

Minnesota Rural Palliative Care Initiative

Learning Collaborative Project Brief

Ten rural Minnesota communities established or strengthened palliative care programs in their communities through the Minnesota Rural Palliative Care Initiative. From October 2008 to April 2010, the communities participated in an 18-month learning collaborative developed and led by Stratis Health, in partnership with Fairview Health Services Palliative Care Program.

Participating communities included Bemidji, New Ulm, Olivia, Red Wing, Roseau, Staples, Waconia, Wadena, Willmar, and Winona. The size of the population served in each community varied from 9,000 to 200,000 with a median of 49,000.



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.

Each community formed a multi-setting, interdisciplinary team that participated in three learning sessions and an outcomes congress, and received ongoing technical support. As a result of participating in the initiative, all 10 communities developed work plans to implement a palliative care program in their communities.

Participating health care professionals reported increased knowledge of symptom management and effective care-goals discussions. Six of the 10 communities were 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, implementation of common order sets across care settings to support effective communication for patient transitions, and provided education on palliative care to health care professionals and others in their communities.

“The initiative helped us stay focused. It’s been a great help. I don’t think we’d be where we are without it.”
- Lakewood Health System, Staples

Palliative Care. 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.

Palliative care may be offered in a variety of settings: hospitals, long term care facilities, clinics, or patient’s homes. As well as improving patient comfort and family satisfaction, studies have shown that 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. Cost savings can result from shorter lengths of stay, or reduced laboratory, intensive care unit (ICU) and pharmacy costs.

Palliative Care in Rural Communities. Rural communities have less access to palliative care services, and do not have specific models of palliative care relevant to their communities to use as guides in developing a program. 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. 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.

To help address this need for palliative care services in rural Minnesota, Stratis Health

developed the Minnesota Rural Palliative Care Initiative.

Minnesota Rural Palliative Care Initiative. The initiative 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*.

Framework for a Custom-designed, Community-based Palliative Care Program

Elements	Evidence-based Guidance
Community data and goals, stakeholder input, community-based team	Community capacity theory and model
Structured process for development/implementation	Learning collaborative model
Access to national standards, intervention models, and resources	NQF Preferred Practices

After acceptance into the initiative, each community team completed a needs assessment and participated in an interview with the project team. These were used to determine education needs, and to understand community structure and issues. Curriculum was designed to respond to those needs and adapted to needs identified throughout the initiative.

The three in-person learning sessions on palliative care 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.

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. Stratis Health created a microsite www.stratishealth.org/palcare, 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.

Limited models or examples of palliative care services exist in rural communities from which to draw best practices. Through the initiative, each community team identified its current gaps in service, needs of its community, and available resources. The teams then developed a program matched to the needs and resources in their community.

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.

“I welcomed the support offered through educational learnings, conferences and networking. We’ve connected with other communities and collaborated together to provide the best care for our patients.”
 – Fairview Red Wing Health Services,
 Red Wing

Results. As of April 2011, six of the 10 communities were enrolling patients and providing interdisciplinary palliative care services. Three of the communities have expanded services beyond their initial pilot site.

- 100% of the communities developed a work plan to implement a palliative care program
- 81% of health care professionals reported increased knowledge regarding effective care-goals discussions, and 73% reported increased knowledge regarding pain management

While most current models for palliative care programs focus on larger tertiary hospitals, rural communities can develop creative methods to provide palliative care services. The models for service delivery developed by the participating communities vary widely. Services are based out of home care, or are led by an RN or NP coordinator housed in the clinic or hospital.

Services are 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.

All 10 of the participating communities worked toward process and system improvements related to aspects of palliative care.

Process and system improvements	Communities implemented
Advanced care planning/advance directives	9
Common order sets across care settings/Consistent order sets among two or more settings	7 3 plan to implement
Community education and outreach	8
Health care professional education	8

Three factors contributed in a major way to the success of the initiative: 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.

Recommendations. Palliative care programs and services align well with other efforts to redesign care delivery across settings of care in communities. The project team identified several recommendations through this initiative, including:

- 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.
- Ongoing networking for learning and sharing is critical to sustaining rural palliative care programs. Most rural communities that participated in the initiative 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.

- Research into appropriate community-based palliative care metrics, and technical assistance for data collection and review, is needed to assess the cost-benefit value of rural palliative care services, including their affect on cost, quality, readmissions, and patient and family experiences.
- Having additional payers and insurers, and ideally Medicare, cover palliative care services as a benefit would make a significant difference to the sustainability of current programs in rural communities, and would greatly enhance the likelihood of interdisciplinary program expansion for additional patients, and/or program development in additional communities.
- Having community-based teams identify their goals and resources, then develop plans for implementation with a focus on current strengths and resources, should be considered as an implementation model for care delivery methods that cross multiple-settings.

Community capacity building and health reform. Palliative care programs and services align well with other efforts to redesign care delivery. The Minnesota Rural Palliative Care Initiative required participating teams to have representatives from organizations across settings of care in their communities. Similarly, health reform efforts at the state and national levels are calling for increased coordination across settings of care. The initiative’s approach of 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/ health care homes, and shared decision making.

Developed within the public health realm, community capacity development theory focuses on transferable knowledge, skills, systems, and resources that affect change on the community and individual levels.

Because palliative care is about caring for the whole person, it requires the support of an

interdisciplinary team. The communities that have participated in the initiative have built and strengthened relationships across departments and across organizations in order to develop and support palliative care services. This connectivity will serve them well in supporting other cross-setting initiatives.

Numerous tools exist to address barriers in care coordination and reducing hospital readmissions—the primary challenge is bringing together community teams to implement the tools, processes, and services.

The [full project report](#) is available online.



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Stratis Health works to establish or strengthen palliative care programs in rural communities. Contact us for assistance related to rural palliative care. More information and our online resource center of actionable resources and best practices to foster palliative care in rural communities are available at www.stratishealth.org/palcare.

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