Long Term Care Claims: Setting Short Term Goals

Agenda

- Introduction of Panel
- Prognosis of Clinical Impairment
- Care Coordination in Short Term Claim Adjudication
- Claims Practices Survey and Case Study

Presenters

- **Presenters**

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Prognosis of Clinical Impairments

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Care "Assessment"

- Understand the disorder
  - How it causes dysfunction
  - Where in the spectrum of severity the client is
    - Is there treatment that will reverse the dysfunction?
    - Will the disease progress despite treatment?
- What disorders have significant potential for recovery?
- Close engagement with claimant and family with short EOB's

Sources of Information

- Acute Medical Care Standards
  - Gives some idea of how severe the acute medical or surgical episode is
  - Little motivation to stay acutely ill
  - Role of depression ubiquitous in all illness
- Disability claims data
  - Insured population with some incentive to stay on claim long
  - Young population with benefits to age 65
    - Univita experience ILTCI 2010: mean age at time of claim of those who recovered: 75.7

Disability Income

- Cancer:
  - Median for all types 12 months
  - Cancers with median > 12 months
    - Head and neck, colorectal, breast, melanoma,
    - Three longest
      - Sarcoma: bone, cartilage, soft tissue
      - Central nervous system, brain
      - Multiple myeloma, Leukemia, Hodgkin's

Disability Income

- Heart disease:
  - Median: 2 years
  - Includes rhythm disturbances, valves, cardiomyopathy
  - Heart failure: 3 years
- Stroke: 9 years
- Chronic fatigue: well over 10 years

Long-Term Care: Who Recovers?

- Dementia: a presentation unto itself.
  - Recognize delirium from dementia.
  - Can sometimes recover from acute delirium.
    - Sepsis from serious infection.
    - Hypotension from serious injury.
    - Side-effects of medications, especially in hospital setting
    - Hypothyroidism
  - Early dementia or mild cognitive impairment can be uncovered with physical stresses leading to delirium.
  - “Failure to thrive” predisposes to delirium with acute illness.

Who Recovers and How

- Recognize frailty and “failure to thrive” in all cases.
  - Fractures
    - Surgical recovery and rehab could challenge 90-day certification
  - Strokes
  - Cancer
  - Arthritis/Spine
    - Pain management and rehab potential
  - Respiratory
    - Acute infections and comorbid heart disease.
    - Assess pulmonary function response to treatment and rehab
  - CHF/Cardiac

Medical Triage: Cancer

- Lower risk because of nature of disease
  - High mortality
  - Response to treatment
  - Acute medical care often given when ill enough to be dependent
  - Depression associated with mortality
  - Vs. the Fight response

Cancer: Risk for Long Claim

- Identify good prognosis in these cancers
  - Sarcoma: bone, cartilage, soft tissue
    - Surgery usually part of treatment.
      - Wound healing
      - Rehab: PT and OT for adaptive strategies
        - » Rehab notes are the best in Medical Care for addressing progress, goals, and prognosis of loss of independence
    - Central nervous system, brain.
      - Neuro deficits often chronic.
        - » Rehab notes give good picture of prognosis.
    - Multiple myeloma, Leukemia, Hodgkin‘s
      - Depression, anemia, malnourishment (low pre-albumin, serum albumin)

Medical Triage: Heart Disease

- Rehab available for : myocardial infarction, bypass or valve surgery, and congestive heart failure
  - Progressive increase of exercise capacity on treadmill
- Loss of myocardium as pump reflected in “Ejection fraction” less than 50%.
- Manifests as decreased endurance as increased demand of physical exertion cannot be met

New York Heart Association Functional Class

- Classes used in much of cardiology literature
  - Class I: Regular activity does not cause fatigue
  - Class II: Comfortable at rest. Regular activity causes fatigue but can be done.
  - Class III: Comfortable at rest. Less than regular activity causes fatigue. May require assistance.
  - Class IV: Unable to carry on physical activity without discomfort. Can be uncomfortable at rest.
- Ejection fractions below:
  - 40% will be symptomatic
  - 30% will be limited
  - 20% will be considered for transplant if eligible

Stroke: General Prognosis

- 90 days is benchmark
- 30 day assessment has correlated closely with 90 day prognosis
  - 25% die
  - 4% have a second stroke within 30 days
    - 12% have a second stroke within the first year
    - 5% per year after 1st year
  - Survival is 40% at 5 years
    - "Disability" predicted by age, severity of stroke, and recurrent stroke

Cerebrovasc. Dis. 2003; 16 Suppl 1: 14-9

Medical Triage: Stroke

- How severe is a stroke?
  - A number of scales used in clinical practice
    - Modified Rankin (mRS): scored from 0-6
      - 0 No symptoms
      - 1 Minimal deficit without interference in usual activities
      - 2 Slight functional loss but still independent without assistance
      - 3 Functional loss requires some assistance but still able to ambulate without assistance
      - 4 Requires assistance with “bodily needs” and needs assistance to walk
      - 5 Severe: bedridden, incontinent, requiring constant care
      - 6 Dead

Medical Triage: Stroke Recovery

- Management of Atherothrombosis with Clopidogrel in High-Risk Patients: 7,599 pts.
- Stroke initially disabling: 20% mRan $\geq$ 3
  - 56% mRan of 3 (needs assistance for ambulation)
  - 42% mRan of 4 (needs assistance with ADL's)
  - 2% mRan of 5 (bedridden)
- At 18 months: 53% had recovered mRan < 3
  - 63% mRan of 3; median time 3 months
  - 41% mRan of 4; median time 18 months
  - 17% mRan of 5

Neurology 2007; 68: 1583

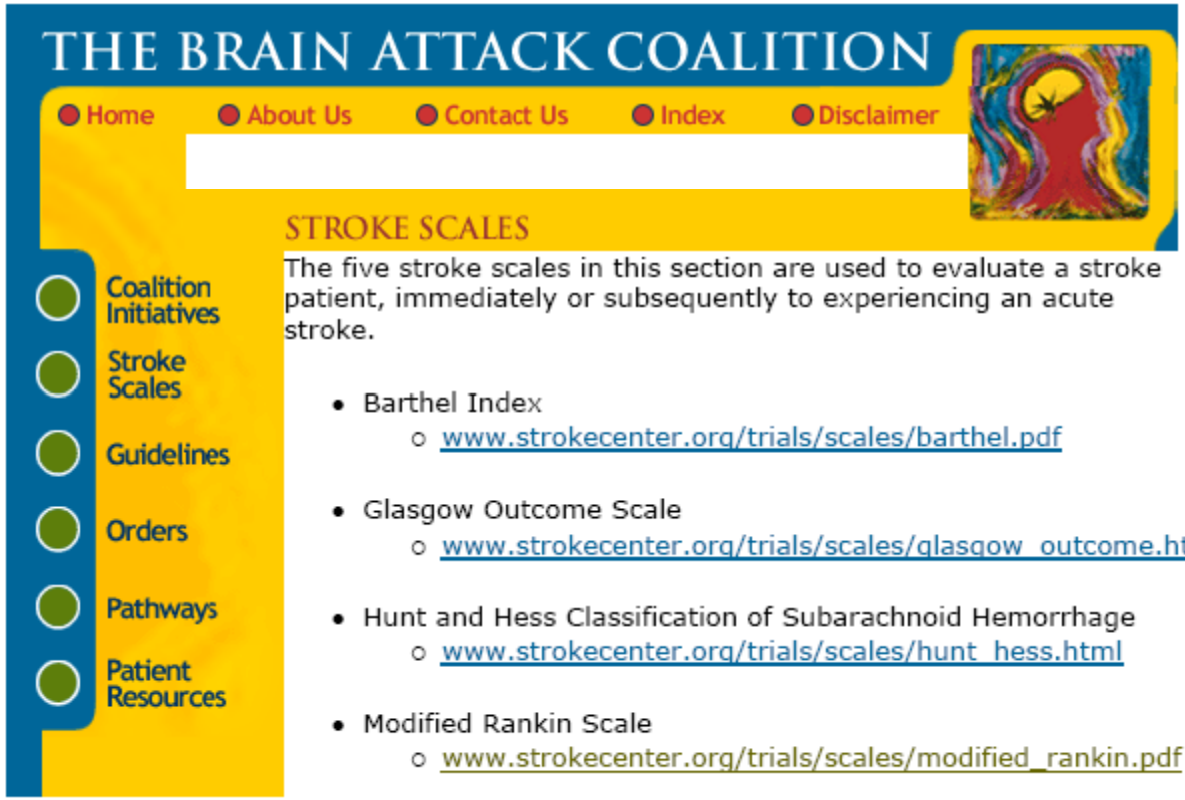
Stroke Severity: NIH Stroke Scale:

- Administered at Baseline, 2 and 24 hours post, 7-10 days, and at 3 months
- Score 0-42 points. Higher scores with more severe strokes.
  - 7 pts for decreased consciousness, orientation, following commands
  - 8 pts for decreased visual gaze, visual fields, facial muscle control
  - 16 pts for motor weakness of limbs (4 pts each limb): ability to hold limb up against gravity for 10 seconds (arms) or 5 seconds (leg)
  - 2 pts for jerky movements (ataxia) with finger-to-nose and heel to shin
  - 3 pts for incomprehension of language or incomprehensible speech
  - 2 pts for slurred speech
  - 2 pts for ignoring one side of body

Criteria for Good Outcome

- Virtual International Stroke Trial Archive
  - 1798 events
  - Most gains occur in first few months
  - "Good outcome" defined as modified Rankin score (mRS) of 0-2 (no functional loss or minimal without activity limitations)
  - Factors that were significant for this recovery at the 7 day mRS assessment
    - mRan of 3: age ≤ 70; 0-2 vascular risks (htn, dm, cad, chf, afib, prior cva); arm strength ≤ 1; language score 0
    - mRan of 4: age ≤ 70; male; facial palsy ≤ 1; visual 0; leg strength ≤ 1; dysarthria 0
    - mRan of 5: tPA treatment; dysarthria 0; leg strength ≤ 2

Cerebrovasc Dis 2009; 28: 341



http://www.stroke-site.org/stroke_scales/stroke_scales.html

Medical Triage: “Failure to Thrive”

- In elderly: global decline leading to physical frailty, cognitive impairment, and functional disability.
  - Weight loss with decreased appetite, nutrition, and dehydration
  - Inactivity
  - Depression
  - Impaired immune function with susceptibility to infections
  - Low cholesterol

“Failure to Thrive”

- Can be part of a chronic illness: cancer, chronic infection (e.g. reactivation of tuberculosis,) polymyalgia rheumatica, thyroid disease.
  - Optimal treatment may reverse disease but improvement may take months to recover
- Depression and multiple drug side effects may be a contributor
- Alcohol and cognitive dysfunction can be comorbids.

Failure to thrive: Treatment

- Multi-disciplinary approach:
  - Nutritional supplements
  - Medical treatments
    - Appetite stimulants: use mark severe problems
      - Megestrol (Megace)
      - Dronabinol (Marilnol)
    - Anabolic medications
      - Growth hormone:
      - Testosterone
  - Physical therapy for gait stability and strength
  - Treatment of depression
  - Socialization
  - Elimination of medications that can confuse the patient

Failure to Thrive: Prognosis

- Little information regarding prognosis of this global condition
- Used to be considered a terminal state of aging
- Positive features for recovery
  - Treatable acute disease: infection, thyroid disease, depression
  - Weight gain
  - Motivation and engagement in physical therapy
    - CMS has strict criteria for eligibility based on progress

Conclusion

- Triage based:
  - How early in the episode of illness or dysfunction
  - Depth of analysis you have resources to put into the up front assessment
  - Knowledge of prognosis for conditions

Care Coordination in Short Term Claim Adjudication

Lori Watson, Practices Leader, LTC Claims, Genworth
Claudia Cummings, RN CCM, Manager, Benefit Administration, MetLife

What is Care Coordination?

Care Coordination is an administrative structure that utilizes qualified nurses and social workers for:

- Gathering medical information to aid in establishing initial and ongoing claimant benefit eligibility
- Assessing claimant's needs for long term care and services
- Developing, implementing and re-assessing plans of care
- Providing on-going monitoring of **functional** (ADL and IADL) and **cognitive** capacity and resulting care needs

How do the services of a Case Manager differ from those of a Care Coordinator?

- Case Manger assesses, plans, implements, coordinates, monitors and evaluates options for care and services to meet an individual's **health** and human service needs

Who are the Care Coordinators?

Care Coordinators are individuals who:

- Have solid clinical backgrounds – may include registered nurses and social workers*
- Have been trained and chosen for their expertise in:
  - Conducting functional and cognitive assessments,
  - Developing initial and ongoing plans of care
  - Identifying and monitoring all types of long term care and services
- Have good written and verbal communication skills, good interpersonal skills and good at working with patients, families and care providers

*Note: vary by carrier

Benefits and Challenges of Care Coordination in Short Term Claim Adjudication?

Benefits:

- Expedites the gathering of information needed to determine claimant benefit eligibility
- Provides individual guidance and assistance during a very stressful time
- Develops comprehensive individualized plans of care
- Ensures the provision of the appropriate care and services needed to remain as safe and independent as possible
- Identifies early on in the claim the claimant's potential for regaining independence and sets expectations and goals for regaining independence with appropriate follow-up
- Preserves claimant dignity by encouraging independence when appropriate

Benefits and Challenges of Care Coordination in Short Term Claim Adjudication?

Challenges:

- Resistance from claimants and their families
- Reliance and dependence of claimant on their care provider and on the assistance they provide (ADL and IADL) even when it is no longer necessary
- Claimant's fear of reoccurrence
- Changes in claimant's psychological needs (e.g. lack of self confidence, withdrawal and isolation)

Care Coordination Interventions and Industry Survey Data on the Utilization of Care Plans

Carey Wagner, MSW, LICSW, Clinical Client Manager at LifePlans, Inc.

Care coordination Interventions and the Utilization of Care Plans

- Care Coordination's role in risk management and potential intervention options: How can we increase rehab potential and minimize time spent on claim?
- Care Coordination challenges: Case example
- LTC survey data and the use of care plans: Areas of variability and consensus

Care Coordination's Role in LTC Risk Management

1. Identify individuals with potential for rehabilitation.
2. Partner with parties to set expectations around service intensity and duration.
3. Identify appropriate interventions.
4. Modify the plan of care recommendations as the policy holder's functioning changes.

Clinical Intervention Options

-Leverage Medicare

-Evaluate Informal supports

-Depression screening

-Home Safety

-Neuro/psych evaluation

-Community Resources

Care Coordination case example

- 74 year old female
- Recent humerus fracture
- Upper extremity weakness affecting ability to bathe dress independently
- Back and shoulder pain due to osteoarthritis

Goals

- Address need to increase upper extremity strength
- Address pain management needs
- Address need for durable medical equipment (DME)

Interventions

- Care coordinator contacted the physician regarding leveraging Medicare for physical therapy, HHA care
- Discussion of pain management and referral for pain evaluation
- Recommendations for DME

Outcome

- Physical therapy improved the insured's upper body strength
- Pain management needs were addressed
- DME in place allowed the insured to manage activities of daily living independently
- The insured did not end up needing to access her long term care insurance benefit payments

Long-Term Care Claims Practices Survey for the Individual Market in 2009: Methodology and Case Study

Carey Wagner, MSW, LICSW Clinical Client Manager, LifePlans, Inc.

Results of the Long-Term Care Claims Practices Survey for the Individual Market in 2009: Methodology

- Data based upon claims activity and practices for 2009
- 12 companies provided data in January of 2010
- Represent roughly 100,000 open claims

Top 10 Primary Diagnoses for Claims

Dementia/Alzheimer's

Mental/Nervous

Arthritis, Joint & Disc Disease

Cerebrovascular disease

Heart

Disease of Circulatory System

Injuries

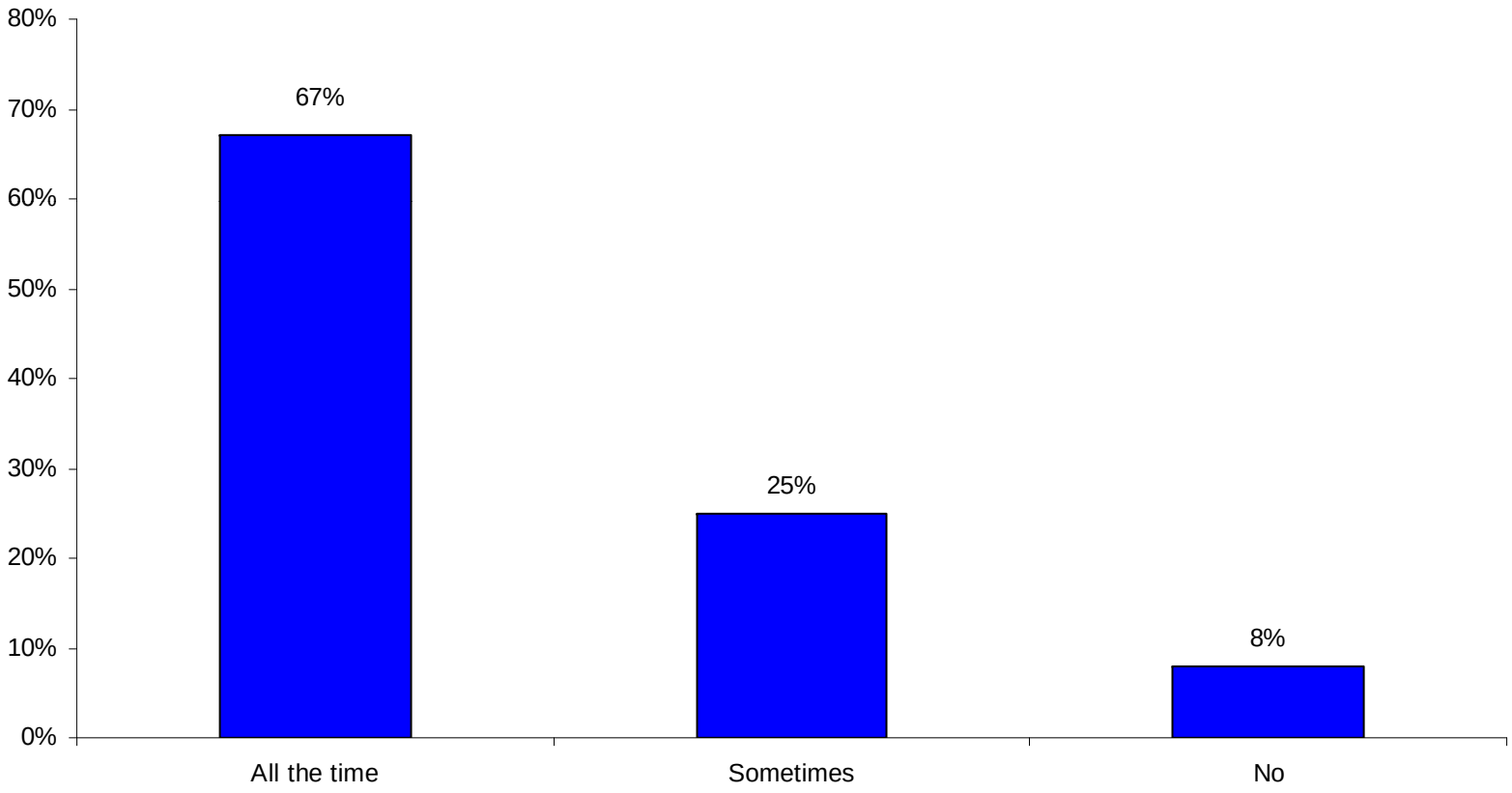
Respiratory

Cancer

Diabetes

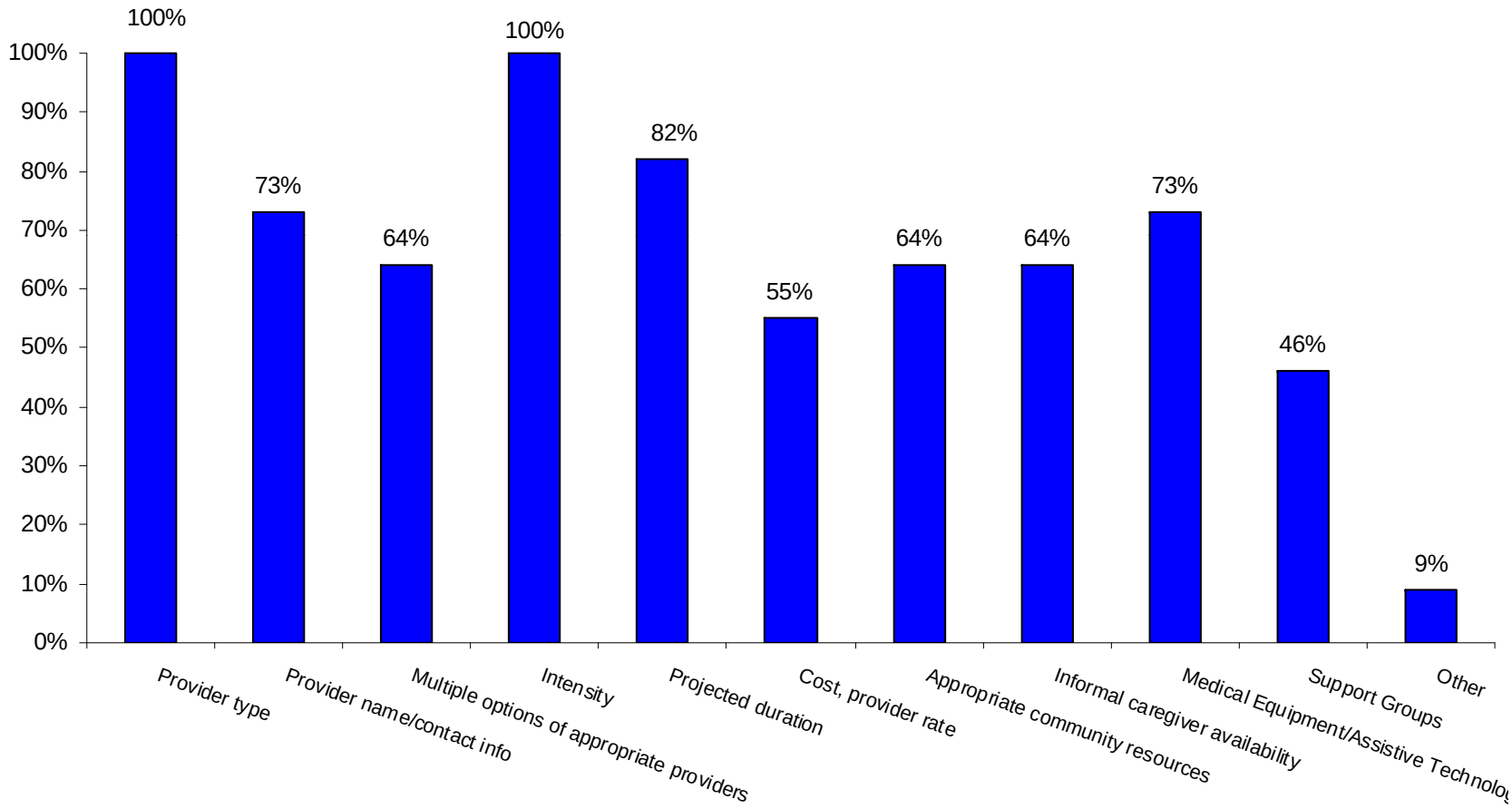
8 companies reporting

Percent of Companies Developing Care Plans in 2009



12 companies reporting

Percent of Companies Requiring Specified Information on the Care Plan in 2009



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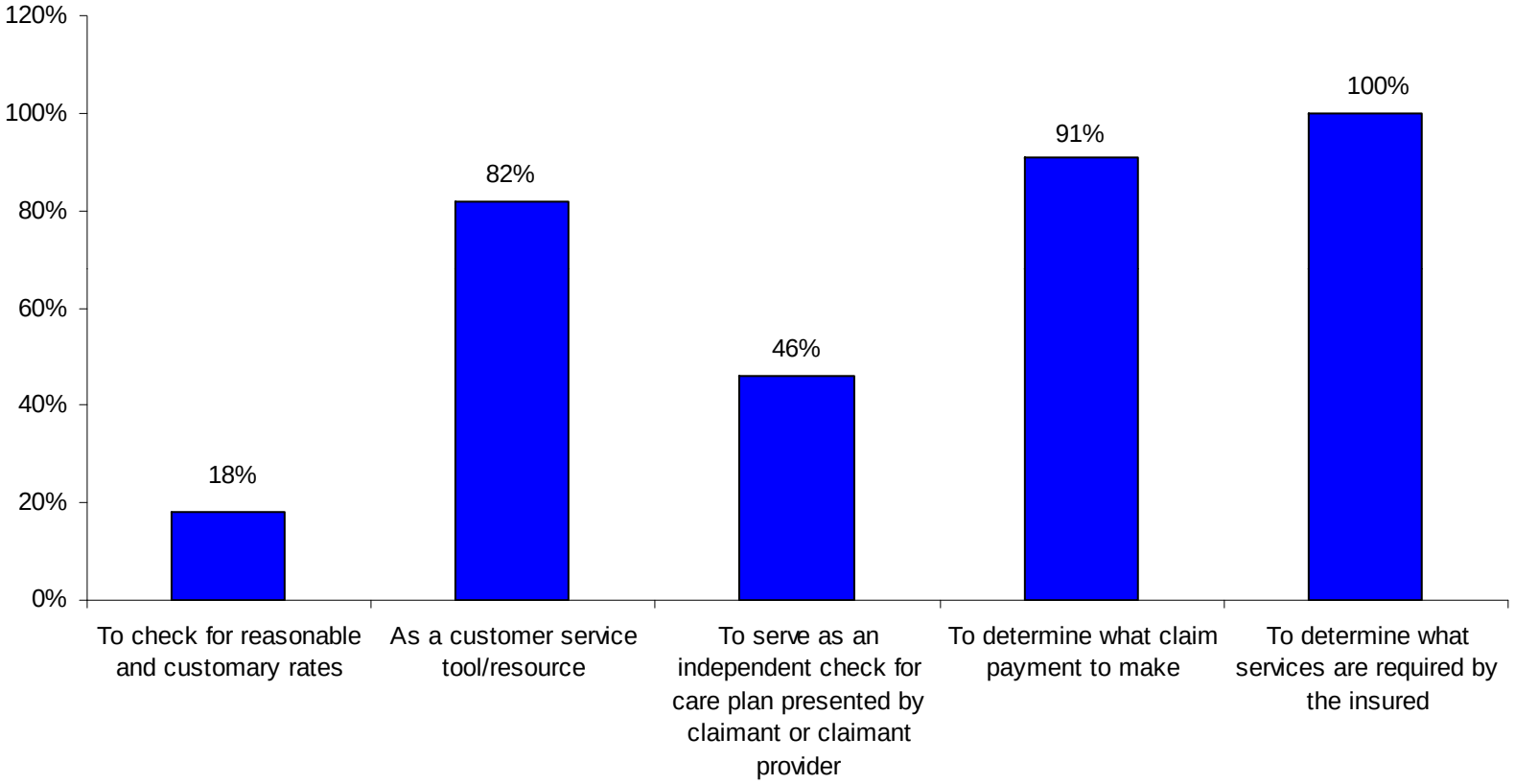
Ways That Participating Companies Utilized Care Plans in 2009



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Questions?