Breaking Barriers
A Health Plan’s Approach

New Hampshire Comprehensive Cancer Collaboration
8th Annual Conference
Catherine McFadyen RNP MSN
Director, Care and Disease Management
Harvard Pilgrim Health Care
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Oncology Program Goals

- Identify high risk members
- Support member, their families and medical team
- Reduce occurrence of side effects that result in ER visits and or unplanned hospitalizations
- Ensure coordination of care
- Support end of life decision making process
Harvard Pilgrim Oncology Program

- Members identified by algorithm, member, provider, employer or Nurse Care Manager (NCM) referral
- Members followed telephonically from early diagnosis and treatment and as needed thru recurrence or end of life
- Utilization of Motivational Interviewing (MI) skills to work with members collaboratively, supporting members throughout their illness and fostering efforts toward self efficacy
Oncology Program Components

- Clinical assessment including depression
- Coordination of care among multiple providers
- Collaboration re pain management planning
- Collaboration re behavioral health support
- Hospital follow-up
- Social worker referral
- Management of benefits
Assessment of toxicities during treatment
Identification of who will take responsibility for surveillance care
Information about how to prevent and detect second cancers
Late drug toxicity monitoring
Psychosocial and vocational needs
Care Management Approach

- Build a relationship with member, family and provider
- Motivational interviewing: Quality of Life (QoL) and End of Life (EoL) discussions
- Referral to bridge and hospice programs
- Meet members where they are
- Support for member to remain at home
Oncology Program Provider Activities

- Palliative care articles in provider publication
- Educational conferences provided by Hospice Federation
- Collaboration re use of bridge and hospice programs
- Utilization of chemotherapy treatment plans sent by providers
Survivorship

- Cancer survivor includes anyone who has been diagnosed with cancer, from the time of diagnosis through the rest of his or her life.
- Family members, friends, and caregivers are also part of the survivorship experience.
- Survivorship Plan of Care (POC) is part of the initial assessment and developed in collaboration with the member.
- The four essential components of survivorship are incorporated into the POC: care prevention, surveillance, intervention, and coordination.
Outcome Metrics

- Decrease in ER and unplanned admissions due to most common side effects of chemo and radiation therapy
  - ER and admissions rate have been consistently lower in managed vs. non managed members
  - Overall lowering of medical expense

- Member satisfaction surveys
  - 93% overall satisfaction program rate (excellent or very good)
  - 99 % rating for professionalism (excellent or very good)
  - 90% rating for usefulness of information provided
  - 87% rating for improving member ability to adhere to tx plan recommendations
Challenges and Factors for Success

- **Provider Acceptance**
  - Complimentary and Supplemental to provider practice

- **Member**
  - 60% engagement rate which is defined as agreement to take calls from the NCM, and establishment of plan of care with follow up
  - Health literacy
  - Conflicting opinions, clarity around prognosis, discussions re quality of life after tx, coordination of care during tx
  - Cultural issues
Challenges and Factors for Success

- **Telephonic approach**
  - Development of rapport and trust with Nurse Care Manager
  - Motivational interviewing
  - Support for discussions of concerns not rushed, easy to obtain and/or schedule
  - No transportation required
  - No cost to member or provider

- **Other factors for success**
  - Staff education and training
  - Motivational interviewing skills
  - Belief in program from the top down
Addendum
Member Tools

- [http://www.cancersurvivaltoolbox.org](http://www.cancersurvivaltoolbox.org)
- National Coalition for Cancer Survivorship NCCS
- Website in Spanish and English: Free online tools in audio or text

- Facing Forward: Life After Cancer Treatment
- Booklet recommended to members asking for guidance after treatment
<table>
<thead>
<tr>
<th>Cost Drivers</th>
<th>Hidden Costs (for Patient/Family/Caregiver)</th>
<th>Cost Containment Strategies</th>
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</thead>
<tbody>
<tr>
<td>• Development/availability of high-cost technology</td>
<td>Financial:</td>
<td>• Rationing of health care</td>
</tr>
<tr>
<td>• Over utilization and/or inappropriate use of technology</td>
<td>• Lost wages</td>
<td>• Cost-sharing between members, families and insurance company</td>
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<td>• Increased aging population</td>
<td>• Transportation/parking</td>
<td>• Financial incentives to nursing homes to provide end-of-life care</td>
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<td>• Complexity of patients with multiple diseases</td>
<td>• Meals outside the home</td>
<td>• Hospital DRG for end-of-life care</td>
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<td>• Differing costs depending upon location of patient</td>
<td>• Over-the-counter medication</td>
<td>• Financial support to family</td>
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<td>• Lack of barriers to hospice or palliative care programs</td>
<td>• Counseling</td>
<td>• Expansion of respite benefits</td>
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<td>• Lack of end-of-life care coordination</td>
<td>• Private pay when care needs exceed ability of family/caregiver</td>
<td>• Decision-making tools for family/caregiver</td>
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<td>• Varying provider reimbursement strategies</td>
<td>• Stress</td>
<td>• Define/measure essential elements of quality, end-of-life care</td>
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<td>• Lack of clinical measures to determine benefit of treatment in late stages</td>
<td>• Depression</td>
<td>• Make exceptional end-of-life care the norm, rather than the exception</td>
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<td>• Avoidance of discussion and lack of planning for end-of-life</td>
<td>• Burnout</td>
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Hospice Benefit

- Traditional medical care and hospice care are usually reimbursed through two separate payment methodologies, without clinical or financial overlap.
- Harvard Pilgrim covers both traditional medical care and all levels of hospice care, including residential care programs.
Hospice Benefit

- **Home**
  - Routine: Nursing services and up to 4 hours per day of home health aide services for up to 180 days
  - Continuous: More than 8 hours (up to 24 hours) of services (primarily nursing care) per day are medically necessary to support the member and family in a period of crisis at end of life

- **Respite**
  - 5 days every three months, to a maximum of 14 days per calendar year

- **Residential**
  - Covered – requires physician review for medical necessity

- **Inpatient**
  - Harvard Pilgrim and the hospice provider determine that the member’s treatment plan requires intervention that cannot be safely performed at a lesser level of care