Health Literacy and Effective Communication in Cancer Support

National Cancer Policy Forum Workshop in Collaboration with the NAM Roundtable on Health Literacy
July 16, 2019
Agenda

• How Humana assists members and caregivers to:
  • Be knowledgeable about recommended cancer screenings
  • Have a care plan, the right people on their care team and get problems attended to
  • Embed patient values into care plan
  • Get back on with life

• Oncology Model of Care program

• Opportunities for improvement
“You don’t know where to start.”

“They started educating me and started throwing all these options at me.”

“If you are waiting weeks to see people and you don’t have answers, you can be quick to make decisions because you want to take action.”

“It’s already happening before you know you need to prepare for it.”
“You don’t know where to start.”
Preventive Screenings | Awareness and Access

• Member specific education via direct mail, myhumana.com and mobile app, primary care physicians, health coaches, personal nurse
• Reminders via Customer Service Representatives, pharmacy interactions
• Incentivize screenings with rewards or charity donations via Go365 wellness program
• Humana in your neighborhood events
• Bold Goal – More Healthy Days
More Healthy Days – Beauty and Barbershop Tour
More Healthy Days – Beauty and Barbershop Tour – cont.
Addressing the needs of the whole person: Bridging the gaps between clinical and social needs
Social Determinants of Health

**Food Insecurity**
- **Prevalence:** 1 in 8 Americans are food insecure
- **Cost to the System:**
  - 50% more likely to be diabetic
  - 60% more likely to have CHF
  - 66% more likely to have to choose between food and medical care

**Loneliness & Social Isolation**
- **Prevalence:** Loneliness in older adults has doubled since the 1980s to 40%
- **Cost to the System:**
  - 4x more likely to revisit the ER within a year of discharge
  - 64% more likely to develop clinical dementia

**Transportation**
- **Prevalence:** 3.6 million Americans claim that the reason they do not obtain medical care is due to transportation barriers
- **Cost to the System:**
  - The annual cost of missed appointments to the healthcare industry is $150 billion
A simple way to find out if a member is food insecure

Use a validated two-question screener from Hunger Vital Sign™, the U.S. Department of Agriculture’s food security screening survey.

An affirmative response to either or both questions should trigger a food support referral.

1. Within the past 12 months, we worried whether our food would run out before we got money to buy more.
   Was that **often**, **sometimes** or **never** true for you?

2. Within the past 12 months, the food we bought just didn’t last and we didn’t have money to get more.
   Was that **often**, **sometimes** or **never** true for you?
What is loneliness vs social isolation?

Loneliness (subjective isolation)

Quality
Value of their relationships, quality of social support, sense of belonging, meaningful social engagement, neighborhood and social cohesion

Risk factors:
Age, marital status, long-term illness, disability, depression, dementia, visual or hearing impairment

Social Isolation (objective isolation)

Quantity
Size and structure of social network, type and amount of social support, frequency of contacts with network, amount of participation in social activities

Risk factors:
Disability, chronic disease, single, divorced, or widowed, rural or remote housing, caregiver, minority, or LGBT

A simple way to find out if a member is lonely

Use the validated UCLA three question loneliness screener.

If a member’s response to any of these questions is some of the time or often, they are experiencing loneliness.

1. How often do you feel that you lack companionship?
   Is that hardly ever, some of the time, or often true for you?

2. How often do you feel left out?
   Is that hardly ever, some of the time, or often true for you?

3. How often do you feel isolated from others?
   Is that hardly ever, some of the time, or often true for you?
“They started educating me and started throwing all these options at me.”
Program Objective
To help members achieve the best outcomes and quality of life, while assisting those who need help navigating the healthcare system

Who We Are
• All nurses are Bachelors prepared
• 14+ years of oncology experience
• Multiple certifications
  ✓ All hold Oncology Nurse Certification
  ✓ Chemo / Biotherapy Certified
• Home Health and Hospice expertise
A team of nurses conduct telephonic outreach to members in active treatment with a focus on:

- Educating the member about:
  - Diagnosis and its medical management and options
  - Side effect possibilities and intervention for management
  - Nutrition for optimal outcomes
  - Infection control prevention and early identification
  - Cancer specific local and national resources

- Call intent
  - Interact with the member undergoing active treatment at a time in their chemo cycle that is most beneficial for the member and most likely to prevent unnecessary visits to the ER or unnecessary hospitalizations; i.e. GI symptoms, susceptible infection, etc.

- Survivorship/end of life guidance and resources
  - Palliative care component added in January 2019
Member Experience

• Nurse evaluates individual needs and creates care plan
• Education on disease management, nutrition, infection control
• Screening for depression, anxiety, pain, social determinants of health
• Collaborates with and engages behavioral health support, home health, social services, community resources
• Nurse calls twice a month, based on treatment regimen and member preference
• Member calls nurse as needed
• Palliative care throughout the journey
• LifeKeeper tool – advanced care planning guide
• Post treatment: Member may call at any time

Average time in program is about 100 days
Members are identified through:
• Authorization request
• Internal program referrals
• Member calls
Member Financial Needs
Member that has a long term diagnosis had been stable for a long time, but was now progressing and needed to go on treatment. In looking at the member as a whole, the treatment was not the issue, the financial strain the treatment brought was what was causing her emotional concerns.

The member was responsible for taking care of her adult son as well as herself and the prescription co-pay was going to be a huge financial burden for her that she wasn’t sure she could afford. The HCP nurse was able to share the Leukemia and Lymphoma Society resource and connect the member to the social worker within Humana.

Ultimately, the member was able to apply for multiple grants and received over $12,000 in grants to help pay for her treatments as well as other expenses. The member was able to alleviate her stress, get her needed treatment, and still provide for her son.
Member Education and Provider Experience
Member newly diagnosed with head and neck cancer, which includes very difficult treatment. Weight loss is a huge side effect. After the first round of chemo, the member was losing weight and was feeling fatigued.

The nurse talked with the member about drinking Ensure as a dietary supplement and asking his MD about an appetite stimulating medication. The nurse educated about the importance of walking and getting up and moving to help with fatigue.

Upon follow-up, the member was drinking 3 Ensures a day, had started the stimulating medication, was walking daily, and was gaining weight and had less fatigue.
Provider Engagement and Hospital Avoidance
Member was going through chemotherapy and on their last round of chemo, White Blood Cells count dropped, meaning the member is more susceptible to infection.

The MD wanted to give the member a medication to help increase their WBC with the next treatment. The member called the nurse concerned that the medication had not yet been approved.

The nurse worked with our third party vendor, New Century Health, and MIT to assure they had all needed information to process the prior authorization. Our associate was able to follow through to ensure the medication was approved in a timely manner so that the member could get it with next chemo to help increase WBC and potentially prevent an infection.
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Oncology Model of Care Program

Quality-based care oncology program design to provide more integrated cancer care for members

**Goal:** Improve patient experience and health outcomes in cancer care through provider delivery of coordinated care

Collaborating with practices committed to building infrastructure to implement initiatives to address industry recognized quality standards that provide the member with expert support

- Education
- Access
- Member values
- Screening for depression and pain
Opportunities

• Social Determinants of Health interventions
• Reduction of administrative burden
• Patient education and assistance that promotes shared decision making and the achievement of patient goals and best possible health outcomes
• Integrated care delivery
Change happens at the speed of trust: Working together to improve health outcomes

Community Organizations
Physicians/Clinicians
Insurance Companies
Commercial Sector
Government
Individuals
Thank you

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