Your Guide to Consumer Information

MINNESOTA Health Care News

November 2015 • Volume 13 Number 11

HOME CARE

# Life care managers

*Helping seniors live healthier, happier lives*

**By Angela Nelson, RN**

Betty nervously waits in the doctor's office for them to call her name. She's had an eventful couple of weeks. Her husband died only a month ago and last week she ended up in the emergency room (ER) after she fell in her kitchen. With everything that was going on, she forgot to fill her prescription. As she sits there, she holds on tight to her purse, which contains a complete list of her current medications (did she remember all of them?) as her thoughts wander to her recent trip to the ER—she's fearful the doctors will suggest she stop driving. Without a car, how will she get to the store, church, or knitting group—she looks forward to that group each week. Instantly she feels sad, for the second time this month, and worries about her independence eroding. Finally, her name is called and she's in the clinic exam room. An hour later she's in her car thinking, "Why didn't I ask the questions I had? What's this new medication supposed to do again? Am I calling the occupational therapist or are they?" Her mind wanders again—"Has it really been just a few weeks since Joe died? I need to stop at his grave on my way home. Funny, the doctor never asked about that."

A few weeks later, Betty ends up in the hospital. And the cycle continues.

*LCMs cross all settings and work with every type of provider.*

## A growing problem

Betty's situation is an example of an all-too-familiar experience shared by seniors and those who care for them, most often their adult children. This roller coaster of health care crisis is costing seniors more than they realize, hitting not just their finances but also their quality of life. In 2014, nearly 18 percent of Medicare patients who were hospitalized were readmitted within one month, costing an estimated $26 billion. Of that amount, $17 billion represented readmissions that were potentially avoidable. This readmission impact has hit 27 percent of Minnesota hospitals, with 36 facilities being penalized for high readmission rates.

As Betty's example illustrates, it isn't just a "health care" issue—it is a life issue. A study by researchers at Boston's Beth Israel Deaconess Medical Center (Annals of Internal Medicine, June 2015) found that many of the risk factors for readmissions, especially those occurring eight days or longer after discharge, are beyond the typical scope of hospital efforts, with many involving socioeconomic status or access to personal support systems. There is widespread recognition of the need for change. Ten years ago, Lifesprk began building a new model to do exactly that:

start with people's individual wishes and goals, then use a whole person approach combined with ongoing advocacy and guidance.

## A new approach: Life care managers

Imagine the difference if Betty had had someone with her at her doctor's appointment. Better yet, if she had a nurse by her side who would ask the right questions, record the information, and relay that information to Betty's family. The nurse would help Betty and her family keep the focus on her goals and wishes, taking a whole person approach to get to know Betty and what matters most to her. The nurse would be an advocate in the midst of all of Betty's life changes, regardless of whether she was at home, in the doctor's office, in the hospital, or even in a nursing home.

*Whole person senior care does in fact work.*

Nurses like this are called life care managers (LCMs). We have seen improved outcomes for seniors who use LCMs as part of their whole person senior care approach. LCMs carefully monitor seniors' health to make sure small issues don't become larger ones. This proactive approach eliminates unplanned hospitalization and dramatically reduces long-term care costs. It's also helping seniors to live healthier, more independent lives, something Lifesprk calls living a "sparked life."

In 2014, Lifesprk conducted a baseline study to document the impact of its whole person senior care approach. We tracked hospitalizations and ER visits, as well as quality of life indicators such as connectedness, happiness, control, and engagement. Comparing data on client experiences in the year prior to our services with data from one year after these services, the study found a 73 percent reduction in hospitalizations and a 52 percent reduction in ER visits for community clients. While many factors contribute to this reduction, one of the key factors for this success is the use of an LCM who is trained to address not only any concerns seniors face but also their individual goals, purpose, and passion.

## The LCM role

LCMs become the trusted advocate for a person's whole life—encompassing everything from health and wellness to purpose and passion. It all starts with an innovative discovery process. In Betty's case, long before she ended up in the physician's waiting room, the LCM would have worked with her to identify her specific goals and passions and to help her and her family build a pathway to those goals. Those goals can be as simple as continuing to attend church and her knitting group each week, or as complex as travel and regaining the strength to walk. Her dedicated LCM would then work side-by-side with Betty and her family to implement their plan and to catch any issues that would interfere with reaching those goals.

In the clinic, her LCM would have held her hand, written down her concerns, and listened as Betty shared stories of her husband. The LCM would have guided the questions during her appointment, then recorded and explained what it all meant so that Betty could incorporate the physician's orders into her daily life. Another important role of the LCM is to keep families informed of health changes and updates, helping to ease the burden of coordination and caregiving demands on the family.

The LCM also serves as a hub for the team of providers involved in the client's care—a service that is often missing or provided only on a short-term basis under other senior care models. LCMs cross all settings and work with every type of provider. They become the eyes and ears in the client's home, providing hands-on support to implement the physician's care plan at home and address critical needs such as support for physician appointments and medication management. They also address psychosocial and non-medical needs such as purpose and passion, which are powerful ways to keep people active, in control, and healthy. Remember Betty's passion for knitting?

LCMs not only help with social supports but they encourage them. Knowing that life can still continue according to their wishes and goals, even as their functionality may change, gives seniors a heightened sense of wellbeing because they are engaged and happy. This sense of purpose focuses their mind not on what's ailing them, but on the meaning and richness of their life.

## Hope for the future

The National Institutes of Health stresses the need "for proven treatments and approaches that not only provide measurable outcomes but also take into account patients' wishes and preferences." While Betty's story paints a common picture of today's senior, there is hope that, with new innovations and approaches to care, providers will begin to see the value in focusing on the whole person and not just fragmented care with a narrow medical emphasis. Research shows that whole person senior care does in fact work to keep people out of the hospital and living healthier, more independent lives.

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