North Dakota Palliative Care Task Force  
Fargo – Tuesday, June 27, 2017  
10 am – 2 pm

Agenda

- 9:45 am – 10:00 am  Registration
- 10:00 am – 10:15 am  Welcome and Introductions
- 10:15 am – 12:00 pm  Palliative Care Presentations and Group Member Sharing  
  - Bill Kalanek – SCR 4010  
  - Donelle Richmond – ANA Palliative Care Paper  
  - Nancy Joyner – Palliative Care Survey Results and Finds  
  - Judy Beck – ND Statistics
- 12:00 pm – 12:30 pm  Lunch and Networking
- 12:30 pm – 1:30 pm  Break into small groups to work to start drafting possible solutions, including possible funding sources, organizations to work on, possible actions steps and plan monthly teleconference call meetings to continue work over summer and early fall
- 1:30 pm – 1:45 pm  Share with large group and receive feedback
- 1:45 pm – 1:55 pm  Discuss hosting Defining Hope film
- 1:55 pm – 2:00 pm  Evaluation, wrap-up, and plan next in-person meeting
SENATE CONCURRENT RESOLUTION NO. 4010

1. A concurrent resolution requesting the Legislative Management to consider studying the status
2. and importance of coordinated palliative care to develop solutions, tools, and best practices for
3. providing better patient-centered care and information to North Dakotans with chronic diseases.
4. WHEREAS, palliative care means patient- and family-centered medical care that optimizes
5. quality of life by anticipating, preventing, and treating suffering caused by serious illness; and
6. WHEREAS, palliative care administered throughout the continuum of illness involves
7. addressing physical, emotional, social, and spiritual needs that facilitate patient autonomy,
8. access to information, and choice; and
9. WHEREAS, palliative care includes discussions of the patient's goals for treatment,
10. treatment options appropriate to the patient, including hospice care, and comprehensive pain
11. and symptom management; and
12. WHEREAS, all patients experiencing complex, chronic health issues that affect quality of
13. life should be offered palliative care as an option, as palliative care is appropriate at any age
14. and at any stage, and can be provided along with curative treatment; and
15. WHEREAS, when palliative care programs are provided, a larger percentage of hospice
16. patients are identified earlier in their eligibility window, enabling them to take advantage of
Purpose

17. valuable services for a longer period of time; and
18. WHEREAS, the United States health care system faces an increased burden with spikes in
19. the senior citizen population, coupled with increases in persons with complex chronic conditions
20. and more people gaining access to health care through insurance coverage for the first time;
21. and
22. WHEREAS, recent studies indicate that by closely matching treatment with a patient's goals
23. and improving the patient's quality of life, palliative care can provide substantial cost reduction;
24. and

Purpose

Sixty-fifth
Legislative Assembly

1. WHEREAS, a population trained about the benefits of palliative care boosts our medical
2. and social care workforce; and
3. WHEREAS, the formation of a state palliative care and quality of life interdisciplinary
4. advisory council and a palliative care information and education program within the State
5. Department of Health would maximize the effectiveness of palliative care initiatives in the state
6. by ensuring comprehensive and accurate information and education about palliative care is
7. available to the public, health care providers, and health care facilities; and
8. WHEREAS, the Legislative Assembly recognizes the importance of coordinated palliative
Purpose

9. care as a quality of life issue, as a way to improve the quality and delivery of health care services, and as a way to more effectively spend limited health care dollars;

10. NOW, THEREFORE, BE IT RESOLVED BY THE SENATE OF NORTH DAKOTA, THE

11. HOUSE OF REPRESENTATIVES CONCURRING THEREIN:

13. That the Legislative Management consider studying the status and importance of coordinated palliative care to develop solutions, tools, and best practices for providing better patient-centered care and information to North Dakotans with chronic diseases; and

15. BE IT FURTHER RESOLVED, that the Legislative Management report its findings and recommendations, together with any legislation required to implement the recommendations, to

18. the Sixty-sixth Legislative Assembly.

SCR 4010

• Bill Kalanek to speak about bill.
Palliative Care Task Force

Donelle Richmond, BAN, RN-C
June 27, 2017

Background:

Role of the panel:

• Complete an environmental assessment
• Examine palliative care nursing within today’s healthcare system
• Identify steps and strategies for nurses to lead and transform palliative care

Areas of focus:

• Practice
• Education
• Administration
• Policy
• Research
Final Report:

• Call for action: Nurses lead and transform palliative care

• Conclusion: Seriously ill and injured patients, families, and communities should receive quality palliative care in all care settings. This is achieved by the delivery of primary palliative nursing by every nurse, regardless of setting.

Recommendations:

1. Adopt the End of Life Nursing Education Consortium (ELNEC) curricula (Core, Geriatric, Critical Care, Pediatric, Advanced Practice Registered Nurse [APRN], and Online for Undergraduate Nursing Students) as the standard for primary palliative nursing education for pre-licensure, graduate, doctoral, and continuing education for practicing registered, vocational, and practice nurses and advanced practice registered nurses.
Recommendations:

2. Petition the National Council for State Boards of Nursing to increase palliative care content on the pre-licensure NCLEX-RN and NCLEX-PN exams.

3. Encourage state boards of nursing with continuing education re-licensure requirements to mandate inclusion of palliative care content.

Recommendations:

4. Advocate the use of the National Consensus Project for Quality Palliative Care *Clinical Practice Guidelines for Quality Palliative Care* in the development, implementation, and evaluation of specialty, evidence-based palliative care services for all organizations.
Recommendations:

5. Recommend that all specialty nursing organizations review registered nurse (RN) and APRN practice standards to include primary palliative nursing care and develop resources and position papers to support and advance primary palliative nursing.

Recommendations:

6. Fund, develop, and evaluate innovative palliative care models to address workforce challenges and the needs of communities of color, underserved populations, and other vulnerable groups, such as Native Americans, persons with intellectual and developmental disabilities, and others in rural and urban areas.

7. Convene a thought leader summit to address practice barriers and develop initiatives to implement primary palliative care.
Recommendations:

8. Incorporate primary palliative nursing as part of the American Nurses Credentialing Center Magnet Recognition Program®, and Pathway to Excellence Program®, American Association of Critical Care Nurses Beacon Award for Excellence, Academy of Medical-Surgical Nurses Prism Award, and other organizational and unit-based credentialing and recognition programs.

Recommendations:

9. Conduct intervention studies testing strategies to alleviate compassion fatigue and moral distress to maintain a healthy workforce.

10. Promote equitable reimbursement and reduction of barriers by all payers for RN and APRN services related to palliative and hospice care.
Recommendations:

11. Support the funding and development of palliative care services for communities with limited resources.

12. Position nurses at decision-making and policy-setting venues, such as healthcare and regulatory boards, to address palliative care needs.

Five Minute Small Group

One minute Self-reflection, write ideas on sticky notes

Four minutes discussion with Group - make sure anything new is reflected on sticky notes
Palliative Care
In North Dakota

Palliative Care
Emerging as a Priority in Chronic Disease Management
**What is Palliative Care?**

Palliative care is specialized medical care for people with serious illness. It is appropriate at any age and at any stage in a serious illness and can be provided together with curative treatment; it is not limited to end of life. Palliative care promotes quality of life by addressing the physical, psychological, emotional, cultural, social and spiritual needs of patients and families. It offers treatment of pain and other symptoms; relief from worry and distress of illness; close communication about goals of care; well-coordinated care during illness transition; provides care across treatment settings; support for family/caregivers; and offers a sense of safety in the healthcare system.

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**Accurate Definition of Palliative Care**

- Specialized medical care for people with serious illness
- Focused on providing relief from the symptoms, pain and stress of serious illness
- Goal is to improve/maximize quality of life for patients and family
- Provided by a team working with patient’s other doctors
- An extra layer of support
- Appropriate at any age, any stage of serious illness
- Can be provided together with curative treatment

(Diane Meier, CAPC, 2017)
Why a Statewide Palliative Care Survey?

• Discussion began in May 2016 at the NDCC Annual meeting
• To understand and support palliative care in ND we need to learn where palliative care services are provided and what those services are
• Small workgroup was formed to conduct the survey

Initial Palliative Care Workgroup Members

• Lynette Dickson – ND UND Center for Rural Health
• Cindy Gohner – Blue Cross Blue Shield of ND
• Deb Knuth – American Cancer Society
• Nancy Joyner - Nancy Joyner Consulting P.C.
• Sally May - ND Quality Health Associates
• Sara McGauvran - American Cancer Society
• Joyce Sayler – ND Department of Health
• Milan Vu - ND Department of Health
North Dakota Organizations Requested To Complete the Survey

- Hospitals
- Skilled Nursing Facilities
- Home Health
- Hospice
- Assisted Living Facilities
- Specialty Clinics

About the Survey

- Focus of the survey
  - What palliative care services are available and where
  - Needs and barriers
- Not a comparison of organizations
- Electronic survey administered by the ND Center for Rural Health
- Goal is to get as many responses possible to better understand the status in North Dakota
- Survey was completed September 2016- December 2016.
ND Palliative Care Survey Cover Letter

See Handout

2016 North Dakota Palliative Care Survey

See Handout
Final Survey Results

N = 110

Palliative Care Respondent Cities

Survey Response
- No Services Reported
- Services Reported
Service Locations
N=155

- In patient setting - 66%
- Hospital-based setting - 50%
- Outpatient clinic – 29%
- Home setting - 29%
- Community based 12%

Most Common Facility Type N=200

- Nursing facility - 43%
- Hospital - 39%
- Assisted living – 201%
- Basic care -18%
- Home Health - 15%
- Hospice - 8%
- SC/CC Cancer - 8%
Top Palliative Care Services Offered

- Pain assessment and management - 93%
- Symptom assessment and management - 91%
- Goals of care planning discussion - 76%
- Preparation for comfort care plan - 74%
- Bridging to Hospice - 68%
- Advanced Care planning - 68%
Palliative Care Services Offered (cont.)

- Bridging to community resources and services – 67%
- Pastoral & Spiritual Consultation/Support – 64%
- Psychosocial support – 61%
- Family/Caregiver Support & Education – 61%
- Mental Health Assess/Management – 40%
- Healthcare Professional Support & – 49%
- Other – 4%

Other Palliative Care Services in Area
N=14

- Yes - 43%
- No - 57%
**Incorporating Palliative Care in the Next Year (N=14)**

- Yes - 21%
- No - 79%

**Interdisciplinary Team Members N=261**

- Physicians - 75%
- Nurses - 89.1%
- Clinical Social Worker - 64.1%
- Nurse Case Manager - 62.5%
- Chaplin - 39.1%
- Physician Assistant - 32.8%
- Advanced Practice Registered Nurse - 31.3%
Palliative Care Delivery Method  
N=81

- Interdisciplinary team not part of a certified program – 83.5%
- Palliative Care Certified Program -11.4%
- Single palliative care provider / professional – 7.6%
Potential Patient Identification
N=107

- Terminal diagnosis/end of life -81%
- Family/Patient request-76%
- Unsatisfactory Symptom management-41%
- The use of a standardized based tool-12%
- Other – 18%

Barriers to Providing Palliative Care Services
N=461

- Lack of time -20.5%
- Lack of funding -34.0%
- Lack of collaboration -51.6%
- Lack of education -38.3%
- Lack of resources -40.9%
- Lack of leadership -38.6%
- Limited understanding of palliative care -8%
- Organizational barriers -15.9%
- Physician burnout -25.1%
- Comfort of physicians -22.2%
- Comfort of patients -18.4%
- Physician-patient relationship -13.8%
- Prognostic uncertainty -13.0%
- Location of the facility -14.7%
- Access to palliative care services -32.0%
- Other -9.9%
Barriers to Providing Palliative Care

- Lack of palliative care education and training - 52%
- Lack of reimbursement - 41%
- Limited understanding of palliative care – 39%
- Lack of organizational resources/funding – 36%
- Lack of staffing – 34.1%
- Access to palliative care services - 33.0%
- Lack of time due to competing priorities - 30.0%

Barriers to Palliative Care (cont.)

- Discomfort of provider referring patients to palliative care -28%
- Discomfort of providers with hard choices conversations – 25%
- Provider-patient decision making process – 20%
- Prognostic uncertainty of patient outcome – 15%
- Location of the facility – 15%
- Provider fear of implying end of life, death, dying – 17%
- Organization's view of palliative care – 9%
- Other – 9%
Conclusion

There are major gaps in palliative care services throughout North Dakota
Major barriers identified include:
• Lack of palliative care education and training
• Lack of reimbursement
• Limited understanding of palliative care
• Lack of organizational resources/funding
• Lack of staffing
• Access to palliative care services
• Lack of time due to competing priorities

ACS CAN Palliative Care Resolution

• American Cancer Society action step (Deb Knuth)
• Survey data for presentation
• 10.11.16- HOEVEN DISCUSSES EFFORTS TO EXPAND ACCESS TO PALLIATIVE CARE AT NORTH DAKOTA CANCER SUMMIT
• 2017 SENATE CONCURRENT RESOLUTION NO. 4010
Next Steps
Following Completion of the Survey

• Sharing aggregated survey results
• Website posting of the survey results
• Formation of a larger workgroup to support palliative care services in North Dakota

Five Minute Small Group

One minute Self-reflection, write ideas on sticky notes

Four minutes discussion with Group- make sure anything new is reflected on sticky notes
Palliative Care Task Force
June 27, 2017
Data Review

Judy Beck, RN, MSN
Quality Health Associates of North Dakota
Quality Improvement Program Director

Quality Health Associates (QHA) of ND

- Non-profit organization for over 40 years
- MISSION: “Improving health and health care for the people of North Dakota”

Ongoing Work:
- Innovate-ND, HRET Hospital Improvement Innovation Network
- Medicaid Review
- Serves as the North Dakota subcontractor to the Great Plains Quality Innovation Network, the CMS Medicare Quality Innovation Network-Quality Improvement Organization (QIN-QIO) for the region encompassing North Dakota, South Dakota, Nebraska, and Kansas.
Percent of Medicare Persons Hospitalized At Least Once During the Last Six Months of Life

The Dartmouth Atlas of Health Care: http://www.dartmouthatlas.org/

Inpatient Days per Person During the Last Six Months of Life

The Dartmouth Atlas of Health Care: http://www.dartmouthatlas.org/
Inpatient Spending per Person During the Last Six Months of Life


Percent of Persons Spending 7 or More Days in ICU/CCU During the Last Six Months of Life

Percent of Medicare Deaths Occurring in Hospital


Care Coordination

- Work on this project is done through community coalitions that include providers, stakeholders and consumers
- Utilize data to perform root cause analysis on causes of readmissions within communities
- Project goals:
  - Reduce hospital admission and readmission rates by 10% by 2019
Community

Medicare claims data provided to the Great Plains QIN by the National Coordinating Center
Source: Great Plains QIN North Dakota Care Coordination Quarterly Report – available under “Reports” at http://greatplainsqin.org/initiatives/coordination-care/

Medicare claims data provided to the Great Plains QIN by the National Coordinating Center
Sally May, RN, BSN, CH-GCN
Quality Improvement Specialist
sally.may@hcqis.org

Jayme Steig, PharmD, RPh
QI Program Manager
jayme.steig@hcqis.org

Five Minute Small Group

One minute Self-reflection, write ideas on sticky notes

Four minutes discussion with Group- make sure anything new is reflected on sticky notes
Open Sharing Session - Perspectives from Group members

LUNCH
**Initial Planning**

Small groups will be formed based on topics from sticky notes.

1. List possible ideas for solutions. 5 minute brain storming session- sky is the limit!

2. Narrow down to 2-3 priority strategies- use voting dots if needed

3. For each strategy, draft initial thoughts on:
   - Draft strategy
   - Goal of the strategy
   - Needed partners
   - Barriers

Plan a time each month to meet as a group to continue to work on the draft strategies.

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**Sharing of Group Work**
Defining Hope Movie Screenings

- [http://hope.film/](http://hope.film/)
- November 1st in Bismarck and Fargo at 7:00 PM
- Have committed to having at least 25 tickets sold at each location. Screening sponsorships are also available
- Can host a conversation, collect data, have a booth etc. in conjunction with each screening- might be a way for this group to collect information or provide education

Next Steps
Planning Next In-Person meeting

THANK YOU!!!!!
Rating of Priority solutions

In very neat handwriting write on your index card what you believe the most important strategy for the Palliative Care Task Force.

Everyone get out of your chair and start walking around the room and pass your card to other people. Keep passing cards until I ring the bell. When I ring the bell you will stop and rate from 1-5 the solution.

1= Not important
2
3= Sort of a important
4
5= Very important

When you have written all three numbers, start passing your card again. When I ring the bell- you will stop again and rate whichever card you have. We will do this a total of five times.

Sit back down and add up the numbers for each of the three steps. 25 is the highest possible. We will find out which ones had the highest scores in each area and also collect the cards for the committee to use.

Contact Information

Tracee Capron
Executive Director
Hospice of the Red River Valley
Tracee.capron@hrrv.org
701-356-1515
1701 38th St S Fargo, ND 58103

Patricia Moulton, PhD
Executive Director
ND Center for Nursing
Past-President, National Forum of State Nursing Workforce Centers
Patricia.moulton@ndcenterfornursing.org
701-639-6548
3523 45th Street South Fargo, ND 58104