Allina Health

Social Determinants of Health: How One Organization Addressed These Using Palliative Care Principles and Practices

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Aim Statement

Overwhelming evidence acknowledges the impact of social risk factors on health outcomes for people with serious illnesses, but the current health system is not structured to address these risk factors. How can we close the gap? Allina Health's LifeCourse™ program is an innovative approach to care for patients in the last few years of a serious illness. By training community health workers (CHWs) in the principles and practices of palliative care, LifeCourse has developed a solution to better address the social determinants of health and overcome barriers faced by patients, family caregivers, health systems, providers, payers, and population health managers.

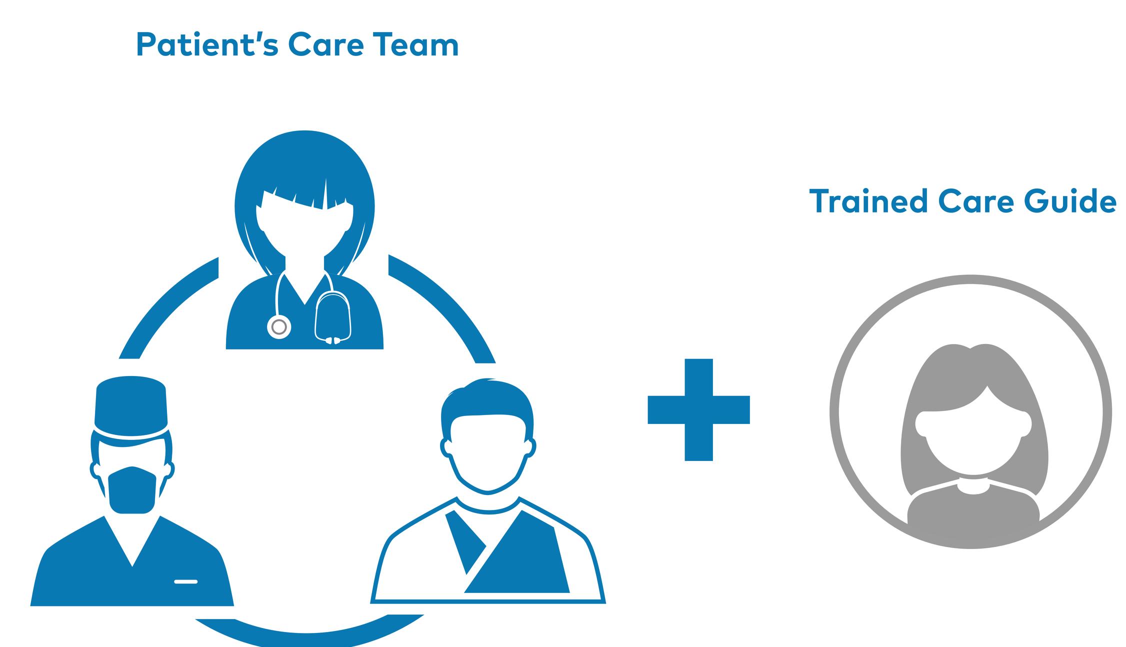
Strategy for Change

LifeCourse supports people with serious illness who have difficulty navigating the health care system.

LifeCourse Key Components

Trained CHWs (care guides) are integrated into the care team, providing regular home visits. A clearly-defined visit framework guides discussions of physical, psychosocial, and financial concerns. Patients articulate preferences and what matters most, and complete advance directives. A community-oriented approach connects patients and families with needed resources.

Our goal was to go where patients seek their care. Not to create another silo but to provide nonclinical, community-based support for the teams that already provide longitudinal support. Thus, the LifeCourse care guide role added a new dimension to the practice-based care teams.



Changes Made to Achieve Improvement

Care Guide Training

Comprehensive 40-hour training on a clearly-defined visit framework delivering whole-person care

- ✓ Palliative care domains*
- ✓ LifeCourse visit framework
- ✓ Advance care planning
- ✓ Communication/collaboration
- ✓ Lay health care worker role and scope
- ✓ Professional boundaries
- ✓ Electronic health record

* "Clinical Practice Guidelines for Quality Palliative Care", National Consensus Project for Quality Palliative Care

Care guide training and education includes:

- The domains of palliative care to give care guides a whole-person, family-oriented approach
- The LifeCourse structured visit framework, which incorporates the use of question sets and standardized assessment tools
- Communication skills, including Open-Ended Questions, Affirming, Reflective Listening, Summarizing (OARS) and Situation, Background, Assessment, Recommendation (SBAR), role definition and scope, and professional boundaries
- Using the electronic health record (EHR) to connect with resources, document patient goals, and communicate with care teams across settings and specialties throughout Allina Health

Care guides also receive in-depth instruction on advance care planning, using the Respecting Choices framework, and how to assist patients in identifying their goals and what matters most. Skills are validated by care guide preceptors.

LifeCourse Visit Framework

		Visit #1	Visit #2	Visit #3	Visit #4	Visit #5	Visit #6	Ongoing
Domain Question Sets	Physical	■						■
	Family/Caregiver	■						■
	Psychological		■			■		■
	Cultural		■	■				■
	Ethical		■	■				■
	Social			■		■		■
	Financial/Legal			■		■		■
	Spiritual							
	Legacy and Bereavement					■		■
	End of Life						■	■
Assessment Tools	PROMIS-10	■					■	■
	ESAS	■			■			■
	PPS	■	■	■	■	■	■	■
	Who's At Your Table?			■		■		■
ACP	Advance Care Planning	■	■	■	■	■	■	■

LifeCourse is a well-defined intervention for CHWs that includes a LifeCourse Visit Framework:

- Based on the National Consensus Project's *Clinical Practice Guidelines for Quality Palliative Care* (includes domains for whole-person care)
- Expanded to include financial and other domains
- Structured visit schedule to cover each domain over time, building an authentic relationship with each patient, progressively covering more sensitive topics
- A defined question set is developed for each domain that is role-appropriate for a CHW
- CHWs administer specific assessments during each visit and record responses in the EHR
- Advanced care planning (ACP) information is discussed and updated at each visit as necessary

Summary of Results

Patient Outcomes

↑ better quality of life
higher patient care experience
more patients with advance care plans

MEDIAN HOSPICE LENGTH OF STAY

- with LifeCourse: 28 Days
- with usual care: 17 days

System Outcomes

- 16% fewer ED visits
- 27% fewer inpatient days
- 57% fewer ICU stays

$959 PMPM savings **8:1** return on investment

Lessons Learned

All of our implementing sites (primary, specialty, and enterprise-wide) would describe themselves as offering coordinated, whole-person care. With LifeCourse-trained care guides, these providers now have an opportunity to stay more connected with their patients and their families in the times in-between clinician visits.

The following table represents the distinguishing features that supported more connected care and better outcomes

How is LifeCourse Different?

LifeCourse	Other Supportive Care Programs
A longitudinal relationship, offering support through the last several years of life	Time limited, many are 30-90 days and focused on a point in time such as post-hospitalization
A continuum-based approach that follows the patient across settings	Typically condition related, i.e., heart failure
Balances medical and nonmedical focus, to promote a whole-person approach	Medically focused on improving specific outcome measures
Trained lay health care workers, called care guides, as primary contact	RN or SW as primary contact
Visits are in person	Contact is primarily telephonic
Supports a generalist approach to palliative care that does not require specialty training	Supports a medical model of care requiring clinical training