Caring for Minnesotans: Quality Palliative & End-of-Life Care

Minnesota Age & Disabilities Odyssey

June 20, 2011

Panel Presentation

Michele Fedderly
Executive Director, MNHPC
MNHPC Goal

- To reach all Minnesotans with information about
  - Hospice Care
  - Palliative Care
  - Advance Care Planning
MNHPC Working With Others
Hospice Care

Palliative care for patients in their last half year of life. Hospice care can be provided in patients’ homes, hospice centers, hospitals, long-term care facilities, or wherever a patient resides.

(AAHPM, 2011)
Palliative Care

Focuses on improving a patient’s quality of life by managing pain and other distressing symptoms of a serious illness. Palliative care should be provided along with other medical treatments.

(AAHPM, 2011)
Palliative Care in Minnesota

- Care Delivery
  - Hospitals – Palliative Consults
  - Community Based
    - Rural
    - Urban
- Payment
Death is inevitable
Planning for future health care decisions
Conversations That Matter™
Put in writing
  Wishes and preferences
  Health care agent
  Funeral plans
POLST
(Providers Order for Life Sustaining Treatment)

- People with chronic conditions
- Medical order
- Emergency responders can follow
- Must be honored until new order is written
- Minnesota trying to use a standardized form

- DO NOT ALTER the form!
Developing Palliative Care Services in Rural Communities
Rural community challenges in palliative care

- Rural populations: disproportionately aging and chronic disease
- Limited availability of specialty clinicians
- Most clinical models developed for large, tertiary care hospitals
  - Lack of research and models specifically for rural care delivery
- Reimbursement challenges
Rural strengths and opportunities in palliative care

- Networks and relationships are often strong and well connected
- Training is available to enhance rural practitioner skills
- Majority of patient/family needs can be met locally
- National Quality Forum’s Preferred Practices are relevant
Stratis Health Rural Palliative Care Initiatives

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

How: Bring together rural communities in a structured approach focusing on community capacity development

Majority of funding to support rural palliative care development provided by UCare. Partnership with Fairview Health Services
Community capacity development theory

- Communities tackle problems through collective problem solving
- Change happens by enhancing existing capacities
- Approach is strength-based
- Requires leadership, broad participation, learning over time
Minnesota Rural Palliative Care Initiative

- Fall 2008 – winter 2010
- Primary strategies:
  - Learning collaborative approach
    - Based on IHI Breakthrough Series model
  - Use of preferred practices
  - Focus on goals of care skill building
Participating communities
Initiative objectives

• 100% of communities develop a work plan to implement a palliative care program in their community

• 100% of participating health care professionals report increased knowledge of:
  – Symptom management
  – Effective care-goals discussions
Results

• After 18 months, 6 of initial 10 rural Minnesota communities are providing palliative care
  – Settings: home care, outpatient, nursing home, assisted living, inpatient, community
  – In process of arranging for health plan contracts to pay for palliative care

• Teams implemented program development and structural and clinical interventions
Results

• Clinical knowledge assessment:
  – 73% responded “yes” to increased knowledge regarding pain management
  
  – 81% responded “yes” to increased knowledge regarding effective care goal discussions
Rural Palliative Care Community Development Project Cohort I

- Summer 2010 – spring 2012
- Activities
  - Needs assessment/kick-off call
  - Day-long visioning and planning workshop
  - Coaching calls/individual technical assistance
  - Community mentoring
  - Quarterly Webinars
  - Evaluation and wrap up – spring 2012
Stratis Health is a nonprofit organization that leads collaboration and innovation in health care quality and safety, and serves as a trusted expert in facilitating improvement for people and communities.

Prepared by Stratis Health, with funding from UCare.
LIFE CARE HOME CARE & HOSPICE-PALLIATIVE CARE 2011
Age & Disabilities Odyssey Conference
Shawny Elyk-Prevost RN CHPN
Jan Carr, LicSW
OUR JOURNEY

- Late spring 2008 received an invitation from Stratis Health to apply to join the rural palliative care initiative
- Applied August 2008
- Joined the initiative and participated in 4 learning sessions from November 2008 to March 2010
- Concurrently started working on program development, policy development and staff education
- Received start up grant from DHS
- First client admitted February 2010, self referral
CARE ACROSS ALL SETTINGS

- Want palliative care to become the philosophy of care throughout the continuum of care at LifeCare
- Routine Home Care:
  - SN, MSW, Aide and chaplain
- Acute Care
  - 1-2 visits by SN & MSW to make recommendations
- Long Term Care:
  - 1-2 visits by SN & MSW to make recommendations
GOALS AND TARGETED CLIENT POPULATIONS

 Overall Goal:
  • To improve the quality of life for people with chronic disease through the development of a community based palliative care delivery model
     To develop a system of delivering care that focuses on relieving pain, suffering and providing the highest quality of life for persons living with life limiting chronic diseases
     Provide support to client’s and their family through provision of physical, spiritual and emotional support

 Population:
  • Chronically ill clients with multiple, complex problems
  • Frail elderly
CLIENT DEMOGRAPHICS

- **Ages:**
  - 36-96
  - Average age 78.1 years

- **Sex:**
  - Female: 26
  - Male: 19

- **Diagnosis:**
  - Cancer 16
  - Cardiac 16
  - Neurological: 5
  - Respiratory: 2
  - Debility: 6
CHALLENGES

- Reimbursement
- Staff education
- Client understanding-this is not hospice
- Community education

Questions????????????

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OUR STORY

HOW THIS RURAL COMMUNITY PROVIDES PALLIATIVE CARE

Julie Benson, MD
Medical Director Hospice and Palliative Care
Lakewood Health System
Staples, MN
Located in Central Minnesota serving 38,000
Morrison, Todd, Wadena, and Cass Counties
Critical Access Hospital (25 beds)
Rural Health Clinic
  - Five Clinics
    Pillager-Eagle Bend-Motley-Browerville-Staples
Senior Services
  - Long Term Care (100 beds)
  - 2 Assisted Living Facilities (65 beds)
Hospice-Home Care (Home-based Palliative Care)
Behavioral Health Unit (10 bed)
2005
• Started Home Care based Palliative Care program
A bridge (pre-hospice) between HC and Hospice

2007-2008
• growing awareness of PC opportunities
• staff wanting to improve and expand service
• goal of patient- and family-centered care
2008

- Received MERC IPE Grant though MN AHEC (Area Health Education Center)

- Palliative Care Learning Center (Fairview Mpls)

- Chosen by Stratis to begin Rural Palliative Care Initiative (1 of 10 MN sites)
CONTINUED GROWTH...

2009 - 2010
- Hired RN case manager and social worker
- Began pilot program serving 5 Infusion Therapy pts
- LTC pilot with 5 residents
- Grant with Northeast Minnesota Inter-professional Rural Health Network (AHEC)

2011
- Currently serving more than 35 patients
- Networking group
- Added half-time RN
Four strategies to implement palliative care in our community…
SUCCESS STRATEGIES

One:
Administrative Buy-in

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

- **Quality of patient care** - The emerging philosophy of care at LHS is based upon case management and coordinated care by care teams.
  - *Medical Home*
  - Joint Connection
  - Obstetrics
  - And now Palliative Care
Two:
Palliative Care Team & Case Manager

Interdisciplinary Team Model
- RN Case Manager
- MD
- Social Worker
- Chaplain
- Pharmacist
- Psychiatric NP
- In Patient Care Coordinator
- Volunteers

Meet every 2 weeks for Infusion Therapy
Every 2 weeks for Long Term Care Center
SUCCESS STRATEGIES

Three:

Education

Staff
- ELNEC
- Webinars
- Nursing Students
- Order set

Community
- Print
- Women’s Health Expo
- Coffee & Conversation
- Community & Service Groups
Four:

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
Barriers to implementing Palliative Care
BARRIERS

Defining Palliative Care
- medical providers
- nursing staff
- patients
- families
- community

Turf issues
Qualified staff/education
Timing – when to refer
Reimbursement
Resources

American Academy of Hospice and Palliative Medicine
www.aahpm.org

Hospice and Palliative Nurses Association
www.hpna.org

Association Hospice Palliative Care Chaplain
ahpcc.org.uk/

Social Work Hospice and Palliative Network
www.swhpn.org
Resources

Getpalliativecare.org provides clear, comprehensive palliative care information for people coping with serious, complex illness.

Leading collaboration and innovation in healthcare quality and safety
www.stratishealth.org/palcare

Center to Advance Palliative Care
capc.org
Care Partners of Cook County

Kay Grindland
Program Director
More than Rural

Cook County

- Population - 5176
  Grand Marais: 1353
- 90% County is public-owned land
Cook County

- Grand Portage Reservation
- “Frontier” independence
- Strong informal community support
- Tourism
- Seasonal and retired population
Health Care

- North Shore Hospital and Care Center
  - Sixteen-bed critical access hospital
  - County-owned

- Sawtooth Mountain Clinic
  - Federally funded community-based clinic

- No surgery
- No assisted living facilities
- No hospice
History of Care Partners

- **2006–7**
  - North Shore Health Care Foundation funds start-up efforts for hospice
  - Negotiations with St. Mary’s Hospice in Duluth
  - St. Mary’s trains 29 local hospice volunteers

- **2008**
  - Negotiations with SMDC end due to low population and economics of Medicare.
  - Efforts continue to start state licensed hospice
  - Volunteers visit in hospital & care center
History of Care Partners

2009
- Hospice coordinator hired
- Focus shifts from hospice to palliative care

2010
- Care Partners formed as a collaborative program
- Stratis Health Rural Palliative Care
- MN Department of Human Services Community Service/Community Services Development Grant
- RN Care Coordinator hired
- 1st clients visited in the home
Is a collaborative program

- North Shore Health Care Foundation
- Cook County North Shore Hospital
- Sawtooth Mountain Clinic
- and other community service organizations.
Provides Supportive Care on the Journey of Aging or Serious Illness

- A palliative care program providing RN care consultation and coordination, companionship & end-of-life volunteers, and caregiver coaching.
Goals

- Improve client’s quality of life.
- Assist them in managing their symptoms and making healthcare choices.
- Enable clients to stay in the home
## A Community-Based Program

### Medical
- North Shore Hospital
- Home Health
- Clinic Physicians

### Social/Emotional
- Care Partners Volunteers
- Human Development Center

### Spiritual
- The Ministerium
- Parish Nurse

### Practical
- Cook County Health & Human Services
- Senior Center
- Grand Portage Tribal Services
Care for the Whole Person

- Good Conversations
- Volunteer Visits
- Emotional Support
- Spiritual Support
- Bereavement

How Care Partners Supports You

Connect You with Community Services

- Referral
- Coordination
- Caregiver Support

Coordinate Medical Concerns

- Managing the Illness
- Someone to Call
- Health Care Directives
- Health Care Advocate
Accomplished 2010

- First Clients In the Home – 6
  - Bereavement visits – 2
  - Consultation – 2

- Hospital & Care Center Clients
  - End of Life – 8
  - Companionship – 5

- Palliative Care Presentations
  - Health Care Provider groups
  - Volunteer Training
Challenges

- New Kid on the Block
  - Not competing
  - In the loop

- How to Hold IDT Meetings

- Adapting Large Hospital Models

- Referrals
  - Earlier in disease progress

- Funding