Domestic and International Expansion of the Hospital Elder Life Program

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Executive Summary

As the world's elderly population is increasing the Hospital Elder Life Program is not expanding as quickly as needed for demand. HELP is an innovative delirium prevention program implemented currently in 61 sites around the world. Because the current hospital care system caters to a younger patient, elderly patients can develop delirium causing an increase in health risks and hospital costs. HELP was created to decrease hospital costs and delirium cases through six intervention techniques. In 2008, Kerry Fenlon was added to the HELP team in order to provide a business background and create a strategic expansion plan for the program which originally relied on opt-in requests from individual hospitals. Due to HELP's limited resources Ms. Fenlon has targeted individual hospitals within the United States northeast. Nonetheless, with the growing demand in geriatric care HELP needs to further invest in a more efficient plan for expansion.

Within the next five years HELP needs to focus on two markets: hospital associations and large medical institutions. Hospital associations will be executed in the eight states that will increase the most in elderly population as well as Canada. This will decrease hospital entrance challenges and increase HELP's hospital network. The second market will be large medical institutions in the northeast. Though working with these institutions is difficult, they do have the capital and varies different niches. Both of these markets allow HELP to spread their resources to a broader market and provide a much larger target market.

After five years the domestic model will be evaluated and if successful the association partnership will be implemented in the three following countries: Germany, Japan, and Italy. These are the countries with the largest elderly population in the world. Unfortunately, due to budget constraints expansion will have to wait for a proposed endowment to generate additional funds. The most important evaluation during the domestic expansion will be that of Canada's because they have nationalized healthcare similar to the three target countries.

This expansion plan will be financed internally by increasing consultant prices to $30,000-$35,000 and focusing efforts on a larger client in hopes to gain a more profitable market share. Not to mention, the second plan for expansion internationally will be financed by an endowment stated in the first expansion plan.

Industry Profile

As fertility declines, life spans increase, and the aging of the Baby Boomer generation increases in the United States and the rest of the world countries will begin to experience a dramatic shift towards an older population.

*Domestic: United States and Canada**

In 2000 12.4% of the US population was of 65 years old and over. It is predicted that by 2030, this percentage will increase to 19.6% reaching 71 million in number. Eight states are predicted to double in the number of elderly including Nevada, Arizona, Colorado, Washington, Georgia, Utah, Alaska, and California.[1] Specifically in Arizona by 2020 more than 1 in 4 people will be over the age of 60 totaling 26% of the population, increasing from 1 in 6 at 17%. This trend is due to the natural increase in population growth and the "snowbird" effect.[2]

Currently, 35% of the US elderly population is hospitalized each year which accounts for more than 40% of all inpatient days. Elderly patients also stay in the hospital 1.3 days longer than other patients. With the growing elderly population these numbers are bounded to increase. Furthermore, the current hospital care structure including rounds, volunteer programs, and dispatch evaluation was created to accommodate younger patients. Because the elderly are not given the correct attention during admittance 7% develop delirium causing 2.2 million persons per year to experience complicated hospital stays, costing an estimated $8 million.[3]

In addition, currently there are only "7,590 certified geriatricians in the US -- one geriatrician for every 2,500 Americans 75 or older. Due to the projected increase in the number

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[1] "Population Profile of the United States." *US Census Bureau*. 8 July 2008. Web. 7 Apr. 2010. <http://www.census.gov/population/www/pop-profile/stproj.html>.

[2] Arizona. Governor's Office. *Aging 2020: Arizona's Plan for an Aging Population*. By Melanie K. Starns.2005. Web. 7 Apr. 2010.<http://azgovernor.gov/Aging/Documents/ Aging2020Report.pdf>.

[3] Inouye, Sharon K., MD, MPH. "CLARIFYING CONFUSION:A RESEARCH APPROACH." *Professor of Medicine Yale University School of Medicine*. Web. 7 Apr. 2010. < F:/shared/inouye/talks&slides/McMaster_Medical Grand Rounds.doc >.

* Canada is considered domestic under HELP operations

of older Americans, this ratio is expected to drop to one geriatrician for every 4,254 older Americans in 2030."[4]

As for Canada their elderly population from 1980 to 2020 is expected to increase threefold from 9.4% to 18.7% of the population.[5] Furthermore, by 2030 1.4 million elderly people are expected to reside in Canada, a significant increase from 1.2 million in 2001. Like the United States, Canada is experiencing and will continue to experience a shortage in geriatric specialists. In 2006, there were approximately 200 geriatricians in the country; since, there has been no increased interest.[6]

Their healthcare system unlike the United States provides universal coverage based on medical needs not ability to pay. In 2005, Canada participated for the first time in the Euro-Canada Health Consumer Index in which they ranked 23rd out of 30 because

> "When the quality of care delivered is compared with the cost of providing that care, Canada falls to the very bottom of the list in terms of value for money. In terms of generosity, with the exception of the provision of sight restoration surgery, Canada performs poorly, and in the areas of patients' rights and information, waiting times and accessibility, and the provision of pharmaceuticals, Canada's performance is in the bottom tier."[7]

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[4] "FAQ." *The American Geriatrics Society*. Web. 7 Apr. 2010. <http://www.americangeriatrics.org/education/index.shtml>.

[5] Future Demographics- Canada: Aging." *Euromonitor*. N.p., n.d. Web. 4 May 2010. <http://www.portal.euromonitor.com.proxyau.wrlc.org/Portal/DocumentView.aspx >.

[6] "Canada's ageing population could run short on docs." Canadian Press. 19 Jul 2007. 04 May 2010. <http://www.ctv.ca/servlet/ArticleNews/story/CTVNews/20070719/aging_population_070719?s_name=&no_ads=

[7] Consumer Lifestyles- Canada: Healthcare System." *Euromonitor*. N.p., n.d. Web. 4 May 2010. <http://www.portal.euromonitor.com.proxyau.wrlc.org/Portal/DocumentView.aspx >.

Western Countries: Western Europe and Japan

Japan is the country with the greatest elderly population in the world and throughout the next 40 years these numbers are expected to grow. The number of "very elderly" (80+) is expected to almost double from 8.3 million in 2010 to 15.5 million in 2030. In fact, UN forecasts show by 2050 a record number 1 million will reach over 100 years of age. This all can be attributed to the Japanese's healthy diet, accumulated wealth, and superior healthcare system.[8]

Japan's national healthcare system is considered to be one of the most efficient and superior systems in the world. The government requires a mandatory employment-based insurance in which the Employee Health Insurance Programme requires private companies to provide private insurance for all employees and small businesses to provide government insurance plans. Whereas, those self employed and retired are required to join the Citizens' Insurance Programme administered by the local government. Recently, the Japanese government decided to move towards a "socialization of care" system for the elderly that provides mandatory long-term care insurance. Individuals themselves pay 15% to 25% of the costs, and the system itself is relatively inexpensive only spending 8% of the GDP due to healthy living and aversion to invasive surgical procedures. Nevertheless, 2 million people in Japan have dementia and cognitive degeneration, and as the elderly population increases so will these numbers.[9]

Similar to the United States, Japan is experiencing a shortage of geriatric specialists. Only 30% of the 79 medical schools provide geriatric learning and not all programs are staffed

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[8] Japan in 2030: The Future Demographics." *Euromonitor*. N.p., n.d. Web. 4 May 2010. <http://www.portal.euromonitor.com.proxyau.wrlc.org/Portal/DocumentView.aspx>

[9] "Lifestyle- Japan: Healthcare System." *Euromonitor*. N.p., n.d. Web. 4 May 2010. <http://www.portal.euromonitor.com.proxyau.wrlc.org/Portal/DocumentView.aspx>

with professors. Due to little private or government encouragement as of 2008 only 1,487 doctors are specialists of geriatrics.[10]

Western Europe's elderly population has been growing for some time now. In 1980 the elderly consisted of 12.8% of the population which is expected to increase to 18.5% by 2020. More specifically, Italy and German both rank second and third as the countries with the highest elderly population.[11]

In Germany, by 2030 there will be 2 elderly people (65+) for every aged person 0-14. As of 2008, Germany provides universal healthcare for all citizens. There are currently approximately 1,800 geriatric specialists in Germany and more that 300 trainees. Geriatrics is considered to be a supra-specialty in Germany meaning physicians have to specialize in another form of medicine first and then they are allowed to consider studying a specialty in geriatrics. In addition, geriatrics is not well represented in the German University system; only 6 of the 36 medical schools have a chair in GM. As for geriatric facilities there are more than 400 hospital/ departments that focus on elderly care. 40% of these hospitals are rehab hospitals with a mean stay of three weeks. The other 60% of departments provide acute care and early rehab with a mean stay time of 10 to 28 days.[12] Currently, there are no measures to reduce delirium within in hospitals for the exception of The German Association of Scientific Medical Society's guideline

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[10] Aria, Hidenori. "Geriatrics in the most aged country, Japan." *Archives of Gerontology and Geriatrics* 49.2 (2009): S1-S2. *Science Direct*. Web. 4 May 2010. <http://www.sciencedirect.com.proxyau.wrlc.org/ science?_ob=ArticleURL&_udi=B6T4H-4XWWC5R3&_user=986260&_coverDate=12/31/2009&_alid=1320853610&_rdoc=2&_fmt=high&_orig=search&_cdi=4975&_sort=r&_docanchor=&view=c&_ct=3419&_acct=C000049872&_version=1&_urlVersion=0&_userid=986260&md5=1ef0fb7eb9fe4be73cef496445a1c943>.

[11] "Future Demographics- Western Euorpe: Older Population" *Euromonitor*. N.p., n.d. Web. 4 May 2010. <http://www.portal.euromonitor.com.proxyau.wrlc.org/Portal/DocumentView.aspx>

[12] "Geriatric medicine in Germany ." *Geriatric Medicine Section of UMES*. N.p., 24 Mar. 2009. Web. 4 May 2010. <http://www.uemsgeriatricmedicine.org/geriatrics_in_eu.php?m=2&c=germany>

on the treatment of alcohol withdrawal delirium in which the German Society for Psychiatry, Psychotherapy, and Mental Disorders were the only participants.[13]

In Italy there is a greater focus on long-term care provided increasingly by immigrants opposed to family members as fewer people desire to be caregivers. In fact, "10% of the elderly in need of long-term care are looked after by paid live-in help." This is comparable to 1% in surrounding areas such as the UK, Germany, and Sweden. These women called "badanti" are paid 1000 Euros a month to carry out similar function as a nursing home. It is predicted that there are currently 800,000 badantis in Italy.[14] Italians are provided with a three-tier state run healthcare system, where services are free to very low costs. However, this has created a huge healthcare deficit that the government has become quite worried about along with their pension increasing pension deficit.[15] In addition, "each year delirium complicates hospital stays for more than 2.3 million older people, involves more than 17.5 million inpatients days, and accounts for more than $4 billion of Medicare expenditure."[16] Yet like most of Europe investment in a preventative system has not been taken.[17]

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[13] Leentjen, Albert F.G., and Albert Diefenbacher. "A survey of delirium guidelines in Europe." *Journal of Psychosomatic Research* 61.1 (2006): 123-128. *ScienceDirect*. Web. 4 May 2010. <http://www.sciencedirect.com.proxyau.wrlc.org/ science?_ob=ArticleURL&_udi=B6T8V-4K8Y76P P&_user=986260&_coverDate=07/31/2006&_alid=1322280580&_rdoc=19&_fmt=high&_orig=search&_cdi=5096 &_docanchor=&view=c&_ct=2015&_acct=C000049872&_version=1&_urlVersion=0&_userid=986260&md5=ef6 b72eac74b689e9d5ba975e530baad>.

[14] Trabucchi, Marco. "Demographic Profile Italy Part 3: Shrinking Safety Net." Interview by James Tulloch. *Allianz Knowledge Partnersite* . N.p., 17 Sept. 2008. Web. 4 May 2010. <http://knowledge.allianz.com/en/globalissues/demographic_profiles/italy/italy_trabucchi_dementia_aging_care.ht ml>.

[15] "Lifestyle- Italy: Healthcare System." *Geriatric Medicine Section of UMES*. N.p., 24 Mar. 2009. Web. 4 May 2010. <http://www.uemsgeriatricmedicine.org/geriatrics_in_eu.php?m=2&c=germany>

[16] University of Bologna. "Postoperative Delirium after elective and emergency surgery: analysis and checking of risk factors." *BMC Surgery* (May 2005): n. pag. *Biomedical Reference Collection: Basic Edition*. Web. 4 May 2010. <http://www.biomedcentral.com/1471-2482/5/12>.

[17] Leentjen, Albert F.G., and Albert Diefenbacher. "A survey of delirium guidelines in Europe." *Journal of Psychosomatic Research* 61.1 (2006): 123-128. *ScienceDirect*. Web. 4 May 2010.

Delirium

"Delirium is an acute, fluctuating disorder of attention and cognition and may be associated with disturbance of mood." (SD) Symptoms of Delirium included confusion, memory lose, and altered mental status. These effects can change within a matter of minutes and worsen throughout the day. Changes in personality can also occur such as irritability, inappropriate behavior, fearfulness, excessive energy, or even hallucinations and paranoia. "Current thinking suggests that delirium is a syndrome that most likely occurs due to disturbances in specific neuronal pathways and certain neurotransmitter systems…. Virtually any metabolic disorder or infection can cause delirium." In fact, 12-39% of all delirium cases are cased by drug side effects. Being able to spot patients reactions to drugs is not only the doctor's responsibility but primarily the nurse's because they spend more time caring for the patient. However, studies show nurses can only accurately diagnose 31% of delirious patients. In fact, "delirium is misdiagnosed as depression in up to 40% of cases."

In addition, 50% of elder hospitalized inpatients develop this syndrome, many of them with pre-existing dementia. However, 72% of delirium candidates go undetected, and studies show that a patient who is undetected has a higher six-month mortality. Which is significant when considering the hospitalized elderly with delirium have a 3-year mortality rate of 75% whereas, those without only have a 51% mortality rate.

Treatment of the syndrome is easy once identified. Because most cases are cased by drug side effects the first order of action is to stop all unnecessary drug intake. Nurses should monitor patients aggressively through the next stage of withdraw to make sure patient remain nourished.

<http://www.sciencedirect.com.proxyau.wrlc.org/ science?_ob=ArticleURL&_udi=B6T8V-4K8Y76P P&_user=986260&_coverDate=07/31/2006&_alid=1322280580&_rdoc=19&_fmt=high&_orig=search&_cdi=5096 &_docanchor=&view=c&_ct=2015&_acct=C000049872&_version=1&_urlVersion=0&_userid=986260&md5=ef6 b72eac74b689e9d5ba975e530baad>.

Lighting should be low however, a nightlight should be used for patients at night so they can identify and reorient themselves. A consistent nursing staff should be provided in order to maintain familiarity with the patient. Last, family visits should be encouraged as well as correction of any untrue or clarification of statements.

Nevertheless, recovery could take anywhere from one week to months due to hospital stay complications and re-admittance.[18] This causes an extra $8 million in costs each year in the United States. As a result, the Hospital Elder Life Program was created to implement a preventative care within hospitals to decreases cases of delirium and costs.

Program Profile: Hospital Elder Life Program

Hospital Elder Life Program (HELP) was developed by Sharon K. Inouye under the Aging Brain Center at the Institute for Aging Research as an innovative approach to prevent delirium and functional decline in hospitalized elderly patients.[19] The program originated from her medical program research and was trademarked and is sold to hospitals to assist in the implementation and design of their delirium and functional decline reduction program. Dr. Inouye wanted to create a program that was medically and economically effective, and would at least cover the costs that hospitals endure each year from delirium.[20]

The main goals of the program are maintaining cognitive and physical functioning of high-risk older adults throughout hospitalization, maximizing independence at discharge,

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[18] Rigney, Ted, MSN ACNP. "Delirium in the Hospitalized Elder and Recommendations for Practice." *Geriatric Nursing* . 27.3 (2006): 7. *Science Direct*. Web. 4 May 2010. <http://www.sciencedirect.com.proxyau.wrlc.org/science?_ob=MImg&_imagekey=B6WG24K3RMR491&_cdi=6810&_user=986260&_pii=S0197457206001339&_orig=browse&_coverDate=06/30/2006&_sk=999729996&view=c&wchp=dGLbVtz-zSkWA&md5>.

[19] Inouye, Sharon K., MD, MPH,, et al. "Dissemination of the Hospital Elder Life Program: Implementation, Adaptation, and Successes." *PubMed*. N.p., Oct. 2006. Web. 7 Apr. 2010.<http://www.ncbi.nlm.nih.gov/pubmed/17038065>.

[20] Fenlon, Kerry. HELP informational interview. 26 Apr. 2010

assisting with the transition from hospital to home, and preventing unplanned hospital readmissions. These goals are accomplished through an intervention strategy focusing on six delirium risk factors (orientation, therapeutic activities, early mobilization, vision and hearing optimization, oral volume repletion, and sleep enhancement), and these interventions involve geriatric specialists and volunteer assistance. (See Appendix 1) The participant positions include:

- Elder Life Nurse Specialist, who is the experienced geriatric nurse on site and provides comprehensive patient assessments and interventions in collaboration with the current nursing staff and other players; can sometimes take the role of Program Director.
- Elder Life Specialist whose role is unique to HELP and is responsible for the daily operations of the program including the coordination of the volunteer staff and participant communication.
- Geriatrician, who is the doctor on-site specializing in elderly patient care and through HELP assists in interdisciplinary rounds, provides clinical consultation, and educational programs for physicians and nurses; can sometimes take the role of Program Director
- Volunteer, though not a paid position this job is what differentiates HELP from other acute and long-term elderly care programs. Volunteers partake in an intense training program that involves 16 hours of class and 16 hours of experienced training. They are required to commit to at least one 4 hour shift per week for a minimum of 6 months. They carry out the following interventions: feeding assistance, early mobilization, therapeutic activities, and daily visitor.[21]

[21] "The HELP Program." *Hospital Elder Life Program*., 2007. Web. 7 Apr. 2010. <http://elderlife.med.yale.edu/public/help-info.php?pageid=01.03.00>.

HELP currently has 48 United States sites, 3 Australian sites, 9 Canadian sites, and 1 site in Taiwan. Recently 12 sites have been funded for the United Kingdom and inquiries are in Oklahoma, Maryland, Vermont, Japan, the Netherlands, and Singapore. (See Appendix 2)

Results show the significant affect that HELP has on delirium and physical degeneration in acute and long-term services. In an evaluation of the UMPC Shadyside program which houses 101 beds, there was an initial reduction in delirium by 14.4%. After full-implementation delirium rates decreased from a baseline of 40% to a steady 32% and saved the hospital a total of $626,261 over 6 months due to decreased hospital stay and costs of caring for a delirium patient.[22]

HELP is currently in a first mover's advantage because there are no other direct competitors. Because the HELP program encompasses the volunteer aspect it has a competitive advantage to other alternatives such as caregiver and outside long-term facilities because it is more cost effective. However, HELP's own dissemination plan has turned into a competitor because many hospitals have implemented similar programs after looking into HELP. Though they have not been as successful as HELP, they do take away potential market share. Non-competitive agreements are created to hinder this copyright infringement however, HELP would not have the monetary resources to carry those to justice that would violate this agreement.[23]

Implementation of the HELP Program

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[22] Rubin, Fred H., MD, et al. "Replicating the Hospital Elder Life Program in a Community Hospital and Demonstrating Effectiveness Using Quality Improvement Methodology." *PubMed*., June 2006. Web. 7 Apr. 2010. <http://www.ncbi.nlm.nih.gov/pubmed/17038065>.

[23] Fenlon, Kerry. HELP informational interview. 26 Apr. 2010

The most successful HELP programs were implemented in teaching, non-profit, urban hospitals. On average it takes 7 months to implement and 24 months to become sustainable.[24] HELP created a business plan packet that interested sites can purchase for $2000 that provides step by step information for implementation including how to gain management support and sustainability. This package is called the HELP Business Plan. Their main argument in this material is that with the current Medicare and healthcare reform reimbursements are not likely to increase so it is up for the hospital itself to become more efficient in order to cut the significant cost of delirious patients. HELP is a completely sustainable program that decreases delirium cases and in some cases is proven to decrease costs as well as. Once a medical facility expresses interest in the program and in purchasing a business plan, HELP has these facilities sign a non-compete agree that states that the medical facility will not create a similar program within the next five years. This is contacted in order for HELP to remain competitive and sustainable. When a hospital decides to develop a HELP program there is an initial $20,000 to $25,000 consulting fee depending on whether the hospital is domestic or abroad.

Ongoing costs include $3,500 for material, $150,000 to $200,000 on HELP staff (depending on location), and the yearly $2,000 program fee.[25] Most programs had multiple sources of funding of which 84% were funded by hospital budget allocations. Other sources have included external grant support, donor support, and in-kind or donated materials from other program.[26]

Challenges

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[24] Inouye, Sharon K., MD, MPH,, et al. "Dissemination of the Hospital Elder Life Program: Implementation, Adaptation, and Successes." *PubMed*. N.p., Oct. 2006. Web. 7 Apr. 2010.<http://www.ncbi.nlm.nih.gov/pubmed/17038065>.

[25] Fenlon, Kerry. HELP informational interview. 26 Apr. 2010

[26] Inouye, Sharon K., MD, MPH,, et al. "Dissemination of the Hospital Elder Life Program: Implementation, Adaptation, and Successes." *PubMed*. N.p., Oct. 2006. Web. 7 Apr. 2010.<http://www.ncbi.nlm.nih.gov/pubmed/17038065>.

Even though there is a sufficient need for the HELP program within many hospitals throughout the United States and abroad there are some challenges that hospitals endure and might deter others from implementation.

I. Lack of Senior Management Support

This is the greatest challenge to the implementation of the HELP program. Some research has been conducted that shows that possible lack of support is due to costs, perceived liability of volunteer program, and disbelief in implementation. However, HELP has identified five key reasons for senior management to encourage implementation: (1) potential to improve safety and quality of care, (2) potential to improve patient/family satisfaction, (3) consistency with the hospital's mission and strategy, (4) potential to increase patient volume and market share, (5) return on investment, and (6) personal identification with geriatric care. However, these benefits to implementation do not address the dire need for the country to be prepared for the influx in demand for elderly hospital care.

II. Sufficient Leadership and Skill

As stated before, there is lack in geriatric interest within medicine and as a result has caused a lack in adequate candidates for the Geriatrician and Elder Life Nurse Specialist position required for the HELP program. In fact, the third and forth reason for not implementing a HELP program is due to “no nurse or physician leader” available.

III. Fidelity of the Program

Most participating sites have made adaptations to the program in order for the program to best integrate with their local and current conditions. The majority of sites (61.5%) adapted the HELP screening and assessment tools for application at their individual sites. Other adaptations

include different altering screening assessments, not adopting the nonpharmacological sleep protocol, and reducing the frequency of intervention with a patient.[27]

Dissemination of HELP

A year ago, Dr. Inouye asked Kerry Fenlon to join the HELP team as the Associate Director to further HELP's growth and maintain communication with current sites. Previously, there was no marketing or expansion strategy. Sites were to opt in to the HELP program with the assistance that HELP provided, however, no targeting was conducted. Likewise, the International HELP Conference was used strictly to invite preexisting sites to share their success stories. Within the last year Ms. Fenlon has developed a strategic plan for HELP focusing on individual hospitals in the northeast due to their limiting financial resources. Even though HELP is completely sustainable the team only consist of seven members, and Ms. Fenlon has put much emphasis on managing HELP's growth, to make sure their staff and facilities can control HELP's expansion. She has positioned HELP as the program that provides on-going support for a delirium intervention program. This support provides a benefit to medical organizations because they do not have the background in business to have the confidence and knowledge to carry out full implementation alone.[28]

Barriers

HELP is currently functioning under limited resources which creates a significant barrier to their domestic and international growth. They can only target US northeastern hospitals because of their location and limited consultants. However, there have been demands throughout the country and world for this product. In order to accommodate these interested clients HELP

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[27] Elizabeth H. Bradley, Ph.D,Tashonna R. Webster, Mark Schlesinger, Dorothy Baker, Sharon K. Inouye. "The Roles of Senior Management in Improving Hospital Experiences for Frail Older Adults." *Pub Med*. N.p., Sept.-Oct. 2006. Web. 7 Apr. 2010.

[28] Fenlon, Kerry. HELP informational interview. 26 Apr. 2010

provides the majority of their assistance and support through telecommunications. This creates a barrier in the communication process until both parties fell comfortable collaborating online.

The lack of face to face communication and resources are not the only barriers that are hindering HELP's dissemination. Barriers are greater when considering dissemination abroad. They include language, differing healthcare systems, and cultural differences specifically with the value of the elderly in Asian countries. The greatest barrier to international expansion is the tolerance of copyright infringement especially in the Asian countries. Because HELP's sole revenue is relied upon the sharing of their delirium intervention program without the cushion of United States copyright laws success abroad is limited. Though HELP conducts business with those that seek HELP implementation abroad, HELP's strategic plan does not currently involve international expansion.[29]

Recommendations

The following describes recommendations for HELP's strategic expansion and program innovation. First program recommendations will focus on possible investment opportunities, as well as decreasing HELP's criteria and increasing volunteer investment. Then domestic and international expansion will be discussed.

Investment

The lack of funds for expansion is HELP's greatest barrier. With the current pricing HELP should take the $2,000 business plan fee as well as the yearly fee and invest this capital each year in an endowment to use for later expansion. This will provide the extra capital to expand its staff and thus the program through out the world. The majority of the consultant fee

[29] Fenlon, Kerry. HELP informational interview. 26 Apr. 2010

should go to the staff; however, investment to raise capital is a must to insure growth and stability for HELP.

The person responsible for the management of the endowment should be outsourced to a financial institution because a sufficient candidate for this task would not be feasible or cost efficient for HELP to hire.

Along with this it is suggested to increase the consulting fee from $20,000- $25,000 to $30,000- $35,000. The extra capital is needed, and under a 6 month implementation period (not including the addition time after implementation that HELP provides) is still only a $22/hour rate, significantly low for a consulting rate.

Decrease HELP criteria

Mental and physical requirements for the HELP should be changed to allow more people to be admitted to the program in fear that some are slipping through the cracks. As stated previously, if a patient becomes delirious they are more costly so by changing the criteria for HELP program admittance from severe risk of delirium to simply risk of delirium individuals will not be missed and costs will in effect decrease. Some hospitals already carry out this variation but do not record their results in fear to skew the numbers. They believe that it is more their mission to provide the most quality health care available and because of the research and results that HELP has generated hospitals themselves have begun to expand the program.[30]

Volunteer Investment

The HELP volunteer programs are some of the most well run hospital volunteer programs. Members have to participate in a grueling training process and commit to a long and time consuming task. With that morale among volunteers must be maintained because such a

[30] Fenlon, Kerry. HELP informational interview. 26 Apr. 2010

demanding program relies heavily on the success, capabilities and reliability of the volunteers. Volunteers are the aspect of the program as stated before that creates a competitive advantage, and to maintain this competitive advantage the volunteer team has to be efficient, cost effective, and results oriented.

HELP provides training for in-depth volunteer training however, they do not currently require or provide suggestions or training on the topic of "losing a patient." This is a very devastating experience for those who are emotionally sensitive; HELP should encourage and provide training on coping techniques and therapy to maintain morale. Morale must be maintained because the volunteers conduct most of the time with the patients. The Hospital Elder Life Specialist will be the one trained on such matters and expected to maintain these techniques.

Domestic

Partnership with Associations

One of HELP's greatest barriers is its lack of resources; thus in order to conduct further domestic expansion HELP should partner with state hospital associations. These associations themselves could purchase the business plan for interested clients. There could also be an expert/ representative on site at the association that could answer any questions and conduct training sessions. The association would receive all HELP material in exchange for this representative and location for information sessions. This would provide HELP with the necessary staffing and location as well as serve as an outlet for greater expansion because associations provide a large network of new clients. Not to mention, advocacy and education of the HELP program would be conducted at the association level which decreases the barrier of lack in upper management encouragement and provides HELP with political representation.

This should be implemented in the following pilot states (Nevada, Arizona, Colorado, Washington, Georgia, Utah, Alaska, and California) because HELP still has limited resources and full 50 state partnerships would be impossible for the current seven member staff. This recommendation will be carried out over the next 5 years because as discussed before the increase in elderly population is suppose to peak in 2030 and implementation of HELP requires a six month period. At the end of 5 years, this partnership will be evaluated and if successful will be expanded to the states that are in the most need of HELP's assistance whether they have a pre-existing program or not.

The product and price for this endeavor will not need to be changed. HELP can still charge the consultant fee depending on the number of engaged participants in the state. For example, if three hospitals were interested in the state of Arizona, that year the Arizona Hospital and Healthcare Association would pay three consultation fees. The associations themselves would not be responsible for funding however funding assistance could be provided.

Associations would want to participate because the implementation of HELP is compatible with their mission. Also HELP increases visibility for associations within the hospital and governmental community. There are no additional costs for the association because representation will either be volunteer or a stipend will be presented from HELP.

As for Canada, association targeting will be the main focus within this country because Canadians run under a nationalized healthcare system provided by their government. The most productive way for HELP to be implemented under a state run government program is not through the individual hospitals but through government regulation. Because the Canadians consistently believe healthcare is a pressing concern, having the lobbying activity of an association is the most effective way for Canadian implementation. This can be positioned to the

government as a way to increase rankings within their healthcare system which for years was ridiculed for its failures.

Ms. Fenlon would be the person to seek this partnership for HELP because she carries out the strategic marketing initiatives. Once the partnership is established follow up for this program and for existing individual hospital programs should be carried out by an assistant director; so that Ms. Fenlon can focus on the strategic growth of HELP.

Target Medical Institutions

HELP's current target is individual hospitals which is not efficient with a small staff and limited resources. As demonstrated with the association partnerships HELP needs to broaden their target market in order to reach more clients using less time and resources. Thus by targeting large medical institutions HELP gains access to a large network of hospitals, and they gain the knowledge of which hospital in the area would be the best to make initial investments.

Other than the network of hospitals the greatest benefit that large medical institutions offer is their capital. By choosing a broader target market HELP will be able to better utilize their resources and staff, and unlike associations large medical institutions have the capital to invest in the program. Like the associations, the implementation of HELP carries out the medical institutions' mission statement by providing their elderly with superior healthcare. Not to mention, HELP will help increase geriatric ratings and cut individual hospital costs.

This will be carried out by Ms. Fenlon under HELP's current target market, northeastern hospitals. This way target market success can be benchmarked with the previous suggested domestic strategy. A five year timeline will also exist for this recommendation and at the end of the five years success will be evaluated. If successful this strategy will be expanded throughout the country.

International

Government Regulation and Implementation

Because international expansion is not HELP's desired focus currently, it is suggested that in 5 years Germany, Japan, and Italy become targeted for the HELP program due to their dire need for assistance in elderly care. To cater to each country HELP will provide different incentives for each. In Germany, HELP will assist in the reduction of hospital stay time. Whereas, in Japan HELP will aid in the reduction of GDP expenditure on long-term care. Last, HELP will start the initial prevention and recognition of delirium in Italy. In five years, after the domestic market has expanded and with the evaluation of association partnerships a similar expansion plan will be conducted in these three countries if this method serves to be effective. However, unlike the United States, political advocacy will be the primary benefit to an association partnership as opposed to increase in market share. International expansion will focus heavily on advocacy because all of the countries chosen to expand in have a government run national healthcare system.

By partnering with an association again the association can serve as a link for the HELP program and hospitals in that state. Not only does this decrease the lack of resources and upper-management encouragement barriers but it also addresses the language, cultural, and healthcare barrier by providing HELP with a partner that understands all of these aspects, and can discover the most effective way for implementation in that state.

Kerry Fenlon will conduct the overall international expansion strategy. However, because international services will not be conducted for another 5 years an additional assistant should be hired in order to assist strategic planning. When hiring such an individual their

cultural intelligence, strategic management, and consensus skills should be taken into consideration for the success of HELP's future growth.

Budget

Over the next ten years, budget allocations will be split mainly into two. For the first five years all resources will be targeting domestic partnerships, with half of the budget give to the northeast large medical provider strategy, and the other half given to association partnerships within the eight selected states and Canada. Most expenses will be allocated to consultants' salaries that assist site implementation. The remainder of the budget will be given to additional marketing or promotional goods that might need to be invested in, in order to market to associations and large medical providers.

Budget allocations will change at the start of year 5 until year 10 to accommodate the three new international target markets. The budget will be split in half: domestic and international. Because targeting abroad is focused mainly on policy after the 7^{th} year budget allocations should be evaluated for reallocation to the domestic plan.

The endowment is expected to grow between 6% and 10% each year thus providing help with an additional $341,046 in investment gain. This number is found by taking the $2000 site fee of the 61 sites and the $2000 business plan investment from the 12 sites and finding the a 8% interest on this investment, well each year a similar estimated revenue is invested. (See Appendix 3)

Conclusion

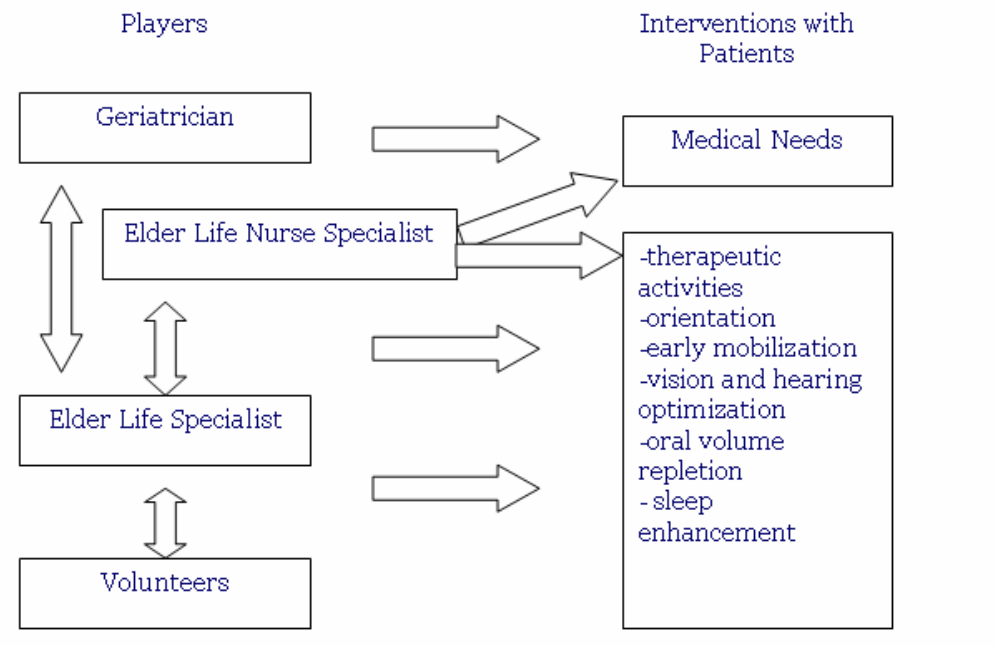
As the world's population ages and fertility decreases people the world will be faced with many short falls including a crowded healthcare system, increased deficits, work shortages, etc.

Hospitals need to be prepared for the influx of elderly patients to remain superior in providing the best healthcare. When the elderly are admitted into the hospital their chance to develop the syndrome delirium drastically increases which increases their risk of morbidity and mortality. Not to mention, it causes additional costs up to $8 million in the US and $4million in smaller abroad countries, due to increased stay and hospital re-admittance. The main reason for this is the current hospital care system is cated for the younger patient.

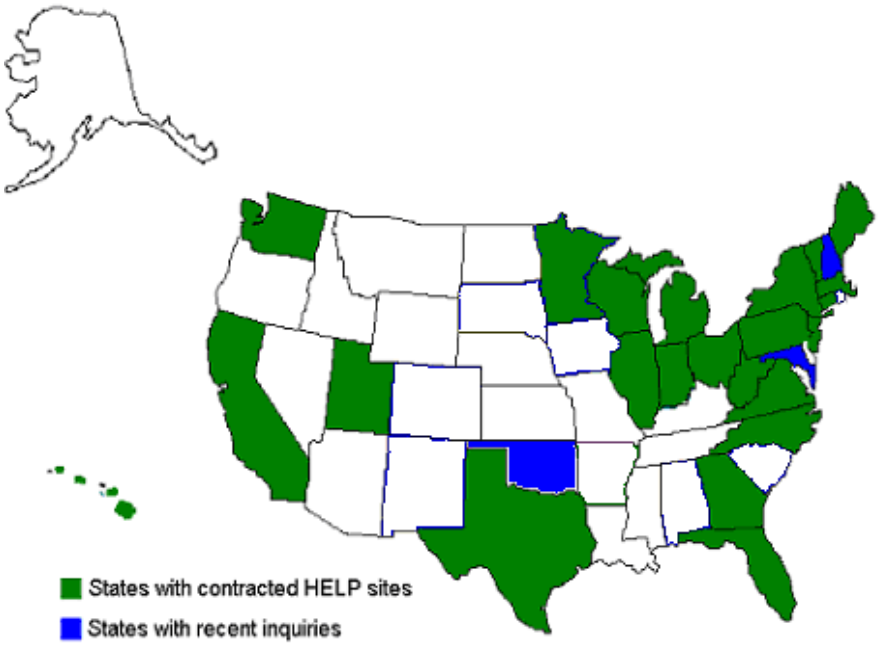
By implementing the Hospital Elder Life Program developed by Dr. Sharon K. Inouye hospitals adopt six interventions that serve to decrease or cover cost and more importantly decrease the cases of delirium. HELP is a completely self sustaining program started in 2007 and remains sustainable through trademark sales of its program.

Due to HELP's limited budget they have not focused on international expansion however, they have assisted implementation in many abroad locations when asked. Furthermore, just last year Kerry Fenlon was added to the HELP team to develop a strategic growth plan for the program. Currently, their target market is individual hospitals in the United States northeast. However, to encourage further growth and capture the large demand for the program HELP needs to further their expansion plan. Thus, it is recommended to conduct a five year domestic expansion plan through large medical institutions within the northeast and partnerships with associations in eight at risk states and Canada. After evaluation of the domestic strategy, in five years the company will focus on an international expansion to Germany, Italy, and Japan through associations and government regulation. As well as, create an endowment to support the international expansion in five years, invest in volunteer grievance assistance, and decrease criteria for admittance. All of these recommendations address the cost benefit ratio and decrease the barriers of expansion, increase market share, and maintain sustainability.

Appendix 1



Appendix 2



Appendix 3

2010	2011	2012	2013	2014	2015
$122,000	$131,760	$142,301	$153,685	$165,980	$179,258
$24,000	$25,920	$27,994	$30,233	$32,652	$35,264