

Palliative Care in Rural Minnesota

Findings from Stratis Health's Minnesota Rural Palliative Care Initiative

BY DEB MCKINLEY, MPH, JANELLE SHEARER, RN, BSN, MA, AND KARLA WENG, MPH

Palliative care, which involves managing symptoms, controlling pain and addressing stress caused by a chronic or terminal illness, has been shown to keep patients out of the hospital and allow them to stay home and live more comfortably with their illness. Typically, it is provided by an interdisciplinary team led by a physician trained in palliative medicine. Rural areas have not always had access to such specialists. Yet, today, rural health care organizations are finding ways to create palliative care programs that meet the needs of their chronically ill and aging populations. This article describes a six-year initiative led by Stratis Health to advance palliative care in rural Minnesota. It highlights the work of FirstLight Health System in Mora and describes Stratis Health's Rural Palliative Care Measurement Pilot Project, an effort to develop and test measures for evaluating rural palliative care programs.

The goal of palliative care is to prevent and relieve suffering and support the best possible quality of life for patients with terminal illnesses and their families. Such care is provided by a team that may include physicians, nurses, social workers, home health workers, clergy and others. Palliative medicine specialists help patients understand their treatment options and address concerns such as pain, anxiety, shortness of breath, fatigue, nausea and loss of appetite. Members of the care team also provide emotional and spiritual support, and facilitate communication among all of the health care professionals involved in a patient's care. This approach has been shown to improve satisfaction among patients, their families and physicians.

Palliative care is not synonymous with hospice (a benefit covered by insurers for people who are in the last stages of a terminal illness) and can be offered alongside curative treatment at any point in the disease process.

Historically, palliative care has been offered in urban hospitals with patient

volumes large enough to allow staff to specialize in the field. All Minnesota hospitals with more than 300 beds report having palliative care programs, as compared with 90% nationally.¹

Minnesota has fared well in its efforts to bring palliative care to patients who need it. The Center to Advance Palliative Care's 2015 report gave Minnesota a grade of A for having palliative care teams in more than 80% of hospitals. It was one of 17 states to receive that grade. Currently, 82% of reporting hospitals in the state with 50 beds or more provide access to palliative care services; the national average is 78%. Only 45% of Minnesota facilities with fewer than 50 beds offer palliative care services; however, that percentage is still well above the national average of 29%.¹

Savings from Palliative Care

Palliative care aligns well with efforts to redesign care delivery in a way that focuses on value (a combination of outcomes, patient experience and cost). Care coordina-

tion is central to palliative care, and many new reimbursement models, including patient-centered medical homes (or health care homes) and initiatives to reduce hospital readmissions, offer incentives to coordinate care for patients with moderate to severe chronic conditions. Thus, palliative care has the potential to support both health care homes and efforts to prevent readmissions, as it has been shown to reduce emergency department visits and hospitalizations.

Studies have shown that 24% of health care costs can be attributed to persons living with long-term, serious illnesses.² Patients in this population are potential candidates for palliative care. One report estimates that having palliative care in hospitals with more than 50 beds can result in an average per-patient per-admission savings of \$2,659. That translates to an estimated \$1.2 billion in savings per year nationally for all patients currently receiving palliative care. Making such care available to all hospitalized patients who *may* ben-

efit from it would result in approximately \$4 billion in savings per year.³

Additional savings could be achieved through palliative care programs that operate outside of hospitals. Community-based services may be offered in clinics, long-term care facilities and even patients' homes. Recognizing this expansion of services beyond hospitals, The Joint Commission recently began offering a community-based palliative care certification for accredited home care organizations.

Community-based palliative care can reduce acute care admissions and hospital deaths at the end of life.⁴ It is also cost-effective. Some estimate the monthly cost of all the community-based, non-hospice palliative care services required for a patient to achieve optimal independence is \$800 to \$900.⁵

Growing Palliative Care in Rural Minnesota

Hospital-based palliative care programs led by a physician or advanced practice nurse are difficult to replicate in rural communities, as few clinicians in small hospitals are trained or board-certified in palliative medicine. However, rural communities are coming up with innovative ways to provide these services.

Between 2008 and 2014, Stratis Health supported 23 rural Minnesota communities as they participated in three two-year initiatives to develop palliative care programs. More than 150 organizations serving communities with populations of 1,200 to 200,000 people were represented.

They included hospitals, home care organizations, hospice programs, long-term care facilities, clinics, assisted living facilities, a college department of nursing, parish nurses, clergy and public health agencies.

Each community assessed its needs and resources as it sought ways to provide palliative care, then shared what it learned with the other participants. Through this work, 15 new rural palliative care programs were created. Other communities are now working to establish programs or to include palliative care principles in care delivery without creating a specific program.

The way services are provided in rural communities varies widely (Table). Most programs operate out of home care organizations or are led by a nurse or nurse practitioner based in a clinic or hospital. Services are directed toward patients receiving home care or outpatient services such as infusion therapy, or those in the hospital or nursing home.

One Health System's Experience

FirstLight Health System in Mora, Minnesota, a participant in Stratis Health's rural palliative care development initiative, began its community-based palliative care program in April 2011. The program serves a five-county region with 34,000 residents, many of whom are poor and have limited health literacy. Initially, COPD and chronic heart failure were the primary diagnoses for referrals. Now, patients with any end-stage chronic disease

can take part. The FirstLight program has an average daily census of 20 patients.

Its palliative care team is led by a social worker and a nurse who work closely with home care organizations, nursing homes, spiritual caregivers and volunteers. The team relies on ancillary services such as pharmacy and respiratory therapy to assist with symptom management and pain control.

A key aspect of FirstLight's program is its regular calls to patients, ranging from daily to monthly, depending on the patient's needs for symptom management or in-home or other services. Another aspect is individualized "urgency plans" that patients and the care team build together and reference in case of symptom exacerbation. Urgency plans often have standing medication orders, such as antibiotics and steroids for COPD patients who are known to have exacerbations. Patients also have access to a telephone number they can call for assistance 24 hours a day.

Because patients now tend to report symptoms sooner than they used to, the FirstLight palliative care team has at times been able to break the crisis care cycle (trips to the clinic, emergency room, hospital and/or nursing home followed by home care). In one case, a FirstLight palliative care nurse knew her patient's history well enough to suggest checking the patient's carbon dioxide levels when she showed signs of respiratory distress. The nurse was able to get the patient a BiPAP machine for home use. Since getting the machine, the patient, who had been in the

TABLE

Rural palliative care—variables in program structure

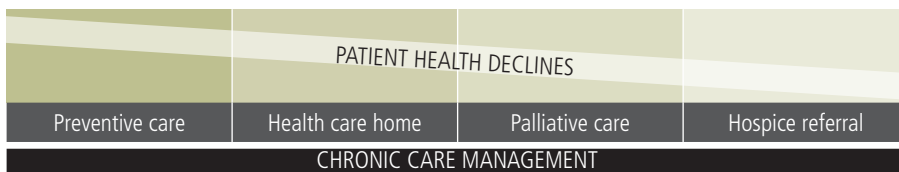
METHOD OF SERVICE DELIVERY	PALLIATIVE CARE TEAM	PATIENT FOCUS	COORDINATING STAFF
Home visits	All teams included physicians, social workers, nurses	Hospice-eligible but refused	Nurse practitioner
Clinic appointments		Infusion therapy	Registered nurse
Nursing home visits	Some had some of the following:	Home care with complex illness	Social worker
Inpatient consultation	Rehabilitation services	Inpatient consult when requested	Certified nurse specialist
Telephonic case management	Volunteers	Physician-referred with complex illness	Advanced practice nurse
Volunteer support visits/services	Nurse practitioners		
	Chaplains	Nursing home residents (triggered by MDS criteria, a clinical assessment used by nursing homes)	
	Pharmacists		
	Advanced practice nurses in psychiatry		

hospital up to twice a month, has not been hospitalized in more than six months and has been able to remain independent and at home.

FirstLight sees palliative care as part of the continuum of care (Figure). If a patient's health declines, he or she is promptly referred for palliative care and later for hospice when that service might be appropriate. FirstLight expects to be certificated as a health care home by the state in 2016, which will allow it to focus efforts earlier on the continuum. The health system credits its readiness to be-

FIGURE

The care continuum



come a health care home and to participate in chronic care management for Medicare reimbursement to the work it did to establish the palliative care program and its experience with care coordination for patients in that program.

FirstLight is also focusing on implementing more rigorous measurement of palliative care's success and savings using metrics developed through Stratis Health's Rural Palliative Care Measurement Pilot Project.⁶

Quality Measures for Community-Based, Rural Palliative Care

Palliative care quality measures have been tested primarily in urban and hospital-based programs. From 2012 to 2013, Stratis Health worked with five rural Minnesota communities to test standardized quality measures, based on National Quality Forum-endorsed measures for palliative care. Measures fell into four categories: operations, cost, clinical quality and patient/family experience.

The organizations involved in the measurement pilot, one of which was FirstLight, received training on the measures

and data-collection tools, and submitted data quarterly to Stratis Health. Information came from chart abstraction, patient and family experience surveys, patient-level health care utilization records and program-level operations surveys.⁷ Information from 138 palliative care patients was included.

The study showed that the 38 preferred practices the National Quality Forum recommends to improve palliative and hospice care (end-of-life planning discussions, informing patients of the availability of spiritual care resources, and holding care

conferences with the patient and family, for example)⁸ are relevant and applicable in rural communities. And, while most small rural communities lack the resources to employ the range of medical specialists that are typically part of a palliative care team in a large hospital (pain management specialists, for example), many have partnerships that allow them to access specialists from larger communities as needed.

Conclusion

Studies increasingly are documenting how palliative care enhances patient outcomes and satisfaction and reduces costs—making it a win-win for value-based care delivery. Rural communities are establishing palliative care programs that utilize resources available to them. The next step is for these communities to evaluate the quality of the palliative care they are providing in order to add to the argument that payers and insurers should further extend reimbursement to nonmedical services such as care coordination and social work. **MM**

Deb McKinley is communications director, and Janelle Shearer and Karla Weng are program managers with Stratis Health.

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