

Choices: Innovative In-home Palliative Care Program for Rural Underserved Population Initiative

Submitted by: Helios Care

Silver Winner

Category: Reaching the Patients in Need

Overview

[Helios Care](#), a hospice organization based in Oneonta, New York, recognized that the lack of palliative care among a marginalized, low-income rural community was a problem. Whole person centered palliative care is rarely offered to rural patients; difficult to access in a community with a shortage of providers; and, hampered by limited funding for reimbursement. The focus of the newly created Choices program was patients with serious illnesses not receiving adequate symptom management with psychosocial and economic challenges preventing access to medical care. The Helios Care Choices program is the only program that provides free patient centered, evidence based palliative care to patients in their homes in three rural counties of New York State. It has increased the comfort and quality of life for patients while reducing healthcare costs. An original budget of \$396,400 was awarded by a private foundation to create the program and served 80 patients on a trial basis. Quality of life has increased dramatically for these patients.

Impact

Palliative care should be initiated when a person is first diagnosed with a serious illness. This is rarely the case in the U.S. which relies on fee for service to pay for healthcare. Plus, patients and providers are frequently unaware of the need for palliative care or how to access palliative care specialists. There is also no financial incentive for a referral as fee reimbursement has not been offered by Medicare, which serves the majority of older rural residents. A lack of palliative care and specialty providers leads to unnecessary emergency room visits and avoidable hospital readmissions, putting an enormous financial burden on our rural healthcare system. Hospice organizations are uniquely positioned to provide palliative care and to assist providers in learning how to provide palliative care. Although the program was originally designed to concentrate on patients who had multiple acute care visits within the last six months, Helios Care realized it could be adapted for any patient needing palliative care. A key component of the program was to demonstrate to providers the value of palliative care and to educate them on appropriate patient referrals. This helps patients, providers and the whole healthcare system. Helios Care operates in a highly rural area with geographical challenges, no metropolitan centers and very few resources for medical, dental and mental health. It is a low-income region where public transportation is minimal. There is only one major healthcare provider. Almost one third of the elderly live alone with very little support and few neighbors. The Choices program has demonstrated a measurable impact through reduction of usage of acute care facilities as a main source of health care, significantly reduced healthcare costs and improved patient/family health. It addresses the unmet

needs of patients in this area through enhanced access to food, utilities, transportation, and mental health services. It reduces the financial burden on the rural healthcare system as emergency room visits and re-admissions have decreased. It provides ongoing symptom management, patient engagement in their own care, and continual access to specially trained medical staff. It also increased the number of patients directly admitted to hospice care and able to receive the full benefit of hospice in their final stage of life. This greatly eased the burdens of patients, families and caregivers. Demand for palliative care will continue to grow due to the aging population nationally and rising health care costs. It also provides a viable solution to those who are resistant to staying in long-term care facilities. The ability to improve access to affordable in-home palliative care among this vulnerable population earlier in their disease process has a significant impact and can be practiced in many rural communities around the nation.

Evidence-Base

Helios Care used validated assessment tools from CAPC and the National Consensus Project for Quality Palliative Care to measure function, symptoms, spiritual needs, social determinants of health, caregiver burden, health engagement, and tracked acute care utilization including ER visits and hospitalizations pre and post enrollment. After evaluation, the following results emerged:

- 73% reduction in acute care and emergency department visits, exceeding the original goal by almost 50%.
- Based on decreased ED visits and hospitalizations, we can extrapolate a 76.6% reduced cost to manage the chronic disease of patients.
- Improved quality of life based on multiple patient assessments

More than half of patients showed improvement in scores for patient health engagement, spiritual needs met, physical function, depression, fatigue, sleep disturbance, pain interference and pain intensity. Many caregivers reported their burden was reduced while the patient was enrolled. Immediate access to clinical staff via telehealth resulted in fewer acute care visits, less exposure to COVID-19, and additional support services. In the first year of the program, 23% of the 99 referrals received for Choices resulted in patients admitted directly to hospice. They had longer lengths of stay on average than other hospice referrals indicating the availability of the program impacted not only access to palliative care, but earlier referrals to hospice care. A total of 35.4% of all Choices referrals transitioned to hospice care and were able to receive the maximum benefits. A previous pilot program conducted with the area's only medical provider network and community agencies indicated that hospital admissions and ER visits could be reduced and symptoms better managed by use of nurse and social worker visits to homes as well as 24/7 Triage telephone support. Lessons learned and successful outcomes from the original pilot program were used to plan the Choices program. It provided significant evidence that positive results would continue. This has been the case and the success of Choices program has proven that palliative interventions, provider training on the use of palliative care and strategies implemented in the homes of patients can reach a greater number of people over time and still retain effectiveness. As more medical and support providers become familiar with palliative care and know when to refer, the program will continue to grow as the need is growing. All rural communities can take advantage of this program and utilize the basic tenets of the Choices program to adapt to their communities. The use of in-home palliative care, telehealth, 24/7 triage care staffed by a RN and addressing psychosocial determinants of health is the future. The expansion of this program in many communities around the nation can be accomplished with a minimum of investment and utilizing already existing personnel. This is the future of elder health care in America.

Feasibility

Key components for the implementation of Choices included education for providers on the availability of the program and patient eligibility criteria. Initially, patients eligible for the program were those with a serious illness and a minimum of three Emergency room visits or two hospitalizations in the prior six months. A key program objective was to reduce acute care utilization among this population by 50%. Over 14 months, utilization data consistently proved the program's success in achieving this objective. Evaluation of the program led to the discovery that program eligibility criteria were a barrier to referrals. Referring partners said many seriously ill patients who could benefit from the program were not referred because they did not meet criteria. Consequently, Helios Care modified the eligibility requirements. A new eligibility screening process was implemented that identified patients likely to become high utilizers of acute care facilities based on clinical indicators such as diagnosis, levels of disease progression, symptom burden and/or social determinants of health. Another program objective was to decrease symptom burden and improve quality of life. Methods included comprehensive assessments by the Palliative Care Nurse Practitioner; goals of care discussions; advanced directives discussions; comprehensive care planning to address all needs including psychosocial determinants; follow-up visits and support from RN and Social Worker; education on disease management; 24-hour on-call phone availability; Telemedicine support; and, linkage to community resources. Results were measured through surveys administered at intake and subsequent 60-day intervals. This formed the basis of the development of an Individual Care Plan. The five assessments used are: The Zarit Burden Interview, the Health Leads Screening Toolkit, the Promis-57 Profile, the Patient Health Engagement Scale and the Spiritual Dimension Screening. Skills needed to implement and maintain this type of program are available from hospice and palliative care organizations throughout the United States thus providing the basis of a program that can be offered anywhere in rural America. The development of in-home comprehensive palliative care is largely independent of fluctuating social and political determinants. Aging is a process that occurs to everyone regardless of political or social beliefs. Since this is a collaborative effort based on medical and social needs without bias, individual beliefs can be easily accommodated as patients are instrumental in the design of their own care. Issues encountered included the emergence of the COVID pandemic causing considerable disruption in referrals as patients delayed care and avoided going to emergency rooms. While 89% of the Choices patients eventually accepted Telemedicine equipment, there was some reluctance with this patient demographic. Lack of internet broadband in rural areas also causes inconsistent use of the technology. The development of the rural broadband capability is being implemented rapidly after funds were authorized by the federal government for this purpose.

Scalability

The replicability or scalability of this program to any area of the United States would be simple and has enormous potential. Most hospice programs have administration and trained staff able to deliver this program to any resident in their geographic area. Other than having a team dedicated to the delivery of palliative care there are no barriers. The team includes a Hospice and Palliative Care RN to conduct periodic home visits to assess patient's needs and make recommendations to patient, family/caregivers and provider. Other team members include a Social Worker, who assist with providing education and support to patients and families and links them to additional community resources if needed and when appropriate. A key replicable component of the program that contributed to its effectiveness is the ability to provide telephone and Telehealth support, available 24 hours a day, seven days a week. Patients and families should have access to reach out to a clinician with questions or concerns at any time.

Sustainability

The initiative will have a sustained impact on the care of patients with serious illness in this area of central New York. Effects have been immediate as evidenced by reduction in acute care visits as well as improvements in patients' symptom management, caregiver burden, reduction in social determinants of health needs, and patient/family satisfaction surveys. The administration of Helios Care and the administrations of insurance carriers and the largest medical provider in the area are fully committed to the program. Negotiations on funding and implementation have been held between the CEOs of these organizations. Helios Care has requested an expansion of its coverage area into five additional contiguous underserved rural counties which will bring the Choices program into more deserving homes.

Helios Care has the infrastructure and referring partners in place to serve additional patients in an expanded service area. Increased coverage by the Centers for Medicaid and Medicare during the next five years will mean many of these in-home palliative services will become reimbursable, thus eliminating a huge barrier. The emergence of Value Based Care is an exciting trend that is in the best interest of patients, families, providers, and insurance carriers. This transition away from fee-for-services will allow for services based on prevention or amelioration of serious illnesses that will dovetail nicely with the objectives of the Choices program. This is a national movement so development of programs around the country similar to the Choices program will resonate with many rural areas transitioning to Value Based Care.

The CEO and Board of Directors of Helios Care have been "on board" with this program from day one. In fact, the effort to develop a Choices program to serve this vastly underserved and marginalized population has been championed by the CEO and the Board. They created the impetus for the grant seeking that led to Choices. The CEO and the Board have been visionary leaders and their work will lead to a tipping point that dramatically alters the healthcare landscape for decades. Their work is part of a long term strategic plan to expand Helios Care service lines and to sustain the organization. It is the goal to care for more patients while also better preparing Helios Care to function in a Medicare and Medicaid Advantage environment in addition to Value Based Incentive Design models.

It is clear from recent data the Aging in Place movement is gaining interest as a way of reducing not just acute care utilization but as a way of allowing patients to age at home in lieu of nursing home placement. Helios Care expects to serve more people for less cost and to prepare for the transition to Value Based Incentive Design contracting which ensures long-term sustainability. The Choices program is a trend-setting program with enormous potential to improve the lives of older rural residents around the nation.

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About the Challenge

The John A. Hartford Foundation Tipping Point Challenge is a national competition to catalyze the spread of skills, ideas, and solutions that will improve health care delivery for all people living with a serious illness. It is sponsored by the [Center to Advance Palliative Care](#) and [The John A. Hartford Foundation](#).

For more information, visit tippingpointchallenge.capc.org.