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The Hospital Elder Life Program: Past and Future

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The Hospital Elder Life Program (HELP) has been in existence and has been studied extensively for a quarter century. Thus, Hsieh et al.'s (1) excellent systematic review and meta-analysis of HELP's effects on outcomes for hospitalized older adults, published in this issue of the *American Journal of Geriatric Psychiatry*, examined a rich body of evidence before concluding that HELP improves patient and family satisfaction while reducing delirium, falls, and costs. Impressively, despite the fact that HELP addresses a challenging problem in a vulnerable population, the program succeeds in every aspect of the Institute for Healthcare Improvement's Triple Aim(2): it improves the individual experience of care, improves the health of populations, and reduces per capita expenditure.

Healthcare providers with geriatrics expertise will likely find these results intuitive. So what makes them so important? We propose three answers to this question:

First, these results are important because they illustrate the value and impact of a proactive, team-based approach designed to optimize care among one of the most vulnerable populations, hospitalized older adults. A lone geriatric provider trying to repeatedly remind the interprofessional team to manage each individual patients' sensory, sleep, hydration, and mobility needs in a one-off manner cannot achieve similar results: hospitalized older adults' complex needs necessitate the layers of support provided by the systematic approach implemented by HELP.

The second reason these results are important is that their success dramatically expands the range of potential interventions for preventing and treating delirium. While the cornerstones of preventing and managing delirium are to treat precipitating medical conditions and avoid iatrogenic risk factors, our current understanding of the pathophysiology of delirium has led

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to few, in any, medications with widespread efficacy in the prevention and treatment of delirium.(3) Unlike a medication, which would theoretically work by targeting a final common mechanistic pathway of delirium, HELP targets multiple environmental factors (e.g., urinary catheters, day-night cues) and care processes (e.g., early mobilization, socialization) that affect the risk of delirium in vulnerable older adults.(4) HELP's success should: (1) make elder-friendly environments and care processes central features of all endeavors to prevent and manage delirium—even while we treat precipitating medical conditions and attempt to develop efficacious medications—and (2) inspire research to elucidate its active ingredients, i.e., to answer the questions which of HELP's components are most effective and why?

Third, these results are important because they prompt us to consider how best to implement HELP. Hsieh and colleagues have provided an excellent supplement to the HELP protocols and quality metrics (www.hospitalelderlifeprogram.org) that will teach administrators and local champions what they have to do to achieve their desired outcomes, what kinds of adaptations they can consider to meet their local needs and use local resources, and how to measure and improve their performance. It will also allow them to prospectively address key intuitional barriers and leverage key intuitional facilitators to ensure their HELP program's success.

This analysis indicates that HELP is ready for scale and spread. Yet, despite its availability for 20 years, as well as rigorous proof of its efficacy and cost savings, its cumulative implementation in just 200 hospitals worldwide suggests that the barriers reviewed by Hsieh et al are substantial. Administrators, for example, set hospital priorities that are influenced by policies, regulations, and public relations, all of which deeply influence the broader culture of medical care.(5) To optimize the scale and spread of HELP and similar complex interventions designed to improve the care of vulnerable older adults, policies, regulations, and public opinion must incentivize the creation of a culture of medical care that prioritizes improving outcomes.(6) Researchers and policy makers must now answer multiple critical questions regarding the implementation of HELP. What competing incentives prevent hospital administrators from prioritizing HELP? How can stakeholders like CMS incentivize HELP's implementation? (Hint: HELP already includes quality assurance measures that could be developed into quality indicators.) What can we learn from the United Kingdom's experience implementing NICE's HELP-based guidelines for delirium prevention?(7) Can we redesign HELP volunteer programs—perhaps using Hospice and Meals on Wheels as models—so that training and maintaining a volunteer pool is not too burdensome, particularly for small, non-urban hospitals? How can we deploy the small corps of trained geriatrics providers within the United States to support HELP programs, even at hospitals that do not have a geriatric specialist on staff?

Over the past quarter century, HELP researchers have made enormous contributions to our understanding of how to prevent delirium and falls among hospitalized older adults. Hsieh et al. rightly argue that HELP is now the reference standard for comparative effectiveness research in this area. However, given numerous barriers to widespread implementation, the full promise of these efforts will only be obtained with large doses of creativity and pragmatism—including thinking beyond HELP to potential new solutions that effectively

generate and sustain the medical culture to which we aspire. Regardless of how they accomplish it, providers, researchers, and policy makers have a responsibility to undertake the additional work required to translate the insights derived from HELP research into a culture of daily practice that ensures the best possible outcomes for older patients.

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