

# Effective Telephonic Care Management for the Seriously-III

# 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 time-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 patients 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

