December 2013

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AACM and You:

We all desire to maintain our life options in a manner that permits us to live out our lives in our chosen environment. Having an advocate on your side to assist with household safety and medication compliance is important for individuals wishing to age-in-place.

Without the assistance of a trained coordinator, obvious safety concerns go unnoticed, putting an aging person's stability at risk. Many health care providers never step foot into their patient's home, so they are unaware of the safety vulnerabilities of their clients.

If you've found yourself caught in the maze of health care coordination, or you have too little time to invest in understanding the facts or monitoring an ongoing condition, a Care Manager may be what you need to keep your life independent and in balance.

Whether you are an individual planning for your future, or you are aiding a loved one, having a knowledgeable advocate can be invaluable. Employing your own personal Care Manager will not only save you money and relieve stress, but you'll know you have an experienced advocate looking out for your best interests or those of a loved one.

Care Management: Agents for Interoperability

In October, Accountable Aging Care Management's Mick Koffend attended his class reunion at Harvard Business School. The weekend in Boston featured a number of presentations from faculty and alumni, and Mick took advantage of the invitation to present to fellow alumni on the subject of caring for our aging population.

However, it was a presentation from a current Harvard faculty member that made the biggest impression during the weekend. Regina E. Herzlinger, MBA, PhD - the first woman to be tenured and chaired at Harvard Business School - discussed the current and future state of health care delivery systems, including a call to action for interoperability in health care. Professor Herzlinger is known for her seminal works <u>Market Driven Health Care</u> (Boston: Perseus, 2000) and <u>Who Killed Health Care?</u> (NY: McGraw-Hill, 2007). What follows is not a compendium of her research, but rather an examination of how Care Management may be positioned to help address challenges related to interoperability in care.

Interoperability is defined as the ability of systems and organizations to work together. Although the term is frequently applied to information technology and systems engineering, a broader definition takes into account social, political and organizational factors that impact system to system performance. The term "interoperability" has enjoyed buzz-word status across different domains in different eras over the past century and a half, most notably in general technology, telecom, military, computing and – most recently – health care information technology.

Perhaps the first instance of a government-mandated interoperability standard codified by law was the Safe Appliance Act of 1893. The law defined airbrakes as the standard for railcars and called for automatic couplers that could be uncoupled without manual intervention. Railcars that were not so equipped were no longer allowed.[1]

Now, let's fast-forward about 100 years. In the early days of computing, interoperability was not a great concern. However, as commercial entities increasingly saw the potential of widespread networking, the interoperability problem moved to the fore. *Information has no value if it cannot be shared.*

As the era of personal computers and client-server computing arrived, information was suddenly being exchanged between hardware and software from different vendors, running on standards that might or might not have been compatible. The problem was akin to trying to hold a conversation between speakers of two different languages. *The language problem was a major hurdle for systems that were developed by and had matured in different enterprises.*

As the computer revolution intensified, so did the need for systems developed by different vendors to work together without manual intervention. The ultimate success of companies like Microsoft resulted from their ability to interface well with others in the ecosystem. Just as was the case for railroads in 1893, agreeing on common standards was a crucial step to keep the information train from derailing. Ultimately, these common standards were a powerful growth enabler. They gave rise to the Internet as we know it today. [2]

So what does this have to do with Care Management? As it turns out, quite a bit.

In the above examples, *an issue of disconnect is overcome by developing common interfaces at the touch points between systems, thus enabling those systems to work together.*

When systems fail to work together, we assume that the problems relate to technical obstacles. **The real problems are organizational obstacles.**   The core issue is a failure to understand the need to exchange information effectively among diverse systems, including those belonging to organizations viewed as competitors.

For the most part, the computer industry embraced standards that elevated both the quality of their products and the value brought to the end user. The standards themselves are merely a byproduct of that revelation. The health care industry seems to have finally embraced this idea as well, and a revolution in health care IT is currently underway.
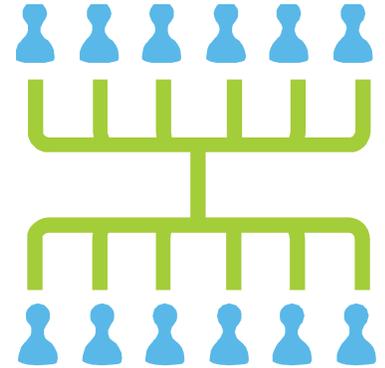
The obstacles to interoperability in health care are similar to those that faced the computer industry. Health care organizations have become increasingly complex and departmentalized, which has only exacerbated the problem of communicating effectively with other health care organizations. To make matters worse, health care is a far more complex environment than computing, because human beings are infinitely more variable than machines, and the potential consequences of errors are far more intense. Knowing that the U.S. health care system is a Complex Adaptive System makes this more understandable but does not necessarily solve the communication problems.

In addition, health care is only one piece in a person's overall "care puzzle." Therefore, there are potential points of failure not only between various healthcare providers but also among all the interconnected puzzle pieces that together form one's own personal care network.

The primary obstacle to interoperability in one's care is effective communication, specifically, the type of communication that characterizes a team. Amid the growing complexity of the health care ecosystem and the many care provider options, it's understandable that many consumers get lost in the shuffle. How, then, can we help seniors and their families accurately understand their situation, and the options available to them? Is there some way that a person can truly get an unbiased, fact-based explanation of their choices? We believe that Care Management is one way to help bridge this disconnect.

When people ask, "What is Care Management?" there is no single answer. Care Management encompasses a wide range of services targeted toward the specific needs of the client and their loved ones. Care Managers assess an individual's care options with comprehensive knowledge, but no bias.   Care Managers simplify choices and provide clear, concise guidance. Care Managers educate clients with respect to the essential facts that they need to make informed decisions.

When requested, a client's Care Manager can act as a single point of contact to ensure that all of the pieces of their individual care puzzle remain in place in the face of constantly changing circumstances and options. Care Managers coordinate the often-disjointed system of care. In other words, *Care Managers understand the language problem and maximize the value of information by acting as a common touch point, enabling multiple independent systems to work together.*

The Language Problem

When computers communicate (i.e. transmit data), they also transmit data about the data (i.e., metadata). Metadata maps each data element to a common, unambiguous vocabulary. Thus, the meaning of the data is transmitted with the data itself in a single self-describing packet. This ability of computer systems to transmit data with shared, unambiguous meaning is known as *semantic interoperability*.
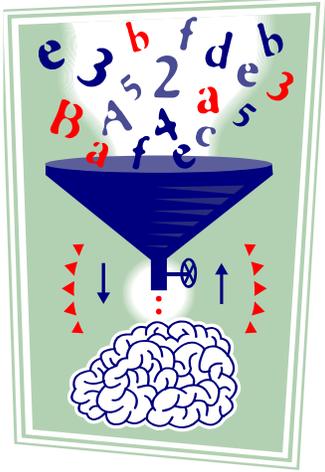
As it turns out, people are much less efficient at communicating than are computers. Unlike computer languages, there is no direct 1:1 relationship between spoken words and meaning. Thus, a meta-analysis of the context, **knowledge of the sender and knowledge of the recipient is required in order to interpret the meaning of human communication.**

By itself, this is a complex process. However, the possibility of miscommunication increases as a person gets older and suffers from diminished executive function. Too often, experts fail to explain complex ideas in ways that are easily understood by their clients/patients. The individual, having found herself in a situation for the first time, may lack contextual knowledge. Care Managers have knowledge of both the sender *and* receiver of the information, and can draw upon their experience in similar situations to provide the needed context so that our clients and their families can see the full picture. In other words, Care Managers help clients to overcome the language problem.

The Value of Information

Information is useless if it cannot be shared effectively. As we age, the pieces of our care puzzle — medical, legal, financial, etc. — grow increasingly interconnected. At the same time, we begin to lose our ability to manage all of the details effectively.

Yet, many times, the only common touch point in an individual's care network is the individual herself, and the burden of managing all the connections and routing pertinent information between all the players involved can be overwhelming.

The experts we employ to help manage our affairs tend to be narrowly focused on performing their specialized roles. They interface with the client, but they often don't have visibility concerning the other pieces in the puzzle and are unaware how issues related to their work may impact work elsewhere in the care network. The effect can be similar to the problem businesses encountered with proprietary hardware/software stacks—*information is confined to a physical location.*

An individual's attorney, financial planner, therapist and primary care physician are all part of different systems. They operate within their own unique environments, and yet the information that each of these gathers may be of great importance elsewhere in the care network, *but only if the information is shared effectively.* Care Managers work to maximize the value of information, leading to best outcomes

Interoperability In Action:

A CPA tax preparer sends notice to a new client couple that they have a tax liability due to the sale of their home. This is the first time the couple has had a professional prepare their taxes. The CPA does not know that one of the spouses has a moderate case of dementia, and that spouse is the one who normally handles financial matters for the couple. Without the care manager being the bill payer and receiving the notice from the CPA, those taxes would probably not have been paid on time, and who knows the consequences of this for sure?

CPAs and other forms of tax preparers are trained in tax law and regulations; not the implications of the aging process.

Enabling Systems to Work Together: A Common Touch Point

Employing a Care Manager adds another common touch point to an individual's care network. Care Managers act both as a surrogate and an advocate, providing guidance while acting as an additional set of eyes and ears for clients and their families. The level of communication between departmentalized health care providers is simply not sufficient to manage the ongoing care of individuals with unique wellness requirements. By engaging in reciprocal communication with an individual's appointed advocate, these silo-like entities have the opportunity to make their maximum care contribution.

Professor Herzlinger advocates moving to a health care system, "…that's organized around the needs of the patient for total care for their diseases and total care for their disabilities."[3] A Care Manager's job is to make a client's life puzzle fit together like Professor Herzlinger's ideal system, at least from the client's point of view.

Not only do Care Managers ensure that all needs of the individual are met, but they also approach each situation holistically, tying all intervention and treatment processes into one package catered toward the individual and their unique set of circumstances.   Care Managers act as a common touch point to enable multiple systems to interoperate.
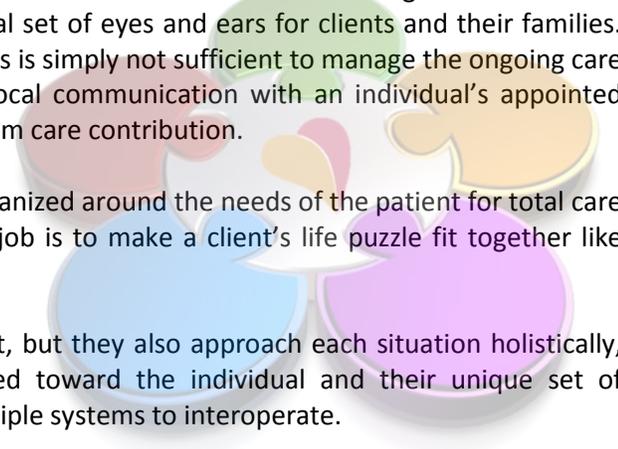
Interoperability In Action:

A Care Manager receives a call from a client's caregiver stating that the client is en route to a hospital. The Care Manager, who has been maintaining a current medication list, faxes the client's medication list to the hospital and arrives in time for the medication disbursement the following morning. The client looks at one of the pills and doesn't recognize it.   This client also suffers from dementia.

After some consultation, it turns out the client had been admitted to the same hospital in the same month two years prior. The hospital had mistakenly applied the medication list from admissions *two years ago.* Individuals 80 – 84 take an average of 18 prescription medications per year, and adverse drug reactions and noncompliance are responsible for 28% of hospitalizations of the elderly, yet many times no single entity is responsible for managing and maintaining and accurate medication list.

Tying it All Together

For Mick and Mary, the most exciting takeaway from the Harvard Business School reunion was not new information, but rather a new lens through which to view the aging process and all its elements. Thinking about care management in terms of interoperability is a new perspective for us. Although the perspective is new, the underlying concept has long been a part of our DNA.

From its inception, AACM has worked to overcome the organization obstacles imposed on its clients due to a lack of awareness within systems of the existence of other pieces in a client's care puzzle. Acknowledging the diversity of elements in the care puzzle drove AACM to its multidisciplinary approach to care management.   A multidisciplinary approach – one which draws upon the diversity of expertise among team members – is a team's best tool for confronting the language problem. Understanding the language problem allows care managers to monitor the flow of information and to intervene when necessary in order to prevent communication breakdowns.   After all, information is useless if it cannot be shared effectively.

AACM's Abbie Theobald and John Lloyd collaborated to produce this article.

Notes:

1. Wikipedia contributors. "Railroad Safety Appliance Act." *Wikipedia, The Free Encyclopedia*. Wikipedia, The Free Encyclopedia, 11 Nov. 2013.

http://en.wikipedia.org/w/index.php?title=Railroad_Safety_Appliance_Act&oldid=581248843 18 Nov. 2013.

2. Microsoft. "Interoperability and Standards, a Catalyst for Maximising Value." Microsoft Corporation, 2012.

http://download.microsoft.com/download/7/E/6/7E665A7C-2D96-4AC7-A473-
B587D7D6BC64/Interoperability%20and%20Standards,%20a%20Catalyst%20for%20Maximising%20Value.pdf 18 Nov. 2013.

3. Herzlinger, Regina. "Imagine This: A Health Care System Organized Around the Patient!" Big Think, 27 May 2009. http://bigthink.com/videos/imagine-this-a-health-care-system-organized-around-the-patient 10 Nov 2013.

Home for the Holidays

mmLearn.org, a program of Morningside Ministries, has produced a webcast of special importance this time of year. The program is titled "Home for the Holidays" and is presented by Maria Wellisch, RN, LNFA. A brief description from mmLearn.org:

"If you are not aware of the needs of your loved one, you will not be able to protect them. When was your last visit with your parents? Are you planning a visit with someone elderly this holiday season? If so - you owe it to yourself, your parents or your loved one to watch "Home for the Holidays" before the visit. This webcast offer great practical advice for determining the overall wellness of an aging loved one. A must see for anyone visiting the elderly during the upcoming holidays!"

Changing Faces

AACM would like to wish a fond farewell to **Jennifer Tobey** as she leaves to pursue a new career venture. We are tremendously fortunate to have worked with her these past few years, both for her quality as a person and the quality of her work for the many clients she has served. Stepping into her role as bill-paying coordinator is **Jenny Aurelius**. Jenny comes to AACM with an educational and professional background in Computer Science. She has held positions in training and system design. Most recently, she worked as a bookkeeper in the non-profit sector and has recent experience utilizing the same software she will be called upon to use in her new role. Although we hate to see Jennifer go, we are glad the position will be handed off to such a competent successor.

Because referrals are the lifeblood of our business, the best way you can thank us, as a satisfied client, is by referring a friend, neighbor or colleague to us! We appreciate all your referrals.

Accountable Aging Care Management Team

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Accountable Aging Care Management is an eldercare consulting and care management firm.

Accountable Aging is a single source for older adults and their families to attain knowledge, resources and on-going assistance with the challenges related to aging or caring for an elder loved one. We serve older adults in Austin, Bryan/College Station, Dallas, San Antonio and the surrounding areas.

With this newsletter, our aim is to provide a trusted conduit for eldercare information and resources and to highlight the services we offer that meet the needs of older adults and their families.

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