Rural Palliative Care: Meeting People Where They Are

NHPCO Palliative Care ECHO

October 26, 2021

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StratisHealth

Session objectives

- Discuss unique rural community strengths and opportunities for advancing palliative care
- Identify key components for supporting rural palliative care program development
- Apply strategies learned from an actual rural community-based palliative care journey

Stratis Health

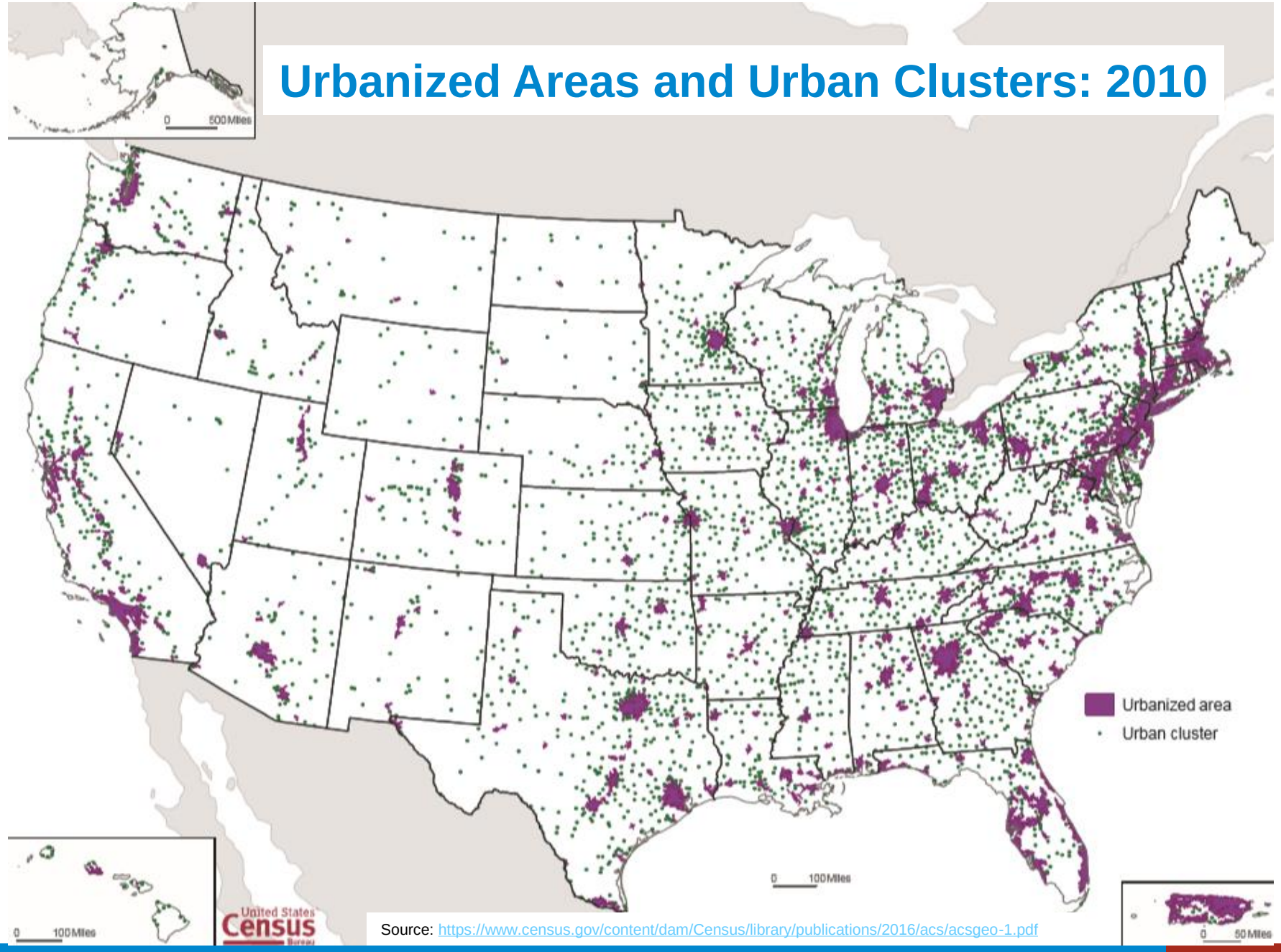
- Independent, nonprofit organization founded in 1971 and based in Minnesota
  - Mission: Lead collaboration and innovation to improve health
- Core expertise: design and implement improvement initiatives across the continuum of care and in communities
  - Funded by government contracts and private grants
  - Work at the intersection of research, policy, and practice
- Rural health and serious illness care are long-standing organizational priorities
  - Have worked on rural palliative care program development in more than 40 communities since 2008

What is rural?

- 97% of U.S. land mass is rural
- 19.3% of the population lives in rural (approx. 60 million people)[1]
- Multiple formal definitions, but often based on perception
  - Am I Rural? [2]
  - Frontier: Fewer than 7 people per square mile

[1] US Census Bureau: What is Rural America
[2] Rural Health Information Hub (www.ruralhealthinfo.com)

Urbanized Areas and Urban Clusters: 2010



Source: https://www.census.gov/content/dam/Census/library/publications/2016/acs/acsgeo-1.pdf

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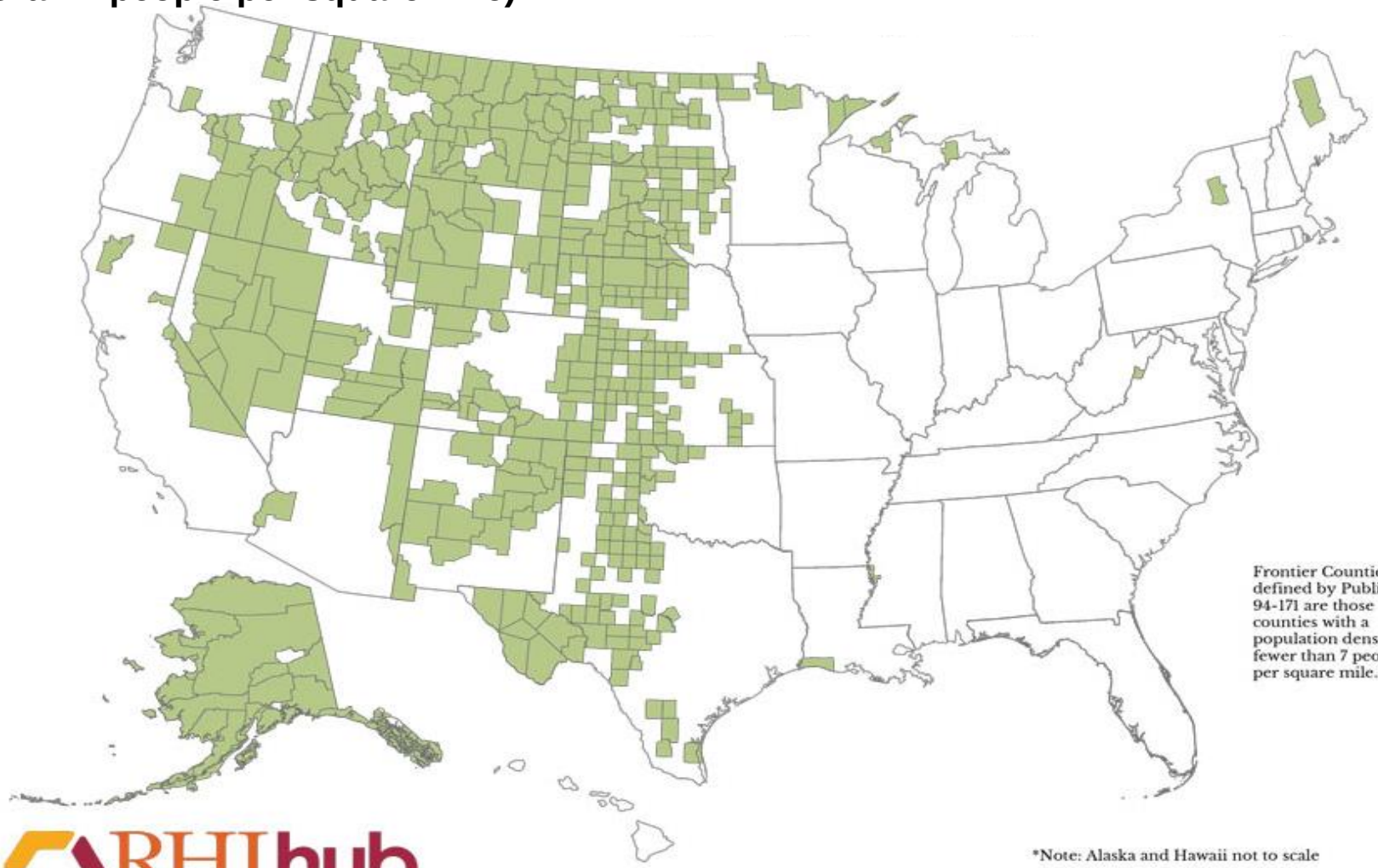
Frontier Counties

(Fewer than 7 people per square mile)



Frontier Counties as defined by Public Law 94-171 are those counties with a population density of fewer than 7 people per square mile.

*Note: Alaska and Hawaii not to scale

Source(s): U.S. Census Bureau, 2010 Decennial Census, Summary File 1

RHIhub Rural Health Information Hub

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Rural Populations

Older, Sicker, Poorer:

- Rural median age is 51 compared to urban median age of 45.[1]
- Rural age-adjusted, all-cause mortality per 100,000 persons is 830.5 compared to urban mortality of 703.5.[2]
- Rural median household income is $46,000 compared to urban of $62,000.[3]

[1]U.S. Census Bureau, 2011-2015. Measuring America. www.census.gov/content/dam/Census/library/visualizations/2016/comm/acs-rural-urban.pdf
[2] North Carolina RHRC (2017). Rural Health Snapshot (2017). https://www.ruralhealthresearch.org/publications/1110
[3] U.S. Census Bureau, 2009-2016. Small Area Income and Poverty Estimates. www.census.gov/programs-surveys/saipe.html

Rural Health Care Delivery: *Rural is not small urban*

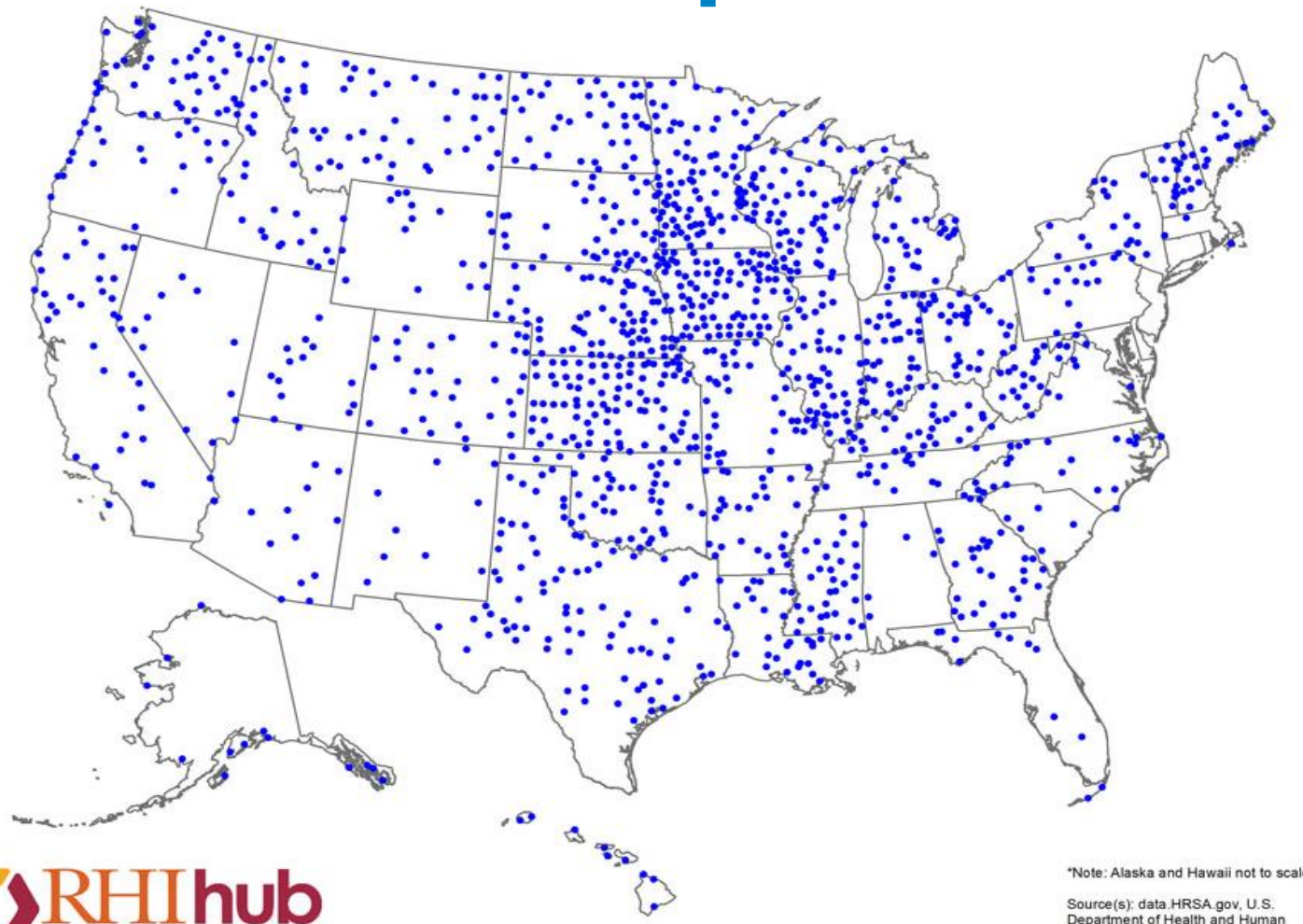
Rural health care organizations have special federal designations and payment programs:

- Critical Access Hospitals (CAH) – 1350, in 45 states
  - 25 beds or less, 96-hour average length of stay
  - 35-miles from another hospital (can vary)
- Rural Health Clinics (RHC) – about 4500, in 45 states
  - Non-urban
  - Health Care Professional Shortage or Medically Underserved Area
- Health Centers (FQHC, or other designation)
  - Approximately 1 in 5 rural residents are served by the Health Center Program

Rural Health Care Delivery: *Rural is not small urban* cont.

- Access to health care services often limited in rural, including services which are important in caring for those with serious illness:
  - Home Care
  - Hospice
  - Mental Health, Substance Abuse

Critical Access Hospitals

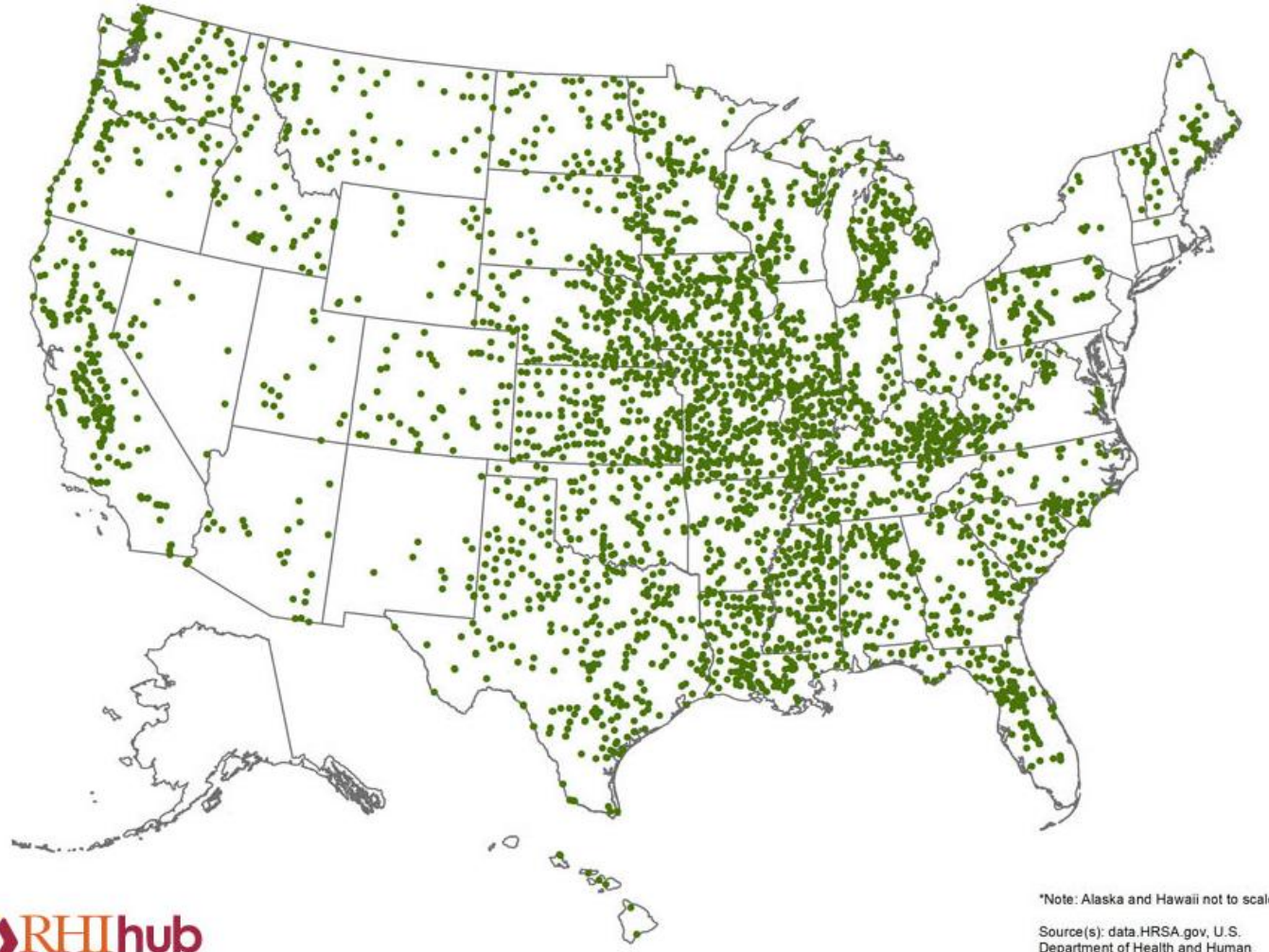


RHI hub
Rural Health Information Hub

*Note: Alaska and Hawaii not to scale

Source(s): data.HRSA.gov, U.S. Department of Health and Human Services, April 2019

Rural Health Clinics



RHIhub
Rural Health Information Hub

*Note: Alaska and Hawaii not to scale

Source(s): data.HRSA.gov, U.S. Department of Health and Human Services, April 2019

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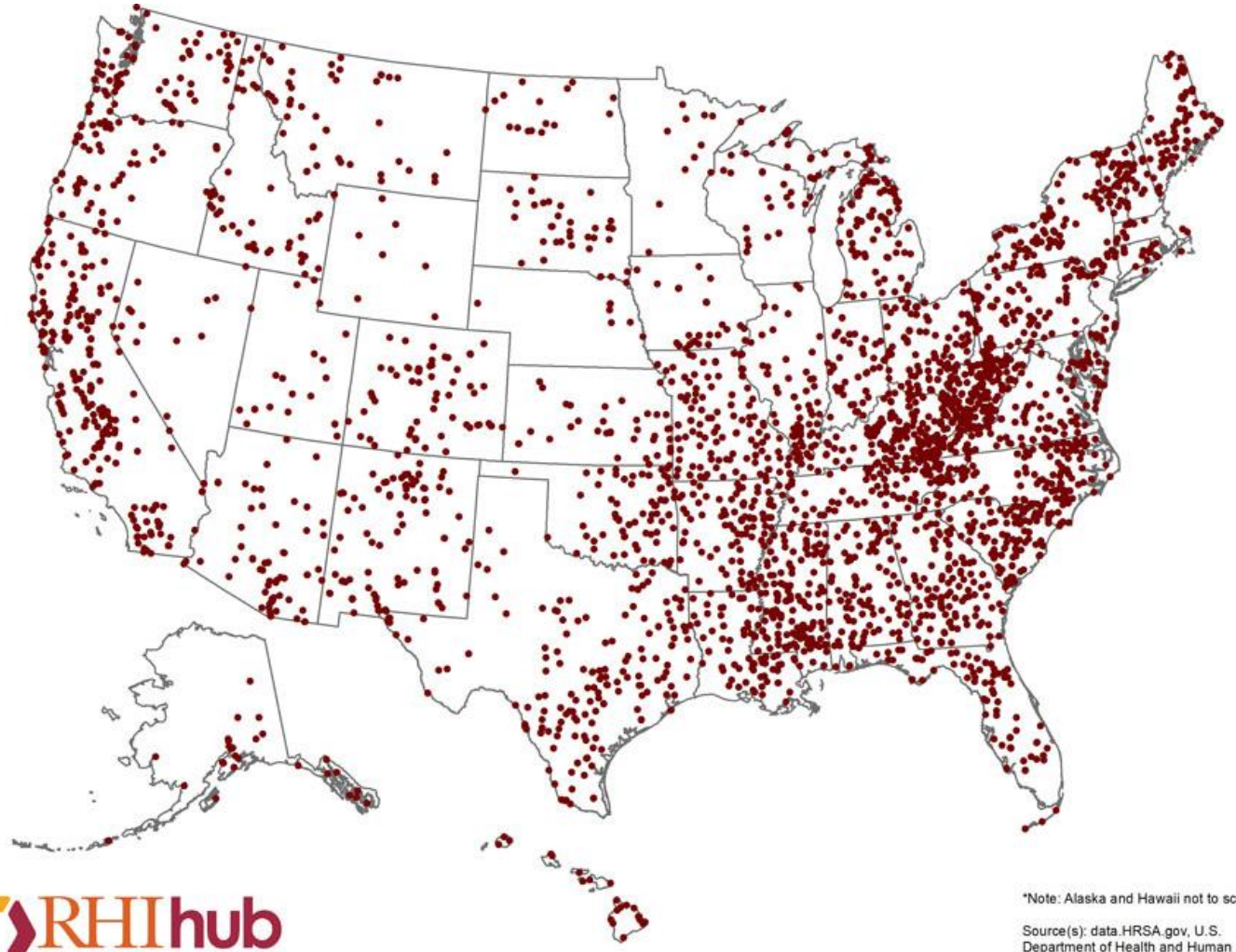
Federally Qualified Health Centers Outside of Urbanized Areas

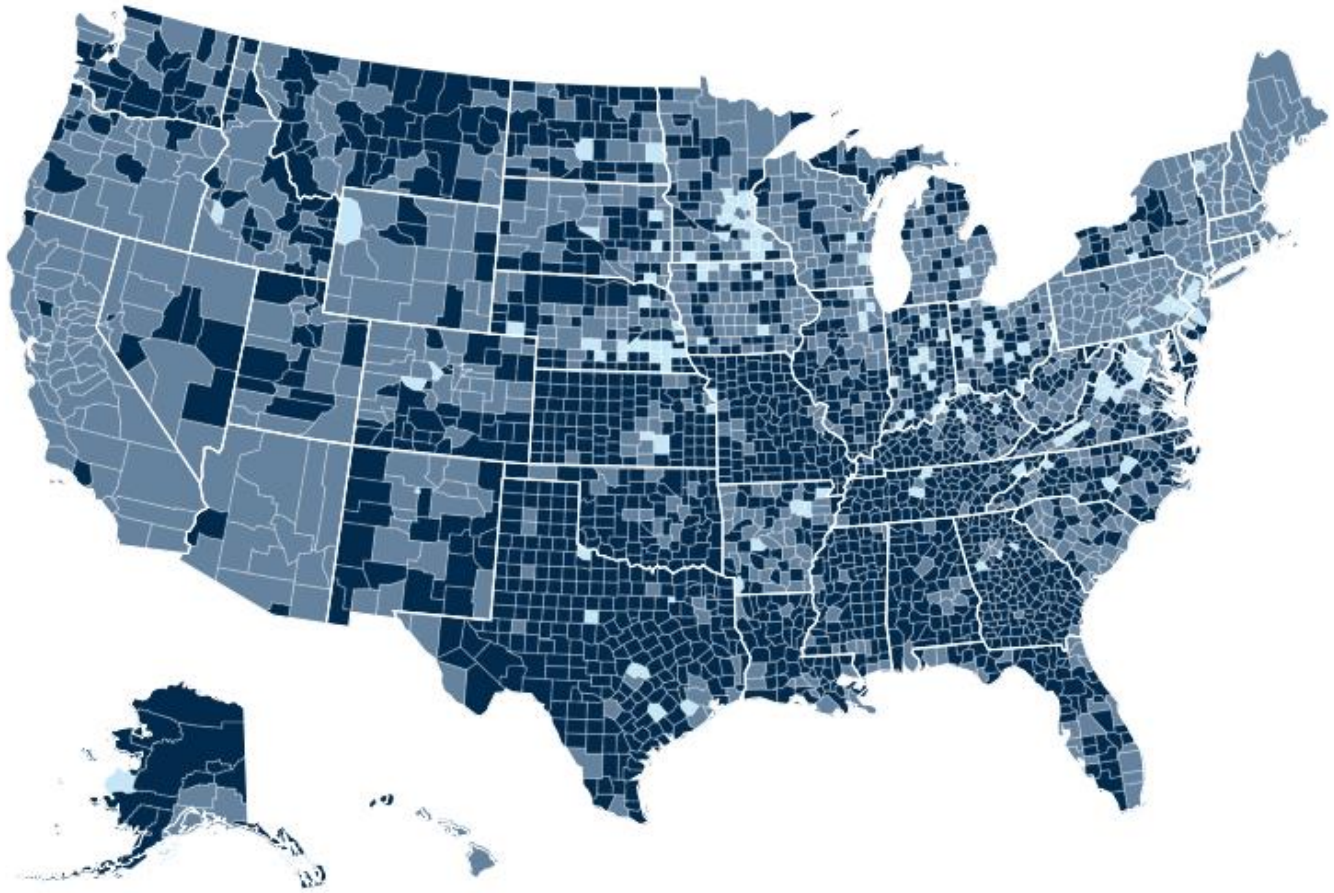


RHIhub
Rural Health Information Hub

*Note: Alaska and Hawaii not to scale

Source(s): data.HRSA.gov, U.S. Department of Health and Human Services, April 2019

Health Professional Shortage Areas: Primary Care, by County, 2020

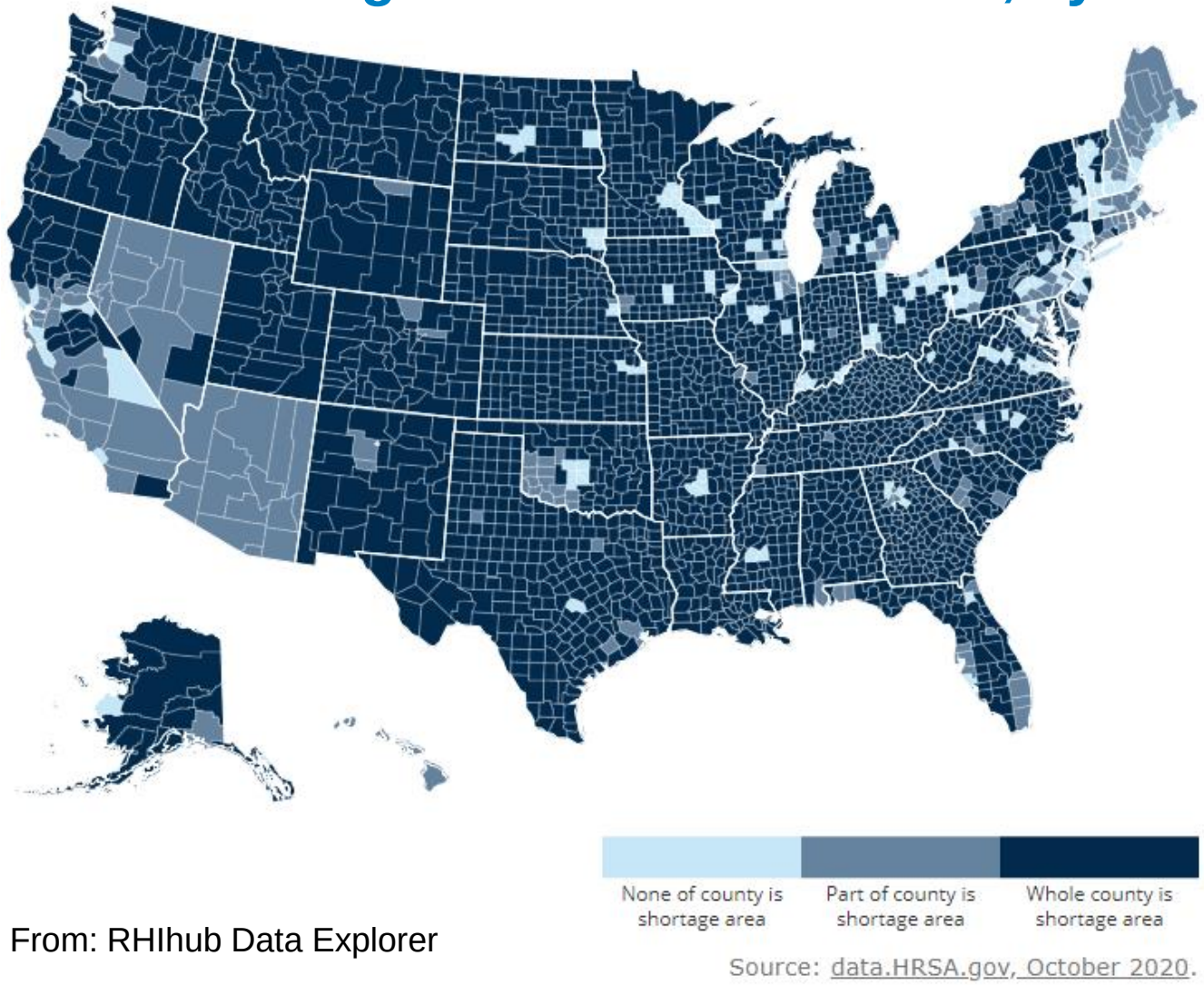


None of county is shortage area | Part of county is shortage area | Whole county is shortage area

Source: data.HRSA.gov, October 2020.

From: RHIhub Data Explorer

Health Professional Shortage Areas: Mental Health, by County, 2020



From: RHIhub Data Explorer

Palliative Care in Rural Communities

Stratis Health Rural Palliative Care Initiatives

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

Why: Rural communities have significant need and are uniquely positioned to align community resources to address disparities in access and services for serious illness

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

What does rural palliative care look like?

- Community-centric rather than hospital-based
- Wide variation in structure and focus
- Often include a focus on process and system improvements such as:
  - Advance Directives
  - Process for goals of care discussions
  - Shared order sets and/or care plans across settings
  - Professional and community education

Variables in Program Structure

Methods of service delivery	Interdisciplinary team	Patient focus	Coordinating staff
Home visits **Clinic appointments** **Nursing home visits** **Inpatient consultation** **Telephonic case management** **Volunteer support visits/services**	**All teams included physician, social work, nursing** **Other disciplines vary:** • **Rehabilitation services** • **Volunteers** • **Nurse practitioner** • **Chaplain** • **Pharmacy** • **Advance practice nurse in psychiatry**	**Hospice eligible but refused** **Infusion therapy** **Home care with complex illness** **Inpatient consult when requested** **Physician referred with complex illness** **Nursing home residents – triggered by minimal data set (MDS) criteria**	**Nurse practitioner** **Registered nurse** **Social worker** **Certified nurse Specialist** **Advance practice nurse**

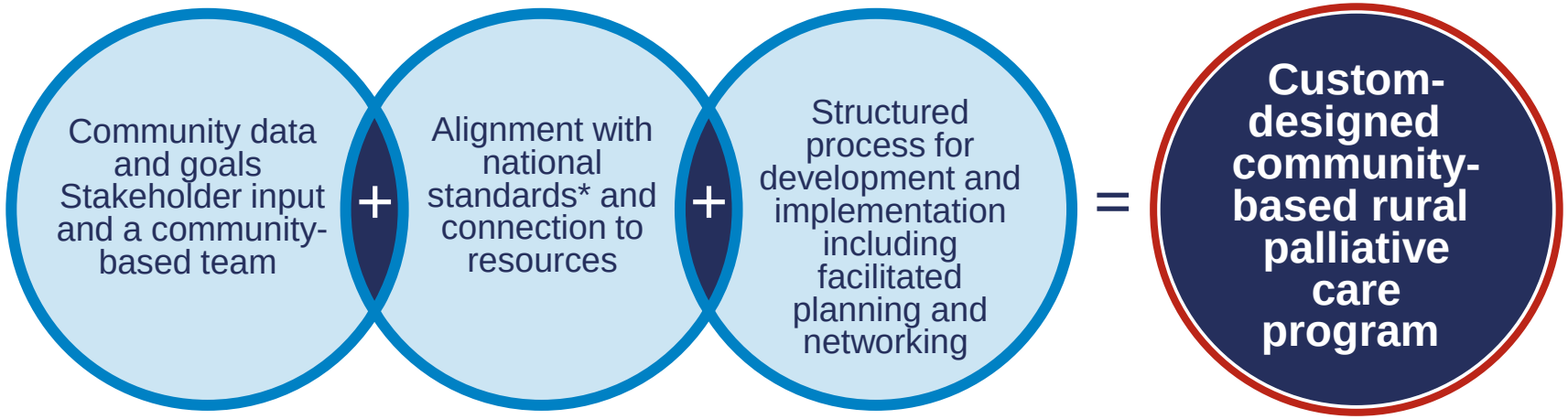
Rural Challenges in Providing Palliative Care

- Chronic workforce shortages
  - Clinical skills
- Financial barriers
  - Lack of direct payment and reimbursement
- Limited availability of supportive services
  - Hospice, home care, behavioral health
  - Social services such as transportation, meals, activities
- Lack of research and models specifically for rural care delivery

Rural Opportunities in Providing Palliative Care

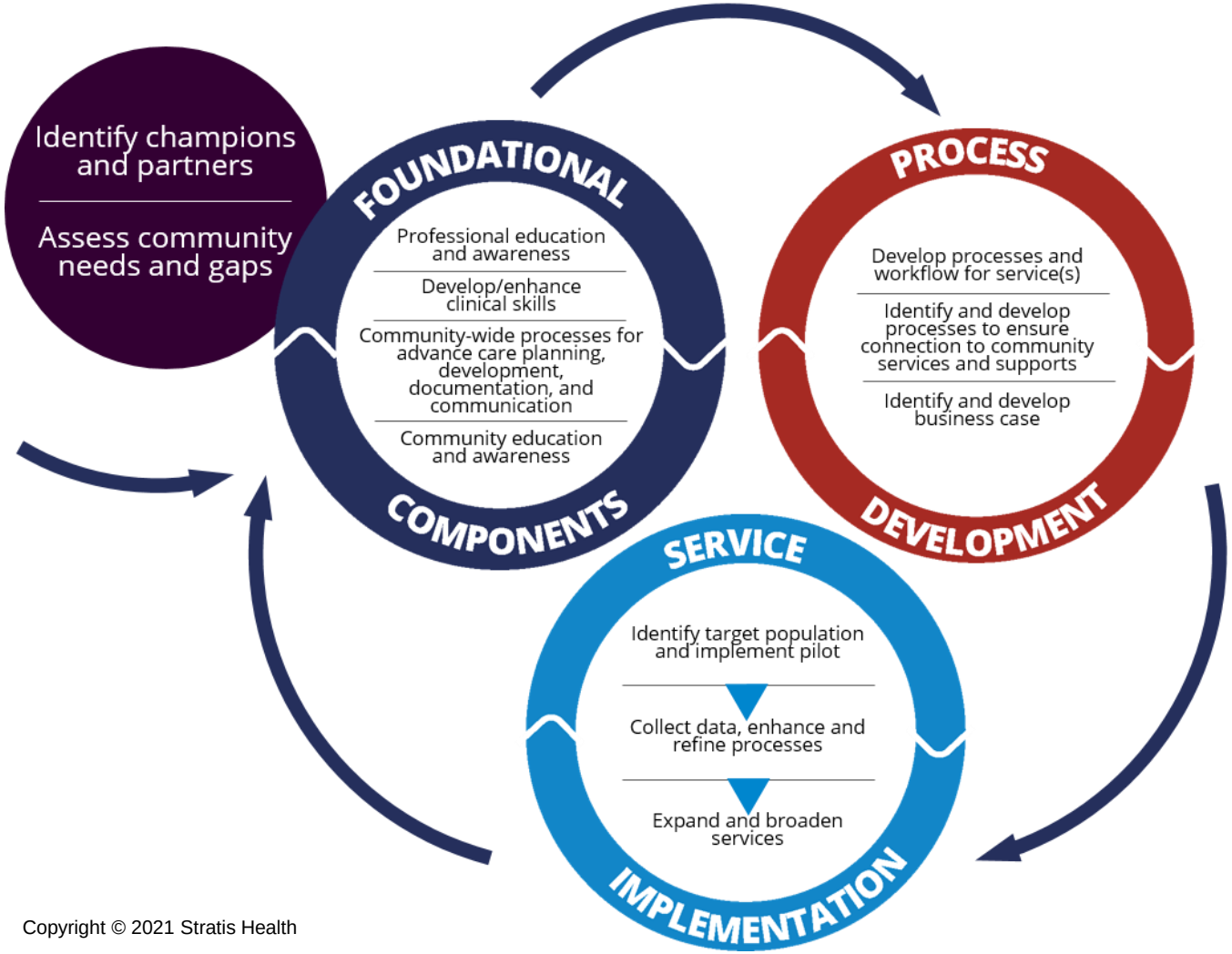
- Networks and relationships are often strong and well connected
- Training is available to enhance clinical skills
  - Allows for care that builds on long-term provider and patient relationships
- Many needs related to serious illness care can be met locally, which is typically the preference of patients and families
  - Telehealth or other consulting arrangements can provide access for specialty needs
- National standards and best practices are relevant
  - Flexibility and creativity to support implementation

Community Capacity-based Formula for Program Development



*National Consensus Project for Quality Palliative Care, 4th Edition Guidelines, 2018

Rural Community-based Palliative Care Service Development Framework



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Rural Palliative Care: Strategies for Sustainability

Billing and Traditional Reimbursement	Grants and Philanthropy	Value-Based Contracting	Emerging Opportunities
What: Direct billing for specific services through Medicare, Medicaid, or private plans. **How:** • **Provider Visits:** Physician, APRN/PA, MSW (in some situations) - E&M codes • **Medicare Care Coordination Codes:** - Advance Care Planning (ACP) - Chronic Care Management (CCM and Complex CCM) - Transition Care Management (TCM) **Align with other services:** • Incorporate as part of covered home health services for appropriate patients. • Potential for earlier hospice admissions (as appropriate) and longer hospice length of stay.	**What:** • Federal, state, local grant opportunities. • Donations or local foundation funds (i.e., auxiliary). **How:** • One-time grants are typically used to fund development costs. • Local foundations might offset operating costs. • Bequests or larger gifts can support services in a variety of ways.	**What:** • Accountable Care Organizations (ACOs) • Bundled payment program especially for oncology or heart failure • Other population-based or risk-sharing arrangements **How:** Understand how focusing on patient goals and active care planning can help: • Reduce potentially avoidable utilization • Decrease use of high-cost treatments and medications as aligned with patient goals. • Generate savings, which can be used to re-invest and help cover costs of palliative care services. Request supplements or bonuses based on performance related quality metrics, such as rates of ED visits, readmissions, and patient satisfaction.	**What:** Medicaid programs, Medicare Advantage plans, and/or other payers develop palliative care reimbursement or benefit options (varies by state and market). Potential for participation in Community Health Access and Rural Transformation (CHART) Model **How:** Advocate for development of palliative care reimbursement options, or benefit and insurance coverage programs, ideally with implementation aligned across payers in a state/region.

Underlying Value

- Providing palliative care is the “right thing to do.”
- Improved quality of care and quality of life for patients with serious illness and/or complex needs.
- Increased likelihood for patients to continue receiving care in their community, close to family and friends.
- Increases patient and family/caregiver satisfaction.
- Supports clinician and staff satisfaction and resiliency.
- Additional palliative care team support for complex patients can reduce clinician stress and enable time to see other patients.

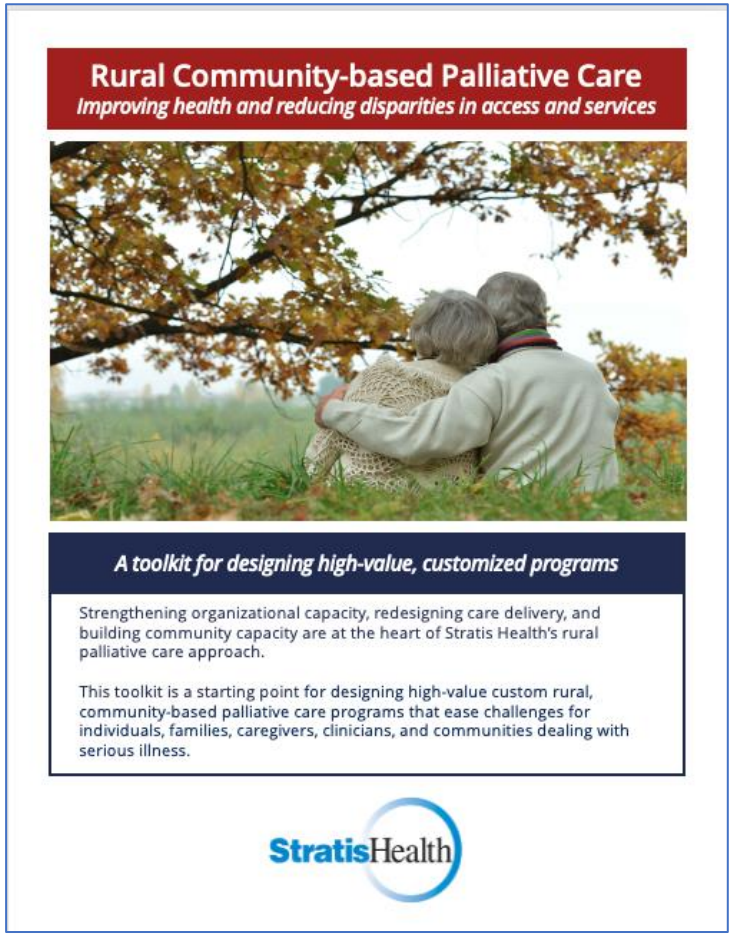
Resource available at https://stratishealth.org/wp-content/uploads/2020/07/Sustainability-Strategies-for-Rural-Community-Based-Palliative-Care.pdf

Lessons Learned & Future Considerations

- Champions— individuals committed to improving access to palliative care in rural communities — at a state and community level are critical for facilitating the development and growth of programs
  - Opportunities that clinical skill development across the interdisciplinary team are needed
  - Networking for rural leaders to learn and share is vital to building and sustaining palliative care
- Financially and programmatically integrating palliative care services with other care delivery and payment changes is essential
  - Lack of reimbursement remains a significant barrier and opportunity
  - Alignment of services and supports across medical and social needs is a core component
  - Collection of standardized community-based metrics is important to quantify impact on cost, quality, potentially avoidable utilization, and patient and family experience
  - Continue rural palliative care model testing, evaluating, learning, and sharing

Tools and Resources

- Rural Palliative Care Toolkit
- Sustainability Strategies for Community-Based Palliative Care
- Project Brief and Evaluation Report
- Journal of Palliative Medicine article (publication anticipated Fall 2021)
- Policy and Regulatory Considerations to Address Urgent Needs During the Pandemic: Recommendations from Minnesota's Serious Illness Action Network



A Rural Program Example

Courtesy of McKenzie County.net

Uniquely Rural?

- McKenzie County - Largest County in North Dakota
  - 2861 sq miles – larger than RI or DE
  - Boom town – from Scandanavian and Native American culture to melting pot from across U.S. and worldwide
  - Between 2010 – 2018 fastest growing county in the U.S. – increasing 114%
  - Population is really unkown
  - From Primarily aging agriculture population to multigenerational energy-based population
  - Many newly insured seeking medical care for chronic conditions not followed by HCP for extended periods

Infrastructure Demands

- Health Care
- Police and EMS
- Housing
- Food
- Utilities
- Schools
- ND lifestyle – climate, rural
- Transient population

Our Palliative Care Journey

- March 2018
  - Recent experience with “Mike”
    - Late 40s - long time resident, well known and liked
    - Married – children preteen – early teens
    - Aggressive cancer
    - 3-hour 1 way commute for cancer treatment
    - No previous ACP – resistance to ACP
    - Full code or no code system mindset
    - Communication struggles with multiple HCPs
    - Ultimately dies in swing bed with less-than-optimal experience (no hospice) for family and staff
    - Family struggled emotionally, spiritually and financially during illness and continues still today

Spring 2018

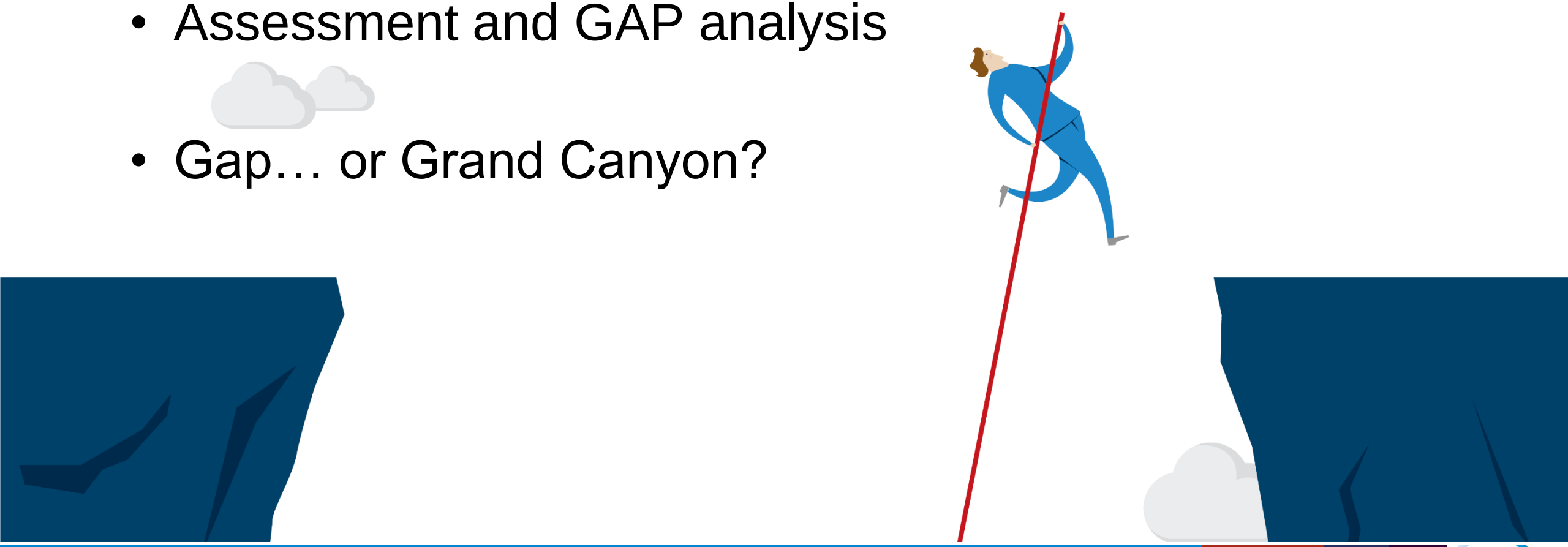
- Stratis Health Rural Community – Based Palliative Care Project Opportunity with UND Center for Rural Health – “frontier” CAHs
- Recent experience – SIGN US UP!
- …oh wait
  - Moving to a new hospital/clinic and revamped LTCF
  - Changing to new EMR
  - Exploding employee, leadership and HCP pool

Rural Health – What's one more hat to wear?!

New Hospital/Clinic/LTCF July 2018

The Process

- Assessment and GAP analysis
- Gap… or Grand Canyon?



An Inventory

Haves:

- Willing team members with strong shared feeling of mission and vision
- UND/Stratis Health support
- Community resources “strained and stretched”
- EMR – conversion
- Health care system with affiliated Acute/Clinic/LTC
- ACO tools and incentives
- Chronic care-transitional care management

Have nots:

- Compliment of disciplines
  - Social Worker, Home Health nor Hospice
  - Palliative/Geratric Expertise
  - Pain Management Expertise
  - Community Health Workers
  - Transportation (limited)
- Staff education opportunities
- Clear idea of palliative care

Visioning Meeting May 2018

- General Palliative Care Introduction
- Review GAP analysis
- Identify Strengths, Weaknesses, Opportunities and Threats
- Develop Action Plan

Visioning and Action Planning
One Bite at a Time

The Initial Team

- Hospital DON and LTC DON
- FNP
- Chronic Care/Transitional Care Manager
- Cardiac Rehab/Pulmonary Therapy
- Clergy
- Senior Companion Program
- Diabetes Educator
- Social Services, EMS, local pharmacy, NDSU extension input

Additions to the Team Over Time

- Pharmacy
- Clinic Manager
- EMS
- MD with palliative/hospice experience
- LTC social service designee

Initial Action Plan

- 5 objectives
  - Formalize team – identify roles and responsibilities
  - Compile resource list – community input and post on hospital webpage
  - Professional stakeholder education – template presentation
  - Advanced Care Planning – 1st Steps facilitators, EMR/ACO documentation and tracking resources
  - Start Planning a Pilot Program

Action Plan

- Reviewed at each meeting
- Updated with new or revised objectives at least quarterly or as needed
- Currently at 15 objectives
- Keeps us focused and accountable

Milestones

- Community Education for ACP – senior day and annual health systems report
- Resource Page
- Brochure development
- Now have Hospice contract for respite and inpatient admissions
- POLST order completions
- Consults across inpatient, clinic and LTCF
- Annual wellness visits increasing and include ACP with billing for ACP- Codes 99497 and 99498
- Networking meetings and calls with other CAH's in project through UND/Stratis

Milestones cont.

- CAPC - The John A. Hartford Foundation Tipping Point Challenge. Tipping Point Winning Organization
  - Courses completed in 2019
  - Also, Honorable mention for Tipping Point
    - Overall course completions
    - Overall staff designations (for modules completed)

  Monthly monitoring of staff completions and monthly reminders.

Center to Advance Palliative Care – Robert

Resources

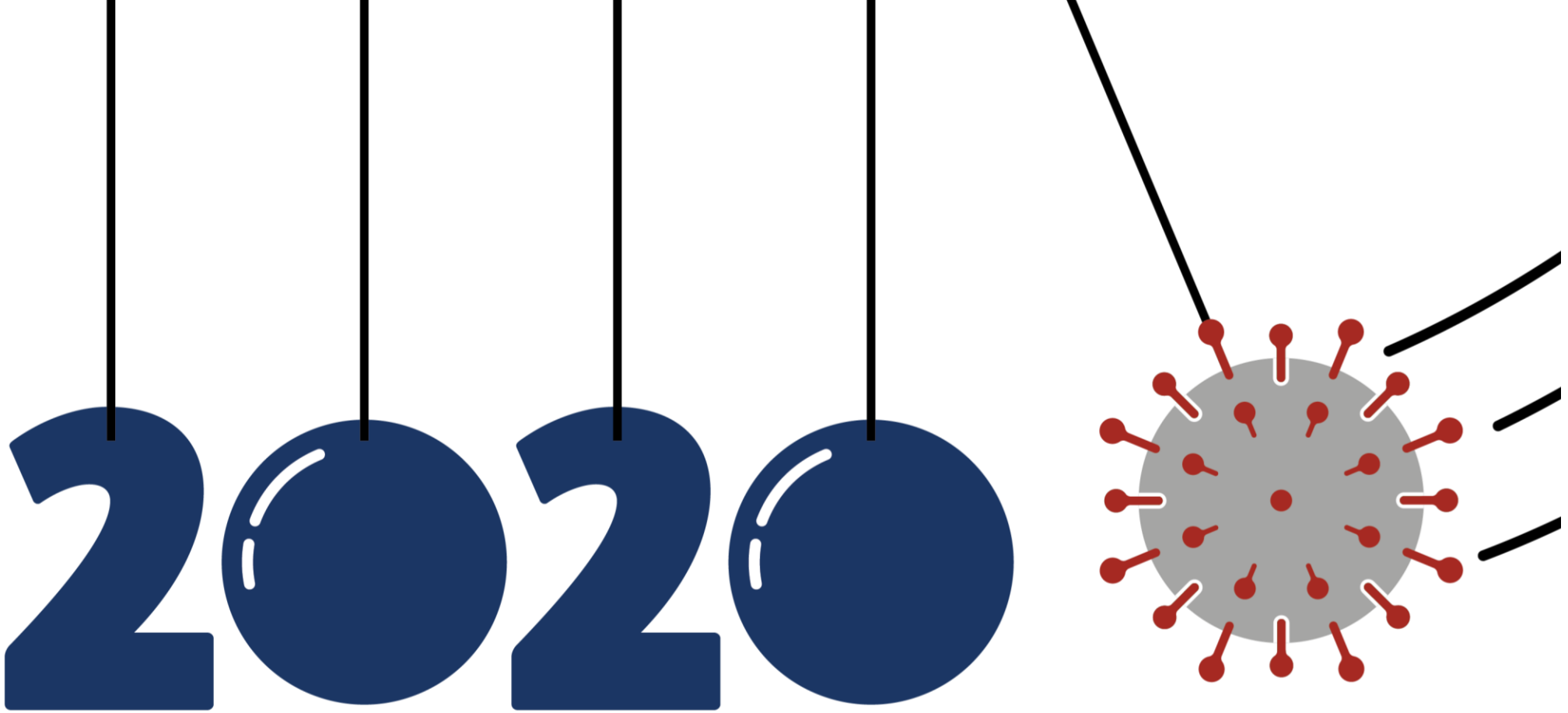
- Clinical Practice Guidelines for Quality Palliative Care – 4th Edition
  - Divided into Domains
    - Structure and Processes of Care
    - Physical Aspects of Care
    - Psychological and Psychiatric Aspects of Care
    - Social Aspects of Care
    - Spiritual, Religious and Existential Aspects of Care
    - Cultural Apects of Care
    - Care of the Patient Nearing the End of Life
    - Ethical and Legal Aspects of Care
  - Appendix for Tools and Resources
  - National Consensus Project for Quality Palliative Care . (2019).Clinical Practice Guidelines for Quality Palliative Care, 4th Ed. https://www.nationalcoalitionhpc.org/ncp/

Resources

- Virtual Library – Center for Rural Health at UND
  - Policies
  - Forms
  - CAPC resources
- Networking with other palliative care projects

Resources

- Center to Advance Palliative Care Membership discount for CAH
  - Education modules – multidisciplinary – CEUs and CMEs
  - Tracking for education modules completed
  - Staff Designations
  - Toolkits – from making the case to providing care and tracking
  - Mapping



…and then there's COVID-19

A New Hat For Our Collection

P is for Pandemic now

- **P**alliative **p**ause- CAH “all hands-on-deck” Economic downturn- Oil hit especially hard - loss of employment and insurance
- Transition to new Palliative champion/team changes
- LTC and inpatient visitation issues
- Vulnerable population to bring into the clinic
  - Tele health options: virtual visits, remote monitoring
  - Aging in place? LTC “heated topic” in pandemic
  - Home based care program development in conjunction with Medicaid
  - Younger population facing their own and their family mortalities

Lessons Learned

- Have An Administration Champion
- Think outside the box and your organization for team members
- Use available resources – don’t recreate the wheel
- Motivational Interviewing is key and an art form
- Have the conversation ANY time, ANY place, ANY where with ANY one you can
- Truly a journey not a destination – even more apparent after COVID experiences.

Experience with Palliative Care Team

- 83 y/o male with gastric cancer “Roger”
- Multiple severe comorbidities – recent MVA with spinal fx
- Independent at home with wife – two children nearby, one out of state
- Clarified goals – resistant to hospice
- POLST orders
- Managed at home for approx. 18 months – before and during covid
- Coordinated care with hospice approx. 2 months before death
- Ultimately admitted for respite care and died surrounded by family

For More Information:

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