Minnesota Physician
The Independent Medical Business Newspaper
Volume XXIX, No. 5
August 2015

Reducing hospitalization for seniors

The role of a life care manager

By Joel Theisen, RN, and Dave Moen, MD

As the impetus for value-based care continues to grow, reducing hospital admissions for seniors remains a top priority for payers and providers alike. According to the 2014 Healthcare Cost and Utilization Project Statistical Brief on hospital stays, spending on hospitalizations accounted for 29 percent of all health care expenses, making them one of the most expensive types of health care treatments.

In 2014, nearly 18 percent of Medicare patients who were hospitalized were readmitted within a month, costing an estimated $26 billion, with $17 billion coming from potentially avoidable readmissions. For Minnesota, the impact has hit 27 percent of the hospitals with 36 being penalized for high readmission rates. There remain large-scale opportunities for further reductions and cost savings.

While physicians have readily available solutions for acute problems, there have been inadequate and often unmeasured solutions for chronic and complex health and social problems, especially in the community. The easy way out was all too frequently to send them to the Emergency Department (ED). In fact, new research published in the Annals of Internal Medicine (June 2015) shows that ED re-visits after an initial ED encounter actually more than double (8 percent above the previously reported rate of 3 percent) and are often more costly.

This drive toward fewer hospitalizations and ED visits has created a shift toward providing more care in the community where people live their day-to-day lives. Community-based care has been, in many ways, a black hole for physicians with few practitioners working in the community and getting brief, if any, glimpses into effective models. While outcomes from programs such as Medicare home health agencies have become standard, few programs outside the Medicare realm are producing outcomes, and yet this private-pay arena for non-medical care is not only one of the fastest growing in the country, it is pivotal for affecting readmissions.

Measurable community-based outcomes

Value-based contracts reward providers for paying attention to all factors that influence a person's health and well-being. Social isolation and a person's purpose (reason for being) play roles that are as important as physiological risk factors such as high blood pressure, obesity, or physical inactivity. Under new payment structures, providers will need to go beyond physical ailments to identify such issues as grief, social isolation, and lack of purpose as contributing factors for poor outcomes and increased rehospitalizations. For example, to fix Betty Ann's broken hip, providers may first have to identify grief as an issue and heal her broken heart. According to the National Institutes of Health, with the shift toward providing more care in the community there is a need "for proven treatments and approaches that not only provide measurable outcomes but also take into account patients' wishes and preferences."

Physicians—as health care leaders—need to be able to evaluate different options based on measurable outcomes. How can they know what works unless providers measure their results and track them over time?

The best way to avoid overusing the ED and hospital is to create accessible and capable community-based teams that build relationships with patients and families over time. Care plans informed by a clear understanding of patient and family goals help physicians address inevitable changes that people will experience once they're home. In the new home care frontier, smart teams supported by engaged and accountable physicians are emerging as a key driver of value, especially for the highest-cost patients.

Tracking hospitalization and ED visits

Within this environment, Lifesprk has been providing population health management for seniors through a combination of care management and home care services in the Twin Cities metro for 10 years. In response to marketplace dynamics, we have developed a whole-person senior care model designed to respond to these problems. In 2014, we undertook a comprehensive effort to fine-tune this model and develop ongoing outcomes management protocols through surveys and other work.

We work with partners and industry leaders to define which key indicators to track. From a long list of options important to different stakeholders, we settled on tracking hospitalizations and ED visits along with quality-of-life indicators including connectedness, happiness, control, and engagement. As we set up the capabilities and technology to track these outcomes on a more sophisticated ongoing basis, we undertook a baseline study.

For the baseline, our company gathered the data through client/family interviews using an external evaluator and reviewed our medical records. The study looked at client experience one year prior to working with our organization and then during a year while working together. The baseline study included clients who had initiated services within the last two years. Longer-term clients were eliminated due to the challenge of gathering accurate, self-reported data regarding their experience prior to using our services. The study involved 221 people and examined their actual experiences. Clients lived in a variety of settings spanning from single-family homes to senior campuses where we served as the in-home care provider. The study found a 73 percent reduction in hospitalizations and a 52 percent reduction in ED visits for community clients (n=58) and a 42 percent reduction in hospitalizations for all clients regardless of setting with a 37 percent drop in ED visits.

Starting in December 2014, we instituted an ongoing outcomes tracking effort to measure rehospitalizations and ED visits for all new clients as well as quality-of-life indicators using the National Institutes of Health's

PROMIS (Patient Reported Outcomes Measurement Information System) tool. PROMIS is a responsive assessment tool that is used globally. Efforts are also underway to enhance the risk stratification of client data. Our overall goal is to prove the efficacy of our whole-person senior care approach, while simultaneously providing continuous data to refine the model.

Reducing rehospitalization

Seniors experience other life challenges beyond physical challenges. When left unchecked, these life issues can lead to frequent ED visits and hospitalizations. This 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 post-discharge, are beyond the typical scope of hospital efforts, and include such issues as socioeconomic status or access to support systems. Yet once the patient is home, these changing risk factors play a very real role in the potential for rehospitalization, especially when chronic conditions are present. These risk factors create the need for a comprehensive approach that goes beyond the scope of transactional home care services.

Our whole-person senior care model builds patient engagement right from the very start with a goal to "spark lives," which means to actively engage people in identifying and achieving their priorities for living a richer, more fulfilling life with as much independence as possible. The model, which includes private-pay home care services as needed, is also designed to plug in to many different types of partner organizations—from health systems and physician clinics to senior living campuses, and even employers and associations—to expand their reach into the communities where patients live. We achieved these outcomes through several key program components:

Assigning a life care manager

All clients are assigned a dedicated Life Care Manager (LCM). A registered nurse, the LCM becomes an ongoing guide and coach for all aspects of well-being, not just health issues. LCMs collaborate closely with physicians, clinics, hospitals, home health, and hospice providers, as well as any other service involved in supporting the client and family.

An often missing, or short-term, component in other approaches, the LCM becomes a hub for the team of providers involved in the client's care. 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 such critical needs as support for physician appointments and medication management. LCMs also examine the broader realm of psycho-social and non-medical needs along with client wishes. A growing body of research points to the need for a long-term coordinated team approach to reduce hospitalizations and foster patient success at home.

LCMs also partner with clients and families to provide a wide range of practical, proactive support and services to safeguard seniors against life challenges and improve their quality of life. The end result is that issues and crises are caught early.

Having a purpose

A whole-person discovery process is designed to engage clients. Our whole-person approach uses a structured, collaborative discovery process that engages clients to identify and prioritize their preferences as the main focus of their individual life plan. The discovery tools use specific questions to review seven elements of well-being, including 1) identity, 2) social support, 3) purpose and passion, 4) finances, 5) health and wellness, 6) home and safety, and 7) thinking and memory.

The issues of social support and client engagement explored through discussions of people's purpose in life are often missing in traditional provider services. Through our experience, we have seen how these discussions effectively engage clients' enthusiasm and active participation in their life plans, which helps to achieve positive outcomes. One 105-year-old client was so enthusiastic about her well-being she decided she wanted to regain the strength to be able to walk into her 106th birthday party, and she did, producing health ramifications that tied directly to her outcomes.

Avoiding gaps in care

A flexible, long-term approach eliminates gaps in support. Most reimbursed services are episodic with limits to their duration and scope. These limits create gaps with little support, ongoing guidance, or continuity for the client beyond a 30- or 90-day post-acute period. Our model provides ongoing, long-term support that adjusts based on a client's need to ensure there are no gaps in support.

Addressing social isolation

A combination of evidence-based algorithms and creative approaches is used. Clinical pathways are well established for conditions such as heart failure and pneumonia, but lacking for emerging issues such as social isolation. Several studies in JAMA Internal Medicine (formerly the Archives of Internal Medicine, July 2012) detail how factors such as social isolation undermine health and well-being, and need to be addressed to stop rehospitalizations and improve outcomes. Yet few physicians address it, or even ask patients about it. Our model not only addresses and measures social isolation through the PROMIS tool but has also developed other creative approaches.

Creating a life plan

A customized whole life plan is important. Broader in scope than a typical patient medical record, the Lifesprk Life Plan is created to build a pathway toward achieving the client's individual goals, incorporating best practices and best fit resources. The plan is then continually measured and adapted to assess outcomes and address new goals and issues.

Preventing hospitalization

While we currently serve many people who are over the age of 65 and who have already experienced one hospitalization, the model is designed for earlier involvement to prevent even initial hospitalizations. Based on experience with our model, the team has learned that there are key opportunities for improvement in home and community-based care to further reduce hospitalizations and ED visits. Practitioners need options that go beyond traditional reactive home care services to:

- Address psychosocial issues that are beyond the scope of other models or covered services.
- Provide proactive guidance to catch issues early, preventing avoidable hospitalizations and ED visits rather than providing services after an initial health event or crisis.
- Provide ongoing guidance and support over the long-term, which closes gaps in patient support where problems or issues can germinate into major health events.
- Provide long-term continuity of coordination between discrete programs of care, crossing all settings.

The next step for physicians

Going forward, physicians can help patients and families make effective decisions on how to invest limited resources, even a patient's own private-pay funds, by seeking outcomes data from home and community-based providers. Our model with its measurable outcomes provides a baseline benchmark they can use to evaluate other home and community-based options. Physicians can use our services for their patients who may be at risk for higher rates of hospitalization as well as for any senior even before a health crisis to establish an ongoing proactive plan to keep patients as healthy and independent as possible in the community.

Physicians also have an opportunity to become more actively involved in home and community-based care and help shape those measurable outcomes in the community by participating in task forces and collaborative efforts to more fully develop community-based population health programs.

Joel Theisen, RN, *is founder and CEO of Edina-based Lifesprk.* **Dave Moen, MD,** *is principal consultant for MoenMDConsulting.*