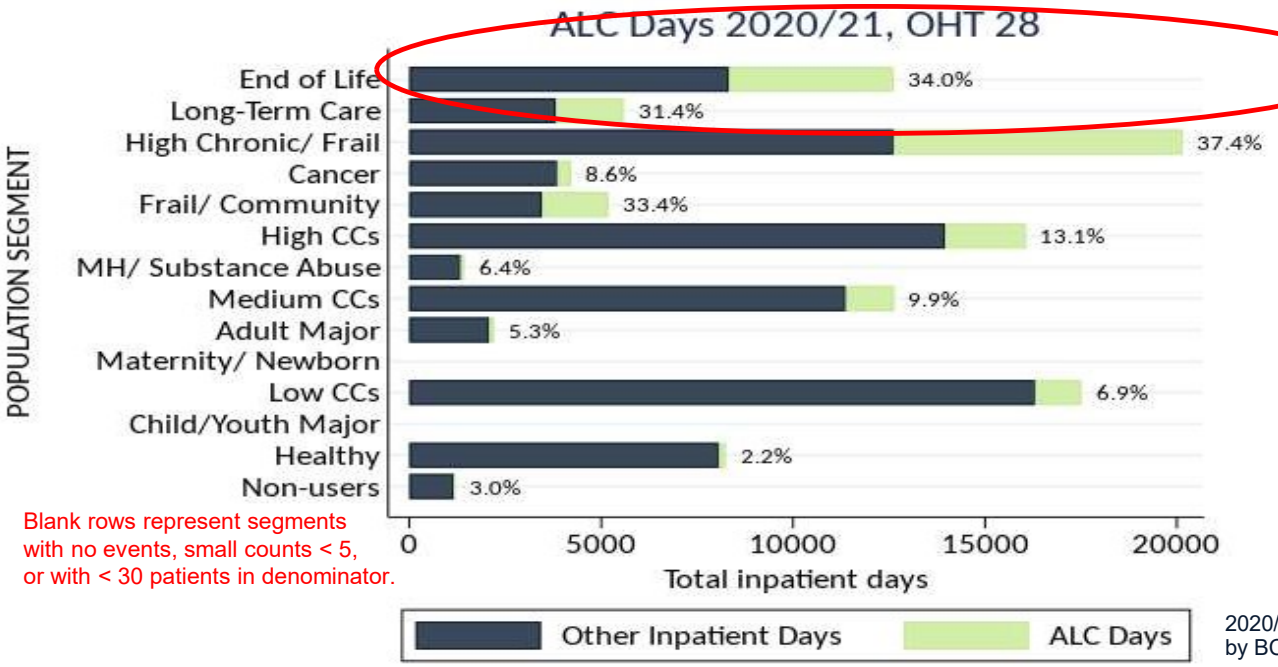

Blank rows represent segments with no events, small counts < 5, or with < 30 patients in denominator.

2020/21 ALC Days (percent of acute days) in acute hospitals by BC Matrix Segment

ALC strategies must consider multiple populations including frail seniors with high chronic conditions, those in Long Term Care and those who have palliative care needs.

IC/ES

Background

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- Long-Term Care Home (LTCH) residents represent the most frail population
- LTCH residents suffer from multiple life-limiting conditions
- Only six percent of residents have a record of receiving palliative care in the last year of life in LTCHs
- Access to palliative and end-of-life care is vital to residents

Background and Current Challenges

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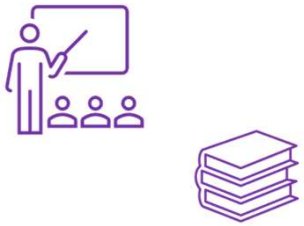
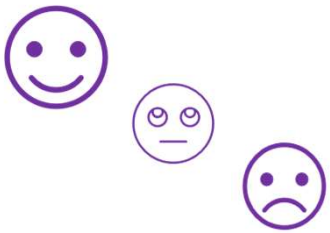
All LTCHs provide Palliative Care

Different approach to delivery of Palliative Care in LTCH



Different level of comfort and competency among LTCH staff and clinicians



Different level of understanding amongst families about palliative care and end of life care

Program Model Design

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Engage key stakeholders including staff, residents and families to develop a palliative care resources and training materials.

Gap Analysis will be performed to determine current palliative care process and outcome components available in LTCHs.

Training plan and education materials will be developed for Train-the-Trainer model.

Communications and change management plan developed.

Resources to assess and determine resident's palliative and end-of-life needs.

Train-the-Trainer model to strengthen palliative care capacity in long-term care homes and other congregate settings.

Policies and quality standards to support palliative and end-of-life care in LTCHs.

Resident's and caregiver's palliative and end-of-life care and needs met resulting in improved access to care in the most appropriate setting.

Evaluation plan to assess the impact of the Train-the-Trainer education sessions.

Surveys to understand the demographic and knowledge changes among participants.

Focus groups to facilitate group discussions.
Key recommendation and gaps will be identified

Program's Goal:
Residents receive care at the right time and place based on need and preference

October – December 2022

January – March 2023

August 2023– March 2024

The Ontario Health Equity Impact Assessment (HEIA)

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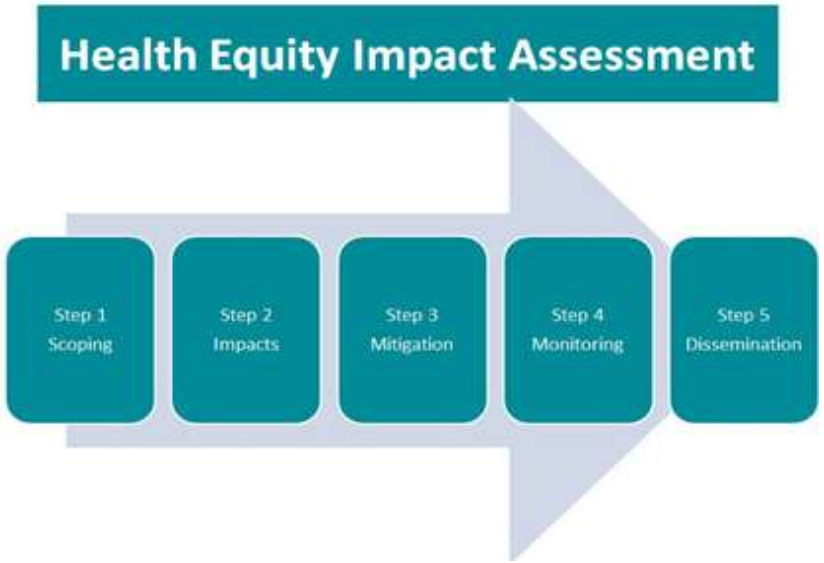
- Originally developed for LTC, HEIA is a flexible and practical assessment tool for unintended health impact (positive and negative)
- Objective for Completing the HEIA:
  - Embed equity in the design of the training
  - Conclusions and recommendations
  - Completed HEIA tool provided



Train-the-Trainer (TTT) model

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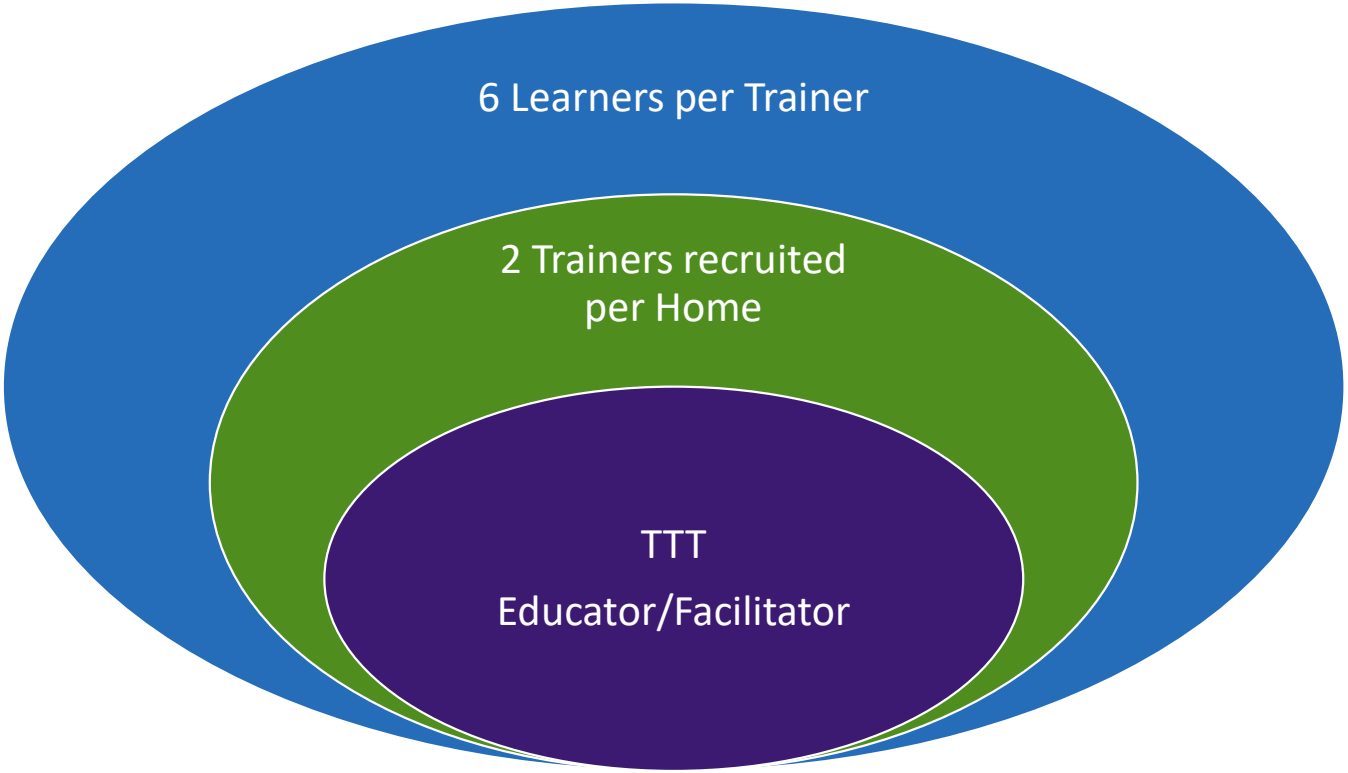

Curriculum and Training Plan

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- Training continued from January to April 2023, 12 weeks
- Curriculum broken in four sessions
- Each session one hour in duration
- Training sessions conducted in person and delivered by the Facilitator
- Recorded sessions are available to access for the trainees and staff if needed
- 40 sessions in total across the 10 LTCH
- Curriculum topics
  - Session 1: Philosophy of Palliative Care Approach
  - Session 2: Identification of Residents for Palliative and End-of-Life Care
  - Session 3: Difficult Conversations
  - Session 4: End-of-Life Care Assessment and Management
  - Session 5: Palliative and End of Life Care Education for Residents, Families and Caregivers

Session 1: Philosophy of Palliative Care Approach

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- Exploring understanding of PC amongst participants –art exercise
- Definition of PC
- PC is an active care
- PC to start early in the disease trajectory: on admission to LTCH
- Palliative Care continuum
- Old model vs. New model of PC
- Palliative care domains:
  - Multidisciplinary team approach, including residents and family
  - Benefits of PC for residents and family/CGs - improvement of quality of life
  - Importance of integration of PC in LTCHs

Session 2: Identification of Residents for Palliative and End-of-Life Care

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- Legacy LHIN algorithm
- Assessment tools: PPS, Gold standard framework, frailty scale, ESAS
- Review of clinical indicators of decline
- Case study review
- Practice with PPS tool assessment

Session 3: Difficult Conversations

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- Explored why conversations about PC and EOL were difficult for the staff and resident/families to discuss
- Reviewed research data why it is important to have these conversations:
  - People want to be asked and heard in order to know their wishes to provide the best quality of care and to improve quality of life
- Discussed effective communication techniques
- Phrases to use and to avoid

Session 4: End-of-Life Care Assessment and Management

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- Attend to the full spectrum of EOL care domains when addressing patient and family's needs: physical, social, culturally and spiritual.
- Utilizing all team members to ensure needs are met and referring as needed to allied health and spiritual care partners.
- Reviewing the signs and symptoms observed at end of life to ensure thorough communication to team and family on patient's condition.
- Reviewed medications and protocols utilized at the EOL
- Discussed myths around opioids at the EOL
- Discussed HCP self-care

Session 5: Palliative and End of Life Care Education for Residents, Families and Caregivers

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- To define what is palliative and end-of-life care approach
- To identify when to start palliative and end-of-life care in LTCH
- To identify myths and facts about palliative and end-of-life care
- To describe the importance of palliative and end-of-life care approach in LTCHs

Evaluation Plan

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Evaluation Plan	**Mixed method model utilizing data driven theory to assess the impact of the train-the-trainer model on staff attending the training sessions.**			
Data Collection	Quantitative Analysis		Qualitative Analysis	
	5-point Likert scale questions to assess participants **knowledge, attitudes** and **beliefs** using pre- and post-training survey Additional descriptive questions identifying years of service, job title, and location in which the participants work		Semi-structured questions assessing **feasibility, accessibility, efficacy,** and **sustainability** Open ended questions looking to facilitate discussion among 7-10 participants during a one-hour session	
Themes Assessed	Learning	Reaction	Behaviour Change	Sustainability
Timeline	*January 2023 - March 2023*		*August 2023 – November 2023*	

Evaluation Timeline

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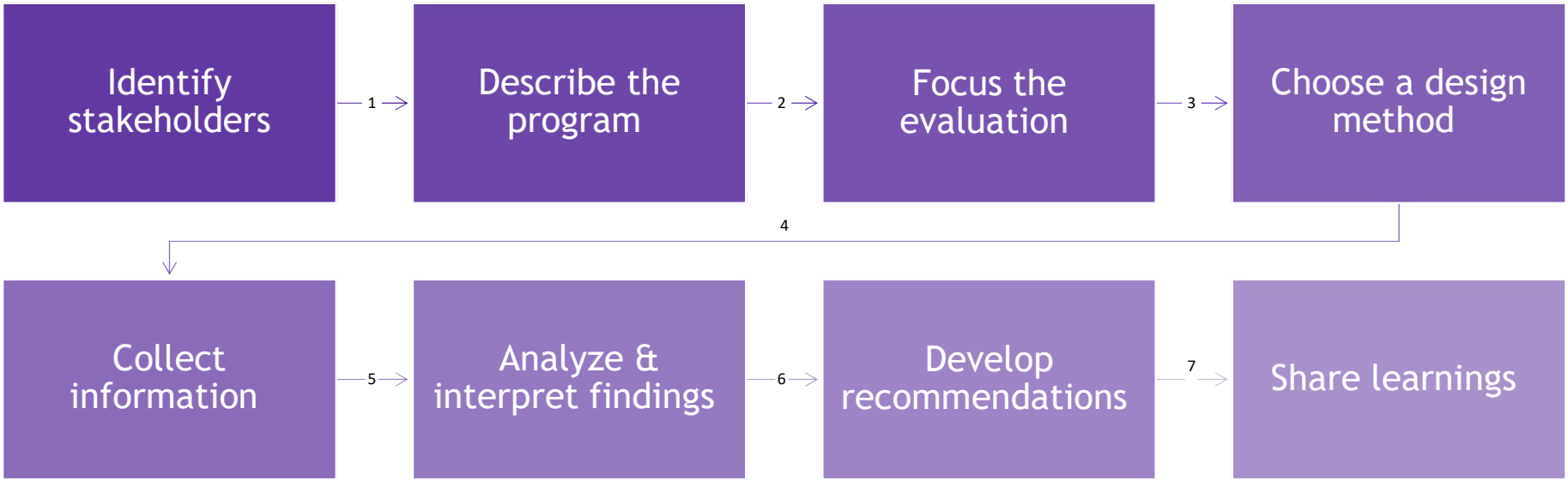

Results to Date

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On Practice:

- We collected data on the number of residents with documented PC/EOL care approach from each home before and after the implementation of the pilot project
- The number of residents with documented palliative care approach before project implementation across all 10 LTCHs were equal to 96 people; this number had increased to 160 residents after the completion of educational modules

On Knowledge:

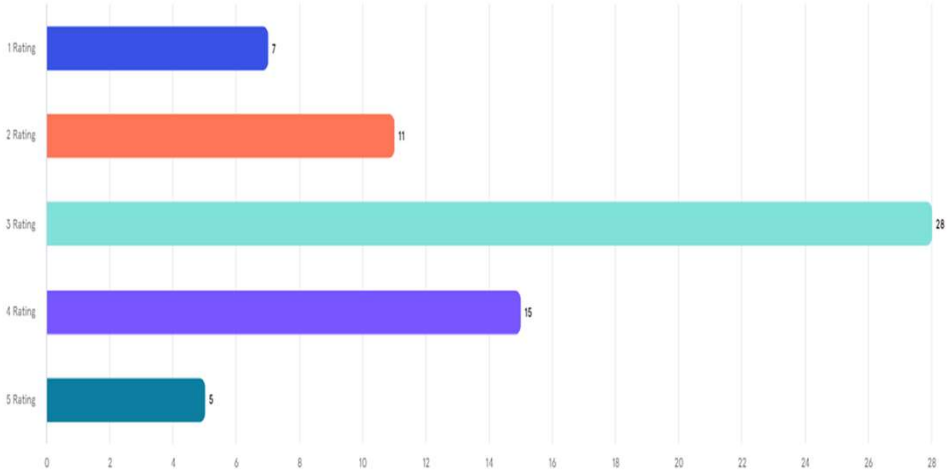
- Pre- and post-surveys were conducted for each session along with a knowledge check at the end of each session
- We used a 5-point Likert scale for the proficiency questions specific to the topic of each individual session
- Examples are provided in the next slides

Philosophy of Palliative Care Approach

Session 1: Pre-Survey

Q.5 What is your knowledge level about integration of palliative care in LTCHs?

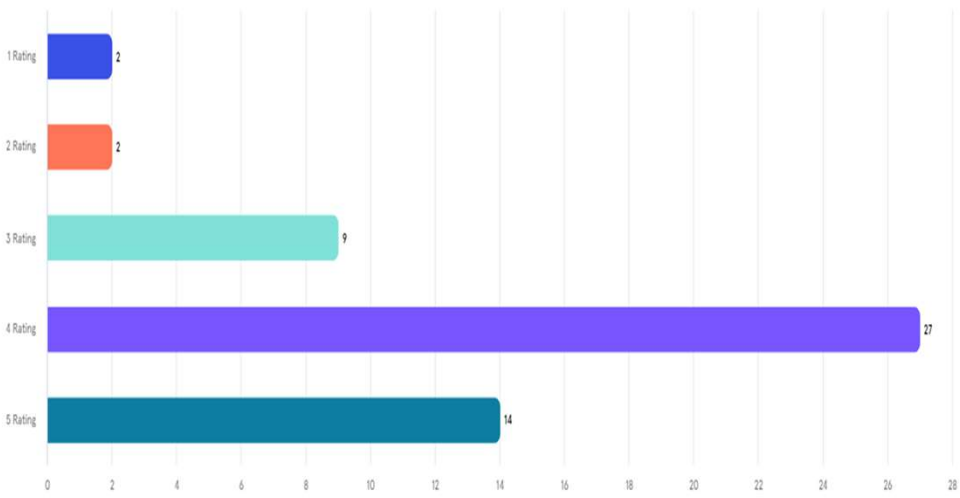
AVG. RATING (MEAN)	MEDIAN	STANDARD DEVIATION	TOTAL COUNT
3.0	3.0	1.1	66



Post-Survey

Q.4 What is your knowledge level about integration of palliative care in LTCHs?

AVG. RATING (MEAN)	MEDIAN	STANDARD DEVIATION	TOTAL COUNT
3.9	4.0	.9	54



Legend
- Novice
- Min Knowledge
- Some Knowledge
- Knowledgeable
- Expert

Novice

Expert

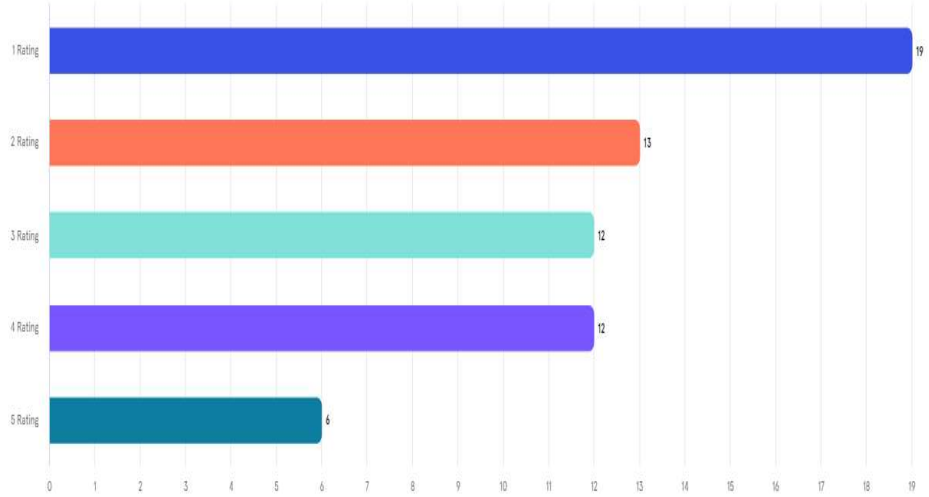
Number of participants

Identification of Residents for Palliative and End-of-Life Care

Session 2: Pre-Survey

Q.4 What is your knowledge level about Golden Standard Framework?

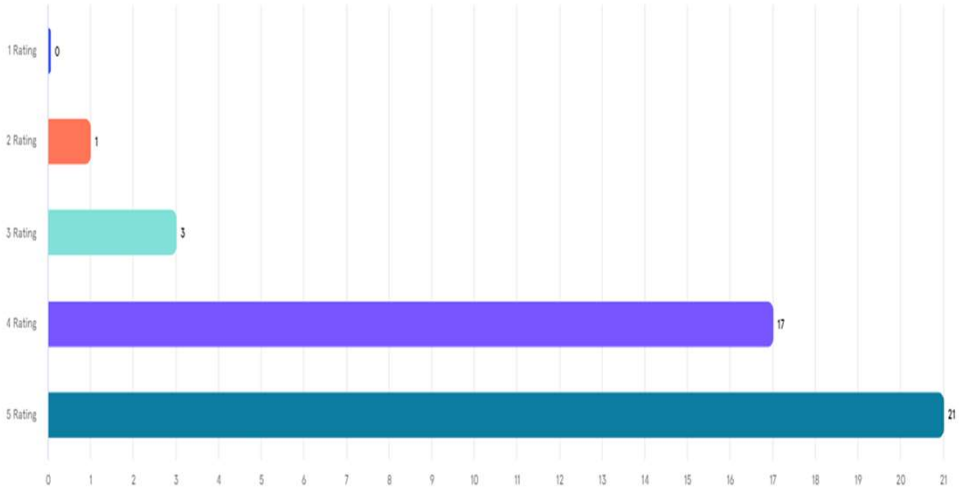
AVG. RATING (MEAN)	MEDIAN	STANDARD DEVIATION	TOTAL COUNT
2.6	2.0	1.4	62



Post-Survey

Q.1 What is your knowledge level about Golden Standard Framework?

AVG. RATING (MEAN)	MEDIAN	STANDARD DEVIATION	TOTAL COUNT
4.4	4.5	.7	42



Legend

- Novice
- Min Knowledge
- Some Knowledge
- Knowledgeable
- Expert

Novice

Expert

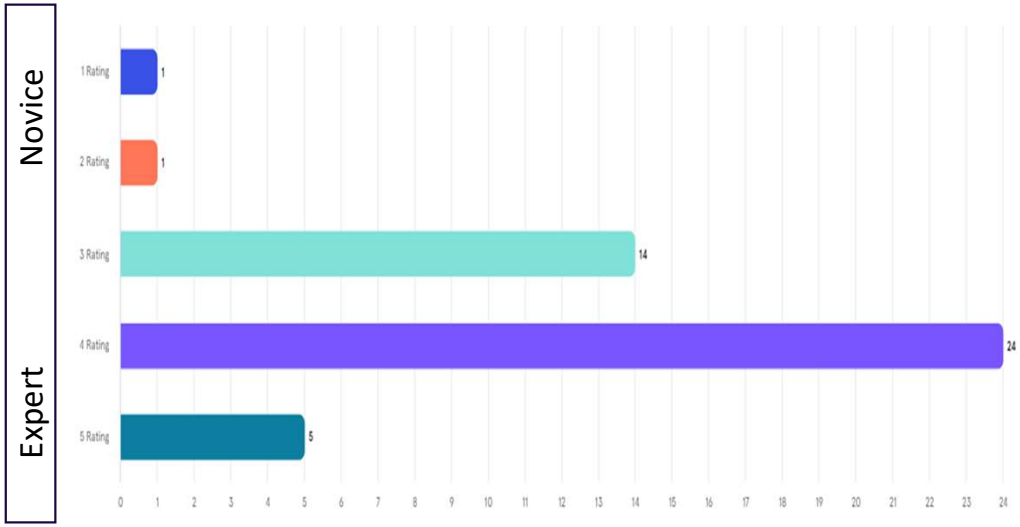
Number of participants

Difficult Conversations

Session 3: Pre-Survey

Q.5 What is your comfort/knowledge level about goals of care discussion?

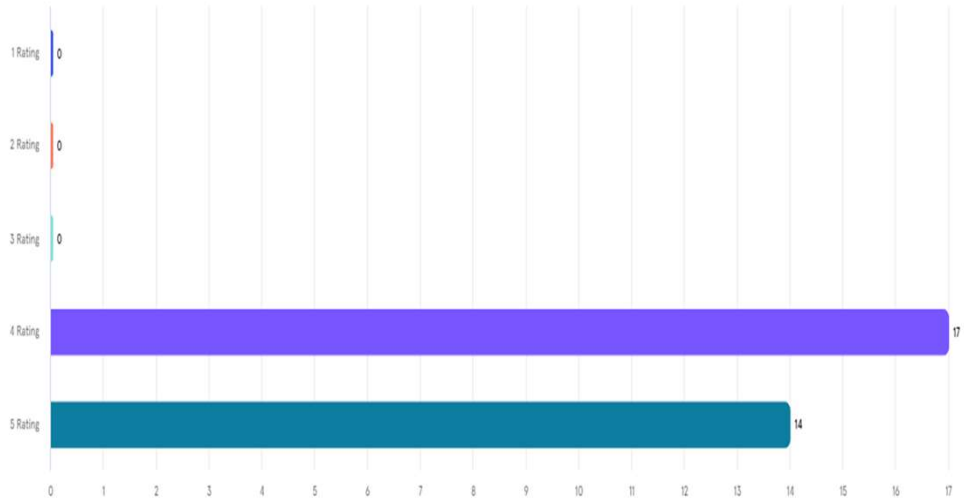
AVG. RATING (MEAN)	MEDIAN	STANDARD DEVIATION	TOTAL COUNT
3.7	4.0	.8	45



Post-Survey

Q.2 What is your comfort/knowledge level about goals of care discussion?

AVG. RATING (MEAN)	MEDIAN	STANDARD DEVIATION	TOTAL COUNT
4.5	4.0	.5	31



Number of participants

Legend

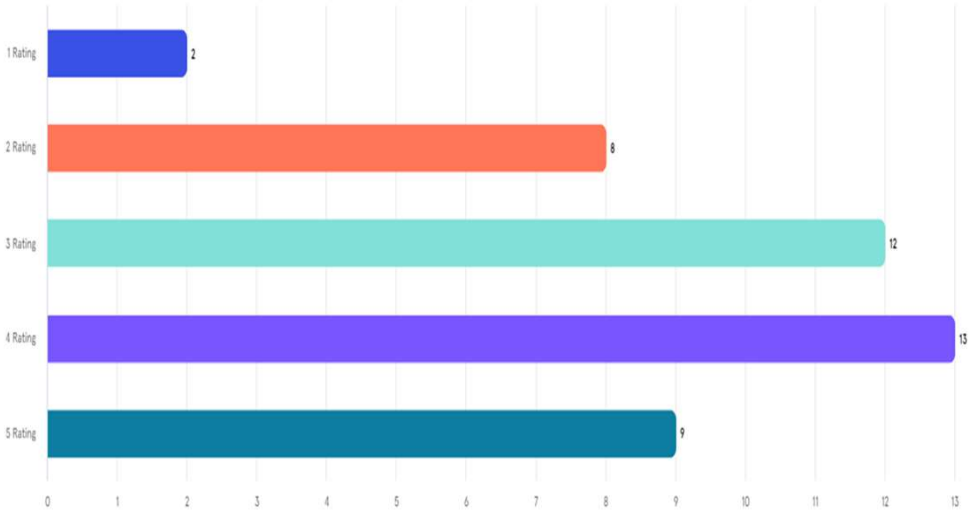
- Novice
- Min Knowledge
- Some Knowledge
- Knowledgeable
- Expert

End-of-Life Care Assessment and Management

Session 4: Pre-survey

Q.7 What is your comfort/knowledge level about pain management modalities?

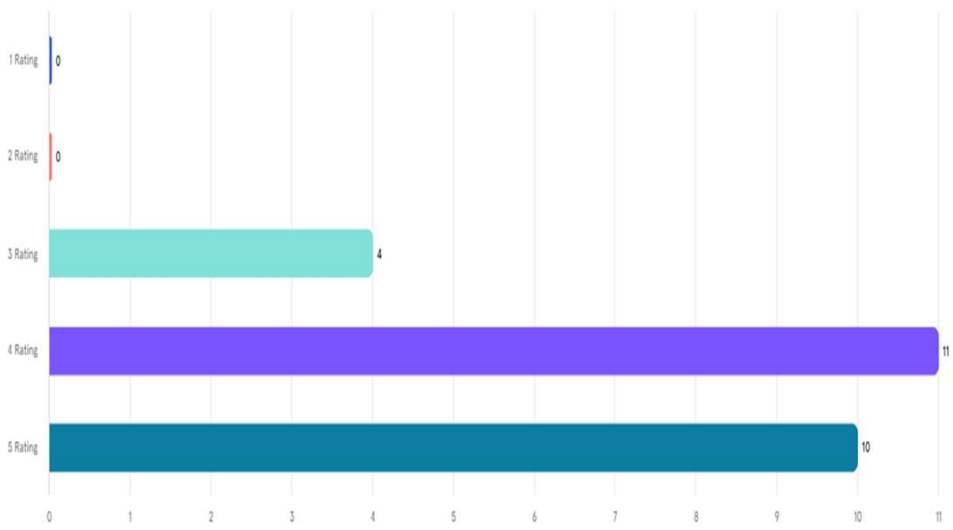
AVG. RATING (MEAN)	MEDIAN	STANDARD DEVIATION	TOTAL COUNT
3.4	3.5	1.1	44



Post-Survey

Q.4 What is your comfort/knowledge level about pain management modalities?

AVG. RATING (MEAN)	MEDIAN	STANDARD DEVIATION	TOTAL COUNT
4.2	4.0	.7	25



Legend

- Novice
- Min Knowledge
- Some Knowledge
- Knowledgeable
- Expert

Novice

Expert

Number of participants

Lessons Learned

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- Need for resources to be allocated towards ongoing training
- Need for formalized palliative care team and champignons at each LTCH
- Limitations often rooted in resident/family/caregivers understanding and involvement in Palliative and EOL care
- Additional opportunities to address gaps including funding for education

Next Steps

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- Training plan with each LTCH to continue staff education
- NLOT RN role in assisting with this education
- Development of Module 5 for family education in Palliative and EOL care
- Working with stakeholders to develop CoP
- Development of Curriculum and training plan for hospital clinicians
- Evaluation is ongoing

Take Home Messages

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- Hospital ALC days continue to increase related to frailty and chronic diseases amongst residents from LTCHs
- Timely initiation of PC and EOL in LTCHs is essential for providing quality of care, preventing avoidable ED transfers, and decreasing ALC days
- PC and EOL care are integral to LTCHs services
- Ongoing staff and physician training is required to deliver and sustain quality PC and EOL Care practices in LTCHs
- WYR OHT Palliative/ALC Days Education Initiative is instrumental in supporting PC and EOL care delivery in LTCHs

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