A Health Plan’s Innovative Telephonic Case Management Model to Provide Palliative Care (TH303)

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Objectives
- Describe SCAN’s Program for Advanced Illness.
- Discuss how SCAN is using palliative care to improve quality of care and patient satisfaction.
- Describe measured outcomes for the first year of an advanced illness management program.

SCAN Health Plan is a Medicare Advantage Plan in California and Arizona serving 170,000 members. In 2013, SCAN launched a case management program to assist members with multiple chronic health conditions manage their symptoms and medications. The Program for Advanced Illness (PAI) is designed to manage the sickest patients in the last months and years of life. The goals of the program are to better manage symptoms, improve member and family/caregiver satisfaction, and improve overall quality of care, while reducing inpatient/ER utilization. PAI is one of several case management programs provided by SCAN to its members. Other programs include Complex Care Management, Memory Program, Care Transitions, and Disease Management.

The PAI program provides telephonic case management for members at any stage of an advanced illness. The approach is patient centered and holistic and incorporates psychosocial, cultural, and spiritual aspects of care. Registered nurses provide the telephonic case management to members and are supported by an interdisciplinary team of social workers, geriatricians, chaplains, and palliative care physicians.

Activities of the program include education about goals of care and documentation of goals, coaching of members and families about how to discuss end-of-life wishes with providers, facilitation of discussion of members’ wishes, pain and symptom management, identifying resources for care, and education about POLST and advanced healthcare directives.

We will present SCAN’s program in detail. We will discuss the training of the RN case managers using a board-certified palliative care physician who provides training and ongoing support. Outcome measures for the first year of the program will be presented. These metrics include increased length of stay in hospice, member wishes followed at end of life, death in place of preference, decreased hospitalization, decreased ICU utilization, and member/caregiver satisfaction.