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Advancing Palliative Care Initiatives in Rural Communities: A Community-Centric Approach

James Joseph*

St. Benedicts Hospice, Specialist Centre for Palliative Care, Sunderland, United Kingdom

Abstract

Creating palliative care (PC) initiatives in rural areas presents difculties attributed to constraints in training, workforce, materials, and financial compensation. The utilization of well-established structures and methods can aid rural regions in crafting high-standard PC programs. Our aim was to implement a guided, community-centered planning procedure, facilitating multiple rural community groups across three US states, to foster the advancement of PC programs.

Keywords: Palliative care; Rural communities; Community-centered planning; Program development; Interdisciplinary teams; Healthcare disparities; Qualitative feedback;, Value-based care; Tele-health integration

Introduction

Rural populations typically exhibit characteristics such as being older, experiencing higher mortality rates, having an increased likelihood of dealing with chronic ailments or physical disabilities, and often belonging to lower socioeconomic strata4 compared to their urban counterparts [1-3]. Despite these factors, rural communities face greater challenges in accessing palliative care (PC) services and assistance5 in comparison to urban areas. The provision of PC within a rural context presents complexities. Numerous rural areas aspiring to offer PC services encounter obstacles linked to insufficient clinical training, limited resources, and a shortage of dedicated PC personnel. Moreover, rural communities frequently lack access to specialized hospice or PC experts, and the payment structures are insufficient to sustain PC programs in regions with low patient numbers. Currently, there is a shortage of models and guidance outlining the most effective ways to deliver PC in rural settings. Urban locales possess better capabilities to sustain both hospital-based and community-oriented PC programs, primarily due to the larger patient volumes that enable the formation of specialized palliative medicine teams [4]. Evidence suggests that implementing palliative care (PC) services within hospital settings leads to a reduction in direct hospital expenses, ultimately resulting in an overall financial advantage for the institution. While there exist instances and evaluations of successful PC programs situated in communities, and established benchmarks for the quality of such programs, the available literature provides minimal guidance specifically tailored to rural contexts. Community-based PC initiatives have demonstrated their ability to lower expenses and curtail hospital and care utilization. These programs also broaden the scope of services to encompass almost any location where patients reside, spanning clinics, residences, and nursing facilities [5]. In rural regions, adopting a community-based approach to PC empowers healthcare providers to more effectively address the diverse needs of patients along the entire care spectrum. By collaborating with an array of partners, this model can align services to cater to both medical and nonmedical requirements, thereby enhancing overall quality of life.

Community-centered palliative care (PC) initiatives also play a pivotal role in early identification of patients with intricate care requirements, addressing issues and hurdles prior to escalation into hospitalization. Furthermore, the push for healthcare organizations to gauge quality and curtail expenses has intensified, making community-based PC programs a strategic avenue for tending to patients who might have high resource utilization potential. Inclusive of caregivers, PC programs can extend their support to those tending to their loved ones [6,7]. Caregivers residing in rural locales dedicate more time to caregiving and often oversee multiple individuals, setting them apart from their nonrural counterparts. This trend underlines an amplified necessity for caregiver assistance. Effectively established community-based PC programs commonly rely on interdisciplinary teams to oversee and synchronize patient needs, administrative responsibilities, and care provision [8,9]. In rural communities, the fundamental aspects of PC can be addressed through three pivotal procedures: planning anchored in community capacity, harmonizing healthcare settings and community services, and enhancing clinical proficiency through workforce training. This article delineates a facilitated planning process that is centered around the community, employing a capacity-based approach that emphasizes strengths. This process aids teams in navigating the development of palliative care (PC) services, accompanied by essential resources and opportunities for peer learning, facilitating the acquisition of necessary skills and workflows. Particularly well-suited for resource-constrained rural settings, the community-centric approach concentrates on harnessing and capitalizing on existing strengths within the community. It entails assembling teams comprised of representatives from various points along the healthcare and community service spectrum, collaboratively pinpointing and amplifying existing assets that can cater to specific PC requirements. The outcomes of an initiative that steered multiple community teams in North Dakota (ND), Washington (WA), and Wisconsin (WI) through this method are presented.

Materials and Method

The project's blueprint drew inspiration from a community

***Corresponding author:** James Joseph, St. Benedicts Hospice, Specialist Centre for Palliative Care, Sunderland, United Kingdom, E-mail: james@gmail.com

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capacity development model previously executed by Stratis Health across 26 rural communities, with a primary focus on Minnesota. This model was also implemented in North Carolina, Mississippi, and ND from 2008 to 2014. Framed around the community-centric ethos, this framework evaluates existing requisites and assets, aligns with national benchmarks, and orchestrates a guided, structured planning process to facilitate both development and execution. The program development strategy comprises three interconnected components: foundational elements, process advancement, and service implementation. The foundational aspects encompass educating and raising awareness among professionals and community members, honing fundamental palliative care (PC) skills, and instituting a mechanism for advance care planning and communicating these plans. Process advancement entails crafting service workflows, establishing links between clinical practitioners and community services, and formulating the rationale for PC from a business perspective. The community teams are encouraged to apply a quality improvement methodology for the implementation of PC services. As processes take shape, this involves pinpointing a specific target population and employing incremental tests of change to construct and refine workflows before embarking on expansion and enlargement. During the service implementation phase, the makeup and nurturing of an interdisciplinary community team stand out as pivotal success factors. The evolution of this team can be tracked through stages: from an initial building phase, progressing to an evolving state, and ultimately reaching a thriving level of maturity.

P a e e : Within this endeavor, the State Offices of Rural Health in the designated trio of states took on the mantle of lead organizations, spearheading community-level implementation with the aid of the structural framework, procedural guidelines, and tools offered by Stratis Health (compensation was extended to State Offices of Rural Health through grant funds for their dedication of time and effort) [10]. To streamline state-level resources and bolster support for community teams, each state-leading entity instituted a state-level advisory consortium, comprising a diverse representation of stakeholders. This consortium contributed insights to an environmental scan of state-specific opportunities and challenges associated with the integration of rural community-based palliative care (PC). They provided counsel throughout the program's execution and played a role in addressing foundational requirements such as workforce training, technological provisions, and regulatory

and clinic sta , clergy, nurses, doctors, and community members fostering mutual understanding. e platform to showcase our services, coupled with pooling our resources to enhance palliative care for patients, empowers us to extend our reach far and wide." Others commended the prospect of ongoing growth while acknowledging prevailing hurdles: "Our health system and community team embrace this program, aspiring for its expansion. However, it would be highly bene cial if our diligent e orts were nancially recognized. In relation to the framework and structure supervised by Stratis Health, a state partner highlighted their appreciation for the program's adaptable guidance and technical support, enabling them to carve a distinct path towards nurturing service development in the involved communities. Several partners underscored the shared dedication and fervor observed among individuals engaged in palliative care, relishing the chance to connect and form networks with like-minded peers.

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