Our process began with bringing Community Representatives together monthly to assess the needs in our community.

Our medical community is dedicated to providing collaborative care within our medical neighborhood.

Our group comprised of:

- Sakakawea Medical Center,
- Coal Country Community Health Care,
- Sakakawea Hospice and Visiting Nurse,
- Local Chaplain,
- Custer Health District,
- Knife River Care Center,
- Local Physician,
- Community Care Staff,
- Licensed Social Worker,
- Pharmacist,
- and Mercer County Ambulance.
Community Strengths:

- We learned we have a very strong community network
  - We serve the residents of Dunn, Mercer, and Oliver Counties
  - We have an active Community Care Program
  - Our Clinics utilize Chronic Care Coordinators
  - Hospice Services
  - County Health Nurses
  - Meals on Wheels
  - Visiting Nurse Services

Community Needs:

- Lack of availability for 24 hour in-home care
- Limited QSP services in our area
- Symptom management in chronic disease
- Assistance/Education regarding Advance Care Planning
- Education regarding POLST
  - Our ambulance created a policy for POLST and began recognizing POLST 1/19
- Education on what services are available within our community
Focus:

- Our program decided to focus our Palliative efforts on bringing together our needs while utilizing our strengths.
- Our focus is Home Based Palliative Care
  - Emphasis on Symptom Management
  - Emotional Support
  - Spiritual Support
  - Coordination of additional services (Visiting Nurse Services, Community Care, QSP etc.)
  - Assistance/Education regarding Advance Care Planning, POLST, and Funeral Planning
  - Assistance with Navigating through the Health Care System

Structuring Palliative Care

- Our Program was structured with the assistance from Stratis Health’s resources and CAPC resources
- Utilized our grant money to obtain a membership to CAPC
- Utilized the strength of our Hospice Program to provide the Palliative Care treatment
- Obtained the support from our Medical Providers in our area
CAPC was a valuable resource for us with forms. Currently our Hospice Program utilizes MACH10 fall assessment, Karnofsky Palliative Performance Scale so we easily brought those scales over to the Palliative Program with the addition of Edmonton Symptom Assessment Scale. Staff were provided education regarding ESAS scale through Stratis Health. Existing forms and assessments from the Hospice Program were modified to meet Palliative Care needs.

### PALLIATIVE CARE SCREENING TOOL

(Not a permanent part of the medical record)

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Basic Disease Process</td>
<td></td>
</tr>
<tr>
<td>a. Cancer (Metastatic/Recurrent)</td>
<td>2 points</td>
</tr>
<tr>
<td>b. Advanced COPD</td>
<td>2 points</td>
</tr>
<tr>
<td>c. Stroke (with decreased severe CAD, CM (LVEF &lt; 25%))</td>
<td>2 points</td>
</tr>
<tr>
<td>d. Advanced cardiac disease</td>
<td>2 points</td>
</tr>
<tr>
<td>e. End stage renal disease</td>
<td>2 points</td>
</tr>
<tr>
<td>f. Other life-limiting illness</td>
<td>2 points</td>
</tr>
<tr>
<td>2. Co Morbidity Disease Processes</td>
<td>2 points</td>
</tr>
<tr>
<td>a. Liver disease</td>
<td>1 point</td>
</tr>
<tr>
<td>b. Moderate renal disease</td>
<td>1 point</td>
</tr>
<tr>
<td>c. Moderate COPD</td>
<td>1 point</td>
</tr>
<tr>
<td>d. Moderate congestive heart failure</td>
<td>1 point</td>
</tr>
<tr>
<td>e. Other condition complicating cure</td>
<td>1 point</td>
</tr>
<tr>
<td>3. Functional status of patient</td>
<td></td>
</tr>
<tr>
<td>Using ECOG Performance Status (Eastern Cooperative Oncology Group) below</td>
<td></td>
</tr>
<tr>
<td>ECOG Grade</td>
<td>Score</td>
</tr>
<tr>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>1</td>
<td>1</td>
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<tr>
<td>2</td>
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<tr>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>4. Other criteria to consider in screening</td>
<td></td>
</tr>
<tr>
<td>a. Is not a candidate for curative therapy</td>
<td>1 point</td>
</tr>
<tr>
<td>b. Has unacceptable level of pain &gt;24 hours</td>
<td>1 point</td>
</tr>
<tr>
<td>c. Has unremitting symptoms (i.e. nausea, vomiting)</td>
<td>1 point</td>
</tr>
<tr>
<td>d. Has uncontrolled symptoms over 3 months</td>
<td>1 point</td>
</tr>
<tr>
<td>e. Has prolonged length of stay in ICU without evidence of progress</td>
<td>1 point</td>
</tr>
<tr>
<td>f. Has frequent visits to the Emergency Department (&gt;1 x mo for same diagnosis)</td>
<td>1 point</td>
</tr>
<tr>
<td>g. Has more than one hospital admission for the same diagnosis in last 30 days</td>
<td>1 point</td>
</tr>
<tr>
<td>h. Is in an Hospital setting with documented poor or futile prognosis</td>
<td>1 point</td>
</tr>
</tbody>
</table>

**TOTAL SCORE**

SCORING GUIDELINES:

- **Total Score = 2**  
  No intervention needed
- **Total Score = 3**  
  Observation only
- **Total Score = 4**  
  Consider Palliative Care Consult (requires physician order)

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Structuring Continued
Being a Rural community we provide monthly visits along with phone calls for Public Health Nurses & Community Health Nurses will attend care conferences if they are providing services to our patients. Visits are staggered between our team members so that our patients receive contact throughout the month not just in one week.

Our Team/Plan

- **Nurses**- Monthly visit and phone calls every two weeks and as needed
- **Nurse Practitioner**- Monthly visits with patients (our only form of reimbursement)
- **Medical Director**- Attends team meetings that are held monthly and is available as needed for difficult symptom management
- **LSW**- initial psycho/social evaluation and monthly thereafter
- **Chaplain**- initial spiritual screening and as needed thereafter
- **Public Health Nurses & Community Health Nurses**- will attend care conferences if they are providing services to our patients.
First Admission:

- Our first admission was 86 year old male with diagnosis of mesothelioma
  - Our patient is currently residing in his home with assistance of his daughter. Patient has been struggling with side effects from palliative chemotherapy and trying to decide if he would like to continue with chemotherapy
  - Patient has been struggling with understanding his prognosis and understanding what physicians are explaining to him
  - He would like education/assistance with completing an Advance Directive
  - Our team is composed of RN’s, LSW, FNP, Physician, and Chaplain at this time
  - PPS of 50%

Care:

- LSW is visiting monthly with patient. Assistance was provided to complete Advanced Care Planning
- Assistance provided for patient to have repeat PET scan and Doctor’s appointment with Oncology to discuss Chemotherapy
- RN visiting patient monthly with phone calls as needed
- Visiting Nurse Services initiated for patient’s port to be flushed until patient decides if he will continue with chemotherapy
- Community Care referral was made to help provide in home supportive services
- Life Alert initiated for patient
- FNP to visit patient monthly to assist with symptom management
- Chaplain to visit patient PRN (per patient request)
- Team meetings are held monthly
Second Admission

- 91 year old male with diagnosis of atrophy to tail of pancreas, HTN, Hydro-nephrosis, weakness, pain, edema
  - Patient is currently living alone in senior housing apartments. Patient has difficulty with macular degeneration and is very HOH. Patient wishes to continue to stay at home with the help of his POA and friends
  - Patient is struggling with increased weakness, increased napping/fatigue, decreased appetite, and abdominal pain especially after eating
  - Patient currently receives community care services
  - Patient wishes to no longer pursue any testing on his pancreas and does not want to have stents placed in his kidney again
  - Patient has chosen a DNR
  - PPS 50%
  - Team will comprise of MD, RN, LSW, Chaplain, Community Care and FNP

Care:

- Patient will be provided assistance with POLST
- Daily weights were initiated due to edema
- DME provided for patient (shower chair with back for more security)
- Life alert initiated for patient safety
- RN visits monthly with phone calls as needed
- FNP to visit monthly
- Chaplain to visit as needed
- Team meetings monthly
- Patient continued to have increased weakness, increased fatigue, increased pain and significant weight loss. Palliative Care Nurses provided multiple visits to patient’s home for symptom management. Decline in patient’s health status initiated a transfer for this patient into hospice care
Lessons Learned

- Rural setting makes it difficult to visit patients weekly so support is offered over the phone and the different professions spread out visits so that the patient does receive visits throughout the month.
- Patients required more visits from LSW than what was originally expected as there are many emotions that go along with this stage of life.
- Our patient population has a very strong spiritual/faith foundation which has us utilizing our Chaplain less than anticipated. Our patient’s receive home visits from their own clergy.
- The transition to Epic for our medical community is helping with the continuity of care by providing ability to access our patient’s records including out of area providers.
- Staff struggles to take off Hospice Hats.