

Care Management Dispatches from the Front Lines:

A Conversation with Lisa Mayfield, President, Board of
Directors, Aging Life Care Association

Carole A. Lambert, Vice President, SmithLambert Enterprises LLC
and Lisa Mayfield, MA, LMHC, GMHS, CMC



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ABSTRACT

A Care Manager is a member of the healthcare team, a team focused on supporting patients and families in restoring and maintaining health and quality of life. The stories of Aging Life Care Managers, members of the Aging Life Care Association, working together with patients, families, and the healthcare team to address the social determinants of health add to our understanding of how collaboration can positively impact health outcomes and improve quality of life for the patient and the family caregiver.

Each of us, at some time in our personal or professional life, will meet someone challenged by concern for a family member whose health status is changing and whose need for support is increasing. As recognizable and perhaps inevitable as this process is, it is at the very least unsettling, and may in fact be deeply disturbing, even frightening. It is unlikely that we ourselves will escape this experience in our own families. The transition from a proud, independent, autonomous individual to a patient, relying on others for information and assistance, is shocking, not to mention unwelcome. As the healthcare team mobilizes around the patient and the family, each team member has a part to play and a contribution to make. The Aging Life Care Manager, as a member of the healthcare team, plays an important role as a communication nexus, positively impacting health outcomes and quality of life for patients and families.

Recently, we had the opportunity to sit down with Lisa Mayfield, a principal in Aging Wisdom® based in Seattle, WA, and president and member of the Aging Life Care Association. We wanted to hear from the front lines of care management, from the people who do so much in ways large and small to support effective transitions of care through collaboration and communication.

CL: Lisa, thanks so much for joining us today.

LM: Thank you Carole for the opportunity to talk about the role of Aging Life Care Managers and how we contribute to the patient's and family's healthcare team.

CL: We know that health care and the practitioners who provide care continue to evolve, driven by increasingly sophisticated knowledge and technology. Science provides the underpinning for much of our understanding and practice, but there is also an art to caring for people. How has care management evolved?

Each of us, at some time in our personal or professional life, will meet someone challenged by concern for a family member whose health status is changing and whose need for support is increasing. As recognizable and perhaps inevitable as this process is, it is at the very least unsettling, and may in fact be deeply disturbing, even frightening.

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LM: We have to go back to 1985 to the formation of the National Association of Private Geriatric Care Managers (NAPGCM). The fifty founding members were mostly nurses and social workers, all business owners, with Master's degrees and experience in human resources and elder care. At that time, the association was seen as a trade association and the goal, at least in part, was to increase the market share as geriatric care management grew.

CL: Good business people – looking ahead.

LM: Indeed. These early members were truly insightful pioneers. Nearly 20 years later (1993), NAPGCM recognized that members were doing work beyond private practice and changed our name to the National Association of Professional Geriatric Care Managers. The association also shifted its focus from a trade association positioning and promoting member practices to a professional association with the primary purpose of advancing the profession.

CL: I imagine the emphasis on professionalism drove more changes.

LM: It certainly did. In 1996, the National Academy of Certified Care Managers (NACCM) was created as a credentialing program for care managers. And, ten years later, the NAPGCM board voted that all members in the Advanced Professional category must hold at least one of four certifications.

CL: What are they?

LM: The four certifications that ALCA recognizes are: Care Manager Certified (CMC) offered through NACCM, Certified Case Manager (CCM) offered through the Commission for Case Manager Certification (CCMC), and two advanced practice specialty certifications offered through the National Association of Social Workers (NASW), Certified Advanced Social Work Case Manager (C-ASWCM) and Certified Social Work Case Manager (C-SWCM).

CL: So you are cross-disciplinary...

LM: Actually, we see ourselves as multi-disciplinary rather than cross-disciplinary because we also include the patient and family as part of our care team.

CL: When did the National Association of Professional Geriatric Care Managers become the Aging Life Care Association (ALCA)?

LM: We made that change as of May, 2015, after an intensive review of who and what we are, who we serve, and how we want to be seen and valued. We became the Aging Life Care Association and our members are referred to as Aging Life Care Managers or Professionals. ALCA remains committed to our evolving mission of promoting the care management profession and supporting our members.

CL: You and I have talked about the nuts and bolts of care management – especially the collaboration and communication aspects – and what I've learned from you has prompted me to reflect on the principles of improved access, improved outcomes, contained costs, and caring for the caregiver. At the front lines of care management, in the Aging Life Care Manager's daily work, do those principles resonate with you?

LM: They do – absolutely! When it comes to access, the Aging Life Care Manager:

- gets resistant clients to the doctor
- gets clients without transportation to medical appointments

- gets clients with memory challenges to the doctor
- can share our observations with the doctor so they really know what is going on at home
- assists with follow through of treatment recommendations

By teaming with the client's healthcare team, we help improve not only access but outcomes as well.

CL: That's a lot of moving parts.

LM: Here are a few other ways Aging Life Care Managers can improve outcomes and effectiveness:

- assist with coordination of care amongst the many providers across various healthcare systems
- find ways to improve compliance with appointments and treatment recommendations
- help create systems for improved medication management in coordination with the pharmacy

With consistent access and improved effectiveness, healthcare costs are contained:

- reducing barriers that get in the way of following through with treatment recommendations
- improved compliance and access with outpatient services leads to less ER visits and hospital stays
- decreasing fall risks also decreases ER visits, hospital stays, and SNF stays

CL: When things go smoothly, it must be a great feeling.

LM: It is. When I reflect on how gratifying this work is, and the ways in which Aging Life Care Managers support our client's healthcare team to improve access, outcomes, quality of life, and cost containment, one of my own clients comes to mind...

He was referred to me through his neurologist's office. Their social worker had encouraged his son to reach out for my help. At that time, his dad was not following through with appointments with them, there at been a recent referral to Adult Protective Services from someone in his life concerned about the care he was receiving at home, and his out-of-town siblings were concerned that not enough was happening to support him. His siblings were also given my name from a friend in town and connected with me at the same time as his son had reached out for help.

My client recently retired from his very successful and visible career in the engineering department at a local university. A recent diagnosis of dementia was the main cause of the current challenges. Like most clients with dementia, he was unable to see the ways in which his brain was changing and was refusing any kind of assistance. Despite family and colleagues trying to increase the level of support, he was adamant that he did not need any help and all attempts to intervene had failed.

Although none of this happened quickly, over time, I was able to build a relationship with the son, his siblings, and my client. By being creative, we were able to insert some professional caregivers which we eventually ramped up to 24/7. The son is now in a support group. My client is now attending his medical appointments consistently. The caregivers share regular updates with me and I can then share their observations directly with his health care

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team. Recently, this allowed me to pick up on subtle symptoms of a bladder infection which led to a visit to his primary care physician and an order for antibiotics. The past three bladder infections, he had ended up in the ER for a diagnosis. My communication with his caregivers led me to pick up on these symptoms early and through my collaboration with his healthcare team, we were able to avoid a costly and unnecessary visit to the ER.

Although there is still plenty to do, our work with the client and his family has been a great example of how Aging Life Care Managers can help support the healthcare team and improve outcomes for the patient as well as the family members.

CL: That's a wonderful story of the value of care management in achieving effective transitions of care as a person and family in need interact with the healthcare system.

LM: Yes...it's a good feeling.

CL: Lisa, this seems like a good moment to take a break in our conversation. I hope we can get together again soon and hear more about Aging Life Care Managers and their experiences.

LM: Let's plan on it!

ABOUT THE AUTHORS:



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