Results from a Health Plan’s Telephonic Case Management Program for Advanced Illness

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About SCAN

Mission
Keeping Seniors Healthy and Independent

Vision
Strive to understand and meet the individual needs of those we serve and to shape the future of care for all seniors

- Founded in 1977 for seniors by seniors
- Approximately 185,000 members
- Medicare Advantage Prescription Drug (MAPD) Plans
- Special Needs Plans (SNPs)
  - Dual-eligible SNP
  - Chronic Condition SNPs
  - Institutional SNPs
- Markets we serve:
  - Southern and Northern California
- Delegated model
Delegated Model: Risk Arrangements

- Global Risk
- Full Risk
- Shared Risk
  - SCAN at risk for hospital admissions
  - Medical group at risk for professional fee
Commitment to Community

Community Giving

Volunteer Action for Aging

Community Education

Program Support

In-Home Assistance

Caregiver Support

independence at home

a scan community service™
Quality

SCAN HEALTH PLAN

4-STAR QUALITY RATING

2017
Preferred Location of Death, California, 2011

- Home: 70%
- Hospital: 16%
- Other: 7%
- Hospice facility: 4%
- Refused: 2%
- Don’t know/Not sure: 2%

Note: Segments may not add to 100% due to rounding.

Source: Californians' Attitudes Toward End-of-Life Issues, Lake Research Partners, 2011. Statewide survey of 1,669 adult Californians, including 393 respondents who have lost a loved one in the past 12 months.
Inpatient Days per Decedent during the last Six Months of Life: 2014
Dartmouth Atlas

[Map showing inpatient days per decedent in different regions of the USA, withSacramento, CA marked at 6.5 and Los Angeles, CA marked at 10.4]
Percent of Decedents Enrolled In Hospice during the Last Six Months of Life: 2012

Dartmouth Atlas

Los Angeles, CA
40.5%

Sacramento, CA
48.0%

Legend
- No data
- 20.1% - <45.0% (61)
- 45.0% - <49.8% (61)
- 49.8% - <55.3% (61)
- 55.3% - <59.5% (61)
- 59.5% - 71.2% (62)
Percent of Medicare Decedents Enrolled in Hospice within Three Days of Death

(Year: 2012; Region Level: HRR)
What we Already Know

Seniors with multiple chronic conditions and in End-of-Life situations bear majority of health care costs

% of Medicare Expenditures by number of chronic conditions

- 1% 3% 6% 10% 12%
- 68%

Rough Estimate of Health Care Costs Distributed Across The Average American’s Lifetime

Gray area under the curve equals 100% of all health care expenditures over a life span

Johns Hopkins University, Partnership for Solutions
Source: Medicare Standard Analytic File, 2001
SCAN’s Utilization of Members with Chronic Conditions: 2014

![Bar chart showing utilization of members with chronic conditions. ER Visits PKMPY and IP Admit PKMPY are compared across different numbers of Chronic HCCs.](chart.png)
SCAN’s Utilization of Members with Chronic Conditions: 2014

- Re-Admission Rate
- % Member Death in Acute Setting

Bar chart showing the utilization of members with chronic conditions in 2014, categorized by the number of chronic health conditions (HCCs). The chart compares re-admission rates and the percentage of member deaths in acute settings across different numbers of chronic conditions.
SCAN Care Management Model

- Traditional Social Care Management
- Geriatric Health Management Expertise
- Traditional Medical Care Management

Identified Needs
- Social, Functional, Behavioral
- Medical, Social, Behavioral
- Medical

Key Features & Attributes
- Designed for the target population—generally frail with multiple complex chronic conditions
- Provides members with the information and assistance necessary to live independently and manage their own health care
- Tailored to providers’ models and capabilities
- Oversees and/or coordinates care and services across agencies and providers, leveraging the community services network
- Supports providers by using evidence-based practice guidelines to guide and plan interactions with members

Program for Advanced Illness
- Complex Care Management
- Disease Management
PAI: Program for Advanced Illness

- PAI: Telephonic case management at any stage of advanced illness
- Holistic approach – incorporating psychosocial, cultural, and spiritual aspects of care
- Centered on member and caregiver
- Offered in conjunction with both curative and/or palliative therapies by direct care providers
- Pilot for members in shared Risk Medical Groups
Program for Advanced Illness

**Inputs**
- Dedicated Staff Positions
- Expertise in palliative care, advance care planning, hospice
- Community Resources
- Guidelines/Protocols
- Clinical Software/Systems
- Educational materials
- Spiritual consultant

**Activities**
- Ongoing case management
- Facilitate member interventions
- Education about POLST/POA/AHCD
- Education about palliative care and hospice referrals
- Provider communication & Coordination of care
- Coaching on pain and symptom management
- Facilitation of discussion of member wishes
- Caregiver support and education
- Community Resource Referrals

**Outcomes**
- Increased referrals to palliative care and hospice
- Increased LOS on hospice
- Member wishes followed
- Death in place of preference
- Cultural and spiritual preferences observed
- Decreased deaths in Acute/facility ICU
- Member/Caregiver increased quality of care at end of life
How are “Right” members identified?

• Data Mining
  – Predictive algorithm*

• Internal Referrals
  – Other case management programs (concurrent/complex case)

• External Referrals
  – Physicians: “Surprise question” - Would you be surprised if this person died within the next year?
  – Medical Group Case Managers
  – Hospital discharge planners

• “A Prognostic Model for 1-Year Mortality in Older Adults after Hospital Discharge” Stacie K. Levine, MD, Greg A. Sachs, MD, Lei in, MA, MS, David Meltzer, MD, PhD. The American Journal of Medicine (2007) 120.
## Data Mining

<table>
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<th>Characteristic</th>
<th>Odds Ratio (CI)</th>
<th>P Value</th>
<th>Points</th>
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<tr>
<td><strong>Age, years</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>70-74</td>
<td>1.6 (1.2-2.2)</td>
<td>.003</td>
<td>1</td>
</tr>
<tr>
<td>75-79</td>
<td>2.2 (1.6-3)</td>
<td>&lt;.001</td>
<td>2</td>
</tr>
<tr>
<td>80-84</td>
<td>2 (1.4-2.8)</td>
<td>&lt;.002</td>
<td>2</td>
</tr>
<tr>
<td>85-89</td>
<td>2.9 (2.1-4.1)</td>
<td>&lt;.003</td>
<td>2</td>
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<td>≥90</td>
<td>3 (2.1-4.4)</td>
<td>&lt;.004</td>
<td>2</td>
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<td><strong>Discharge to nursing home or skilled nursing facility</strong></td>
<td>1.7 (1.4-2.2)</td>
<td>&lt;.005</td>
<td>1</td>
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<tr>
<td><strong>Length of stay ≥5 days</strong></td>
<td>1.5 (1.3-1.8)</td>
<td>&lt;.006</td>
<td>1</td>
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<tr>
<td><strong>Comorbidity conditions</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Congestive heart failure</td>
<td>1.3 (1.1-1.7)</td>
<td>.005</td>
<td>1</td>
</tr>
<tr>
<td>PVD</td>
<td>1.8 (1.4-2.3)</td>
<td>&lt;.001</td>
<td>1</td>
</tr>
<tr>
<td>Dementia</td>
<td>1.6 (1.2-2.1)</td>
<td>&lt;.001</td>
<td>1</td>
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<tr>
<td>Renal disease</td>
<td>1.7 (1.3-2.2)</td>
<td>&lt;.001</td>
<td>1</td>
</tr>
<tr>
<td>Hematologic and solid malignancy</td>
<td>1.7 (1.3-2.1)</td>
<td>&lt;.001</td>
<td>1</td>
</tr>
<tr>
<td>Metastatic cancer</td>
<td>3.1 (2.2-4.4)</td>
<td>&lt;.001</td>
<td>2</td>
</tr>
</tbody>
</table>

CI = 95% confidence interval; PVD = peripheral vascular disease.
PAI Program Planning

- Launched in late 2013
- Identifying target population
- Staffing
- Training of staff
- Pilot with few shared risk Medical Groups without palliative care trained physicians in the hospitals
- Setting & measuring goals
Referral Source on all cases
2015 vs. 2016

- Provider External: 82 (2015), 16 (2016)
PAI Program-Jeanette Despal, MPH, RN
CCM Manager

"I'm right there in the room, and no one even acknowledges me."
Program design

- Dedicated registered nurses
- Care Enhance Case Management system
- Telephonic assessment of current clinical status and focused on member goals of care
- Education on
  - Advanced planning
  - Disease trajectory
  - Pain and symptom management
- Completion of advance directives, shared with family and providers
- Coordination of care and needed services
PAI Program Nurse qualities

• Registered Nurses who are:
  – Comfortable with end of life discussions
  – Strong medical background in hospice or prior palliative care experience
  – Calm demeanor
  – Listening skills
  – Trust building
  – Palliative care certification and or case management experience a plus
Staffing for Program for Advanced illness

- Three experienced RN case managers
  - Case manage 45-55 patients each
  - Frequent contact with members/caregivers
  - Bilingual with training in motivational interviewing
  - Assist with:
    - Assessing goals of care
    - Assist with symptom management
    - Communicate with direct care providers
    - Completion of POLST/Five Wishes
    - Identify healthcare proxies
    - Assist with referral to hospice/palliative care
Clinical Resources

- Ongoing IDT support
- Teaching tips and tools from HPNA
- Motivational interviewing training and support
- Program brochure to facilitate referrals
- Conversation project
- Coalition for compassionate care
- Attendance of conferences on palliative care
Assessment Nuts and Bolts

- Comprehensive baseline and ongoing assessment tools
- Medications—a focus on identifying ways to decrease those that are out of line with member treatment goals
- Depression and Cognitive screenings
- Physician communication with significant findings or care gaps:
  - Intro letter
  - Ongoing issues letter
  - POLST
- Discharge summary to capture key program outcomes
Member Program Components

- Welcome packet-includes 5 wishes or POLST
- Member Welcome letter-focused on family communication/supportive resources
- Nurse magnet-key contact information
- Program directory including administrative support
PAI program metrics

- Process Metrics
  - Conversion rate
  - Average caseload
  - Program completion
  - Program outcomes

- Outcome Metrics
  - Pain control
  - Symptom management
  - Hospitalization / ER visits
  - Hospice referral (when appropriate)
Call to Conversion to PAI program

Called vs. Participated

<table>
<thead>
<tr>
<th>Year</th>
<th>Participating</th>
<th>Did Not Meet Participation Criteria</th>
<th>Grand Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015</td>
<td>708</td>
<td>1,211</td>
<td>1,919</td>
</tr>
<tr>
<td>2016</td>
<td>700</td>
<td>1,184</td>
<td>1,884</td>
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<tr>
<td>2017</td>
<td>209</td>
<td>107</td>
<td>209</td>
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</table>

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Program Outcomes

- Ensuring members goals are documented and met
- Reduced utilization (hospital days, ER visits, ICU days, readmissions)
- Decreased deaths in acute facility/ICU
- Death in place of preference
- Appropriate referral to hospice/palliative care
- Increased LOS on hospice if member enrolls in hospice
- Increased member and family satisfaction with communication and end of life care
Program Outcomes: Was pain managed?

% of Mbrs with pain managed to their satisfaction

- 2015: 56%
- 2016: 62%
Program Outcomes: Were EOL wishes observed?

% of member's end of life wishes observed

2015: 70%
2016: 74%
Program Outcomes: POLST completion

% of Mbrs w/ POLST completed while enrolled in PAI

- 33% in 2015
- 21% in 2016
Program Outcome: Hospice enrollment

% of members enrolled in hospice while in program?

- 2015: 40%
- 2016: 21%
Program Outcome: Place of Death

Place of Death

- Home with Hospice: 50% (2015), 44% (2016)
- Acute Care Hospital Med/Surg: 17% (2015), 5% (2016)
- Home: 6% (2015), 5% (2016)
- Acute Care Hospital ICU: 19% (2015), 6% (2016)
- Unable to Obtain: 6% (2015), 12% (2016)
- Custodial Facility w/Hospice: 5% (2015), 7% (2016)
- SNF with Hospice (GIP): 3% (2015), 4% (2016)
- SNF with no Hospice: 3% (2015), 2% (2016)
- Misc: 4% (2015), 2% (2016)
Case Closure Reasons
All Cases

Case Closure Reason for all (2015-2016)
CASE: #1 Success story
75 y/o Hispanic male with history of metastatic prostate cancer status post chemotherapy with two different types of chemotherapy. He was declining physically, his wife was distant during phone calls and would end the calls after a few minutes. After about one month the wife was more open on the phone and admitted that the patient was worsening and she was worried. She mentioned the “nurse” who visited the home. The PAI RN contacted the medical group and discovered the patient had an NP from the practice who had made a few home visits as part of a program but those had stopped. He called the NP, updated her on the patient’s decline, and asked her to go to the home to have a goals of care discussion. This led to the patient completing a POLST, becoming DNR/DNI, and going on hospice care.
Case #2-unsuccessful

74 y/o Hispanic female with DM, CAD s/p CABG, CKD stage III, chronic UTIs, and chronic pain. She had had 9 hospitalizations and 5 SNF admits in the prior 1 year. Hospital admissions for GI bleed, MRSA, osteomyelitis of spine, UTIs, chest pain and abdominal pain. She lives with husband who is on dialysis, an adult son who is who is disabled with DM and BKA and her daughter.
• RN has had multiple conversations with the daughter and son. They are polite but only stay on the phone a few minutes. The patient is always sleeping and rarely will talk on the phone. According to home health agency family non-compliant and non-coachable. During a goals of care conversation the son stated “my mother cared for her 9 siblings and immigrated from Mexico 50 years ago. She is a fighter and will fight until the end as she has done all her life.” Patient has POLST and is full code.
Lessons Learned

- Identifying target population: engage provider stakeholders to enroll the right patients.
- Staffing: We are cross-training other CCM nurses to deliver program to increase enrollment/caseload, which is still under review. 45-55 of high-intensity complex members are hard to find and maintain.
- Training: Targeted training by palliative care-trained physician and/or certification course is essential.
- Ongoing support of a multidisciplinary IDT.
- Setting & measuring goals: Capturing key program outcomes in system supports data gathering.
- Outreach: Important to provider partners.
  - Training done to foster referrals
  - PAI program brochure
Rebecca Yamarik, MD, MPH, FAAHPM
Palliative Care Physician
Literature review on Telephonic Case Management in last year of life

- **ENABLE II RCT**: adv. cancer patients (1 yr prognosis) contacted weekly for four weeks by APN and then monthly until death
  - QOL and mood improved, utilization unchanged

- **ENABLE III RCT**: adv. cancer patients, PC consultation plus 6 telephonic sessions at diagnosis or 3 months delayed
  - Improved survival for early group, utilization and home death unchanged
Literature review on telephonic case management in last year of life

- Aetna: Compassionate Care Program uses embedded case managers in PCP offices
  - Decreased utilization
  - Increased hospice use

- Optum: Telephonic case management program for cancer patients led by oncology RNs.
  - Increased hospice use
  - Decreased costs for survivors
Education of RN Case Managers

• Initial Educational Program - 2014:
  – 3 RNs

• 20 hours of didactic lecture, discussion and roleplays on Palliative Care topics
  – Goals of Care: Communication roleplays
  – Advance Care Planning Training
  – Symptom Management Training
  – Prognosis: Illness trajectory
  – Psychological/Spiritual aspects of care
National Consensus Project for Quality Palliative Care

- Published in 2013 JPM 7; 2004
- Clinical Guidelines
- Domains of Quality of Palliative care
  1. Structure and Processes of care
  2. Physical
  3. Psychological
  4. Psychiatric
  5. Social
  6. Spiritual, Religious and Existential
  7. Cultural
  8. Care of Imminently Dying
  9. Ethical/Legal
Ongoing Education

• Bi-Monthly 1 hour in-person Interdisciplinary group meetings between Palliative Care MD and RN case managers – Psychology/Social work often present

• RNs bring difficult cases to discuss
  – Patients not accepting terminal prognosis
  – Unsafe living situations
  – Symptom/Prognosis questions
  – Abusive/difficult family members
  – Lack of clarity on goals of care
Ongoing Education

- Phone Observation Program: Palliative MD sits in on phone calls between PAI RN Case Managers and members.
- Feedback given to RN Case managers on how to engage and assist families in a telephonic case management model
- Serious Illness Guide training
- 2-hour adapted version of Harvard’s program for non-palliative care trained physicians to have a goals of care discussion
- Trained RNs in the 7-question guide
Some Questions from the Guide

• What is your understanding now of where you are with your illness?

• What are your biggest fears and worries about the future with your health?

• What abilities are so critical to your life that you can’t imagine living without them?

• If you become sicker, how much are you willing to go through for the possibility of gaining more time?
Program Limitations

- Telephonic
  - Patients/families stop answering the phone
  - RNs are not in charge of treatment decisions
  - MDs often are disengaged and difficult to reach

What are other limitations?
Results
PAI Pre/Post Utilization

Source: 2014 SCAN Claims and Encounter Data
Figure 3. Percent member with IP or ER admits before and after PAI intervention.
Challenges with Data Mining as the Referral Source

Does not meet criteria referral source (2015 & 2016)

- Risk Stratification: 76%
- SCAN Internal: 18%
- Provider External: 6%
- Self: 0%

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Challenges

- Referrals from PCP.
- 24/7 presence
- Identification of the appropriate members.
# What % age died within 15 days of referral

<table>
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<tr>
<th>Row Labels</th>
<th>Count of CloseReasonDesc</th>
<th>% of total expired</th>
<th>% Within Case Days Open Range</th>
<th>% of total cases</th>
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<td>over 30 days</td>
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<td>178</td>
<td>46.60%</td>
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<td>0-15 days</td>
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<td>66</td>
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<td></td>
<td>382</td>
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<td>17.73%</td>
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Summary

• SCAN PAI program is an additional resource to manage complex members
• Key barriers are identifying “Right” members to enroll
• Preliminary results show improvement in certain key areas – Pain control, symptom management etc.