Washington Rural Palliative Care Initiative

Sponsored by the Washington State Office of Rural Health

And a public-private partnership of over 24 different organizations

Report on the

2018 Rural Palliative Care Telehealth Case Consultation Pilot

EXECUTIVE SUMMARY

The Washington Rural Palliative Care Initiative (WRPCI) is a pilot effort to better serve patients with serious illness in rural communities.The Palliative Care: Rural Health Integration Advisory Team (PC-RHIAT) guides the Washington Rural Palliative Care Initiative, engaging seven rural communities in the first cohort. Members of PC-RHIAT represent 24 public and private organizations with rural health, palliative care and telemedicine expertise. It is led by Pat Justis, executive director of the State Office of Rural Health at the Washington State Department of Health. This public-private partnership is designed to assist rural health systems and communities to integrate palliative care in multiple settings, such as emergency department, inpatient, skilled rehabilitation, home health, hospice, primary care, and long-term care.

The initiative is also integrated within a multi-state project led by Stratis Health, the quality improvement organization for Minnesota (MN). Stratis began rural palliative care work in 2008, helping two dozen MN rural communities sustain palliative care.

Palliative care is specialized care for people living with serious illness. Care is focused on relief from the symptoms and stress of the illness and treatment—whatever the diagnosis. The goal is to improve and sustain quality of life for the patient, loved ones, and other care companions. It is appropriate at any age and at any stage in a serious illness, and can be provided along with active treatment. Palliative care facilitates patient autonomy, access to information, and choice. The palliative care team helps patients and families understand the nature of their illness, and make timely, informed decisions about care[1].

The overarching goals of this initiative are to:

- Assist rural health systems and communities to integrate palliative care in multiple settings to better serve patients with serious illness in rural communities.
- Move upstream to serve patients with serious illness earlier in their illness.
- Develop funding models for sustainable services.

Rapid cycle quality improvement tools and methods using small tests of change underpin the initiative. Eventually rural centers of excellence in palliative care will assist with statewide spread of rural community-based care for serious illnesses.

Chartered work groups coordinated through PC-RHIAT focus on:

- Community engagement
- Clinical and culture change strategies
- Telehealth case consultation and clinical telemedicine

A partnership with payers to develop value-based contracts and benefit designs for palliative care drives sustainability. This set of interventions can result in better symptom control, an improved care experience for the patient and family, improved quality of life, fewer hospital stays, fewer emergency department visits and readmissions, and reductions in transfers out of the community. This improved

[1] Adapted from the Center for the Advancement of Palliative Care (CAPC) and the National Consensus Project for Quality Palliative Care

care can reduce the total cost of care significantly enough that payers may contribute savings back to rural communities to sustain the program, and health plans may offer robust palliative care benefits. As rural communities face the challenge of a disproportionate boom in an older adult population, these services will be critically important to the quadruple aim of better care, better health, improved value and better experiences for rural clinicians.

THE TELEHEALTH PILOT

In June 2018, the Telehealth Case Consultation and Clinical Telemedicine Work Group launched a telehealth case consultation pilot program and began using an expert palliative care interdisciplinary team on a HIPAA-compliant web-based platform.

- The seven palliative care cohort site teams participated in a team-based case consultation pilot, designed to develop a learning community over a six-month period with 12 sessions.
- A nursing coordinator screens and organizes the cases from the seven sites, prepares the expert team, and facilitates the consultation process.
- The tele-palliative care case consultation pilot was funded by funds from three sources:
    - Amerigroup/Anthem, a private insurance company is contracted by Washington State to serve the Medicaid population with managed care,
    - Stratis Health, a healthcare quality organization passing through private foundation funds, and,
    - The State Office of Rural Health federal grant (grant H95RH00130).
- Plan-do-study-act (PDSA) cycles have created a culture of continuous improvement. Each session is followed by a staff and panelist debrief, and a participant experience survey is disseminated to all who attended.

GOALS OF THE PILOT

- The pilot provides expert consultation on patient cases from an interdisciplinary palliative care expert team, giving rural teams access to professional skill sets not present in the community.
- Case consultation also serves as a developmental step in the process to get each site ready to use technology for telehealth and clinical delivery of telemedicine. The stage is set to advance to telemedicine for patients and families. Initially healthcare organizations will serve as an originating site, then add patient homes and tele-monitoring.
- The pilot was geared to increase the confidence of the rural clinicians in the belief they would be able to care for patients with more skill as their confidence increased.
- It was hypothesized that medical staff support for the initiative would grow as providers received concrete assistance with challenging serious illness management.
- The consultation uses an interdisciplinary team of experts in interaction with an interdisciplinary rural team. We want to avoid a physician- or provider-centric model.
- Case consultation sessions occur via a HIPAA-compliant videoconference platform in combination with web-based Zoom, contracted with Northwest Telehealth. Northwest Telehealth also provides technical assistance and technical coordination for each session.

- All seven sites are asked to attend each session with rotating case presentations. Six of the sites view the consultation gathered as teams. The frontier county team (Okanogan) is spread over several different communities and signs on individually.
- The expert panel comprises three board-certified palliative care physicians and a former oncologist who provides volunteer house call palliative care, a palliative care pharmacist, a master's of social work (MSW), registered nurse, chaplain, and palliative care specialized pharmacist. Contracts with a mental health therapist and a nurse practitioner were not able to come to fruition at this time.
- The cases drove different learning objectives for each session and dyadic instruction was interwoven.

Total number of telehealth case consults: 12
(June to November 2018)
Total participating panelists by profession:

Physician	4
Pharmacist	1
Spiritual Care	1
Social Worker	1
Registered Nurse	1

> "I think there is a lot of value in talking through examples from other similar cases."
>
> Cohort participant

NURSE COORDINATOR ROLE

Deb Watson, RN from Pullman Regional Hospital, serves as a clinical coordinator and represents nursing on the expert panel. This role served as a critical point of coordination.

- She helps gather, screen and refine cases, ensures patient privacy and prepares the consulting panelists for the telehealth event.
- Deb provides a level of support and mentoring that bolsters the confidence of case presenters, helps participants calibrate expectations, and encourages the uptake and use of standardized clinical tools such as the adopted screening tool.
- She drafted and refined templates to support the case presentation process, including the framework that drove the agenda. She also kept records of each session.
- During the sessions, Deb made introductions of panelists and case presenters, and ensured smooth transitions and on-time closure.

THE PORTAL

Initially, cases were distributed by confidential email, which proved cumbersome. As part of building out a portal of resources, a team space was launched that offers a password-protected platform where case details are posted, and where panelists can review the case and interact with each other to plan the session. Participants receive auto-notifications when new messages are posted.

The portal will also support a comprehensive repository of rural palliative care resources and team spaces for the cohort and PC-RHIAT.

EXAMPLE IMPROVEMENTS AND LESSONS LEARNED

- In initial sessions the case presentations took a great deal of time. This was changed to a distributed longer case that was verbalized with synopsis for the session. Teams also learned to more sharply pinpoint what they sought from the consultation.
- To increase the confidence of the rural clinical teams, it was important to give them an opportunity to interact, express their knowledge, and have their knowledge and skills confirmed. This meant the panelists learned to step back from the pressure of being the "I have the answer" expert and employ empathy, appreciation for strengths and create a collaborative dialogue.
- The initial sessions were more medication-centric. Soon the team learned to use the full range of disciplines artfully to explore many different types of approaches to a particular patient and family, and to think more holistically about the care.
- Panelists have different ways of preparation. Some were comfortable responding in the moment while others preferred case material in advance to prepare the response. This required a cycle of case screening and posting that was deadline-driven.
- Deb works to find the "sweet spot" in communication to keep the panelists and cohort team leads informed without overwhelming with multiple emails. She arrived at a weekly digest that summarizes the information for the week.
- The case presentations need a pace that allows for going deeper into some cases; not all cases fit into the same time frames. This became the art of the clinical coordinator to recognize the time needs of a particular case. Cases naturally point to education topics for the future and needs for particular policies or protocols.
- The teams learned that they crossed paths with patients with serious illness who might benefit from palliative care services in many different places within the rural health systems. This stimulates planning focused around "no wrong door" and the ability to follow the patient through different settings. This is not possible in all communities because of resources but is an aspirational design.
- The gap between the patient and family needs teams began to identify and the capacity to provide services was an acknowledged source of both angst and motivation. The business case for palliative care emerges as a continual theme for further work. The teams are committed to find ways to move beyond the fractured and incomplete payment.
- We added follow-up reports so the panelists could hear how the patient did after changes to the care plan. Later we integrated having panelists present and model their thinking process with a complicated case.
- Participants became committed to help their financial and executive leaders understand the importance of palliative care.

> "The consultants and participants all interacted in a collaborative, positive educational manner which was wonderful."
>
> Cohort participant

COMMON CLINICAL THEMES

- Pain control
- Pharmacy/drug interactions
- Addiction and alcoholism concurrent with serious illness
- Behavioral health
- Helping family and patient come together on next steps
- Family and grief counseling
- Team processing and meeting the team's needs for debrief after hard cases
- Dementia care
- Impaired family caregivers
- Patient self-neglect
- Long-standing psychosocial patterns and the realistic role of the team

"I really feel these consultation presentations are valuable and the information is pertinent to providing quality care."

Cohort participant

RESULTS

Although only 20 percent of participants responded to session evaluations, those who did respond gave positive feedback.

- 88 percent strongly agreed telehealth case consultation was useful to their job
- 85 percent found the case consultations valuable.

Report out by numbers:

Total unduplicated attendance by profession and community:

Community	Profession	Total Number
Pullman (18)	Nurse	7
	Social work/social services	3
	Pharmacy	5
	Nurse Practitioner/Physician Assistant	1
	Hospice Chaplain/spiritual care	2
Dayton (18)	Nurse	6
	Social work/social services	3
	Nurse Practitioner/Physician Assistant	4
	Physician	3
	Administration (CEO)	1
	Student	1
Port Townsend (5)	Nurse	2
	Social work/social services	1
	Physician	1
	Quality Improvement	1
Ephrata (11)	Nurse	4
	Nurse assistant	1
	Social work/social services	1
	Nurse Practitioner/Physician Assistant	1
	Physician	2
	Administration	1
	Other	1
Colfax (3)	Nurse	2
	Other	1
Okanogan County (11)	Nurse	3
	Nurse Practitioner/Physician Assistant	2
	Physician	5
	Social work/social services	1
Newport (13)	Nurse	8
	Social work/social services	2
	Pharmacy	1

	Administration	1
	Other	1
Total team participants by profession	**Nurse**	**33**
	Nursing Assistant	**1**
	Social work/social services	**11**
	Pharmacy	**6**
	Nurse Practitioner/Physician Assistant	**8**
	Hospice Chaplain/spiritual care	**2**
	Physician	**11**
	Quality Improvement	**1**
	Administration	**3**
	Other	**3**
Total participants		**79**
Administrative/PCRHIAT Team	**DOH**	**4**
	Stratis	**1**
	Nurse Coordinator	**1**
	Northwest Telehealth	**3**
Total Administrative/PC-RHIAT		**9**
Total All (including panelists, participants, administration)		**95**

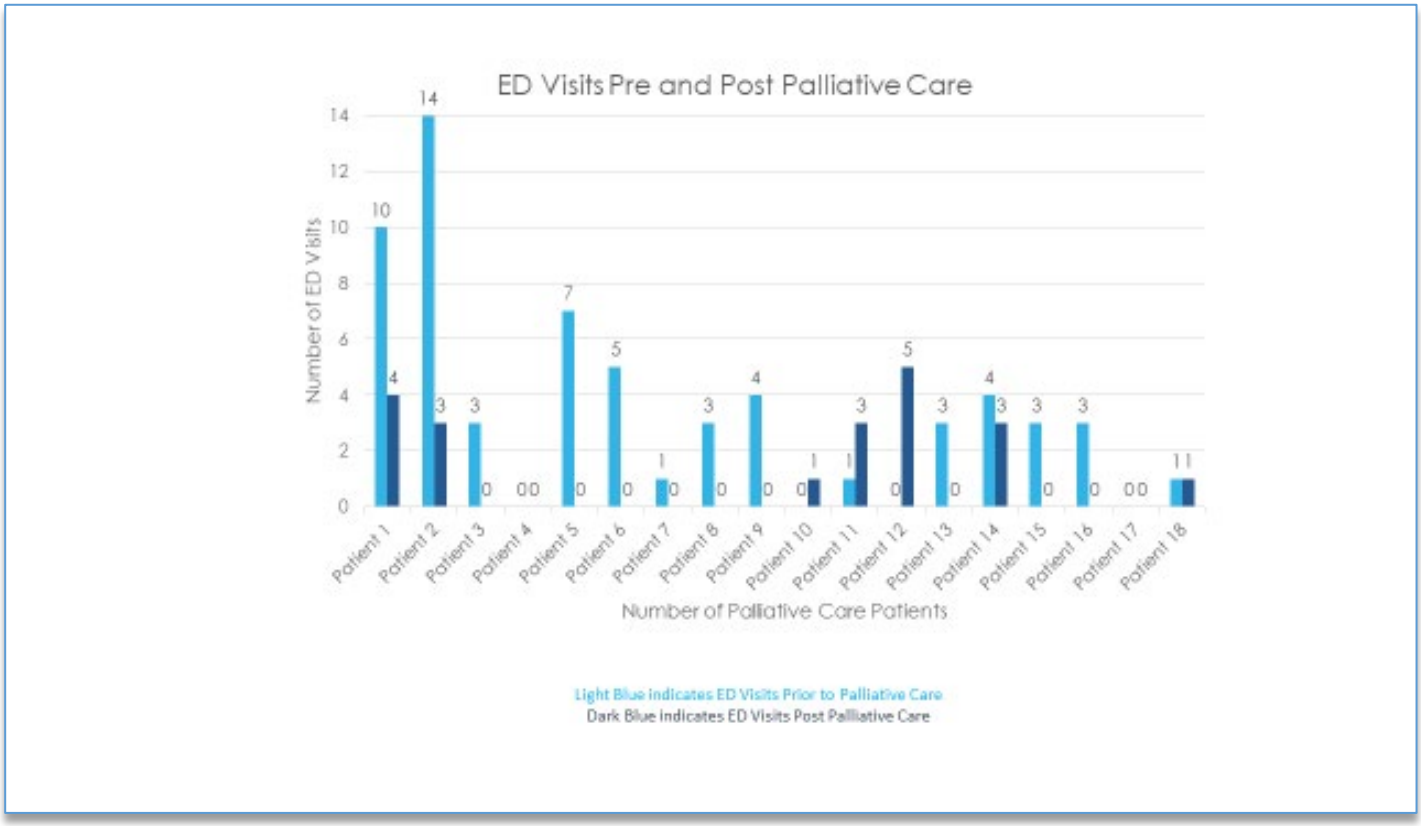
"Without this rural, health care resource, it would have been very difficult to keep my dad in his own home. I will be forever grateful for the CC Palliative care service that provided the supportive, compassionate care that was given to us in our time of need."

Family member in Waitsburg, WA
Population 1,195

POLICY IMPLICATIONS

On December 10 participants from three health organizations in the first cohort were invited to present on palliative care to the presenters [h] for the work group of the Joint Legislative Executive Committee and Aging and Disability. The presenters from Dayton and Pullman both asked for state funding for the rural palliative care telehealth case consultation service because of the value they believe it has had.

Of note, on an early data pull, Dayton's Columbia County Health System was able to show a 68 percent reduction in emergency department (ED) visits for the patients on service with an N of 17. Although the pre and post time frames are of different length, there is an unmistakable trend of decreased ED use.



Graph prepared by Stephanie Carpenter, RN, Columbia County Health System, Dayton

NEXT STEPS AND GOALS

- In 2019 we are offering the case consults once time per month instead of twice because of budget restrictions.
- We will alternate the case conferences with rural palliative care webinar education with two sessions directly focused on telehealth.
- Also on the schedule, cohort roundtables have been introduced to share operational solutions and challenges.
- The participant surveys will provide education topics to grow our educational offerings.
- We will continue to seek capacity-building funds.
- Increased funding could return telehealth frequency to two per month or even more frequently if the demand increases, and potentially open the cohort up to other rural teams. More than a dozen other rural health systems have expressed interest.
- The communities will receive assistance to instigate their delivery of direct clinical telemedicine to patients and families.
- At a national level, Project ECHO group has started a palliative care interest group; Four Seasons palliative care training center in North Carolina has begun rural tele-palliative care services. As community-based and telehealth and telemedicine approaches grow, we hope that payers including CMS for Medicare recognize the critical importance of caring for rural residents with serious illnesses in their own community.
- We hope to play a role in developing a cohesive, multi-setting palliative care benefit in Washington that pays for an interdisciplinary team approach and offers parity for telemedicine.

SUMMARY

Our first-year pilot of a telehealth case consultation for rural palliative care exceeded our expectations. A steady progression of PDSA cycles brought the format to a smooth, interactive, well-paced and deeply respectful process. The rural communities believe their expertise is recognized while they are encouraged to develop skills and knowledge to further strengthen care for community members with serious illness.

CONTACT:
Washington State Department of Health
Bonnie Burlingham, State Office of Rural Health Program Manager
Bonnie.burlingham@doh.wa.gov
360-236-2819

Pat Justis, Executive Director, Rural Health
Patricia.justis@doh.wa.gov
360-236-2805

609-008