



Care and Service  
Coordinator Roles



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## MCE Provider Manuals



[Humana Healthy Horizons](#)

[United Healthcare Community Plan](#)

[Anthem Medicaid](#)

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## Who is Eligible?

### Indiana residents who are Medicaid enrollees that meet the following requirements:

- 60 years of age and older
- Eligible for Medicaid based on age, blindness, or disability

### It may also include individuals:

- Eligible for full Medicare benefits (dually eligible)
- Residing in a nursing facility
- Individuals receiving home and community-based services (A&D Waiver)

### Who is not eligible:

- Anyone aged 59 and under
- Partial Medicare benefit dually-eligible
- DDRS waiver recipients (including TBI waiver)
- I/DD residents in an ICF
- PACE recipients
- RCAP, ESRD Waiver, MA-12, ESO Family planning only, MAGI, TBI out of state

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## Indiana PathWays for Aging Goals

### Choice

Hoosiers want to age at home, but only 45% of residents who qualify for Medicaid are able to do so.

### Cost

Developing long-term sustainability. Only 19% of LTSS spending is going to Home and Community-Based Services (HCBS)

### Quality

Hoosiers deserve the best care. In 2020 Indiana was ranked 44th on AARP's LTSS Scorecard; this improved to 27th in 2023.

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# Questions from Nursing Home Providers



## Payment

*How and when are we going to get paid?*



## Coordinators

*Who are they, and what will they do?*



## Quality Goals

*Will MCE goals align with current nursing home expectations?*

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# Nursing Home Areas of Interest



## Payment

*How and when are we going to get paid?*



## Coordinators

*Who are they, and what will they do?*



## Quality Goals

*Will MCE goals align with current nursing home expectations?*

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# Probari and MCE Collaboration

- Material Review
- Provider Engagement
- Content matter expertise
- **Coordinator Education**
- Coordinator Role Design

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## Coordinator Education

### Modules

1. Care Planning
2. Working with Family in the Nursing Home
3. Hospice and Palliative Care
4. Nursing Home Environment and Workflow

### Other Educational Opportunities

- In-person sessions
- Live Zoom sessions

PROBARI

### Care Planning in NURSING HOMES

START

PROBARI

#### Care Planning in NURSING HOMES

Key Terms

- Minimum Data Set (MDS)
- Care Area Assessment (CAA)
- Interdisciplinary Team (IDT)
- Probari's Planning and Resident Review (PARR)
- Resident Goal
- Interventions

Click on each button to learn more.

PROBARI

#### Care Planning in NURSING HOMES

Objectives

- Describe key terms utilized when nursing home staff build a Care Plan
- Describe the importance of a well written Care Plan for the resident
- Describe the nursing home processes for creating and reviewing the Care Plan
- Identify the nursing home roles (MDS, IDT, Nursing, etc) that contribute to the Care Plan
- Identify the challenges for staff to complete routine assessments and updates to the Care Plan
- Verbalize how the Minimum Data Set, or MDS, assessment process contributes to Care Plan creation





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## Probari and MCE Collaboration

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- **Coordinator Role Design**

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## Probari's Approach to the Role

-  Simple and clear
-  Reduce overlap and disruption
-  Collaboration
-  Identify potential for added value

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## PathWays Resources Site

Care Coordinator	Service Coordinator
<p>A person who may contact you to create a personalized care plan based on your preferences and needs.</p> <p>They can also help answer questions about your health care and help you with your providers.</p>	<p>A person who will work with you to create a personalized Service Plan to help coordinate your Home and Community Based Services.</p> <p>The Service Plan will help develop a plan of care of services and supports that best meet your needs and goals.</p>

<https://www.in.gov/pathways/resources/>

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## Coordinators in the Nursing Home

- Most of the services are already available in the NH
- Likely both roles will be handled by one person
- This person will be responsible for multiple facilities
- Coordinators will often have a clinical background

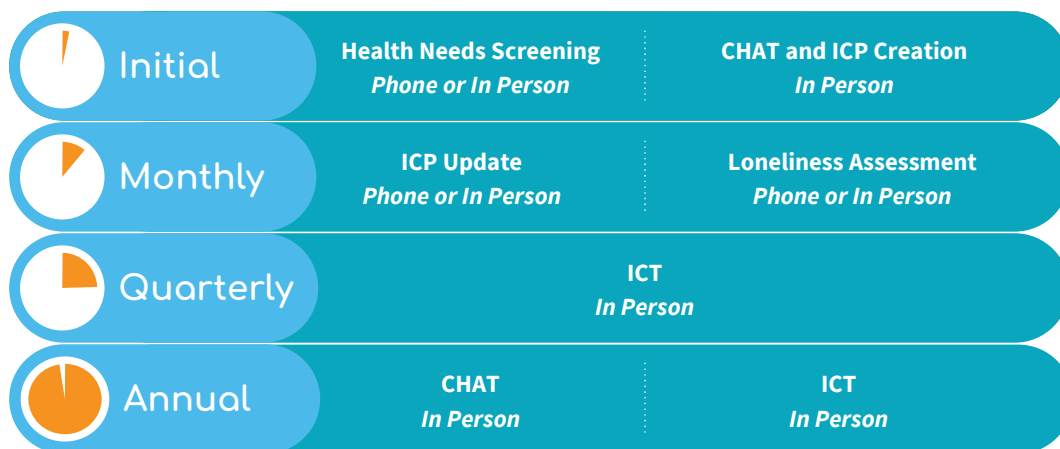
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## Care and Service Plans

- MCEs are encouraged to use the facility Care Plan as their care/service plan
- Coordinators may have a “copy” or “addendum” to support and supplement their own processes
- The MCE care plan should not have state survey related implications as MCE and Facility documentation will be separate

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## Timing of Assessments



Note: IDT and ICT are the same

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# interRAI CHAT *(Comprehensive Health Assessment Tool)*

HC interRAI™ Home Care (HC) Assessment Form 1 

**SECTION A. Identification Information**

1. NAME      
 a. (First) b. (Middle Initial) c. (Last) d. (Jr./Sr.)

2. GENDER  
 1 Male  2 Female

3. BIRTHDATE

4. MARITAL STATUS   
 1 Never married 2 Married 3 Partner / Significant other 4 Widowed 5 Separated 6 Divorced

5. NATIONAL NUMERIC IDENTIFIER   
 a. Social Security number   
 b. Medicare number (or comparable railroad insurance number)   
 c. Medicaid number [Note: "+" if pending, "N" if not a Medicaid recipient]

6. FACILITY / AGENCY PROVIDER NUMBER

7. CURRENT PAYMENT SOURCES [Note: Billing Office to indicate]  
 0 No  1 Yes   
 a. Medicaid   
 b. Medicare   
 c. Self or Family pays for full cost

10. PERSON'S EXPRESSED GOALS OF CARE  
 Enter primary goal in box at bottom

11. POSTAL / ZIP CODE OF USUAL LIVING ARRANGEMENT

12. RESIDENTIAL / LIVING STATUS AT TIME OF ASSESSMENT   
 1 Private home / apartment / rented room  
 2 Board and care  
 3 Assisted living or semi-independent living  
 4 Mental health residence - e.g., psychiatric group home  
 5 Group home for persons with physical disability  
 6 Setting for persons with intellectual disability  
 7 Psychiatric hospital or unit  
 8 Homeless (with or without shelter)  
 9 Long-term care facility (nursing home)  
 10 Rehabilitation hospital / unit  
 11 Hospice facility / palliative care unit  
 12 Acute care hospital  
 13 Correctional facility  
 14 Other

13. LIVING ARRANGEMENT

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## Coordinator Day in the Life...

### Preparing for a Facility Visit

- Prepare list of residents at facility
- Notify facility and resident in advance
- Review EMR records
- Identify areas of need to discuss

### Visiting the Facility

- Check in with leadership team
  - Plan for the day
- Member interviews and assessments
- Care Plan coordination with point person
  - Discuss new findings
  - Collaborate on care plan changes
  - Updates on ACP
  - Benefit discussion
- Documentation
- Check out meeting
  - Review residents with leadership
  - Discuss any changes that were made

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## Transition Teams and Realignment

- In addition to the coordinator, there could be a separate team managing transitions home
- A potential transition home could be prompted by several factors
  - Desire from resident/family
  - Facility staff
- MCEs will work with facilities to ensure follow-up protocols accurately assess the resident's ability to return to the community safely

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## Early Implementation

- Post launch will be a learning process – patience and communication is essential during this time
- Coordinator changes or absence will not affect facility reimbursement or the relationship with the MCE
- Your task - ***business as usual!***

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## Potential Coordinator Value



Extra set of eyes on  
the residents



Care Plan Clean Up



Lay groundwork for  
Advance Care Planning



Benefit Assistance

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## Quick Start Packet

### *What's Included?*

- MCE PathWays program Overview
- Collaboration Guide
  - How to prepare for the visit
  - What to do with the information from the Coordinator
- Role One Pager - overview to share with staff on coordinator role
- Facility Information template - Facility preferences, contact info, etc
- Coordinator contact information page

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## Probari Tips for Success

- Use the quick start packet
- Introduce the roles to your staff
- Identify 2 point people
- Have way to communicate
- Have a place for them to go
- Give them EMR access

[probarisystems.com](http://probarisystems.com)

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## Questions?

[probarisystems.com](http://probarisystems.com)

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## Additional Questions

- Quick start packet feedback
- Communication preferences
- Where would you like these people to sit?
- Other concerns with this role?
- How else can we support you?