Growing and Sustaining a Rural Palliative Care Program

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Objectives

1. Identify the five key steps in building a rural community-based palliative care program.
2. Describe the components of the Palliative Care Team development in rural settings.
3. Distinguish the themes for sustainability strategies for rural community-based palliative care programs.

Stratis Health

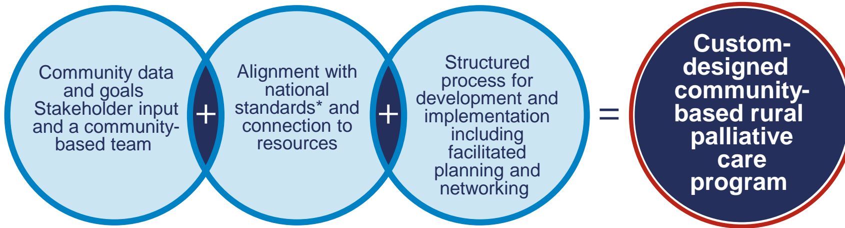
- Independent, nonprofit organization founded in 1971 and based in Minnesota
  - Mission: Lead collaboration and innovation to improve health
- Core expertise: design and implement improvement initiatives across the continuum of care and in communities
  - Funded by government contracts and private grants
  - Work at the intersection of research, policy, and practice
- Rural health and serious illness care are long-standing organizational priorities
  - Have worked on rural palliative care program development in more than 40 communities since 2008

2017-2020 Rural Community-Based Palliative Care Project

- Multi-state effort working in partnership with State Offices of Rural Health in North Dakota, Wisconsin, and Washington
- Build capacity for state leadership
- Alignment of partners and resources
- Facilitated asset-based community planning process
- Sustainability

Rural Community-based Palliative Care Partnership

Community capacity-based formula for program development



*National Consensus Project for Quality Palliative Care, 4th Edition Guidelines, 2018

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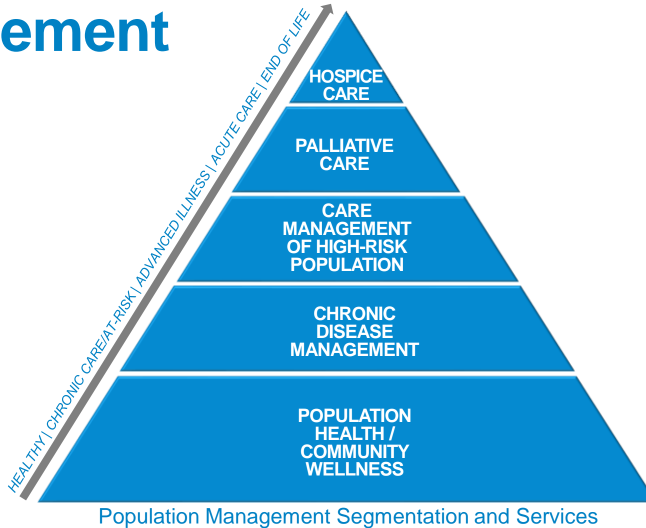
Role of Palliative Care in Population Management



Population Management Segmentation and Services

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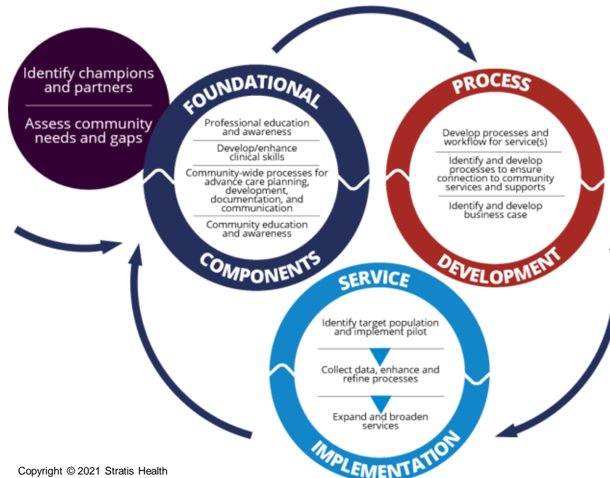
Rural Community-based Palliative Care Service Development Framework



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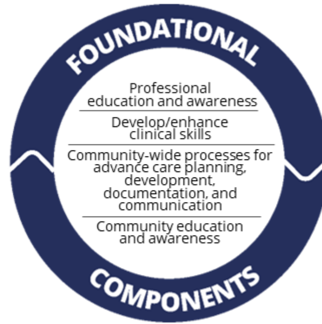
Getting Started: Building a team and assessing needs

Champions – passionate, medical staff, organizational leadership

Community team

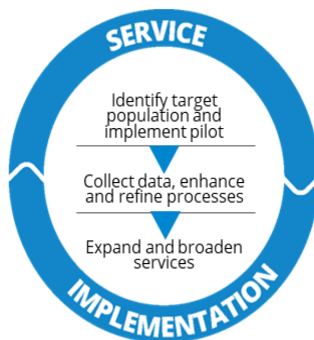
- Interdisciplinary
- Health care organizations
- Community organizations

Foundational Components



Process Development

Service Implementation



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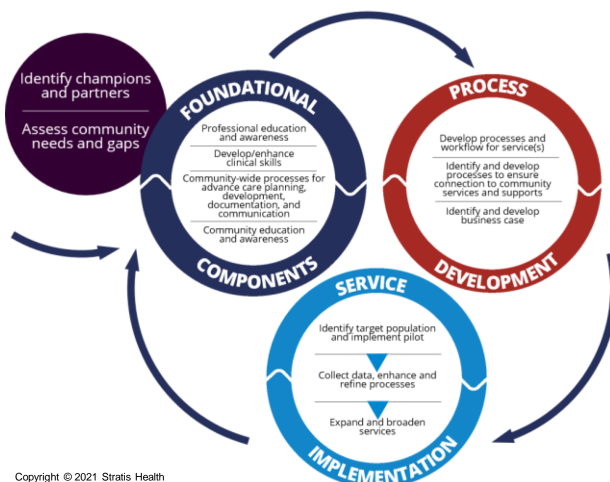
Rural Community-based Palliative Care Service Development Framework



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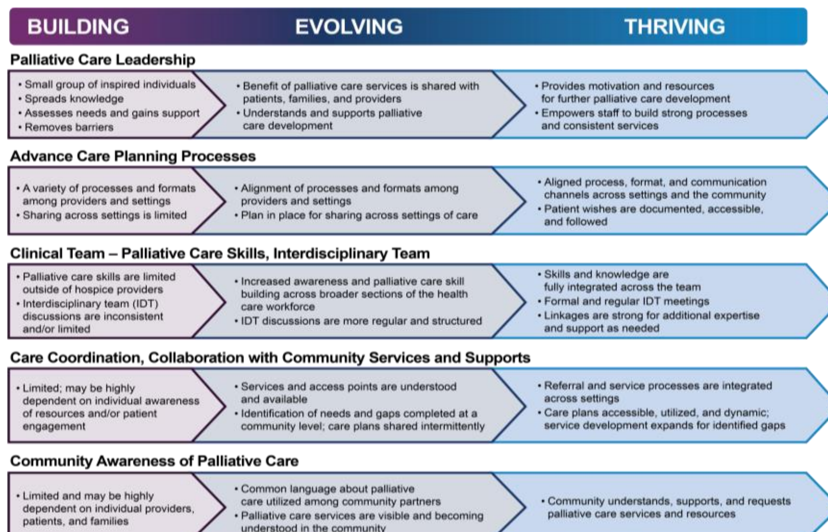
Variables in program structure

Methods of service delivery	Interdisciplinary team	Patient focus	Coordinating staff
Home visits Clinic appointments Nursing home visits Inpatient consultation Telephonic case management Volunteer support visits/services	All teams included physician, social work, nursing Other disciplines vary: • Rehabilitation services • Volunteers • Nurse practitioner • Chaplain • Pharmacy • Advance practice nurse in psychiatry	Hospice eligible but refused Infusion therapy Home care with complex illness Inpatient consult when requested Physician referred with complex illness Nursing home residents – triggered by minimal data set (MDS) criteria	Nurse practitioner Registered nurse Social worker Certified nurse Specialist Advance practice nurse

Community Team Development



Access this resource as a full-page handout: https://stratishealth.org/wp-content/uploads/2020/07/pc-team-development-continuum-dia.pdf

Rural Palliative Care: Strategies for Sustainability

Billing and Traditional Reimbursement	Grants and Philanthropy	Value-Based Contracting	Emerging Opportunities
What: Direct billing for specific services through Medicare, Medicaid, or private plans. **How:** • **Provider Visits:** Physician, APRN/PA, MSW (in some situations) - E&M codes • **Medicare Care Coordination Codes:** - Advance Care Planning (ACP) - Chronic Care Management (CCM and Complex CCM) - Transition Care Management (TCM) **Align with other services:** • Incorporate as part of covered home health services for appropriate patients. • Potential for earlier hospice admissions (as appropriate) and longer hospice length of stay.	**What:** • Federal, state, local grant opportunities. • Donations or local foundation funds (i.e., auxiliary). **How:** • One-time grants are typically used to fund development costs. • Local foundations might offset operating costs. • Bequests or larger gifts can support services in a variety of ways.	**What:** • Accountable Care Organizations (ACOs) • Bundled payment program especially for oncology or heart failure • Other population-based or risk-sharing arrangements **How:** Understand how focusing on patient goals and active care planning can help: • Reduce potentially avoidable utilization • Decrease use of high-cost treatments and medications as aligned with patient goals. • Generate savings, which can be used to re-invest and help cover costs of palliative care services. Request supplements or bonuses based on performance related quality metrics, such as rates of ED visits, readmissions, and patient satisfaction.	**What:** Medicaid programs, Medicare Advantage plans, and/or other payers develop palliative care reimbursement or benefit options (varies by state and market). Potential for participation in Community Health Access and Rural Transformation (CHART) Model **How:** Advocate for development of palliative care reimbursement options, or benefit and insurance coverage programs, ideally with implementation aligned across payers in a state/region.

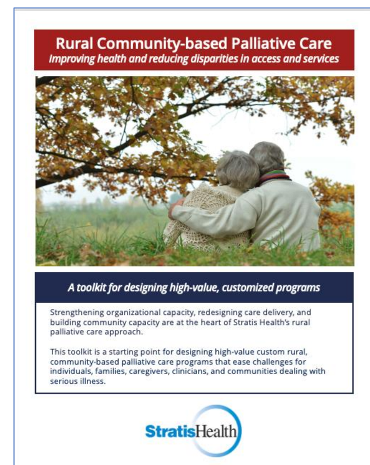
Underlying Value

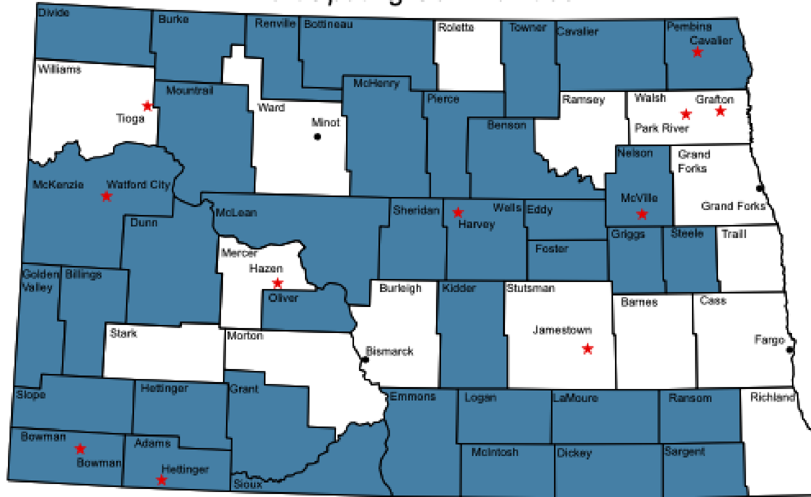
- Providing palliative care is the “right thing to do.”
- Improved quality of care and quality of life for patients with serious illness and/or complex needs.
- Increased likelihood for patients to continue receiving care in their community, close to family and friends.
- Increases patient and family/caregiver satisfaction.
- Supports clinician and staff satisfaction and resiliency.
- Additional palliative care team support for complex patients can reduce clinician stress and enable time to see other patients.

Resource available at https://stratishealth.org/wp-content/uploads/2020/07/Sustainability-Strategies-for-Rural-Community-Based-Palliative-Care.pdf

References, Tools, and Resources

- Rural Palliative Care Toolkit
- Sustainability Strategies for Community-Based Palliative Care
- Rural Community-based Palliative Care 2017 - 2020: Project Brief and Evaluation Report
- Journal of Palliative Medicine article: Developing Successful Palliative Care Teams in Rural Communities: A Facilitated Process
- North Dakota Rural Community-Based Palliative Care
  - North Dakota Rural Community-Based Palliative Care Project Participating Communities





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Rural Community-based Palliative Care Program Case Study

Presenters

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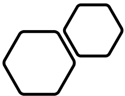
Kelly Labonte, RRT

Nancy Joyner, MS, CNS-BC, APRN, ACHPN®

Representing Unity Medical Center

Grafton, ND



Background

- Unity Medical Center: 14-Bed CAH
- Grafton Family Clinic (Grafton- population 4,139)
- Park River Family Clinic (Park River-population- 1,478)
- 15 miles between the towns
- Shared resources between hospital and clinics

Initial Steps: Rural Community-based Palliative Care

- UND Center for Rural Health Outreach Specialist (the idea)
- Elicit support and stakeholders/champions
- Develop a Community Team
- Asset and Gap Analysis
- SWOT worksheet
- Action Plan

Complete an Asset and Gap Analysis: A. Current Services Provided in the Community

- Adult/geriatric nurse practitioner
- Bereavement care (apart from hospice)
- Case management for chronic disease
- Community Health Workers/ Community Health Representatives
- Home care (supportive care, quality service providers)
- Home health services (medical care)
- Hospice care
- Medical social worker
- Pain management consultation
- Parish nursing
- Pastoral care/chaplaincy
- Respite care for family caregivers apart from hospice
- Support groups, such as caregiver support groups or grief support groups
- Transportation

Asset and Gap Analysis: B. Rate overall health care community's current level of experience/expertise:

- Bereavement care (apart from hospice)
- Continuity of care/care management
- Family conferencing with goals of care discussions
- Hospice
- Interdisciplinary team care
- Pain management consultation
- Staff education on palliative care
- Symptom management (other than pain)

Asset and Gap Analysis: C. Opportunities for Improving Community Care

- Advance Care Planning
- Alternatives to hospital admission at end of life
- Chronic disease case management
- Comprehensive care plan for those requiring comfort care
- Home visits as part of care coordination (not part of home health services or home care)
- Pain management consultation
- Providing education to families/caregivers about caring for people with advanced illness

Asset and Gap Analysis:
D. Background in Palliative Care Training/Knowledge

Disciplines

- Chaplain
- Nurse
- Nursing assistant
- Nurse practitioner
- Pharmacist
- Physician
- Physician's assistant
- Social Worker

- Certification
- EPEC/ELNEC training
- Palliative Care Leadership Center (PCLC) training
- Palliative Care awareness/knowledge/education

Asset and Gap Analysis:
E. Educational Needs and Opportunities

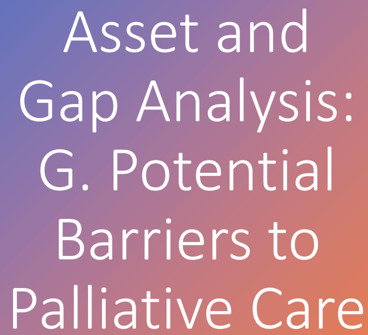
- Advance Care Planning
- Understanding philosophy of palliative care
- Ethical dilemmas in palliative care
- Grief counseling
- Health insurance literacy (e.g., understanding coverage and costs to help patients and families with decision making)
- Interdisciplinary teamwork
- Involving patients/families in care decisions
- Pain assessment and management
- Providing emotional support to patients/families
- Strategies to inform patient/family of diagnosis/prognosis
- Symptom management (other than pain management)
- Understanding cultural beliefs/values
- Understanding family dynamics/support systems
- Understanding local community resources
- Understanding spiritual needs of patients/families

Asset and Gap Analysis:
E. Support systems for Health Care Professionals

- Debriefing sessions
- Discussion groups within disciplines
- Interdisciplinary discussion groups/forums
- Staff support groups
- Time off for staff

Asset and Gap Analysis:
F. Quality Mechanisms and Measure

- Data collection (e.g., hospital readmissions, emergency department utilization, pain scores, etc.)
- Quality/performance improvement initiatives (e.g., chronic disease management, medical home, reducing hospital readmission, Advance Care Planning)
- Meaning of success for implementing rural community-based palliative care program (based on previous survey questions)



- Community awareness/understanding of palliative care
- Human resources to provide services
- Time
- Travel/distance
- Lack of clinician knowledge and experience about palliative care
- Coordination of care between providers/ settings
- Medical staff commitment/buy-in to palliative care
- Reimbursement

Strengths, Weaknesses, Opportunities, Threats

	STRENGTHS *Attributes that help achieve the vision.*	WEAKNESSES *Attributes that hinder the vision.*
INTERNAL		
	OPPORTUNITIES *External conditions that help achieve the vision.*	THREATS *External conditions that damage the vision.*
ERNAL		

Action Plan

(Use SMART* criteria):	Process Steps	Responsible Person	Date/Timeline	Measurement
Objective 1				
Objective 2				
Objective 2				

* SMART: specific, measurable, achievable, relevant, and time bound objectives

Q & A

Key Takeaways

- Certain steps are needed in building a rural community-based palliative care program
- Palliative Care Team development in rural settings moves from building to evolving and thriving
- Sustainability strategies for rural community-based palliative care programs include billing, grants & philanthropy, ACO and value-based team approach.