Partnering for Palliative Care: Improving Quality of Life in Rural Communities

Cohort:
2019-2022

Team Members:
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Location:
Okanogan, Washington

Focus Areas:
End of Life/Late Stage Care
Health Care Access
Rural Health

Wicked Problem Description

Okanogan County, Washington is a huge, sparsely populated, poverty-stricken county with higher rates of chronic disease and worse health outcomes compared to Washington State and the U.S. For context, the county is 5,281 square miles, yet only has a population of 41,742. Residents of Okanogan County who are chronically ill, elderly and/or experiencing poverty suffer disproportionately and have higher mortality compared to the rest of the state and the country, and this is magnified by the rural nature of the county and the fragmented medical system. County residents who identify as LatinX or Native American face additional challenges, including linguistic, socioeconomic, and cultural barriers to care. All county residents have limited access to specialty care, and most patients who need specialty services have to travel 75-150 miles to the nearest metropolitan area. The COVID19 pandemic has exacerbated the pre-existing challenges that many county residents face in managing chronic illness, accessing healthcare and providing for themselves and their families.

Multidisciplinary, integrated palliative care is not currently available in Okanogan County. There are multiple health service organizations spread across the County, but collaboration among these healthcare agencies has often been stymied by competitiveness, a lack of an electronic means of communication among settings and long distances

separating would-be collaborators. To offer integrated palliative care across the diverse and fragmented care settings in the County, we need a new model of effective, multi-agency collaboration. Creating a sustainable palliative care service is a formidable challenge anywhere, but especially in a large, rural and under-resourced area such as Okanogan County. In rural areas there is a lack of trained palliative care providers and the small, under-resourced healthcare systems struggle to support palliative care services because the traditional fee-for-service reimbursement model does not cover the cost.

Project Strategies

Current Actions

1) We are integrating the Palliative Care team into the local Federally Qualified Community Health Center clinic system. It will serve as our administrative home. As part of this process, we are developing a collaborative effort with Community Health Workers to help serve the LatinX and Native communities.
2) We are refining workflows and a referral process for the clinical service and offering direct services to a limited number of patients as a pilot. We are also developing best practices, utilizing telehealth to reduce travel time and costs and to improve safety for both patients and providers during the COVID19 pandemic.
3) We are consulting with Four Seasons regarding our procedures and policies in Palliative Care delivery. With input from the consultant, we have developed a billing strategy for our clinical service.
4) We are providing Advance Care Planning services across the county, leveraging the training we coordinated for community partners.
5) We are onboarding a new member of our Palliative Care team: Nurse Practitioner Sharmon Figenshaw.
6) We were awarded a 4-year Rural Health Outreach grant from the Health Resources Services Administration (HRSA).
7) We are developing a website for our Palliative Care Initiative that will be a resource for healthcare providers, patients and the general public.
8) We are providing Palliative Care educational offerings via email to community healthcare providers. We are partnering with a doctoral student to develop a Goals of Care conversation training for providers and staff.
9) We are partnering with Honoring Choices Pacific Northwest to outreach to LatinX patients with a Spanish-language program (Prepare) and iPads for delivery of this Advance Care Planning service.

Future Actions

1) We will offer direct palliative care clinical services to a growing number of patients across settings (the home, clinic, hospital and possibly long-term care).

2) We will develop a business plan to reflect the financially sustainable model we will develop in Year 3.

3) We will continue to train community providers across settings to integrate basic palliative care skills into their practices. Our educational efforts will target primary care, hospital and EMS providers.

4) We will continue to expand Advanced Care Planning through ongoing training of Facilitators across the county, as well as educational offerings and patient services.

Outcomes

Overarching Aim: To improve the quality of life of patients with life-limiting chronic disease in Okanogan County

Completed Outcomes:

- Provide palliative care training for Specialty Team, community providers & EMS
- Increase advance care planning, including Latinx and Native communities
- Establish a specialty palliative care clinical service across the County (currently in pilot phase)

Anticipated Future Outcomes:

- Develop financially sustainable model for the palliative care clinical service
- Improve access to palliative care for all patients with special focus on minority populations
- Reduce unnecessary cost, including emergency department visits and hospital admissions

Timeline (for the remaining fellowship time period)

Year Three – Complete integration with administrative home (Family Health Centers) and launch clinical service within the clinic system. Six to 12 months after launching the service within the clinic system, we will be prepared to take palliative care referrals from other partnering healthcare agencies (clinic systems and hospitals). Identify and serve 50-75 patients, providing service throughout the County. Use and evaluate appropriate billing codes. At least double the number of LatinX and Native American patients served compared to year 2. Expand team-based service utilizing Community Health Workers. Promote Advance Care Planning county-wide and continue to train ACP Facilitators to expand the range of service. Perform long term strategic and sustainability planning. Engage with the WA State Palliative Care Initiative to apply billing strategies developed in Years 1,2 (see below). Continue to collect metrics and report to stakeholders.

Partnerships

The Clinical Scholars team is the leadership component of the larger Okanogan Palliative Care Initiative. Partnering agencies include clinics, hospitals, long term care facilities, hospice and emergency medical services. Furthermore, the Okanogan Palliative Care Initiative is in the first cohort of the Washington Rural Palliative Care Initiative, an initiative of the Washington State Department of Health (2017-2020) that supports rural communities in building skills and services in palliative care through networking, sharing best practices, providing a platform for telemedicine, and lobbying to develop palliative care billing codes and strategies. We have a Memorandum of Understanding with 4 key partners (one hospital, 2 clinic systems and Home

Health and Hospice). We are in the process of embedding our services into Family Health Centers (FHC).

Evaluation Strategies and any findings so far

We are designing systems to collect quantitative and qualitative data to assess the project's impact in four areas:

- Clinical Measures
- Clinical Utilization and Cost
- Operational Measures
- Satisfaction and Engagement measures of patients, clinical providers and partners

Our Administrative Assistant is working closely with Family Health Centers finance staff and grant manager to carefully track utilization data and financials. Her skills in grant tracking and management have proved very useful as we expand our funding sources.

Contact Person Information

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