

Community-Based Palliative Care in Rural Oregon



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Objectives

- Discuss ways to develop and sustain community-based palliative care programs in rural communities.
- Explore techniques to address the challenges inherent in rural palliative care.



The Peace Harbor Community-Based Palliative Care Program



The Community

- Located on the Oregon coast
- Population:
 - Florence = 8,800 people
 - Mapleton = 918 people
 - Deadwood, Swisshome = approximately 500 people
 - Peace Harbor's patient panel = 18,000
- Retirement community
 - 36.4% of population is over the age of 65-years-old (2010 census)
 - Volunteerism
- Our demographic area – approximately 950 square miles





Palliative Care Program Objectives and Goals

- Improve the quality of life for patients and their families
- Offer compassion, psychosocial, and spiritual support
- Improve access and continuity of care
- Provide education to patients and families regarding the disease process and advance care planning
- Eliminate and/or decrease needless and unwanted hospitalizations and Emergency Department (ED) visits
- Coordinate care with community partners

Program Scope

- Available Monday through Friday from 8 a.m. to 5 p.m.
 - Offer 24-hour coverage to facility patients only
- Serving patients in 7 different local facilities (memory care, assisted living, foster homes)
- Now admitting the highest need home-based patients
 - Usually home bound
- Serving patients discharged from hospice (no longer meeting hospice admission criteria) and have significant difficulty getting into the clinic for appointments.

The Team



- Dr. Stephen Kerner – Board-Certified Hospice & Palliative Care Physician
- Marti Manko – Nurse Practitioner
- Suzan Larson – Medical Office Assistant (MOA)
- Donna Becker – Medical Social Worker
- Marti Free – Chaplain
- Kyla AndrewsMcNew – RN / Program Manager
- Volunteers – 29 current volunteers

- Offer a “primary care” model of Palliative Care
 - Dr. Kerner resumes as the Primary Care Provider for most of our patient population
 - Increases time requirements for patients
 - Helps patients:
 - Less confusion about who to call for what
 - Helps our team to manage care better – we are tending to all symptoms, medication needs, etc. Less likely to go to the Emergency Department or the hospital.



The Volunteer Program

- Offer companionship, support, and respite care
- Licensed Massage Therapist
- Transportation volunteers
- Office Volunteers
- Check-In Volunteer
- Pet Care program



The Patients

- Current census of approximately 85 to 105 patients
 - 2/3 of patient population resides in a facility
 - 1/3 of patient population in their own home
- Our program has served over 311 patients thus far
- We have approximately 35 to 40 pending patients at any given time.
 - Averaging 8-9 admissions per month.
 - Averaging 6-7 discharges per month.
 - Averaging 16-17 new referrals per month.



Program Success Stories

- Community Support:
 - Before the business plan was completed and approved, we had funding available for the first 2 years of the program (community and staff donations + one grant).
- We have an active and thriving Palliative Care Volunteer Program.
 - Over 1600 hours donated in 2018.



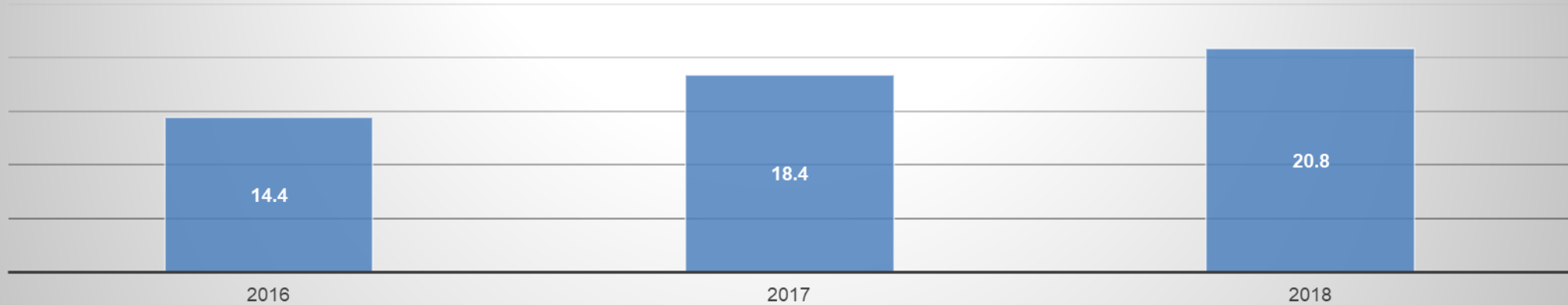
- Completed/revised over 140 Physician Orders for Life Sustaining Treatment (POLST) forms – this assures that patient's wishes are respected at end-of-life.
- We are maintaining sustainability due to Dr. Kerner's ability to bill for services. As a result, we were able to hire a Nurse Practitioner for our team.



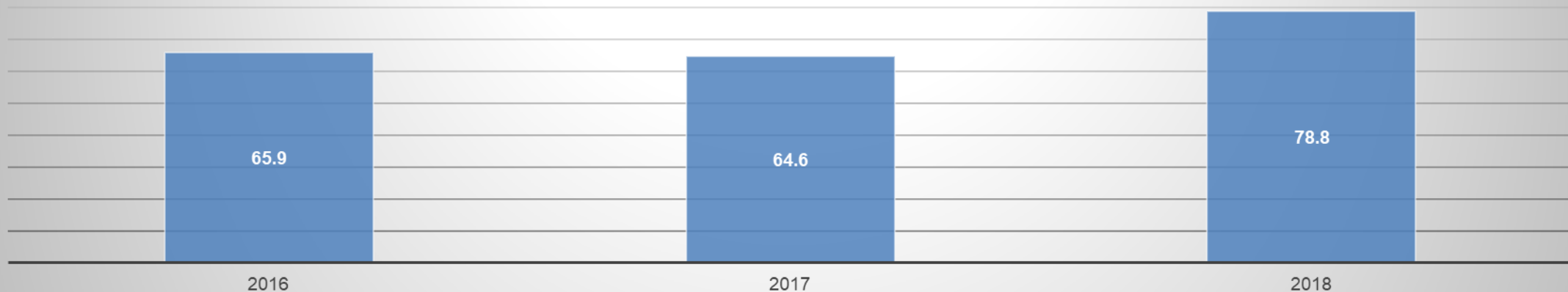


- Increased hospice census and length of stay (LOS)

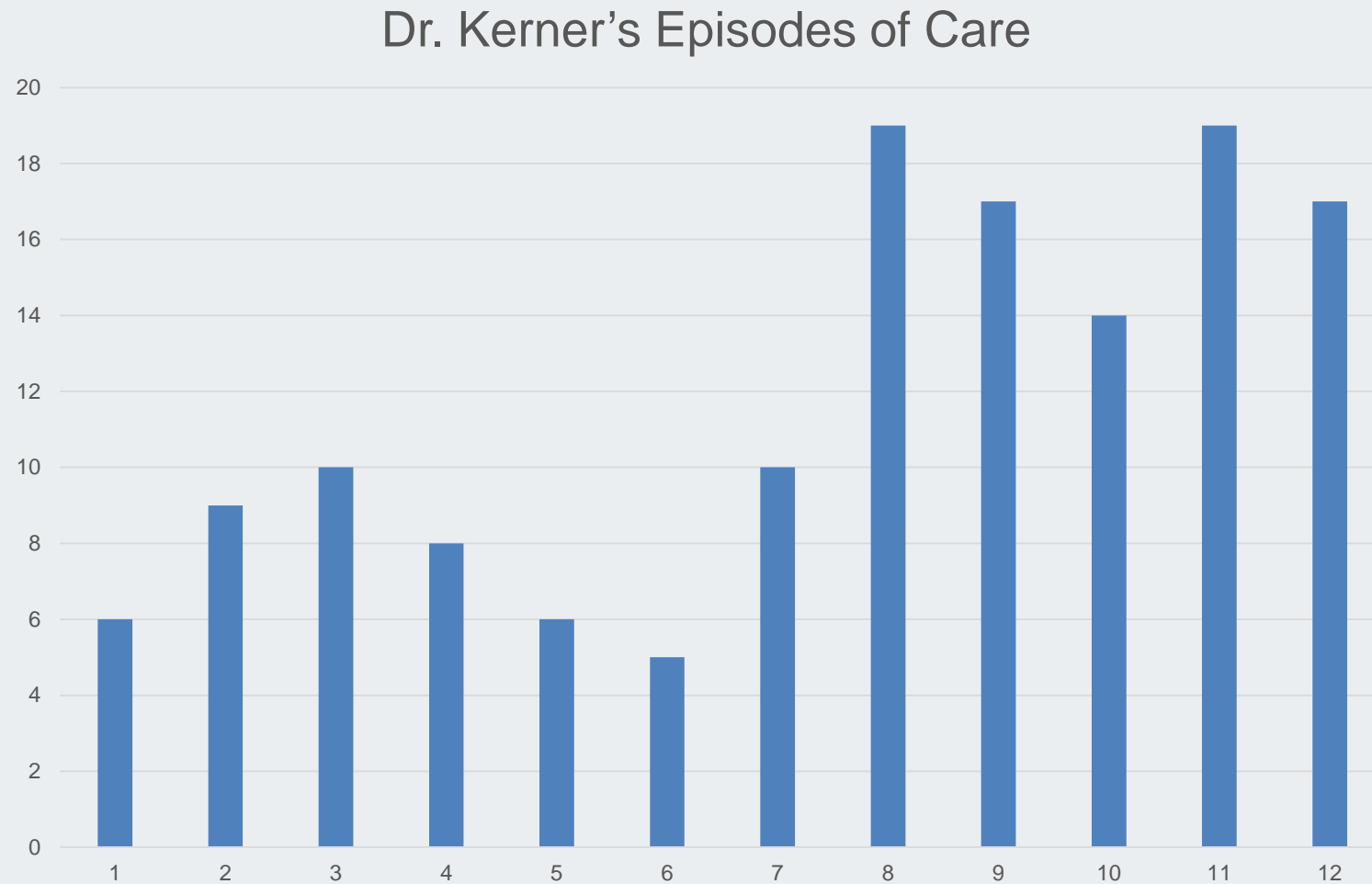
Hospice Census



Hospice Length of Stay



- Increase in Home Health referrals, census and episodes of care

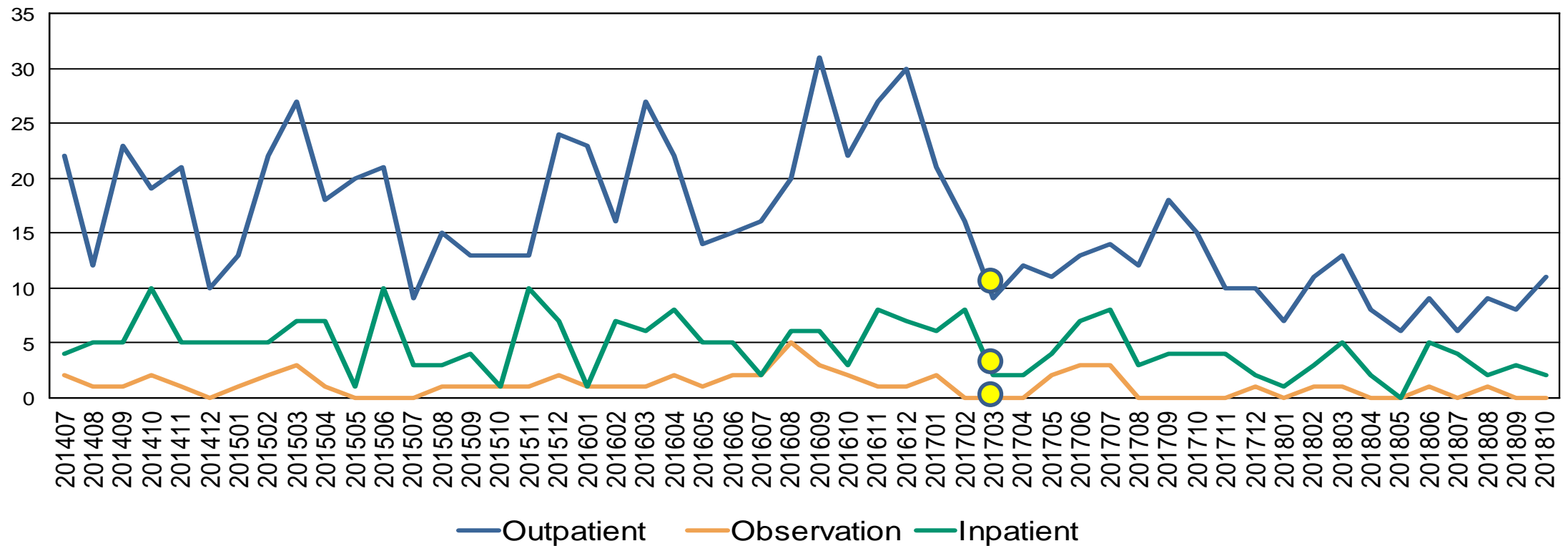


- Reducing unnecessary Emergency Department visits and hospitalizations
 - If a facility calls with an urgent patient need, Dr. Kerner can usually arrange to see the patient either the same day or the next day.

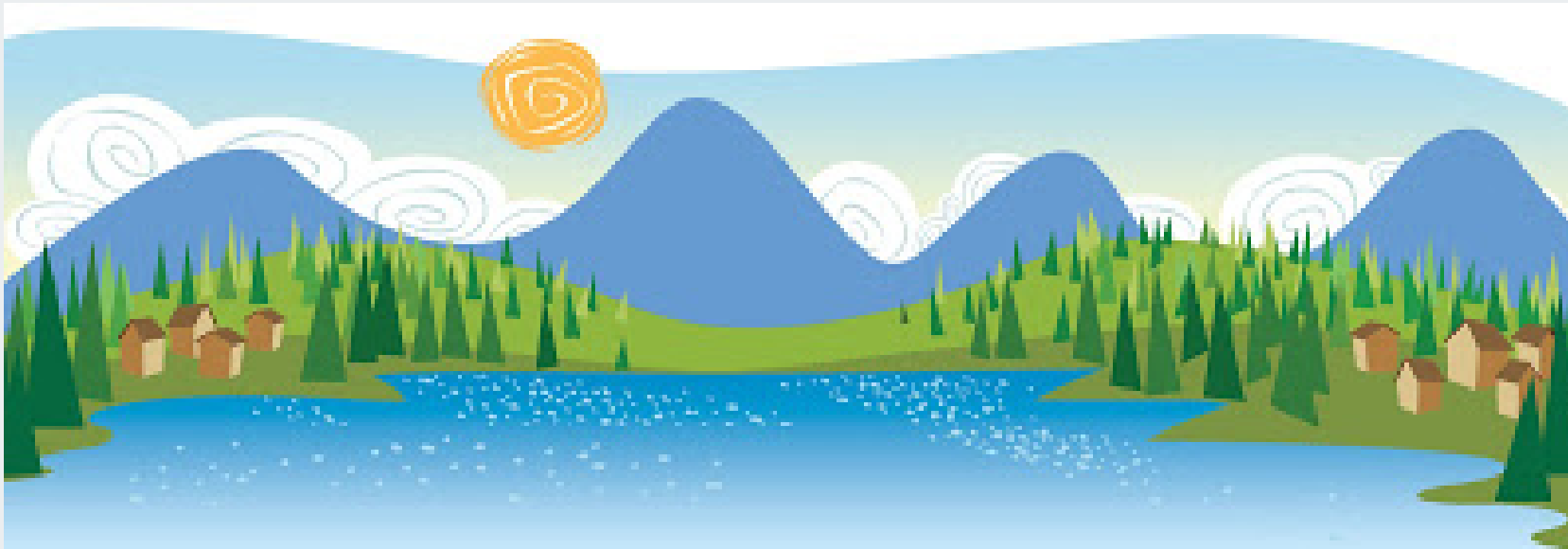




Reduction in Emergency Room Visits and Hospitalizations - patients from local facilities




Palliative Care: The Challenges of Rural Communities



The Challenges

- Staffing and Resources
 - Recruiting Palliative Care Team Members in rural settings
 - Striving to offer interdisciplinary support
 - Offering coverage that meets patient's needs and team goals
 - Time – optimizing the skills and time available with small teams
 - Funding (staffing, supplies, operation costs, etc.)
 - Accessing medical services (labs, imaging, etc.)
- Working with several Electronic Medical Records (EMRs)

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- Managing referrals
 - Creating capacity to manage new referrals and current patients
 - Demonstrating Program Value
 - Tracking statistics and metrics
 - Balancing value-based services in a fee-for-service world
 - Patient Experience Surveys
 - Education
 - Providers and staff
 - Community partners and facilities
 - Community

Addressing the Challenges





Staffing and Resources

- Recruitment
 - It took our team 18 months to recruit a Nurse Practitioner
 - Finding qualified providers
 - Willing to train the right candidate
- Striving to offer interdisciplinary support to our patients
 - Started with physician, social worker, and medical office assistant
 - Recognized the need to offer comprehensive services:
 - Added a chaplain to our team with Foundation funding
 - Advocating for nursing support
 - Advocating for mobile labs and imaging

- Offering coverage that meets the patient needs and team goals
 - Able to offer 24-hour support to facility-based patients only
 - Recruited 2 other providers to help with call schedule
 - Still unable to offer 24-hour support to home-based patients





- Time – optimizing the skills and time available with a small team in a rural setting
 - Maintaining regular contacts with patients
 - Assuring that a team member is connecting with patients on a regular basis (telephone, in-person visits)
 - Formed collaborative relationship with Mobile Integrated Healthcare worker (Community Paramedic)
 - Works with our team one day per week and “as needed” during the week
 - Formed collaborative relationship with clinic nurse care coordinator
 - Works with our team one afternoon per week

- Formed collaborative relationship with local surgeon – willing to do home visits
- Use of Volunteer Program:
 - Respite and companionship volunteers
 - “Check-In” Volunteer
 - Calls all home-based patients/caregivers once per week
 - Uses a “call script” to assess for needs
 - Helps to identify patients with more urgent needs (medications, new symptoms, etc.)



- Travel time
 - Grouping visits – rounding at the facilities on specific days, seeing several patients in the same vicinity on the same day



- Funding
 - Community Support – continue to receive regular donations for our program
 - Dr. Kerner and Marti's ability to bill for services
 - Ongoing relationship with Peace Harbor Foundation to access support for highest needs (i.e., chaplain)
 - Continuously looking for funding opportunities including private donations, grants, collaborative relationships with our CCO



- Improving patient access to medical services
 - Mobile Integrated Healthcare worker has been drawing labs for all home-based, homebound patients
 - Exploring ways to offer mobile phlebotomy, laboratory and imaging services
 - Our program belongs to a larger healthcare system – specialists including Cardiology, Urology, Oncology, etc. come to Florence on a regular basis.

Electronic Medical Records

- Dr. Kerner has to work with several EMRs – our program's EMR, local facilities each have their own EMR, and our Home Health and Hospice team has their own EMR
- Difficulty with Medication Reconciliation, getting updated notes, etc. – our Medical Office Assistant is constantly requesting records and updating our EMR



Managing Referrals

- Receive 13-16 new referrals every month
 - Increased awareness of the program in our community
- Wait list – continued to grow during 2018
 - Recognizing the need is higher than expected





- Referral sources

- Approximately 35-45% from Primary Care Providers, 20-30% from local care facilities
 - Education regarding appropriate referrals
 - Education about the wait list
 - Contact all referrals to inform them of the wait list
 - Urgent situations – can usually see them within a few days



- Establish eligibility criteria and defining population to serve
 - Started slow – facility patients only and hospice discharges
 - Gradually added highest need home-based patients
 - Homebound and cannot access medical care
 - Patients without a Primary Care Provider
 - Frequent Emergency Department visits and hospitalizations
 - Use a Screening Tool to help prioritize patients
 - Continuously re-evaluating eligibility criteria and discharging patients who are no longer appropriate.

- Recommend completing a Community Needs Assessment to define program criteria; assure you are meeting the needs of the target population.



Demonstrating Program Value

- Continuously tracking program statistics and metrics
 - Using volunteers for data entry
 - Running quarterly and annual reports
 - Assuring this information is distributed to people who need to see it
- Balancing value-based services in a fee-for-service world
 - Support from administration
 - Providing more community-based services
 - Goal of eliminating unnecessary and unwanted ED visits
 - Preventing hospital readmissions

- Completed a 12-question Patient Experience Surveys
 - Received positive feedback regarding what is working well and where we need to make some changes
 - Will continue to do annual surveys



Education



- Accepting offers for community education
 - Completed over a dozen presentations about Palliative Care
 - Community organizations, faith communities, etc.
 - Provider meetings, clinic staff, hospital staff
 - Facility staff meetings
 - Balancing increased community awareness with rising number of referrals

