Rural Palliative Care Networking Group Meeting

September 27, 2016
Via webinar/teleconference
Agenda

• Welcome and Introductions
• Educational Session: *Community-based Palliative Care: The Journey of Two Programs*
• Networking discussion
• Wrap-up and next steps
Community-Based Palliative Care: The Journey of Two Programs

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Jennifer Peterson, MSW and Jenny Friday, RN, FirstLight Health System, Mora, MN
Objectives

• Identify the unique opportunities and challenges of developing a rural community-based palliative care program
• Describe an approach to developing and sustaining community-based palliative care
• Learn about the palliative care journey of two rural communities
Developing a Rural Palliative Care Program

September 27, 2016
Julie Benson, MD
Medical Director

Lakewood Health System
Staples, MN
To cure sometimes, to relieve often, to comfort always – this is our work.

Found in Hopkins Postdoctoral Survival Handbook
What Palliative Care Should Look Like

Diagnosis potentially life-limiting disease

Curative Focus: Disease-specific Treatments

Palliative Focus: Comfort/Supportive Treatments

Hospice

Bereavement Support

Death

Palliative Care

www.lakewoodhealthsystem.com
Located in Staples, MN (population 2,974)
• Central Minnesota serving ~ 38,000
Border 4 counties
Critical Access Hospital (25 beds)
Rural Health Clinic
• Five Clinics
  • Staples + 4 satellite clinics
Senior Services
• Long-Term Care (100 beds) with Secure Dementia Unit
• 2 Assisted-Living Facilities (65 apartments/boarding rooms)
Behavioral Health Unit (10 bed)
Hospice-Home Care
Ambulance service and Non-emergent transportation
Medical Staff

13 Family Physicians
4 ER Physicians
2 OB/GYN
1 Rheumatologist
1 Podiatrist
1 Dermatologist + PA
1 Pediatrician
2 Psychiatric CNP
2 General Surgeons

4 Anesthetists
2 Women’s Health Nurse Practitioner
2 Midwives
2 Mental Health Nurse Practitioners
9 Physician Assistants
2 CNP – family medicine
4 Mental Health Providers

+ more than 10 visiting specialties
Birth of Palliative Care at LHS

2005
- Started Home Care-based Palliative Care program

2007-2008
- Grant provided seed money to begin development of a palliative care program
- Chosen by Stratis to begin Minnesota Rural Palliative Care Initiative

2009 - 2013
- Pilot Programs in Infusion therapy and Care Center
- Growth of service to patients and staff
- Provide care to patients in all venues we serve
Fall of 2008 - Winter of 2010

• Goal: Assist rural communities in establishing or strengthening palliative care programs

• Primary strategies:
  – Learning collaborative approach
  – Use of National Quality Forum (NQF) preferred practices
  – Focus on community capacity development

• After 18 months, 6 of the initial 10 rural Minnesota communities were providing palliative care
How to Start?

- Venue of care
- Interdisciplinary Team
- Model of Care
- Services
- Quality Metrics
Venues of Care

Long-term care
• IDT, consultative services, ongoing support

Homecare/Hospice
• Home-bound palliative care by hospice team

Out-patient services
• IDT, telephonic support, home visits

In-patient services
• Consultative services, supportive care, transition care
Interdisciplinary Team (IDT)

- RN case managers
- Social worker
- Chaplain
- Pharmacist
- Medical director, Family Medicine and HPM Board Certified
- Spiritual volunteers
- Therapists as needed (massage, PT, OT)
- Mental Health practitioners as needed

* Medical Home RN, Home Care RN, LTC staff and RNs, other therapies
Model of Care

• Rural models of care are rare and did not really exist
• Belief that PC is an ongoing process, not only episodic consultations
• Selected hospice model of care
  ▪ Ongoing care
  ▪ Interdisciplinary Team meetings every 2 weeks
  ▪ Plans of Care updated as disease changes
  ▪ Attending Provider continues to direct care with patient
  ▪ Medical Director roles
  ▪ No CMS guidelines to follow or certifications
Other Models

- Inpatient
- Outpatient
- Home-care Based
- Long-term Care
- Cancer Center
- Consult Service or episodic care
Services

- In home admission whenever feasible
- Telephonic support with proactive and responsive calls
- Support at clinic/specialty visits
- Support in the ED or inpatient units
- Transitions of care
- Family meetings
- Advanced care planning
- POLST
- Grief Support
Strategies to Building a Program

1. Administrative Buy-in
2. Palliative Care Team & Case Manager
3. Education
4. Use the 8 domains of Palliative Care to guide care
5. Quality Metrics
6. Leadership
7. Creative Staffing
8. Hardwire PC Principles
9. Workforce Development
Administrative Buy-in

- **Financial considerations** – For profit vs Critical Access payment system

- **Quality of patient care** – Mission driven care at LHS is based upon case management and coordinated care by care teams.
  - Medical Home
  - Joint Connection
  - Obstetrics
  - Palliative Care
Financial Considerations

Patient-Centered Care is the philosophy of care at Lakewood
  • Mission Alignment

Financial incentives for PC frequently cited
  • Decreased LOS, decreased ICU days, decreased procedures

For Rural hospitals/clinics this may not be an incentive
  • Critical Access Hospitals and Rural Health Clinics are paid “cost plus”
  • So reducing LOS, ICU days and procedures actually reduces income

Health Care Reform
  • Hospitals will be responsible for total care of patient regardless of cost
  • Decreases in silos of care and better interdisciplinary care
Now palliative care is the best example of how to take care of complex patients that is

- Patient centered (improved experience)
- Quality driven
- Contains cost (reduces waste)

This is the Triple Aim
Value = Quality + Service/Cost

- Affordable Care Act is shifting payments from Fee-for-Service to value-based payment
- But we aren’t there yet
- Time of great uncertainty
- Ongoing data mining
Palliative Care Team & Case Manager

- Interdisciplinary Team Model
  - RN Case Manager
  - MD
  - Social Worker
  - Chaplain
  - Pharmacist

- Every 2 weeks for Community-based, Home-based, Long-term Care patients with team that includes hospice team

- Inpatients are rounded on daily
Strategies

Education

Staff

• ELNEC/Stratis/CAPC/PCLC/PCNoW
• Webinars
• Grant-funded courses
• Order sets

Community

• Print
• Community & Service Groups
• Word of Mouth – volunteers & patients
• Season of Lights annual remembrance ceremony
Strategies

Use the 8 domains of Palliative Care to guide our care

1. Structure and processes of care
2. Physical aspects of care
3. Psychosocial and psychiatric aspects of care
4. Social aspects of care
5. Spiritual, religious, and existential aspects of care
6. Cultural aspects of care
7. Care of the imminently dying patient
8. Ethical and legal aspects of care
Quality Metrics

Build in quality measures from the beginning

• use your clinical informatics team – the data has to be gathered anyway

• Resources for metrics:
  • National Quality Forum Preferred Practices
  • CAPC
  • NHPCO
  • Hospice quality metrics
  • Quality Measures for Community-Based, Rural Palliative Care Programs Minnesota: A Pilot Study (citation)
Leadership

• Don’t always need to recruit new hires. Look for PC champions in the staff you already have and train them.
• Medical staff who have been doing primary PC for years but aren’t board certified.
• Geriatricians
• APNs
• Hospitalists
• LTC RNs
• Discharge planning team – social workers, homecare nurses
Creative Staffing

• Look at the Hospice IDT in your service areas
• Social worker at LTC or hospice
• System chaplain
• Infusion therapy nurses
• Hospice volunteers (crossed trained to both PC and hospice)
• Pharmacist
Strategies

Hardwire Palliative Care Principles

Train core nursing staff with basic PC principles

• All our LTC RNs receive training on core PC principles. It has increased primary PC in all LTC residents. We try to offer PC classes 3 times a year to LPNs/CNAs – they take care of the residents and do most of the talking to the families. If they have solid training everything else goes more smoothly especially when transitioning between venues.

• ELNEC trained staff can return to your system and train your staff
Workforce Development

Develop PC training for any students you have coming through your system. Medical students, nursing students, social work interns, chaplain interns, pharmacy students are your future workforce. If you train them now they will be that far ahead when they come back to work for you.

We dedicate structured time twice yearly to holding classes for a variety of students. ELNEC curriculum is a great resource.
• Most quality data on palliative care services originates in large hospitals
  – Lengths of stay
  – ICU days
  – Procedure costs

• Stratis Quality Measures Pilot
  – Rural healthcare quality data
  – 2012
  – Early unpublished data
Number of ED visits

6 months prior to PC
After PC

May-July 2012
August-Oct 2012
In-patient stays

6 Months prior to PC
After PC

May-July 2012
August-Oct 2012
In-patient days

May-July 2012

6 months prior to PC

August-Oct 2012

After PC
You matter because of who you are. You matter to the last moment of your life, and we will do all we can, not only to help you die peacefully, but also to live until you die".

--Dame Cicely Saunders
Resources

ICSI - Institute for Clinical Systems Improvement
National Consensus Project
CAPC - Center to Advance Palliative Care
Stratis Health Palliative Care Resource Center
PCNoW - Palliative Care Network of Wisconsin (Fast Facts)

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Palliative Care Program
Our Journey
FirstLight Palliative Care Program

- Began with three Community agencies in 2008
- FirstLight Health Systems
- Kanabec County Public Health
- St. Clare's Long Term Care
Our Mission

- Provide resources and coordination to empower patients to meet their needs and support relationships with family, care providers and the community.
Community Needs Assessment

- Survey to identify the needs of our community

- Overriding Concerns
  - Pain Control
  - Autonomy
  - Maintaining Function
Enter Stratis Health

- Fall of 2009 received Stratis Health Grant and begin working with our team.
- After visioning day identified the top priorities for our group
Top Needs/Goals

• Implement a community based, hospital housed palliative care program
• Educate staff and community
• Increase community involvement
• Increase collaboration across organizations
Action Plan Objectives

• Provide education on palliative care in each organization

• Advanced Care Planning:
  • Honoring Choices utilization in each organization
  • Have a certified trainer

• Develop a common palliative care order set/care plan

• Provide patient and community education
Program Vision

- Hospital Housed
- Community Based
- Continuity between resources
- Best utilization of our current community resources without additional financial responsibilities
Components

• Provider
• Primary provider
• Supportive patient centered care plan made with the patient and members of the support team

• Phone Calls
  • Hospital
    • Maintains a list of all palliative care (and now Care Team) patients
    • Proactive calls done by primary Care Coordinator and other identified members of the patients care team
How Are Patients Identified

- Nurse
- Primary provider
- Social service staff or home care nurses in the hospital or community
- Family
- Patient
- Other community agencies
How Do They Get Started

• Referral comes to social services department
  • Discuss/assess palliative care options and criteria
  • Initial assessment with patient, family or caregiver, palliative social worker, palliative nurse, PharmD, and whom ever the patient wishes to have present.
• Palliative team will connect with:
  • Primary care provider (MD, NP or PA)
  • Patients caregivers
  • Other supporting community resources
Care Plan/Urgency Plan

- Patient centered

- Multidisciplinary (pharmacy, provider, chaplain, social work, RN, RT, PT)

- Documented and updated in medical record system every time there is a call, a change in condition or plan, or monthly at our IDT (inter-disciplinary team) meetings.

- Urgency plans developed with patient and provider for specific disease states and urgent issues. Patients often have RX to start at home to aid in avoiding unnecessary visits to ED and hospital admissions.
Utilizing students

- RPAP
- Pharmacy residents
- Social work students
- Nursing students
- Growing bereavement and volunteers
- Further integration of palliative care under the Health Care Home umbrella (Care Coordination)
Care Team Model

- PATIENT & Care Coordinator
- Social Worker
- Nurse
- Pharmacist
- Primary Care Provider
- Home Care Staff
- Spiritual Support
- Family or Friends
- Specialists
- Rehab Specialists
- Dietitian
- Anyone who is supporting you in your care

Anyone who is supporting you in your care
Care Coordination Programs

Health Care Home (Care Coordination)

CCM (Medicare)

Palliative

Health Care Home (MA)

Palliative
Current Program

- Diagnosis
  - CHF
  - COPD
  - Cancer
  - Chronic disease

- Living situation
  - Own home
  - Assisted living
  - Nursing facility
Current Program

• Census averages 15-20 palliative care patients

• 105 Care Team patients (CCM/Health Care Home/Care Coordination)
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Networking Discussion

Community-based palliative care services/programs
Next Meeting

Thursday, January 19, 2017 at 1-2 pm (CT)
Topic: Advance Care Planning
Presenter: Karen Peterson, Honoring Choices MN
Questions?

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