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New Model for the Home Hospice



Home care for dependent individuals in rural areas



1. Who is this innovation for?

The innovation is dedicated to individuals living in rural areas who are simultaneously:

- elder and alone
- ill, or terminally ill, dependent, often at the final stages of their lives
- caregivers of the above mentioned individuals

The innovation is directed at all kinds of decision makers and individuals working in hospices and providing palliative care, who see the problems with access to a high quality care for dependent individuals, particularly in rural areas.



Photo from the film on innovation **New Model for the Home Hospice**, Sangaj Studio Filmowe Dorota Migas-Mazur

2. What social problem does it address?

The innovation constitutes a real lifeline for ill, lonely and dependent individuals, who are “trapped” in their houses in the countryside. It addresses two problems that are prevalent in the rural areas – a healthcare system that’s inefficient and inadequate to the needs and difficulties with providing good quality care for the elderly, the ill and the dependant.

Access to healthcare in the countryside is 2–2.5 times harder than in the city. The number of medical facilities in the rural areas is over two times lower than in the cities, which translates into less medical advice, prophylactic testing, illness detection and many other factors that influence health of people in the countryside (from: *The European Fund for the Development of Polish Villages*).

Countryside is also suffering from depopulation. It results in older populations often being left without anyone to help them in sickness, or everyday care. Sick elderly, who rest in beds without proper care and rehabilitation soon develop bedsores and pass away from pneumonia, or general infections that stem from improperly dressed bedsore wounds.

The innovation prevents emergence, or progression of already existing disabilities by creating a flexible model of care for dependants and their caregivers.

3. Description

Where did the idea come from?

Innovators based on their experience of several years at the Prophet Elijah Hospice in Miachałów (rural-urban municipality, Podlaskie Voivodeship). After operating for seven years, they have observed that the system offering specialized, at-home palliative-hospice care in rural areas is inefficient. Not only family doctors, but also municipal welfare centers, The State Fund for Rehabilitation of Disabled People (PFRON), priests

and local leaders, who know the needs of local populations are all asking for help. These are the people and organizations that the Prophet Elijah Hospice works with. With sparse human resources, making it exceedingly difficult to build and sustain a team of medical professionals in villages and sparsely populated areas – it's in that cooperation where the key to the success is hidden. It was tested in practice, while testing the innovation – only after combining forces and collaborating it was possible to bring real help to those areas.

Another obstacle is a deficient list of diseases qualifying for home hospice-palliative care and financing from the National Health Fund (NFZ). From seven disease categories only two contain diseases that qualify for hospice care – cancer (C-00 – D-48) and bedsores (L-98).¹

Meanwhile, there are 35 patients under the hospice's care, over 50 percent of which do not meet the criteria of the NFZ that would qualify them for refunds. It is for the care for those individuals that the foundation is attempting to find funding from alternative sources.

The hospice's team also wanted to support and unburden the caregivers in their everyday responsibilities at home with the dependant. Patients are often cared for by elderly individuals, who need rest and care themselves.

Innovators searched for a solution that would allow to meet the needs of all the patients and their caregivers, while simultaneously sustaining the level of care without raising the costs of hospice's operations.

Essence of the innovation

The Prophet Elijah Hospice in Michałów streamlined the current system of care as part of the innovation. It is based on increasing the flexibility of the model of care and expanding the range of recommendations that would qualify patients for hospice care.

New Model for the Home Hospice is based on two pillars: adjusting hospice services to real needs of patients in the rural areas and adding caregivers to the hospice team, which would help the experts with caring for patients and provide much needed rest for the caregivers on the ground.

¹ According to International Statistical Classification of Diseases and Related Health Problems ICD10.



Photo from the film on innovation **New Model for the Home Hospice**, Sangaj Studio
Filmowe Dorota Migas-Mazur

Applying the flexible model of hospice care that includes a broader catalogue of illnesses than currently recognized by the NFZ allows for an increase in the impact of preventive care. Naturally, in the case of patients who qualify for the palliative care we can't hope for a radical improvement in one's health. We can, however, prevent complications, such as bedsores, or pneumonia, as well as increase mobility and social activity, or delay emergence of new health problems. In a long run it means savings for the healthcare system that doesn't have to spend funds on hospitalizing patients, their transportation in ambulances, refunding of additional medicine and visits to and from health specialists.

Innovation step by step

1. **Creating the team**

The first stage was creating a “new” hospice team. The basic medical hospice team is composed of three doctors, four nurses, three physiotherapists and a psychologist. As part of the innovation three caregivers and one physiotherapist would join the team.

Adding one more physiotherapist turned out to be a much easier task than creating a new group of caregivers. A requirement to own a car turned out to be a major barrier during the recruitment process. Distances are one of the most expensive factors when looking at the care for patients in rural areas. Sometimes the medical personnel have to travel couple dozen kilometers a day in order to reach a patient. Hence, it's necessary for the new caregivers to be mobile.

Introducing caregivers into the hospice's team resulted in several changes, but its long-term effects will be observable only in the next couple months. Caregivers' support comes with significant savings for the hospice itself and in a longer term – for the healthcare system as a whole. It's a result of decrease in the involvement of qualified specialists in the care for patients – from nurses, through physiotherapists and ending with doctors. Caregivers can fulfill fundamental nurse responsibilities, monitor patient's condition, exercise with them according to physiotherapists instructions, while unburdening individuals at home, who were providing care up to that point.

2. **Establishing the rules for the team**

During our meetings we have established work rules for the entire hospice team:

- patient is qualified for the team's care by a doctor during his first visit. The doctor is also responsible for creating the initial visit schedule (who and how many visits per week/month)
- all members of the team are in communication with each other and can reach one another almost every day regarding the patients' care
- there is a team meeting once a month. During briefings the team discusses patients' condition and plans care for the coming month. If there's a need, the number of visits by particular members of the team is modified



photo: Piotr Mojsak

3. Team's work

Work of the team is guided and coordinated by a **doctor**. Wherever it's needed a **nurse** can perform a visit. Because the innovators pay a lot of attention to supporting and educating individuals who take care of the sick on a daily basis (the caregivers at home), each member of the team, particularly a nurse, shows and teaches ways to take care, dress wounds, feed, etc.

A **caregiver** also helps with bathroom related care. She is also responsible for help with everyday chores, such as bringing in wood for the stove into the house, or making a meal. A caregiver is also capable of exercising with the patient as recommended

by the physiotherapist. Her final task is to unburden the home caregivers and allow them to rest, or to substitute for their help when they need to be away.

Visits from a **psychologist** are necessary for patients, just like they are necessary for the team. They allow the team to discuss problems and coping mechanisms adopted in difficult situations. A psychologist also helps to understand difficult situations that the individuals find themselves in.

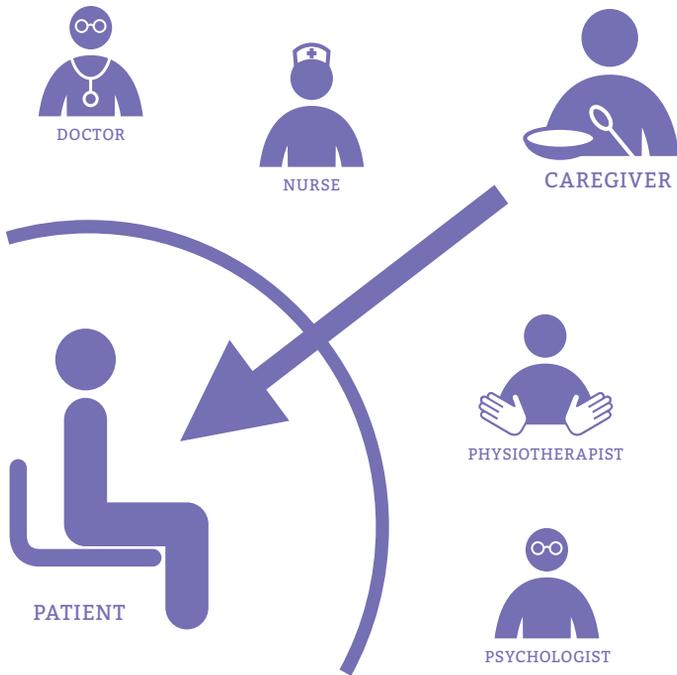
The most spectacular effects of help can be observed through the work of **physiotherapists**. Thanks to their work (number of hours adjusted to the needs of the patient, not assigned by the NFZ) individuals who were bedridden begin to sit down, some of them are able to get up and learn to walk again. Exercises increase functionality, independence and make the patients feel better. By being more independent they unburden their caregivers, who are often seniors with limited functionality as well.

As a result, in many households the members of our team are eagerly awaited and their visits are considered a small holiday. Their professionalism and good relationships are the best definition of methods that allow for good care for the patients.

IMPORTANT:

In order to be able to take good care of the patients it is absolutely crucial for the relationship with providers of the “help services” – family doctors, community nurses, social workers – to be good. Sometimes the innovators collaborated with those providers to plan the most effective care for a patient, even if they were to be only a small part of it.

The relationships inside the team are incredibly important as well. Part of it is sharing in the successes and triumphs, or quick spread of information pertaining to issues and arising problems. Mutual respect and trust are just as important for the team as they are when working with a patient. Building long-term relationships is a long-term task – health care professionals with habits from hierarchical health care institutions often have to learn to collaborate with a team that works according to a different set of rules.



1/3

That's how much the costs of patient care decrease when applying the New Model for the Home Hospice

Someone who suffered a stroke ends up at home, immobile in their bed and under care of a family doctor, who will visit once a month and prescribe them some anticoagulant medication and that's it. That person will qualify for our help only after they develop bedsores. But we start going before the bedsores develop and the person often ends up getting up and living and functioning normally.

Pawel Grabowski, the innovator

When a caregiver comes around she puts the patient into a bathtub, scrubs him or her, then dresses them and the person is clean. So that's part of caregivers' duties as well. She helps feed our patients. At Ms. Y's place she would go and fetch wood for the stove. So it's a mix of care and household chores and in some houses they just sit down and talk, because some of those folks are simply suffering from loneliness and need somebody to come and they're happy every time someone visits.

Paweł Grabowski, the innovator

How much does it cost?

Testing proved that the flexible model of care is most definitely more cost-efficient (more prophylactics than medical treatment) and the quality of care increases in comparison to that assigned according to the rigid rules.

Costs:

- administrative costs (negligible, most often the project can be realized using already existing human resources by proposing increase in pay)
- costs of running the equipment rental
- costs of office supplies (mostly for patient documentation)
- accounting costs (depending on the structuring of the innovation, they may not change, or increase marginally)

Personnel costs: additional cost takes the form of caregivers' compensation and commute to patients. However, in comparison to the "traditional" hospice care, that additional cost allows for a decrease of about 1/3 in the overall costs of provided care, because visits by other members of the team – the doctor, nurses, psychologist, physiotherapist – can be fewer without a negative impact on the patient.

Material costs: bags and equipment for the caregivers (around 300PLN/bag). Basic equipment in the bag consists of: blood pressure monitor, latex gloves, hand sanitizers, equipment and cosmetics for patient care.

4. Who's behind it?



photo: Piotr Mojsak

The Prophet Elijah Hospice Foundation's team

Paweł Grabowski – founder and chairmen of the board of the Prophet Elijah Hospice Foundation, medical doctor, palliative medicine expert

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5. Contact information

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