Stratis Health, based in Bloomington, Minnesota, is an independent 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.

Stratis Health developed and led the program, in partnership with Fairview Health Services, and with generous funding from UCare, and Minnesota Department of Health - Office of Rural Health and Primary Care.
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Executive Summary

Rural areas typically lag behind urban areas in access to palliative care services. Models for service delivery to support palliative care programs in rural communities are lacking. To help address this need for palliative care services in rural Minnesota, Stratis Health developed the Minnesota Rural Palliative Care Initiative (MRPCI). Through the initiative, Stratis Health assisted 10 communities in establishing or strengthening palliative care services in rural Minnesota. With funding from UCare and supportive expertise in palliative care program development from Fairview Health Services, Stratis Health developed and led an 18-month learning collaborative from October 2008 to April 2010 through which community teams developed or improved palliative care services.

Palliative care is an interdisciplinary approach to managing serious and advanced illness that centers on relieving suffering and improving quality of life for patients and their families. It customizes treatment to meet the needs of each individual, seeking to relieve pain, anxiety, shortness of breath, fatigue, nausea, loss of appetite, and other symptoms. Practitioners of palliative care help patients and their families understand treatment options, and facilitate effective communication among health care professionals, patients, and family members. Emotional and spiritual support for the patient and family are hallmarks of palliative care.

Palliative care is increasingly recognized as an integral part of the care for people of any age with advanced illness and their families. Studies demonstrate positive clinical and financial impacts from providing palliative care services. The clinical care, psychosocial, and spiritual support provided through palliative care services improves the quality of life for patients and their families.

The MRPCI’s framework was built on community capacity development theory, a learning collaborative model, and the National Quality Forum Consensus Report: National Framework and Preferred Practices for Palliative and Hospice Care Quality. The 10 communities participated in three learning sessions on palliative care, which included content on essential elements of a palliative care program and considerations for rural communities and core processes for palliative care. Between the learning sessions, the communities worked to achieve goals with technical support from the project team. The work culminated with an outcomes congress in April 2010, where key learnings and accomplishments were shared. The technical assistance and program evaluation continued through October 2010.

As a result of participating in the MRPCI, all 10 communities developed a work plan to implement a palliative care program in their community. Participating health care professionals reported increased knowledge of symptom management and effective care-goals discussions. Six of the 10 communities are enrolling patients as of April 2011 and providing interdisciplinary palliative care services. The other four developed and/or improved processes to improve certain aspects of palliative care such as advanced care planning or implementation of common order sets across care settings to support effective communication and patient transitions.
Background/Overview

Palliative care describes an approach to managing serious illness that centers on quality of life. The Center to Advance Palliative Care (CAPC) defines it as “interdisciplinary care that aims to relieve suffering and improve quality of life for patients with advanced illness, and their families.”\(^1\) Palliative care customizes treatment to meet the needs of each person, seeking to relieve pain, anxiety, shortness of breath, fatigue, nausea, loss of appetite, and other symptoms. Practitioners of palliative care help patients and their families understand treatment options, and facilitate effective communication among health care professionals, patients, and family members. Emotional and spiritual support for the patient and family are hallmarks of palliative care.

Palliative care differs from hospice in that it is appropriate at any point in a serious illness and can be provided at the same time as curative treatment. By contrast, hospice is for people who are in the last stages of a terminal illness. The Medicare hospice benefit extends only to medically-certified terminally ill patients with six months or less to live, without covering curative treatment for the terminal illness.

Palliative care may be offered in a variety of settings: hospitals, long term care facilities, clinics, or homes. As well as improving patient comfort and family satisfaction, studies have shown that hospital based palliative care can have a positive economic impact. Palliative care helps align the plan of care with patient goals, often resulting in decreased use of resources.\(^2\) Cost savings can result from shorter length of stays, or reduced laboratory, intensive care unit (ICU) and pharmacy costs.

Palliative care is increasingly recognized as an integral part of the care for people of any age with advanced illness, and their families. Numerous research studies have demonstrated positive outcomes for patients receiving palliative care including reduction in pain scores, increased satisfaction with provider communication, and less resource use. Palliative care is viewed as one approach to address personal and family suffering as well as the mounting health care costs at the end of life.\(^3\)\(^4\)

In November 2008, the National Quality Forum launched the National Priorities Partnership, a collaborative effort of 28 national organizations to identify a set of priorities and goals to help focus improvement efforts on “high-leverage areas”—those with the most potential in the near

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\(^1\) Retrieved from the Center to Advance Palliative Care Web site, [www.capc.org](http://www.capc.org).


term to result in substantial improvements in health and health care—and thus accelerate fundamental change in our health care delivery system. Providing patients with life-limiting illness access to high quality palliative and end-of-life care was one of the six areas identified as a national priority that will reduce disease burden, patient harm, disparities in care, and wasteful use of health care resources.4

Access to palliative care for people with advanced illness has increased in recent years primarily through the development of hospital based palliative care programs. According to the Center to Advance Palliative Care (CAPC), palliative care programs are present in over 1,400 hospitals nationwide with the majority of programs in large hospitals.5

Rural communities, however, have less access to palliative care services, and do not have specific models of palliative care relevant to their communities. The hospital-based palliative care team model, with a certified physician or advance practice nurse, is difficult to implement in rural communities. The rural practice environment is different, and urban hospital-based palliative care models are generally not applicable, due to the lack of palliative care specialists, smaller patient volumes, and less financial benefit for small rural hospitals. Hospitals designated as critical access have a per diem cost-based reimbursement system so do not have the same financial benefit for earlier discharge or less intense care than other hospitals.

To compound this situation, demographic data illustrate a disproportionate and growing population of older adults in rural communities. People are generally living longer, often with multiple serious chronic illnesses and an accompanying need for palliative care. In Minnesota, although only 30 percent of all state residents live in rural communities, 41 percent of rural residents are over age 65.6 In a 2008 report, the National Palliative Care Research Center gave Minnesota a grade of “B,” in part due to the lack of palliative care programs in rural communities.7

In 2007, Stratis Health convened a diverse group of health care professionals and rural health experts to form an advisory committee to explore rural palliative care needs and opportunities. These experts concluded that there is a great need for training clinical and non-clinical professionals in rural areas to better facilitate difficult conversations and provide improved care for those with chronic diseases or in advanced illness.

To help address this need for palliative care services in rural Minnesota, Stratis Health developed and implemented the Minnesota Rural Palliative Care Initiative (MRPCI) to assist communities

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to establish or strengthen palliative care services in rural Minnesota, with funding from UCare and subject matter expertise from Fairview Health Services.

**Partner Organizations**

*Stratis Health* is an independent nonprofit organization focused on health care quality improvement, founded in 1971 and based in Bloomington, Minnesota. The organization leads collaboration and innovation in health care quality and safety, and serves as a trusted expert in facilitating improvement for people and communities. Its work encompasses the continuum of care delivery, including hospitals, clinics, nursing homes, and home care. The organization conducts its quality improvement work across the continuum of quality—for individuals, setting-based, communities, and populations.

Stratis Health’s work focuses on providing tools, resources, and expert assistance in clinical quality, but also includes helping health care provider organizations address teamwork, organizational culture, and leadership. The organization is an external change agent supporting sustainable transformational improvement by:

- Providing hands-on technical assistance and consulting.
- Developing and leading education and training.
- Convening and facilitating
- Serving as a clearinghouse, policy influencer, and information translator.
- Serving as a data resource to support transparency and using data to guide decision-making.

Stratis Health is committed to improving health care in all areas of Minnesota, including rural communities, and has identified rural health as one of four priority program areas for the organization. Stratis Health is nationally recognized for its expertise in rural health quality measurement and improvement. In 2005, it received the first National Rural Health Association quality award. It has served as the national support and resource center for the Medicare Quality Improvement Organization (QIO) program in the area of rural hospital quality and patient safety, and regularly gives presentations and testimony at local and national level on rural health quality.

Stratis Health developed and led the MRPCI. The organization provided overall leadership and staffing, including project management, program and curriculum design, logistics management, advisory committee coordination, drawing on its long history of supporting quality improvement with rural health care providers, across the continuum of care.

*Fairview Health Services* served as a key partner, providing clinical and palliative care program development expertise to the initiative. Fairview is one of Minnesota’s largest nonprofit health care systems; with seven hospitals; 36 primary care and 55 specialty clinics; and services for hospice, home care, and long term care. It has over 20,000 employees, serving more than 2.5 million patients annually. Its mission is to improve the health of the communities it serves. In 1997, a group of Fairview health care professionals created a palliative care program to better respond to the suffering among hospitalized patients and improve the quality of life for patients with multiple chronic illnesses and their family members. The palliative care program expanded
to include clinical services in home care, inpatient consult teams, a palliative care clinic, and other quality and educational initiatives. Because of these programs, Fairview received the Circle of Life Award from the American Hospital Association in 2006 for innovation in system-wide palliative care programming. Additionally, CAPC designated Fairview’s palliative care program as a Palliative Care Leadership Center, one of six in the nation. Fairview has mentored more than 400 health care and administrative professionals from 30 states and trained over 120 hospital teams in developing and operating a palliative care program.

UCare is the fourth largest health plan in Minnesota and has provided health coverage plans throughout the state for 24 years. It has received numerous awards of excellence, including its Medicare Advantage program ranking in the top eight percent of health plans nationwide. UCare has been studying the impact of palliative care on financial outcomes with providers in the Twin Cities metropolitan area over the past several years. The health plan also had a medical director passionate about ensuring adequate advanced illness care for all populations, and who served on the MRPCI advisory committee and as a subject matter expert.

The Minnesota Department of Health, Office of Rural Health and Primary Care provided supplemental funding to cover a stipend to each community to help offset travel costs for the Minnesota Rural Palliative Care Initiative.

Stratis Health formed an advisory committee to help guide the development and implementation of the project (Appendix A). The advisory committee member roles were to identify opportunities and issues that may affect the rural palliative care project, provide feedback and input on the design and development of the project, and help make connections to potential participant communities and other stakeholders. The MRPCI core project team included two program managers from Stratis Health and a subject matter expert from Fairview Palliative Care.

**Project Framework**


<table>
<thead>
<tr>
<th>Table 1. Framework for a Custom-designed, Community-based Palliative Care Program</th>
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<tr>
<td><strong>Elements</strong></td>
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<tr>
<td>Community data and goals, stakeholder input, community-based team</td>
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<tr>
<td>Structured process for development/implementation</td>
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<td>Access to national standards, intervention models, and resources</td>
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Community Capacity Development Theory
The theory of community capacity development (CCD) guides community and public health initiatives as well as projects focused on social change. In defining the components of community capacity development, the Centers for Disease Control (CDC) started with two definitions, both of which encompassed the intent of the MRPCI:

1. The characteristics of communities that affect their ability to identify, mobilize, and address social and public health problems.
2. The cultivation and use of transferable knowledge, skills, systems, and resources that affect community- and individual-level changes consistent with public health-related goals and objectives.9

Because limited models or examples of palliative care services exist in rural communities from which to draw best practices, the MRPCI worked with communities to focus on components of community capacity to develop palliative care services that fit the needs and resources available in their community, rather than identifying an evidence-based best practice model that the communities then worked to attain. In Stratis Health’s experience, some rural communities can have a tendency to focus on what they do not have as insurmountable barriers (e.g., palliative care specialists, large patient volume). Using a strength based community capacity approach, Stratis Health guided community teams to focus on the resources they do have available (e.g., engaged volunteers and clergy, strong linkages between care settings, one or more practitioners passionate about palliative care).

Learning Collaborative Model
The MRPCI was implemented using a learning collaborative model to provide education and support to the community-based teams. The learning collaborative methodology typically includes three to four in-person learning sessions over 12 to 18 months, facilitated by an external organization—in this case Stratis Health and Fairview—with ‘faculty’ experts in subject matter relevant to the topics at hand. There is a strong role for measurement and tracking. Teams measure and share results to track progress throughout the collaborative, supported by data assessment and submission tools developed by the collaborative organizers.

Technical assistance is provided proactively by ‘faculty’ experts between learning sessions, supporting the teams as they try to close the gap between best practice and the current practices at their organizations. Support, assistance, and expertise are offered through regular conference calls, email, and Web site interaction with experts from the collaborative, accompanied by site visits when possible to the participating facilities. The collaborative learning format has been used nationally by the Institute for Healthcare Improvement (IHI) (Figure 1).

Participants in the learning sessions have the opportunity to:

- Learn about theory and proven strategies for improving care.
- Implement small tests of change in their organization as a method to improve processes of care.

• Develop a network of colleagues at other organizations pursuing similar work and learn from each other.
• Make and refine plans for improvement for their organizations.

Figure 1. IHI Learning Collaborative Model

National Quality Forum Consensus Report: National Framework and Preferred Practices for Palliative and Hospice Care Quality
Although limited service models for palliative care delivery in rural communities exist, the MRPCI did focus on working with community teams to incorporate best practices in palliative care into their action plans. A third guiding component of the program framework was the NQF Consensus Report: Preferred Practices for Palliative and Hospice Care Quality. The highly influential NQF report provided a framework and set of NQF-endorsed preferred practices focusing on improving palliative care and hospice care across the Institute of Medicine’s six dimensions of quality: safe, effective, timely, patient-centered, efficient, and equitable. In developing their initial action plans, community teams were encouraged to review and focus on adopting at least one of the preferred practices in developing or improving processes related to palliative care services.

The learning collaborative structure, paired with a focus on community capacity development and guided by the NQF Consensus Guidelines and Preferred Practices, was the basis of program development for the MPRCI.

**Goals and Objectives**

The goal of the Minnesota Rural Palliative Care Initiative was to assist communities to establish or strengthen palliative care services in rural Minnesota. The initiative had funding to bring together 10 rural communities for an 18-month learning collaborative starting in fall 2008 to foster their abilities to start or expand palliative care in their communities.

The learning collaborative had a dual focus of operational program planning and clinical training. Participants worked in community-based teams to design a model or focus for their community, and received education to improve clinical skills in palliative care.

The project’s initial objectives were:
- 100% of communities will develop a work plan to implement a palliative care program in their community.
- 100% of participating health care professionals will report increased knowledge of symptom management.
- 100% of participating health care professionals will report increased knowledge of effective goals-of-care discussions.

Expected outcomes were twofold. The short-term outcomes related to programming and included:
- Evidence of broad community support for palliative care, as demonstrated by a team that fully participates in the project’s initiative.
- Increased use of resources for palliative care (technical, financial, educational).
- Increased application of the clinical practice guidelines as issued by the National Consensus Project for Quality Palliative Care, NQF preferred practices for palliative care, Institute for Clinical System Improvement (ICSI) Palliative Care Guideline, and associated quality measures.

Long term expected outcomes of improving patient-centered care were not measurable within the time frame of this project. They will result from improved clinical training and community education and include:
- Decreased number of patients having to leave their home community for palliative care elsewhere.
- Increased number of patients reporting improved management of symptoms.
- Increased satisfaction in family/clinician relationship.
- Increased discussions of goals of care reflected in the care plan.
- Decreased reported problems around care transitions.
- Earlier and increased referrals of patients appropriate for palliative care.
- Earlier and increased referrals of patients appropriate for hospice care.
Implementation

Recruitment and Team Selection
In spring 2008, Stratis Health began recruiting interested communities to participate in the Minnesota Rural Palliative Care Initiative. The definition of “rural” for this project included those communities in Minnesota served by a hospital licensed with fewer than 150 beds. Information about the opportunity to participate was publicized in a variety of venues, including a presentation at the annual Minnesota Rural Health Conference, exhibiting at the Minnesota Academy of Physicians annual conference, mailings to eligible communities, and via the Stratis Health Web site and electronic newsletters. Targeted groups included hospitals, home health agencies, long term care facilities, and hospice programs. Stratis Health hosted a conference call for interested participants as an opportunity to answer questions and provide additional information. By the deadline, 35 communities had sent applications. Stratis Health completed a multi-phased review of the applications to select the 10 participating teams. Selection criteria included:

- Commitment by the lead organization for resources to fully participate in the initiative,
- Commitment of key leadership in the organization, including the CEO, with an indication to continue the efforts beyond time frame of learning collaborative,
- Commitment of a physician champion in the community for the community-based effort
- Some experience with palliative care or hospice work, and
- Demonstrated interest from community partners to engage in the project—specifically, communities were required to have a cross-setting team involving at least three partners, with representatives from clinic, home care, hospice, hospital, or long term care settings.
- Diversity in geographic location, community size, targeted population, and variety of partners involved.

Members of the 10 community teams represented rural communities across the state of Minnesota. The size of the population served in each community varied from 9,000 to 200,000 with a median of 49,000. All communities had an existing hospice program and had hospital participation on the team. Four of the hospital participants were federally designated critical access hospitals (CAHs). The community teams included nurses, physicians, social workers, chaplains, and others. Many participants had experience in caring for people with advanced illness in different settings within their communities. Participants represented hospitals, home care, hospice programs, long term care, clinics, assisted living, a college department of nursing, parish nurses, clergy, and public health agencies. A total of 64 organizations were represented across the 10 teams.

Figure 2. Location of MRPCI Communities
Learning Collaborative Implementation
After acceptance into the MRPCI, each community team or lead individual on the team completed a needs assessment and participated in a telephone interview with the project team. The assessments and calls were used to determine education needs, and to understand community structure and issues. Curriculum was designed to respond to those needs and adapted to ongoing needs identified throughout the initiative. Across participating teams, understanding palliative care philosophy was identified as the top clinical education need, while providing education to staff about caring for people with advanced illness was identified as the greatest opportunity for improving care.

Following the structure of learning collaboratives, three learning sessions and a concluding outcomes congress took place. All learning sessions were held in St. Cloud, Minnesota, which provided a central location for the 10 communities. Presentations on aspects of palliative care program development and small group discussion time were a critical part of each session. Interaction among the teams was highly valued by the participants.

The project team offered technical assistance on aspects of palliative care program development and resources such as documentation tools that facilitate implementation of palliative care processes. Stratis Health created a microsite, http://www.stratishealth.org/palcare, within its Web site dedicated to palliative care information, with resources for program development, links to national guidelines and resources, example action plans, descriptions of relevant quality improvement projects, clinical order sets, and example clinical assessment tools. These resources allowed health care professionals to use previously developed tools in implementing their tests of change. At each learning session, participants received a binder of written information that included presenter handouts and other resources such as suggested readings.

Over the course of the learning collaborative, three Webinar conferences were offered, covering the topics of implementing family conferences, pain management, and starting a rural palliative care program. In the experience of both Stratis Health and Fairview, periodic mentoring calls are a key component to success in learning collaboratives. Replicating this concept, the MRPCI team held individual mentoring calls every two to three months with the community teams. Six mentoring calls per team were held over the course of the project.

Participation Summary
Learning sessions. All 10 teams participated in each learning session and the outcomes congress, with the exception of Learning Session 2. Only six of the 10 teams participated in Learning Session 2 due to a spring blizzard. For teams unable to attend, recordings of the educational presentations from that session were made available. Learning session evaluations indicated high satisfaction with participation in the in-person sessions. All four workshops received an overall rating of 3.5 or higher on a four point scale (4 indicated highly satisfied).

Active engagement of a champion practitioner was a key component for successful teams in the learning collaborative. Four of the teams had a clinician champion, physician (MD) or nurse practitioner (NP), attend all four in-person sessions. Two teams had clinician participation in two of the sessions. Four teams did not have clinician participation in any of the learning sessions.
Webinar conferences. Live participation by the teams in the Webinar conferences varied by topic. All sessions were recorded, but access of the recorded sessions was not tracked.

The pain management and the difficult discussions topics were selected based on the clinical needs identified in the project needs assessment. Teams were encouraged to offer participation to all relevant clinical staff in their communities. The call highlighting the program in Bozeman, Montana, was scheduled after participants indicated interest in hearing from other rural communities that were implementing a palliative care program.

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<th>Table 2. Participation by Webinar Conference</th>
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<tr>
<td>Conference topic</td>
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<tr>
<td>Difficult Discussions: Family Conferences</td>
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<tr>
<td>Pain Management</td>
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<tr>
<td>Starting a Rural Palliative Care Program:</td>
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<tr>
<td>Bozeman Montana</td>
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Mentoring calls. Mentoring calls were offered to each community team at intervals of every two or three months throughout the project. An agenda was developed for each call to help focus the discussion and give teams an opportunity to review and prepare information prior to the call. The agenda included ample time to discuss any items that the team wanted input on. A Stratis Health program manager and the subject manager expert from Fairview participated in each of the mentoring calls. The majority of teams were able to participate in all six mentoring calls offered, the remainder participated in five calls. Seven of the teams had three or more team members participate in the mentoring calls.

Results
Initial project objectives included a focus on community work plan development and increased clinician knowledge in the areas of symptom management and effective goals-of-care discussion. As the initiative developed, the project team also identified the opportunity to measure additional areas of program impact such as the provision of palliative care services, system changes to support palliative care processes, and satisfaction with participation and various aspects of support offered to communities through the MPRCI.

Initial Program Objective Evaluation
Objective 1: 100% of communities will develop an action plan to implement a palliative care program in their community.
Through the MRPCI, all teams developed and refined an action plan, identified a population for the focus of their plan, and included at least two strategies relevant for palliative care, based on the needs and resources within their community. There was considerable variation in the scope, focus, and implementation of the community teams’ strategies and action plans.
A small number of communities focused on a specific, narrowly defined population when developing their palliative care services, such as patients seen in an infusion center or residents of a nursing facility. The majority of teams targeted their strategies to a broad group of people with advanced, chronic, or life-limiting illness.

For strategies, some communities focused on physical symptom assessment and management, and others on a comprehensive approach that included multiple aspects of palliative care. All communities focused on palliative care as defined by the national consensus guidelines. Common elements of action plans at the community level included education of health care professionals about palliative care, review of processes and order sets related to palliative and end-of-life care, community education and outreach, and effective use of advance directives. Teams with more-advanced implementation also focused on identification of appropriate patients and developing and refining processes to provide interdisciplinary palliative care services.

For several of the communities, this was their first experience in working with a multi-setting team in developing and implementing a work plan. The project acted as a catalyst to bring professionals together in a formal structure. Members of other community teams described this as a new opportunity to work together around a common goal.

Participants appreciated acquiring practical ideas, enhanced knowledge of palliative care, and a sense of the possibilities from peer communities with more mature programs.

Objective 2 and 3

Objective 2: 100% of participating health care professionals will report increased knowledge of symptom management.

Objective 3: 100% of participating health care professionals will report increased knowledge of effective care-goals discussions.

These objectives were evaluated through a survey in January 2009 and a follow-up survey in June 2009. Community teams were instructed to distribute the surveys, either electronically or in hard copy, to clinical staff in their community as appropriate. Communities had wide variation in participation, with 63 individuals completing both surveys.

The live clinical education Webinars “Difficult Discussions” and “Pain Management” were offered between the surveys. Of the 63 individuals that completed both surveys:

- 73% (46/63) responded they had increased knowledge regarding pain management.
- 81% (51/63) responded they had increased knowledge regarding effective care-goals discussions.

Evaluation comments indicated that several providers were already familiar with these concepts, so the basic education provided through these sessions would not increase their knowledge.

In addition, in completing the final program evaluation, communities indicated a slight increase in pain and symptom management needs being met in their community. The average score increased from 2.8 in the initial needs assessment to 3.0 at the completion of the initiative, on a scale from 1 to 5, with 5 being the highest.
**Program Satisfaction**
The final evaluation survey included several questions to assess the value and helpfulness of various aspects of the MPCRI and satisfaction with participating in the initiative. Each community team completed an evaluation survey in December 2010.

Overall, participating teams were satisfied with their experience in the MRPCI. All 10 communities indicated they would recommend participation in the MRPCI. All components of the initiative were identified as helpful, with the mentoring calls and Webinar conferences receiving the highest marks.

Several teams indicated that networking with the other communities was a valuable part of participation.

- “Having one community further ahead was very helpful!”
- “Networking with the other communities to see what they are doing, what they have tried and did work well, and those things that did not work too well. Networking is wonderful!”

Teams also were asked to evaluate their satisfaction with how well their team functioned and with the progress their community made during the MRPCI. Seven teams indicated satisfaction with how well their team functioned together. Six were satisfied with the progress they made during the initiative. Comments included:

- “Frankly, I was surprised that we were able to get a program off and running!”
- “I was surprised that we were unable to progress beyond the initial phase.”

**Program Impact**
The overall goal of this initiative was to develop or strengthen palliative care services in rural Minnesota. Of the 10 teams participating in the MRPCI, only one was seeing palliative care patients at the start of the initiative. As of this final report, six communities are actively enrolling and providing palliative care services to patients in their communities. In addition to those communities that launched a program and are seeing patients, all 10 communities have worked on system processes and communication efforts to support palliative care related services such as provider education, common order sets that cross settings, and advanced care planning. A summary of each of the participating communities’ activities can be found in Appendix C.

**Palliative Care Services**
As of May 2011, six of the 10 communities that participated in the Minnesota Rural Palliative Care Initiative were enrolling patients and providing interdisciplinary palliative care services. Each community of these communities developed a unique model of how to support patient needs across a variety of settings including home care, outpatient, nursing home, assisted living, and inpatient. Some of the programs also developed processes to support patients with visits from volunteers and to tap into support from clergy as many of the communities do not have formal chaplain services available. Three of the communities have expanded services beyond their initial pilot site.
Developing a strategy to identify patients appropriate for palliative care was a key hurdle in program development. One team developed a tool to identify patients appropriate for palliative care based on the ICSI Palliative Care Guideline.\textsuperscript{11} To create awareness of palliative care and to generate requests for palliative care from patients and their families as a consumer, demand-side strategy, other community teams included community education as part of their action plans.

At the April 2010 outcomes congress, Dr. Barry Baines, MD, chief medical officer, UCare, announced that the health plan would offer contracts to provide palliative care services to UCare members for those communities that could demonstrate meeting key criteria of a palliative care program structure. As of this report, three communities have signed UCare contracts. Three additional communities are working with health plan contractors to pay for palliative care. There is hope that other payers in Minnesota will follow suit and start contracting for palliative care services in a similar manner.

Palliative care is such a new field of care that it lacks standard quality indicators for services, particularly in the outpatient setting. Of the six communities seeing patients, all but one were looking at data regarding pain scores and symptom scores to measure effectiveness of their palliative care services. Four are looking at quality-of-life scores and four are looking at patient/family satisfaction data. One community indicated it was looking at hospital and emergency department admissions as an indicator of effectiveness. Most of these six communities have indicated they would be willing to participate in data collection of standardized quality measures as a way to help improve their services.

\textbf{Figure 3. Evaluation Measures Used by the Communities Offering Palliative Care Services}

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\includegraphics[width=0.5\textwidth]{evaluation_measures.png}
\caption{Evaluation Measures Used by the Communities Offering Palliative Care Services}
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**Process/System Improvements**

All 10 of the participating communities worked toward process and system improvements related to aspects of palliative care. Focus areas included common order sets across care settings, advanced care planning, provider and staff education, and community education and outreach.

\textsuperscript{11} ICSI Health Care Guideline: Palliative Care, Third Edition November 2009, \url{http://www.icsi.org/guidelines_and_more/gl_os_prot/other_health_care_conditions/palliative_care/palliative_care_1875.html}. 
Nine have been working on efforts for advance directives. Eight are implementing and two have plans to implement health care professional education. All 10 of the communities either have (7) or have plans to implement (3) consistent order sets among two or more settings. A summary of implementation of system and process changes can be found in Figure 4.

**Figure 4. Percent of Participating Communities Using Process or System Improvements**

Community Assessment of Knowledge and Experience
To help understand if the MRPCI had an impact at a community level, Stratis Health compared answers from the initial needs assessment of the community teams against the final evaluation survey. Results indicate a general sense among community teams that knowledge and experience with palliative care has improved over time. Specific results can be found in Figures 5 and 6.

**Figure 5. Improvement in Level of Experience/Expertise of Participating Communities**
Medical Student Participation
One unanticipated but very positive outgrowth of the MRPCI effort was the engagement of six students from the Rural Physician Associate Program (RPAP) at the University of Minnesota Medical School in five of the communities. RPAP students are in their third year of medical school and participate in a nine-month experience in a rural community that includes participation in a community focused project. The RPAP students brought great interest and excitement to the community teams and participated in a variety of ways, from delivering community presentations to working on order sets. For at least two of the students, participation in the MPRCI community teams had a significant impact on their future career direction, according to Kathleen Brooks, RPAP director at the University of Minnesota, and an MRPCI advisory group member. We are hopeful that exposure to palliative care in a rural setting during their training will help engage these future physicians in supporting palliative care across the continuum as they become family practitioners in rural communities.

Discussion
Contributors to Success
Three factors contributed in a major way to the success of the MRPCI: the commitment of the community team leads and team members, the increasing local and national attention given to palliative care during the course of the project, and the structure and resources provided by Stratis Health and its partners.

A primary factor to success was the commitment of the community team leads and team members. Despite economic challenges, additional role responsibilities, and other priority obligations, the community teams remained invested throughout the project. In addition, the
support of senior management in all of the participating organizations was a major success factor and demonstrated their sense of the importance of improving care for people with advanced illness.

On both the local and national level, increased attention was given to palliative care during the course of the project. Announcement of palliative care as one priority of the National Priority Partnership, recognition of the National Quality Forum’s Preferred Practices for Palliative Care, inclusion of palliative care as a topic in discussions about health care reform, and renewed interest among the Minnesota health care community on standardizing methods of advanced care planning through an effort called Honoring Choices Minnesota, all supported a focus on this topic at this time, and bolstered support for the project.

Project flexibility was also a key contributor to the success of this effort. Curriculum for each of the learning sessions was developed based on discussions from mentoring calls and other inputs, to best meet the real time needs of the community teams. Online offerings were made available when in-person participation was not possible at one of the learning sessions. Mentoring calls were scheduled based on community team needs and timed to coincide with their regularly scheduled meetings whenever possible. Lastly, although program direction was grounded in the NQF Preferred Practices for Palliative Care, broad flexibility was available to teams as they identified areas of focus for their efforts.

Several community teams indicated that the ongoing process of mentoring calls was a key aspect to continue activity among their team. In addition to offering an opportunity to problem solve and identify resources, they provided a structure for external accountability for the teams which prompted them to complete tasks and make progress before their next call.

The structured approach offered to communities through participation in the project led to success that would have been unlikely on their own. Participation in a project over 18 months gave structure and accountability to the communities, provided customized guidance and technical assistance in terms of how to take action, and offered practical and rural-specific resources, tools, and networking.

**Challenges**

At the project planning level, a challenge in program development was blending the use of a learning collaborative approach with the theory of community capacity development. The learning collaborative model is designed to share proven strategies to guide the development of participant-chosen goals and strategies. However, research-based models for palliative care program implementation in rural communities are not available and community capacity development theory enabled ideas and practices to emerge. The initiative used the learning collaborative model as an overall structure for organizing the project, yet varied the model to accommodate the lack of evidence-based rural palliative care approaches. The MRPCI provided resources about key components of palliative care and the NQF preferred practices for palliative care, education on improvement methods to implement tests of changes, and program development tools such as marketing and developing business plans.
At the community level, the implementation and the success of community teams in this effort faced several challenges.

- Four of the 10 teams were unable to attend Learning Session 2 because of a snowstorm, and the content for those that were able to attend was abbreviated as the session ended two hours early to allow for safe travel. Unfortunately, this learning session came at a pivotal time in the project as teams were in early stages of action plan implementation. The missed opportunity for sharing challenges and lessons learned among the teams as well as presentations of didactic content impacted momentum and slowed progress. Although the presentations were made available on the Stratis Health MRPCI micro Website, these postings could not provide participants with the same value as the face-to-face discussions, the ability to talk with the project team, and networking among members of all the community teams.

- Bringing together a diverse and multi-disciplinary, cross setting group within each community to improve palliative care proved a challenge. Team members may not have had prior experience working together or had a clear understanding of the parameters of relationships between the organizations they represented. Teams differed in their group and project skills, and some teams failed to assign basic roles such as scribe or meeting organizer. While each community team was able to work through this, progress for some of the teams was slowed, especially during the early stages. One community team, which struggled to organize its team at the beginning, overcame this challenge by using Private Business Networks, www.pbnet.com, for its online meeting space for minutes and meeting coordination. The community team demonstrated this resource to the other nine communities at the third learning session.

The economic downturn, and its impact on rural communities and health care financing, was a third and unforeseen challenge. Almost every team presenting at the outcomes congress cited lack of financial reimbursement as a barrier to developing a program. A payment source for non-provider palliative care visits (e.g., social work or chaplain) and palliative care assessments would have likely stimulated additional innovative designs of processes to deliver palliative care. To help better understand payment options for the participating critical access hospitals, the project team arranged for a conference call discussion with a representative from Eide Bailey, an accounting and consulting firm that provides support to numerous CAHs regarding billing structure and processes. Through that call, it was clarified that CAHs could bill for palliative care services provided to patients during an inpatient stay, but that funding stream could not be utilized to support services provided in outpatient or community settings where many teams had identified their primary need for services.

In the MRPCI collaborative, consistent with the theory of community capacity development, each team’s first step was to identify the goal most important to its community, and then develop an individualized model tailored to its community’s needs and resources. Many community teams first visualized a comprehensive palliative care program and became overwhelmed with initial steps to achieve a goal that was not realistic. The project team recognized the need to re-focus community teams on establishing a pilot program then expand as processes and resources were developed and identified. After the first round of mentoring calls, the project team clearly saw a wide variance in the understanding of basic process improvement concepts such as use of
the Plan, Do, Study, Act (PDSA) model to make small tests of change. Based on this recognition, a portion of the agenda of the second learning session was dedicated to process improvement methods and how they could be used in this effort.

Those community teams where the majority of health care settings/agencies were under common ownership (such as a health system that owns the hospital, home care, nursing home, hospice, and clinic) were typically able to make progress more quickly than those with diverse ownership and management structures.

Although the learning collaborative model needed to be adapted for the initiative, the overall process worked to guide participants. The mentoring calls were valuable in supporting positive steps, encouraging a realistic goal by limiting focus on a specific population or setting, and reminding teams of the importance of small tests of change, especially when linked to their institutions’ current priorities. The project team recognized that one-on-one support for initial development of the team’s action plan, which is not typically part of a learning collaborative process, would be a valuable component for supporting future teams in getting initial community-based efforts off the ground.

A final challenge was the inability of some communities to engage a strong physician leader or visible administrative support for their efforts. In the application process to participate in the MRPCI, teams had to identify a physician champion and have the CEO of the lead organization sign off on the applications, indicating support. However, in some cases, leadership priorities changed over time, or there was a lack of initial understanding by physician leadership and/or administration of what participation in the initiative would entail. Efforts were hampered significantly in communities where the visible leadership needed by a physician and/or administration was lacking. This lack of support came as a surprise to some communities. On average, medical staff commitment/buy-in was ranked higher as a barrier at the end of the project on the final survey, than it had been during the initial needs assessment. This was also indicated in survey comments such as:

- “External factors beyond everyone’s control influenced our team’s progress, mainly by removing many important players from the team at the start and removing financial support for group members associated with the hospital.”
- “A positive, motivated leader, a positive motivated physician, and a positive motivated administrator are absolute ‘musts’ in order for a community to succeed in this project.”
- “It is an eye opener that this does not just happen… We really need to have a ‘champion’ that can dedicate their time to building a program… we need to have that person.”

**Models for Palliative Care in Rural Communities**

As previously indicated, research-based models specific to delivering palliative care services in rural communities are not available. Most palliative care programs are located in large urban hospitals, which have different needs and resources. Low patient volumes in rural hospitals hinder adoption of urban models that typically rely on dedicated specialists. This lack of proven models was an added challenge for the communities participating in the MRPCI to develop their own service structures.
Despite the lack of rural-specific palliative care models, six of the 10 communities in the MRPCI developed approaches to provide palliative care services in their communities. Consistent with the community capacity approach, the teams identified their current gaps in service, the needs of their communities, and their available resources. They then developed a program matched to the needs and resources in their individual communities. Although it is too early to speak to sustainability of these programs, as most were launched in the past 12 to 18 months, the goal is that they will be sustainable because each program was specifically developed to align with the needs and resources of the community team.

The models for service delivery developed by the participating communities vary widely. Services may be based out of home care services, or led by an RN or NP coordinator housed in the clinic or hospital. Services may be focused on patients in the hospital or nursing home or those receiving home care or outpatient services such as infusion therapy. Several teams support home based and community level support through telephone contact and/or volunteer visits. The table below outlines various characteristics of the program structures.

**Table 3. Variables in Rural Palliative Care Program Structure**

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

**Recommendations**

Through the Minnesota Rural Palliative Care Initiative, the project team identified several themes that lead to opportunities for continued support of rural communities to start or strengthen their community-based palliative care services.

*External resources and support are needed for rural communities to develop palliative care services.* Although many rural communities have strong interest in developing palliative care
services, as evidenced by the 35 applicants for this initiative, few communities are able to move forward without some external technical assistance and support. The community capacity development approach of focusing on community goals and resources is effective in helping develop a program that meets the specific needs and resources available in each community. Outlining options for models of how to provide community-based services (e.g., home care, RN coordinated, and NP coordinated) along with a roadmap of the steps in the process to developing services could be useful tools to assist other rural communities in this process.

Ongoing networking for learning and sharing is critical to sustaining rural palliative care programs. Most rural communities that participated in the MRPCI indicated a need for ongoing networking opportunities once the initiative ended. Working with Stratis Health to assist in coordination, several communities were involved in developing the Rural Palliative Care Networking Group, which met four times since May 2010. Twenty-eight individuals from 14 communities participated in the April 2011 networking group meeting either in-person or by phone. The location of the meeting rotates among volunteer host sites each quarter. The group has decided on a structure of an educational presentation followed by networking/sharing among participants. The topics of the educational sessions are identified by the group and have thus far included palliative care in long term care, collaborating with community partners, and implementing Honoring Choices Minnesota, focused on advanced care planning. The group needs to work on how to become self-sustaining or transition to another coordinating organization, as Stratis Health grant funding ends.

New approaches to assessing the cost-benefit value of rural palliative care services are necessary to make the business case for such programs. The MRPCI focused on assisting rural communities with program development and improving palliative care related processes. As more rural communities develop and provide palliative care services, additional focus is needed on value-based program metrics to guide improvement efforts and to quantify the value of services provided, and their affect on cost, quality, readmissions, and patient and family experiences. Few quality improvement metrics have been developed for palliative care services, and those that exist are more appropriate for urban hospital-based programs. Research into appropriate community-based palliative care metrics, and technical assistance for data collection and review is needed to further the field in this area.

Innovative content delivery mechanisms are needed to spread rural palliative care in cost-effective yet meaningful ways. Although the learning collaborative model of implementation received high satisfaction from participants, as financial and resource needs grow for health care providers it may be less feasible for full teams of multi-disciplinary professions from any given community to travel and participate in multiple full-day workshops. Hosting the large workshops can also be an expensive endeavor for the supporting organization. During implementation of the MRPCI the program team recognized the wide variations among teams and team members relating to use of quality improvement methods such as PDSA, and that training provided during the learning sessions only reached those team members able to attend.

Through two different projects that explored innovative and cost-effective program development, one in three communities across the country and another with six additional rural Minnesota communities, Stratis Health has found that hosting one on-site workshop with each individual
community provides better access to the full continuum of local participants. This approach also provides focused technical support in palliative care program development for writing an initial work plan. It also allows education about PDSA and process change to the full team rather than a handful of representatives. The on-site workshop is then followed by periodic mentoring calls and educational offerings, similar to the MRPCI format. The challenge with implementing on-site community workshops is to ensure adequate opportunities for networking among the teams in the collaborative, during the process of implementation. Many teams in the MRPCI indicated the networking/sharing across teams was a valuable component of the initiative. Participation in the Rural Palliative Care Networking group provides one opportunity to learn from other teams. Posting of tools and resources on the Stratis Health micro Website is another tool to promote sharing across communities. Periodic conference calls for groups of communities in the same phase of implementation efforts may be another opportunity to support networking and learning across teams.

Reimbursement for palliative care services as a covered benefit from payers and insurers is important. A primary barrier cited by participating teams is identifying financial resources to support a palliative care program. Medicare does not currently have a palliative care benefit, nor do most of the health plans that provide commercial and public program coverage in Minnesota. For several communities, the potential to contract for services with UCare to cover costs for their members has been helpful in continuing to engage administrative support for palliative care efforts. Expansion of coverage to additional payers, and ideally Medicare, would make a significant difference to the sustainability of current programs in rural communities, and greatly enhance the likelihood of interdisciplinary program expansion for additional patients, and/or program development in additional communities.

Palliative care programs and services align well with other efforts to redesign care delivery. The Minnesota Rural Palliative Care Initiative required the participating teams to have representatives from organizations across settings of care in their communities. Health reform efforts at the state and national levels are calling for increased coordination across settings of care. The approach to the MRPCI in combining community capacity theory with a learning collaborative model may be useful in supporting additional cross setting initiatives that are gaining national prominence such as coordination of care, reducing hospital readmissions, medical homes, and shared decision making. The MRPCI focus of having a community-based team identify the goal and resources, as well as develop the plans for implementation, should be considered as an implementation model for care delivery methods that cross multiple-settings.
Appendix A. Minnesota Rural Palliative Care Initiative Advisory Committee

Barry Baines  
UCare Minnesota  

Kathleen D. Brooks  
University of Minnesota Medical School  

Lyn Ceronsky  
Fairview Health Services  
Palliative Care Leadership Center  

Michele Fedderly  
Minnesota Network of Hospice and Palliative Care  

Patricia Freeman  
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Stratis Health  

Kate Peterson  
Stratis Health  

Janelle Shearer  
Stratis Health  

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Cook County Northshore Hospital  

Cally Vinz  
Institute for Clinical Systems Improvement  

Lores Vlaminck  
Lores Consulting  

Karla Weng  
Stratis Health  

Rhonda Wiering  
Avera Health
Appendix B. Minnesota Rural Palliative Care Initiative Core Project Team

Janelle Shearer, RN, BSN, MA, CPHQ, Program Manager, Stratis Health
Janelle has been a program manager with Stratis Health since 2003 and co-leads the Minnesota Rural Palliative Care Initiative. She has worked with home health agencies on outcomes based quality improvement, and with other provider settings to improve overall coordination of health care in the community. She has more than 10 years experience as a home health/hospice services director, and has had an active leadership role in the Minnesota HomeCare Association. She has experience in a variety of clinical areas including: home health, hospice, coronary care unit (CCU), medical-surgical, and obstetrics. Janelle has a Master of Nursing from Bethel University, Bachelor of Science in Nursing from the University of Iowa, and is a Certified Professional in Healthcare Quality (CPHQ).

Karla Weng, MPH, CPHQ, Program Manager, Stratis Health
Karla Weng has been a program manager for Stratis Health since 2000 and co-leads the Minnesota Rural Palliative Care Initiative. She is the rural program area lead for the organization and also supports collaborative performance improvement project efforts among Minnesota health plans and provides expertise to a variety of Stratis Health efforts focused on rural providers. Karla directed Stratis Health’s rural QIO Support Center (QIOSC) work from 2005 to 2008, has been the primary liaison for hospitals and clinics in the northwest and north central regions of Minnesota, and has led Stratis Health’s improvement efforts with clinics and health plans. Karla has a Master in Public Health Administration from the University of Minnesota, an undergraduate degree in Community Health Education from Minnesota State University – Moorhead, and is a CPHQ. She is also on the board of the Minnesota Rural Health Association and was a 2008 National Rural Health Association fellow.

Lyn Ceronsky, DNP, GNP, FPCN, Palliative Care, Fairview Health Services
Lyn Ceronsky has directed the Fairview system palliative care program since 2000 and is the principal investigator for the Fairview Palliative Care Leadership Center. She serves as faculty for the Center to Advance Palliative Care (CAPC). She provided content expertise for the Minnesota Rural Palliative Care Initiative, which formed the context for her doctoral work in palliative care program development. Lyn is certified as a gerontological nurse practitioner, and as an administrator in hospice and palliative care. She has over 35 years of experience in oncology, geriatrics, and palliative care in hospital and clinic settings. She is a board member for the National Board of Certification for Hospice and Palliative Nursing, and was named a fellow in Hospice and Palliative Care in 2010. She received the Oncology Nursing Society award for excellence in writing in nursing research in 1997. Lyn received a Bachelor of Science from the College of St. Benedict and her master's and doctoral degrees from the University of Minnesota.
## Appendix C. Minnesota Rural Palliative Care Initiative Summary of Community Activities – March 2011

### Table 1. Communities Providing Palliative Care to Persons/Families

<table>
<thead>
<tr>
<th>Community/setting</th>
<th>Comments</th>
</tr>
</thead>
</table>
| **Red Wing**      | • Utilize nurse practitioner in nursing home as key palliative care contact  
| Nursing home, outpatient clinic, community | • Implemented palliative care in all three LTC facilities in Red Wing  
| | • Conduct interdisciplinary team (IDT) communication with nursing home staff  
| | • Conducted a patient satisfaction survey  
| | • Conducted “Living Well with Chronic Conditions” workshops to community members that included palliative care and advanced care planning  
| | • Implemented Honoring Choices Minnesota (participated in 2010 pilot) |
| **Roseau**        | • Provide services to patients that qualify for the Medicare Home Care benefit as well as other provider sources (VA)  
| Home care        | • Services provided:  
| | o Pain and symptom management  
| | o Social services  
| | o Rehabilitation services (PT, OT, ST)  
| | o Volunteers  
| | • Palliative care team consists of: chaplain, social worker, nursing, volunteers  
| | • Using ICSI guidelines  
| | • Received palliative care grant from DHS  
| | • Plan for palliative care to be a part of their chronic disease management program |
| **Staples**       | • IDT meets every 2 weeks. Team consists of: MD, nursing, pharmacy, APN in psychiatry, social worker  
| Outpatient (infusion center), inpatient consultation, nursing home (care center) | • Services provided:  
| | o Pain and symptom management  
| | o Social services  
| | o Volunteers  
| | o Bereavement  
| | • Use symptom management order set across the continuum  
| | • Hired RN palliative coordinator in early 2010  
| | • Hired social worker in mid-2010 (palliative care, medical home, outpatient)  
| | • Participating in the Northeast Minnesota Health Education Center Palliative Care Initiative  
| | • Received the Stratis Health Building Healthier Communities Award for “Staples Community Physician Orders for Life-Sustaining Treatment (POLST) Project” |
| **Waconia**       | • Inpatient consult model using CNS and MD for initial consult, then CNS will continue. |
| Inpatient consultation model | |
| **Wadena**       | • Provide services to patients that qualify for the Medicare Home Care benefit  
| Home care        | • Services provided:  
| | o Pain and symptom management  
| | o Spiritual care  
| | o Volunteers |
| **Winona**        | • Provide services to patients that qualify for the Medicare Home Care benefit  
| Home care, nursing home | • Nursing home focus is on advanced care planning.  
<p>| | • Have standard order sets |</p>
<table>
<thead>
<tr>
<th>Community</th>
<th>Main area of Focus</th>
<th>Comments</th>
</tr>
</thead>
</table>
| Bemidji   | Health care professional and community education (palliative care)                | • Developed community education brochure  
• Speaking to multiple community groups  
• Presentation on local television station  
• Multiple presentations to health care professionals |
| New Ulm   | Advanced care planning using Honoring Choices Minnesota model                     | • Advanced care planning facilitators are trained in hospital, clinic, nursing home, home care and hospice  
• Implementing POLST form |
| Olivia    | Comfort care order set End-of-life packet (symptom management)                    | • Order set first used in hospital. Plan to extend to other areas, such as home care and long term care |
| Willmar   | Comfort care order set                                                            | • Using order set in the hospital setting  
• Plan to expand to use in nursing home |