

Effective Telephonic Care Management for the Seriously-III

Center to
Advance
Palliative Care™

capc

Outline

- Intro: the role of CM in serious illness
- Step 1: Engaging patients
- Step 2: Assessment for unmet needs/ areas of distress
- Step 3: Clarifying goals of care
- Step 4: Coordinating with providers to adjust the care plan to align with patient goals
 - Referral to palliative care as needed

INTRO TO CASE MANAGEMENT FOR THE SERIOUSLY ILL

Common Needs and Gaps of Seriously Ill Patients

- Inadequate treatment of pain and symptoms
- Lack of knowledge about disease expectations and all care options
- Lack of support for setting goals and informed decisions
- Lack of communication with treating provider(s)
- Difficulties in understanding prognosis
- Late referral, or no referral for palliative care consultation
- Caregiver stress and burn-out
- Undue financial burden of medical expenses

How do CMs help to address these gaps?

- Provide empathetic support to patients and their family caregivers
- Help to educate the patient and family about all their options, and help them think through the pros and cons
- Facilitate communication across all points of contact, ensuring that:
 - Appropriate attention is given to managing pain/other symptoms
 - Care is given in concordance with patient preferences and goals
- Facilitate access to resources and supports for patients and their family caregivers
 - Physical, emotional, spiritual, and financial

What should CMs not do?

- Recommend or steer patients and families to any particular choice or option
- Expect that the completion of an Advance Directive form or POLST will ensure communication across all points of contact, or ensure concordance of care with wishes
- Expect that treating providers understand the need for high-quality palliative care during curative treatment

INITIAL ENGAGEMENT

Preparing for the Initial Conversation with the Patient (and Family)

- Study the case – familiarize yourself with the clinical condition and the cultural and social milieu as much as possible with whatever information is available.
- Unless referred by the physician, reach out to the physician(s) (might be office personnel) – let them know what you plan to do. Solicit cooperation, information, advice. Verify appropriate case.
- Based on what you learn, plan an appropriate approach, based on the condition, status, culture. Discuss with your Mentor if you think this will help.

Timing of the Initial Call

- Patients are more likely to engage when they are “in crisis”
 - Within 2 months of a hospital discharge, post-acute discharge, home health episode, or emergency department visit
 - Within 1 month of a DME order

Conducting the Initial Conversation: Introduction

- Introduction – who are you, who you represent, ask if it is a convenient time to have the conversation
 - Make sure to say you're a nurse if you are!
 - If you have their doctor's permission, make sure to say that “Dr. X knows that I'm calling you”
- Indicate you are reaching out to provide “an added layer of support” to the patient/member and their caregivers to ensure that you get “the care you deserve”

Conducting the Initial Conversation: Assess Patient/Family Knowledge

- What is their current knowledge of the condition and likely course? What has the doctor explained?
 - Is there a need for additional discussion with physician(s)? Can you help facilitate that?
- Has the patient and caregivers begun the process of planning for dealing with a progressive illness? What decisions have been made; and what decisions need to be made?

Sample Introduction

Hello is this Mrs. Jones?

My name is Mary and I am a nurse that works with XYZ Health Plan.

Dr. Smith is aware that I am calling.

We noticed that you were in the hospital recently, is that right?

Can you tell me what you know about what's going on?

Tips for Telephone Contacts

- Ask good, open-ended questions
- Think about the tone of voice you're using
 - Don't be afraid to use hand gestures and smile. Although the patient won't be able to see you, these motions will translate into your tone.
- If you don't understand something the patient says, don't be afraid to ask what they mean
- When finishing up the call, summarize the conversation and articulate your specific next steps(e.g., a conversation with the doctor)
- For voicemails, be sure to either leave a callback number OR state you will follow up at another time

Conducting the Initial Conversation: Don'ts

- Don't forget to introduce yourself
- Don't be too busy to be nice – people can tell when you're busy and they're just part of your list of calls
- Don't speak too quickly – make sure the patient has time to process every word you're saying
- Don't be in an overly noisy area - try to eliminate background noise and distractions; if you can't hear them, they probably can't hear you
- Don't forget to take notes of what the conversation is like – this may be helpful in future care planning

ASSESSMENT

Start By Screening for Impact on Function and/or Caregiver

- It is only through a conversation that you can find out about:
 - Pain and other symptom distress
 - Impact on daily function
 - Impact on family and caregivers
- *Good question: how likely do you think it is that you will wind up in the ED in the next 1-2 months?*

Formal Assessment Recommendations

→ Symptom Burden

- Condensed Memorial Symptom Assessment Scale (CMSAS)

→ Functional Impairment

- Palliative Performance Scale (PPS)
- Karnofsky Performance Status Scale

→ Caregiver Burden

- Zarit Burden Interview

See CAPC's *Addressing Key Gaps in Care tool*

Sample Telephonic Screening Questions

- May I ask you a few questions about your health?
- When was the last time you were able to go out (give suggestions such as family event, work, hair salon, restaurant)? How do you get there?
- How do you mostly get around (probe for walker, wheelchair)?
- Sometimes medical conditions cause uncomfortable symptoms – so we can best help you, may I ask you about them?
- Do you have anyone who helps you (aide or family member)?
- How likely do you think it is that you will wind up in the ED in the next month or two?

Critical Elements

To be effective, you will need to allow and provide the following:

- **Time.** This population is complex and requires adequate time to listen, support, and develop a plan that aligns with the patient's goals.
- **Open-ended questions.** A checklist of "yes/no" questions often prevents the identification of more specific needs.
 - Don't ask questions as if you are reading them. Use questions as a guide in reaching out to the patient.
- **Listen and understand.** Being able to hear shortness of breath or listen for signs of anxiety, despair, or family tension helps identify needs over the phone.
- **Empathize.** Demonstrate empathy and build a rapport over time. Building trust and an effective relationship enables deeper conversations and insight on needs.

Draw from your care management training in skills such as motivational interviewing.

CLARIFYING GOALS OF CARE

Goals of Care and Advance Care Planning Discussions: Before You Start

- Take these CAPC courses:
 - Clarifying Goals of Care
 - Basic Advance Care Planning: Introduce and Motivate
 - Basic Advance Care Planning: Guide and Document
- *Tip: try holding the conversation with your own family for practice!*

How To Do This

- Ask open ended questions and LISTEN
 - “How have things been going for you at home?”
 - “What is bothering you the most?”
 - “When you think about what lies ahead, what worries you the most?”
 - “When you think about the future, what do you hope for?”

Tips for Goals of Care Discussions

- Always start by listening.
- Explain that you have knowledge and experience with this situation, have worked with people in their situation before, and are available to answer questions, suggest resources, even just talk.
- Make it clear again that you will facilitate communications with their doctor, and additional services, and will support whatever decision they make.
- Make it clear that goal setting is appropriate for any medical condition.
- Give them the space to consider how their goals may change with circumstances.

Be supportive, not prescriptive

- Do provide useful and actionable information
 - Do remember that it's not your decision to make
 - Do keep communications open between medical and community services, and hospice if applicable
 - Don't betray your biases or “recommendations”
 - Don't steer decisions
 - Don't interfere with palliative care team or Hospice care manager if they are involved.
- Provide support but back off unless you are being helpful.

Creating a Care Plan: 3 Stages

- Adults who have not started or engaged in the planning process:
 - Selecting and preparing a healthcare proxy
 - Clarify goals of care based on personal and cultural values
- Individuals engaged in active disease management experiencing complications:
 - Understanding future complications based on illness trajectory
 - Identifying goals if complications result in “unacceptable outcomes”
- Individuals in their last few years of life:
 - Define preferences in context of lime-limiting illness
 - Integrate individual’s preferences into Physician’s Orders for Life-Sustaining Treatment (POLST)

Modifying a Care Plan

- The frequency of care plan evaluation depends on each patient's condition: symptoms, level of assistance they require, etc.
- Identifying important changes in each patient (new symptoms, behavior changes) will help to discern what needs to be created or modified within the care plan
 - By educating patients and families on which symptom changes to look out for, appropriate and necessary changes can be made to the care plan immediately

COORDINATING WITH PROVIDERS

Circle Back to the Treating Care Team

- Ensure that the care team understands the patient's goals and preferences
- Ensure that the care team understands the levels of symptom burden and pursues alleviation to the fullest extent possible
- Ensure that the care team understands the patient's functional status and addresses through treatment, accommodation, and assistance
- Coordinate meetings and communications between patient, family, and care team

Arrange Additional Services As Needed

- Palliative Care Specialist Team consultation
- Home-based primary care and/or palliative care
- Social work services
- Psychological services
- Chaplaincy services
- Community services (e.g., meals on wheels, friendly visiting, financial assistance)
- Respite and counseling for the caregiver

Palliative Care Specialists Can Be Brought in As Appropriate

All Clinicians and Complex Case Managers

Basic communications:

- * Explaining prognosis and what to expect
- * Clarifying goals of care
- * Advance care planning

Pain and symptom management:

- * Comprehensive assessment
- * Safe prescribing and monitoring

Caregiver support:

- * Assessment
- * Recommendations for education and services

Palliative Care Specialists

Consultation or co-management

- * Quality-of-Life perspective
- * Management of intractable symptoms
- * Expert communications for complex situations

Home-based Palliative Care

In-home support for those with intractable symptoms and/or high levels of burden and impairment

Hospice