Creative Solutions to Complex Nursing Home Transitions: *Creating a Plan for Success*

Ami Jo Probst, BSW, Housing Program Manager

Jennifer Ford-Bey, MSW, LSW, Manager of Behavioral Health and Collaboration Services

AmeriHealth Caritas

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Delivering the Next **Generation** of Health Care

Agenda

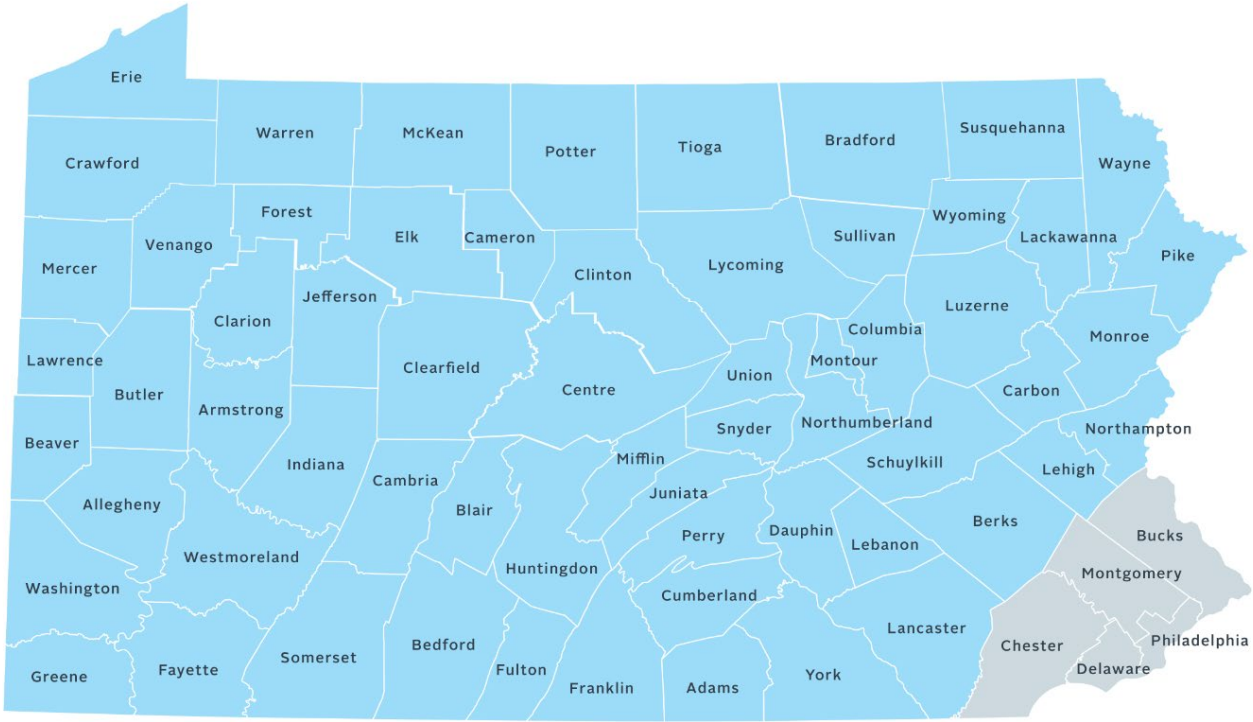
- Background
- Nursing Home Transition Process
- Complex Case Reviews

Background

Who We Are

The Plans offer benefits and services to eligible enrollees of the Community HealthChoices (CHC) program, plus special programs and benefits available to CHC Participants.

- Keystone First CHC covers the following counties: Philadelphia, Bucks, Chester, Delaware, and Montgomery.
- AmeriHealth Caritas Pennsylvania (PA) CHC covers the remaining counties.



About Us

Our mission

To help people get care, stay well, and build healthy communities. We have a special concern for those who are poor.

A national leader in multicultural healthcare

The National Committee for Quality Assurance (NCQA) has awarded our Plans with the prestigious Multicultural Health Care (MHC) Distinction. The award honors health plans that monitor and improve culturally and linguistically appropriate services and reduce healthcare disparities.

What is Community HealthChoices (CHC)?

- CHC is Pennsylvania's mandatory managed care for dual-eligible individuals and individuals with physical disabilities.
- CHC will coordinate the Participants health care coverage to improve the quality of your health care experience serving more people in communities rather than in facilities, giving them the opportunity to work, spend more time with their families, and experience an overall better quality of life.
- CHC provides Long-Term Services and Supports (LTSS) to Participants who need the level of care provided in a nursing home.
- Participants who meet this criteria will receive LTSS services and physical health services from their CHC-MCO, including nursing facility care.
- Long-Term Services and Supports (LTSS) — Services and supports provided to a Participant who has functional limitations or chronic illnesses that have a primary purpose of supporting the ability of the Participant to live or work in the setting of his or her choice, which may include the individual's home or worksite, a provider-owned or -controlled residential setting, a NF, or other institutional setting

https://www.dhs.pa.gov/HealthChoices/HC-Services/Documents/Understanding%20Community%20HealthChoices%20vs.%20HealthChoices.pdf

definition for LTSS. 2023 CHC AGMT

Who Are CHC Participants?

Individuals who are eligible for CHC:

- Individuals ages 21 and older who are dually eligible for Medicare and Medicaid.
- Individuals ages 21 and older who need the level of care provided by a nursing facility.

Nursing Facility Clinically Eligible (NFCE):

- The individual has an illness, injury, disability or medical condition diagnosed by a physician; and as a result of the illness, injury, disability or medical condition, the individual requires the level of care and services provided in a nursing facility ~~above the level of room and board~~.

Nursing Facility Ineligible (NFI):

- The individual has clinical needs that do not require a level of care provided in a nursing facility.
- Not eligible for LTSS benefits.

https://d2l2jhoszs7d12.cloudfront.net/state/Pennsylvania/Pennsylvania%20Human%20Services/httpwww.dhs.pa.gov/Personal%20Care%20Home%20Forms/Order%20Medical%20Assistance/s_002582.pdf

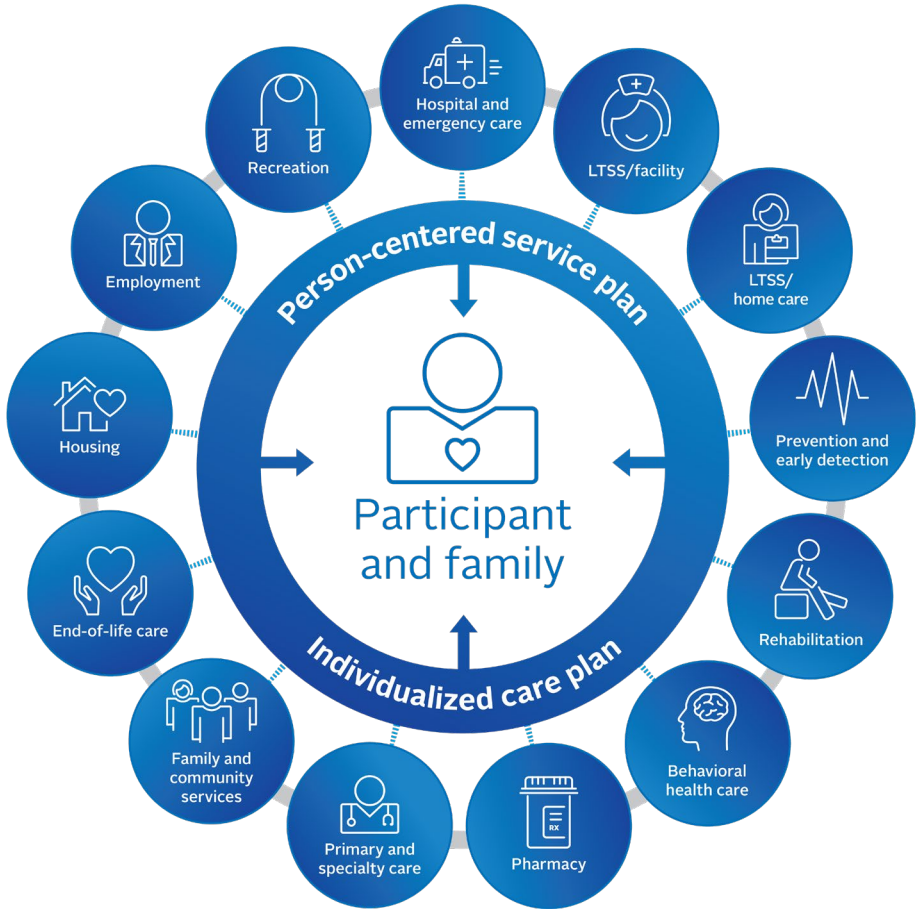
Our Person-Centered Approach

Our multifaceted approach addresses our Participants' needs, connecting them with the health care and services they need to get well and stay well. Our approach includes:

- Engaging, educating, and empowering Participants to actively participate in improving their health outcomes.
- Providing Participants with the information they need, when they need it, through our use of technology and Participant portals.
- Involving Participants, along with their care team made up of the Participant's care manager, service coordinator, physicians, service providers, and community and natural supports, in the care planning and management process.
- Using community-based services to appropriately avoid or delay institutional care, supporting Participants who desire to remain in a home- and community-based setting.

Person-centered approach to Participant care

Integrated health care management programs address Participants' comprehensive needs



Covered Benefits

- Adult Daily Living
- Assistive Technology
- Benefits Counseling
- Career Assessment
- Community Integration
- Community Transition Services
- Employment Skills Development
- Exceptional DME
- Financial Management Services
- Home Adaptations
- Home Delivered Meals
- Home Health Services
- Job Coaching
- Job Finding
- Non-Medical Transportation
- Nursing Facility Services
- Participant-Directed Community Supports
- Participant-Directed Goods and Services
- Personal Assistance Services
- Personal Emergency Response System
- Pest Eradication
- Residential Habilitation
- Respite
- Specialized Medical Equipment and Supplies
- Structured Day Habilitation
- TeleCare
- Therapeutic and Counseling Services
- Vehicle Modification

https://www.keystonefirstchc.com/pdf/providers/training/orientation-for-home-and-community-based-services-providers.pdf

LTSS Service Coordination

- The Plan will facilitate and coordinate Participants' access to all necessary covered services including Medicaid, Medicare, behavioral health, and other services.
- The Service Coordinators' role is personal and includes face-to-face contact, to help Participants navigate the system and coordinate their care. They are a single point of contact for Participants with a primary function of providing information, facilitating access, locating, coordinating and monitoring needed services and supports for LTSS Participants.
- Service Coordinators are responsible for informing Participants about:
  - Available LTSS benefits
  - Required needs assessments
  - Participant-centered service planning process.
  - Service alternatives
  - Service delivery options including opportunities for self-direction.
  - Roles, rights including Department of Human Services (DHS) Fair Hearing rights, risks and responsibilities, and to assist with fair hearing requests when needed and requested
- All nursing facility Participants are assigned a Service Coordinator.

What is Nursing Home Transition?

CHC-MCOs are required to provide CHC NF Participants, who request transition out of a NF, with the necessary support and services to facilitate a safe discharge to home.

Examples of transition coordination activities:

- Assessing for the transition from a nursing facility to the community, this includes gathering information about the need for health services, social supports, housing, transportation and other social determinants of health.
- Assisting in finding and securing housing.
- Assessing the need for any home adaptations that may need to be completed prior to the individual transitioning to the community.
- Providing information to the Participant about community resources and assisting the individual, family, nursing facility staff, and others to provide timely and coordinated access to home and community-based services, behavioral health services, and any other services to meet the needs of the individual.

https://www.dhs.pa.gov/hc-landing/Documents/CHC%20Ops%20Memo%202019-04%20Nursing%20Home%20Transition.pdf

Nursing Home Transition Process

"Blessed are the flexible for they will never be bent out of shape."

- Unknown

Nursing Home Transition- Participant Identification

A nursing facility Service Coordinator may become aware of a Participant's desire to transition by:

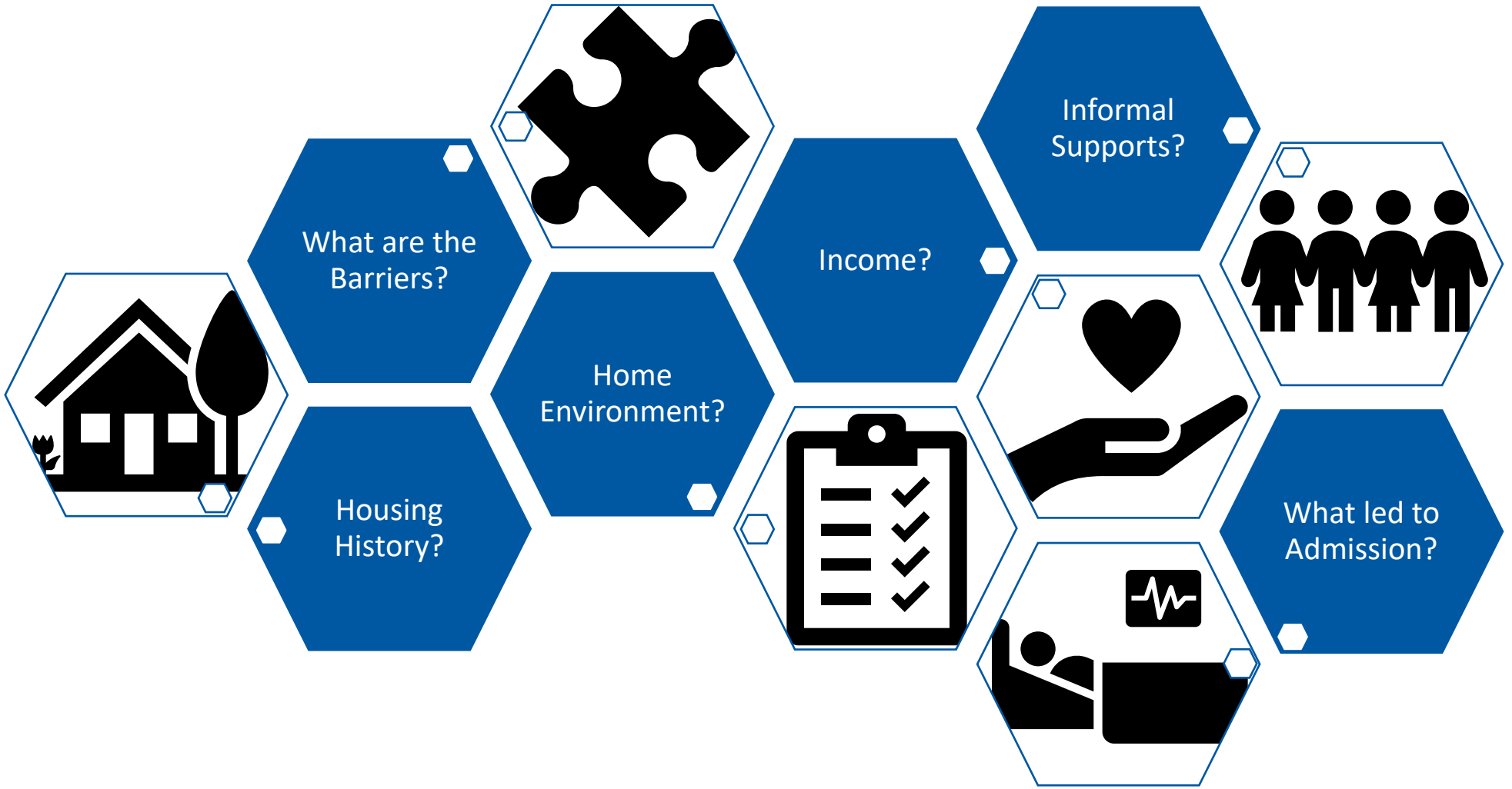
- A self-referral from the Participant.
- A referral from a family member, friend, power of attorney, etc.
- A referral from the nursing facility social worker or administrator.
- Completion of assessment (initial, trigger or annual).

The Participant must agree to receive NHT services prior to a referral being made.

Common barriers might include:

- No housing.
- Enrollment into home- and community-based services (HCBS).
- Need for a Home modification.
- Not having the necessary documents to apply for housing (PA ID, Social Security Card, Birth Certificate).
- No informal supports.
- Access to funding for the first month's rent/security deposit required to obtain a housing unit.
- High care needs.

Where to Start, Putting the Picture Together



Coordination/Collaboration

Service Coordination

- Submits for waiver services, but does not approve
- Might need to ask for competency or more documentation on cognitive status

Nursing Home Transition Agencies

- Locates housing
- Assists with obtaining new ID cards: Social Security, Photo ID, etc.
- Shopping/furniture/household items

Behavioral Health Coordination

- County by county
- Behavioral health services can be initiated via Service Coordination or direct contact can be made with the Behavioral Health Managed Care Organization (BH-MCO)

Welcome to the Team

Community Transition Services

Community Transition Services are one-time expenses for individuals transitioning from an institution or another provider-operated living arrangement to a living arrangement in a private residence where the person is directly responsible for his or her own living expenses. The following are allowable expenses that may be incurred:

- Essential furnishings and initial supplies such as a bed, a table, chairs, window blinds, eating utensils, and food preparation items;
- Moving Expenses;
- Security deposits that are required to obtain or retain a lease on an apartment or home;
- Set up fees or deposits for utility or service access, Examples – e.g., telephone, electricity, heating;

Items not included:

- Ongoing payment for rent or mortgage expenses.
- Food, regular utility charges, and/or household appliances or items for purely diversion/recreational purposes.
- Those services available under Assistive Technology, Home Adaptations, Pest Eradication, Specialized Medical Equipment and Supplies, and Vehicle Modifications

$4,000 per Participant per lifetime

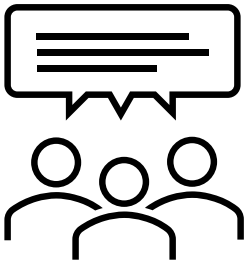
https://www.dhs.pa.gov/about/DHS-Information/Documents/InformationforAdvocatesandStakeholders/Managed_Long-Term_Services_and_Supports_Subcommittee/2015MeetingDatesandTranscripts/CHC%201915c%20Service%20Definitions.pdf

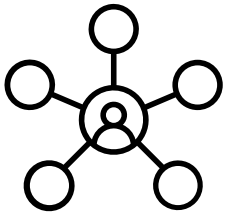
Discharge Meetings

Items to be covered by Medicare (if applicable)

Waiver Services:

- Personal Emergency Response System
- Adult Day
- Transportation
- Home Delivered Meals
- Nutritional Counseling
- Incontinence Supplies
- Community Integration
- Personal Assistance Services





Medication/Pharmacy

Back up Plans

Community Resources

Caregiver Support

Follow up & Documentation

Enrollment into Home and Community-based Services ("HCBS") Prior to Discharge

Participant ***did not*** have HCBS prior to their nursing facility admission:

- A referral to the PA Independent Enrollment Broker (IEB) is required
  - Physician Certification
  - Level of Care Determination
  - PA 600 L Completed
  - IEB will send the PA 1768 to the County Assistance Office (CAO) prior to discharge from the nursing facility

Participant ***had*** HCBS prior to their nursing facility admission:

- The nursing facility Service Coordinator will send the PA 1768 to the CAO prior to discharge from the nursing facility

Complex Case Reviews

Clinical Case Rounds

“If you transition one person, you transitioned one person.”

NHT Clinical Case Rounds

NHT Case Rounds were created with the purpose to:

- Have a more comprehensive discharge planning conversation with the Interdisciplinary Team.
- Review the NHT cases that might be at risk of re-admission to either:
  - Provide guidance on how to best approach the case.
  - Close the NHT case due to the inability to create a safe plan of care.

Case Scenario Exercise

Thank You

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Questions?