Caring for Minnesotans: Rural Palliative Care

Aging and Adult Services Division,
Minnesota Department of Human Services

Video Conference
November 17, 2011

Michele Fedderly
Executive Director, MNHPC

Palliative Care

• Specialized medical care for people with serious illnesses

• Relief from the symptoms, pain, and stress of a serious illness - whatever the diagnosis

• Improves quality of life for the patient and family
Palliative Care

- Provided by specialists who work with a patient’s doctor(s)
- Appropriate at any age or stage in a serious illness, and can be provided together with curative treatment

Center for Advancement of Palliative Care (CAPC)

Recent CAPC Report Card

- Reviews hospitals only
- 89% of Minnesota’s medium and large hospitals offer palliative care
- Minnesota received an “A” (1 of 7 states)
Where Palliative Care is Delivered

• Hospitals

• Community/Clinics
  • Rural
  • Urban

Palliative Care

• Partially covered by Medicare, Medical Assistance, and private insurance or managed care programs as part of regular health care

• Need to check with your insurance source

• And, if you are a veteran...
Palliative Care and Hospice Care

Fitting the Pieces Together

Advance Care Planning
Health Care Directive
POLST Form

Minnesota Network of Hospice & Palliative Care
Resources

• www.mnhpc.org
  Advance care planning, health care directives, POLST Form, hospice care and palliative care

• www.metrodoctors.com
  Honoring Choices Minnesota Health Care Directive

• www.polstmn.org
  POLST Form

Contact Information

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Palliative Care for Veterans in Minnesota

Introduction

- Veterans are aging and succumbing to acute and chronic illnesses at an increasing rate
- Veterans Administration (VA) has improved inpatient and outpatient hospice and palliative care in all of its medical facilities
- The VA is committed to supporting community-based hospice programs so that Veterans who choose to die at home can be actively cared for and supported (Shreve, 2010)
### Minnesota Veteran Statistics

<table>
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<tr>
<th>Peak Year</th>
<th>FY2010</th>
<th>FY2011</th>
<th>FY2012</th>
<th>FY2013</th>
<th>FY2014</th>
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<tr>
<td>Veteran Deaths 2005</td>
<td>11,785</td>
<td>11,388</td>
<td>11,242</td>
<td>11,080</td>
<td>10,906</td>
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<tr>
<td>Living Veterans 2000</td>
<td>465,041</td>
<td>375,294</td>
<td>366,750</td>
<td>358,360</td>
<td>350,140</td>
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< 25% of all deaths in US are Veterans  
< 4% of Veteran deaths are in VA facilities  
~ 33% of Veterans are enrolled in VA
A small percentage of veterans die under VA care

(Shreve, 2010)
What’s the Vision of the Veterans Health Administration?

Access to quality hospice and palliative care for all Veterans

VHA Comprehensive End of Life Initiative

• Special Purpose Funding
  – Facility Palliative Care Teams
  – VISN Program staff
  – Hospice Units (new/existing)
  – Bereaved Family Surveys
  – HPC for homeless & rural veterans
• Palliative Care Nursing Assistant Training for Veterans-HPNA
• EPEC for Veterans
• Palliative Care Leadership Training
• ELNEC for Veterans
  – HEN- On Line ELNEC subscription for one year
Improving Hospice and Palliative Care Access

<table>
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<tr>
<th>VISN 23 HPC Measures</th>
<th>F Y 07</th>
<th>F Y 10</th>
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<tbody>
<tr>
<td>Inpatient Consults</td>
<td>41%</td>
<td>78%</td>
</tr>
<tr>
<td>VA CLC deaths w/ consults</td>
<td>64%</td>
<td>100%</td>
</tr>
<tr>
<td>Deaths in ICU beds</td>
<td>28%</td>
<td>22%</td>
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PROMISE (Bereaved Family Survey)

Performance Reporting and Outcomes Measurement to Improve the Standard of care at End-of-life
PROMISE: Measuring successes and identifying opportunities

- To identify and reduce unwanted variation in the quality of end-of-life care for Veterans.
- To define and disseminate processes of care that contribute to improved outcomes for Veterans near the end of life and their families.

VISN 23 GOALS

- Established and fully staffed HPC teams
- All team members educated and trained in HPC, and certified or planning to be certified as specialists in HPC
- Basic HPC education disseminated to all facility staff and tracked
VISN 23 GOALS

• PROMISE survey results meet or exceed national benchmarks for all facilities
• Establish collaborations with all service lines within the VA
• Integrate Palliative Care into every venue of Veteran healthcare at every facility

VISN 23 GOALS

• Establish new community partnerships and nurture existing ones (community hospice programs, SVH’s, etc)
• Begin unique state and community partnerships for the benefit of Minnesota Veterans
What Have We Learned?

• Themes and Challenges:
  – Communication and partnerships are not always smooth, integrated, or well organized
  – Community agencies often found VA partners to be non-engaged and inconsistent

(National Hospice and Palliative Care Organization)

What Have We Learned?

• Themes and Challenges:
  – Community partners often do not perceive the importance of asking Veterans about their military service or enrollment
  – Knowledge deficits were found in both the community agencies and the VA
    • VA enrollment process
    • Available VA and other community hospice and palliative care resources
    • Veteran specific issues at end-of-life

(National Hospice and Palliative Care Organization, 2010)
VISN 23 Hospice Veteran Partnerships

- 2004 Nebraska HVP
- 2005 Minnesota HVP
- 2005 North Dakota HVP
- 2009 Iowa HVP
- 2010 South Dakota HVP

Why are Hospice Veteran Partnerships (HVP) Needed?

- Education is needed for veterans:
  - Many veterans, especially those who are not enrolled for care at a VA facility, are not aware that hospice & palliative care is a basic VA benefit
  - Veterans are not aware that Medicare eligible veterans whether enrolled in the VA or not have access to hospice care through Medicare
  - Veterans not eligible for Medicare may have hospice benefits through Medicaid or private insurance, but most importantly may be able to have hospice paid by the VA!
Benefits of Hospice & Palliative Care

• The emotional and spiritual components of palliative care can be especially meaningful to veterans, who often face issues near the end of life relating to their military/combat experiences.

• Support is even more crucial for veterans who do not have a strong network of family and friends.

Veterans Health Benefits

• Enrollment, Eligibility and Costs
  – Most must enroll for benefits
  – Enrolled veterans assigned to priority group 1 - 8
    • New regulations regarding low income and those with special health needs
    • Effective June 15, 2009
  – Geographic Means Test utilized to assess cost-share
    [link](healtheligibility/eligibility/PG8Relaxation.asp)
Medical Benefits Package (Standard Benefits)

- Preventative Care Services
  - Immunizations
  - Physical Examinations
  - Health Care Assessments
  - Screening Tests
  - Health Education

- Ambulatory (Outpatient) Diagnostic and Treatment Services
  - Emergency outpatient care in VA facilities
  - Medical
  - Surgical
  - Chiropractic Care
  - Mental Health
  - Bereavement Counseling for families of veterans in hospice and select mental health programs
  - Substance Abuse

- Inpatient Diagnostic and Treatment
  - Emergency Inpatient Care in VA facilities
  - Medical
  - Surgical
  - Mental Health
  - Substance Abuse

- Medications and Supplies *
  - Prescriptions medications
  - Over the counter medications
  - Medical and Surgical supplies

*Generally medications must be prescribed by a VA provider and be available under the VA’s national formulary system

Special and Limited Health Care Benefits

- Agent Orange Exposure Treatment and Registry Examination
- Automobile Assistance
- Beneficiary Travel (including Ambulance)
- Bereavement Counseling
- Bind Veterans Services
- CHAMPVA
- Combat Veteran Eligibility
- Dental Care
- Domiciliary Care
- Emergency Care in Non-VA Facilities
- Extended Care
- Eyeglasses
- Foreign Medical Program
- Gulf War Illness
- Hearing Aids

- Home Health Care
- Home Improvement and Structural Alterations
- Homeless Programs
- Hospice
- Ionizing Radiation Exposure Treatment and Registry Examination
- Long Term Care
- Maternity Care
- Military Sexual Trauma Counseling
- Non-VA Health Care Services
- Nose and Throat Radium Treatment
- Nursing Home Care
- Project 112/SHAD Participants
- Prosthetic (Medical Equipment and Sensory Aids)
- Readjustment Counseling
- Women Veterans Services
What is the VA doing for Veterans at End-of-Life?

• Hospice care is a covered basic benefit
  — VA supported inpatient care
  — Purchased home based care provided by community Hospice agencies

• Each facility has an active Palliative Care Consult Team
  — Moving hospice upstream to palliative care consults
  — Inpatient, outpatient, and Home Based Primary Care

• The VA is committed to working closely with community partners in addressing the palliative care needs of Veterans

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Fargo Outpatient Hospice and Palliative Care Clinic

St. Cloud Hospice and Palliative Care Unit
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.

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 health care 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

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
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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- Jan Carr, LicSW
  - 218-463-2500
  - jcarr@lifecaremc.com
OUR STORY
HOW THIS RURAL COMMUNITY PROVIDES PALLIATIVE CARE

Julie Benson, MD
Medical Director Hospice and Palliative Care
Lakewood Health System
Staples, MN

LAKEWOOD HEALTH SYSTEM

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)
BIRTH OF PALLIATIVE CARE AT LHS

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

CONTINUED GROWTH...

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

SUCCESS STRATEGIES
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

SUCCESS STRATEGIES

**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

SUCCESS STRATEGIES

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