Slide 1

PROBARI

PathWays **FOR AGING**

Care and Service
Coordinator Roles

LeadingAge® Indiana

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Slide 2

MCE Provider Manuals

Humana Healthy Horizons™

UnitedHealthcare® Community Plan

Anthem Medicaid

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

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Probari and MCE Collaboration

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

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

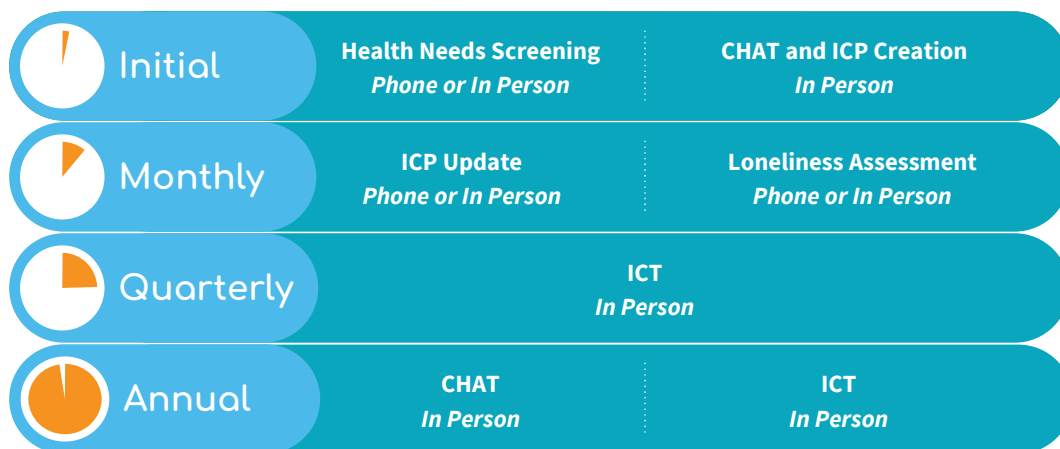- Coordinators will often have a clinical background

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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 <u>should not</u> have state survey related implications as MCE and Facility documentation will be separate

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Timing of Assessments

	Health Needs Screening *Phone or In Person*	CHAT and ICP Creation *In Person*
Initial		
Monthly	ICP Update *Phone or In Person*	Loneliness Assessment *Phone or In Person*
Quarterly	ICT *In Person*	
Annual	CHAT *In Person*	ICT *In Person*

Note: IDT and ICT are the same

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interRAI CHAT *(Comprehensive Health Assessment Tool)*

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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

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Questions?

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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?

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