

# Internet Health Management



PERSPECTIVES

## Digital collaboration can improve palliative care

Greer Myers | Nov 6, 2018

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Feeling lonely and isolated from friends, family and familiar places is more than simply an emotional quagmire for millions of Americans. Many contend that these issues may represent a greater public health hazard than obesity or smoking. While this is a challenge that transcends all age groups, it is particularly troublesome for seniors, particularly those who are experiencing a serious or advanced illness, where the physical challenges of mobility make the effort required to socialize with friends and family overwhelming.

Some experts think the [problem is getting worse](#), driven by an aging population, changes in family structure, reliance on technology in place of face-to-face discourse and other forces. Thankfully, both public and private sectors are starting to pay more attention. An AARP loneliness study published in 2010 and now being updated reported that approximately 42.6 million U.S. adults ages 45 and older were suffering from loneliness.

Former surgeon general [Vivek Murthy—who dubbed the issue a public health crisis during his term](#) 2014-17—noted that one of the reasons we are now paying more attention to social connections is because they are woven into other persistent health issues, such as addiction and depression. He recently labeled loneliness an “epidemic” and indicated the government should play a role in trying to confront it. Murthy [has made loneliness](#) his post-government cause, and is currently writing a book and opening an institute focused on the issue.

This is not a problem confined solely to the U.S. with [countries such as the United Kingdom, Denmark, Australia, and Japan](#) now addressing the issues. For example, in January, British prime minister Theresa May [appointed a minister for loneliness](#). Ten months later, the government [announced a government-wide strategy](#) to tackle the issue.

## **Technology connects palliative care clinicians and patients**

Palliative care is specialized medical care for people with serious illness. This type of care is focused on providing relief from the symptoms and stress of a serious illness. Some researchers maintain that Americans are no lonelier than in past generations, and they say technology can bring people closer together as well as drive them apart. But others argue [that psychologists, social workers, medical practitioners and policymakers should treat loneliness and isolation with the same urgency](#) as drug abuse or other major social ills.

Given the exigency to effectively address the struggles of loneliness, isolation and other factors characterized as social determinants of health (SDoH), new, innovative models of specialized community-based palliative care (CBPC) are structured to meet these challenges. CBPC is specialized care for those suffering from a serious or advanced illness, providing relief from symptoms and stress, establishing goals of care, improving communication and care coordination—all of which serve to improve quality of life for patients and their caregivers.

Digitally driven palliative care utilizing predictive analytics and artificial intelligence for appropriate patient identification can train and deploy networks of palliative care professionals of primarily nurses and social workers to engage with patients in the community. This approach brings a systemized process of palliative care delivery, providing consistency across geographic regions to patients in health plans or accountable care organizations.

Palliative care teams in select CBPC models are technologically empowered, which enables more accurate and rapid assessment, treatment, and communication with treating physicians and the medical home. The gathering and sharing of non-medical information derived from information-rich home visits is vital to a holistic approach, including acknowledging and creating treatment plans that account for SDoH. This is critical, given that non-medical determinants of health are believed to account for up to 60% of health outcomes.

In fact, optimized CBPC leverages health information technology to facilitate an approach that helps professionals provide meaningful and accessible programs to populations that wrestle with loneliness and other SDoH. Systematized health risk assessments (HRAs), for instance, collect relevant data to provide missing context critical to health and well-being decision-making. Accessing the right questions requires knowledge about social determinants.

Combining SDoH data with medical data allows for the delivery of personalized programs that positively affect populations with a serious or advanced illness. Through the aggregation of these disparate data sources, combined with outcomes data, we are afforded the ability to employ both natural machine learning and artificial intelligence to inform best approach, as well as predict risk of noncompliance, adverse events, and poor outcomes.

### **Coverage for supplemental benefits and palliative care**

The Centers for Medicare & Medicaid Services (CMS) has expanded Medicare Advantage (MA) guidelines to cover more [supplemental benefits](#) potentially addressing certain SDoH, including a combination of genetic, environmental, economic, political and social factors, such as isolation and loneliness. This reinterpretation of the statute to encompass SDoH is an important step in supporting value-based care and aligning commercial payers and states across the country to recognize the need to address these factors. The goal is to enhance patient engagement, improve care quality and outcomes, and lower costs.

Besides isolation, other key determinants for individuals with a serious or advanced illness include economic instability, education level, poor social support, substandard housing, hunger, lack of transportation, and limited access to quality care, all of which impact a wide range of health, functioning and quality-of-life [outcomes](#).

CMS changes have direct relevance for provision of palliative care and social services for beneficiaries in MA plans. Specifically, [MA plans](#) will soon be allowed to pay for services matched to the needs of these beneficiaries, including food, transportation, personal care aides, and home-based palliative care.

### **Loneliness also impacts family caregivers**

More than 40 million adults in the United States experienced a [serious illness](#) in the past three years, and more than 41 million provided [unpaid care](#) to elderly adults during the past year.

Caregivers also have to contend with loneliness and isolation. Many express their frustration that no one will understand the complexity of challenges that they face on a daily basis. A [caregiver in Chicago explains](#), “The emotional toll of caregiving can be significant; it is isolating and lonely, and we really want people to know that there is support for them and there’s understanding and there is help. They don’t have to go it alone.”

A recent survey conducted by [Embracing Careers](#), a global initiative launched in 2017 that aims to increase awareness and discussion about the needs of caregivers, found that 47% of caregivers have feelings of depression, and almost 57% feel they need medical care/support for a mental health condition (i.e. depression, anxiety, stress) because of their role.

### **Halting the “loneliness epidemic”**

People with serious illness experience distress over and above the physical symptoms of their specific condition. A new survey from the [Commonwealth Fund](#) reveals that many are distressed. Sixty-two percent feel anxious, confused, or helpless at some point. Nearly half have emotional or psychological problems. Social isolation, a known risk factor for worse health outcomes, is common, with [one-third](#) of respondents reporting feeling left out, lacking in companionship, or isolated from others.

Researchers conclude that strategies for delivering a better health care experience—one that ensures comprehensive, holistic care while always respecting the dignity of the individual already exist. They just need to be adopted on a much wider scale. Among the recommendations, in fact first on the list, is this directive:

[Build the capacity to identify and manage the behavioral health needs of patients and their caregivers.](#) Integrating behavioral health services into medical care requires more than simply improving communication among siloed professionals. [Multidisciplinary care teams that include behaviorists, social workers, and patients working together](#) can ease the sense of helplessness, the loss, and the social isolation that seriously ill people commonly experience.

Many hail this conclusion as an implicit endorsement of CBPC to halt the feelings of loneliness and isolation among those with serious illness. For palliative care professionals, this vote of confidence further strengthens the spirit of dedication to continue the work already underway that helps “all the lonely people.”

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