Role of Community HealthChoices (CHC) Service Coordinators in Nursing Facilities

Long-Term Services and Supports (LTSS) Subcommittee Meeting

August 7, 2024

Presenter: Jocelyn Saggese, Director of Service Coordination

AmeriHealth Caritas

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Role of the Service Coordinator

Development of Person-Centered Service Plans based on Participants' individual needs and desires in directing their own care while a long-term resident in a nursing facility

Advocate for Participants and their Authorized Representatives. Make sure Participants receive quality care and develop a partnership with the nursing facility's multi-disciplinary team to work toward Participant's identified goals.

Service Coordination

Identification of Participants who have a personal goal to transition back to the community.

Make referrals, as necessary, for behavioral health support, specialty physicians, specialty medical equipment, specialized services (community integration, etc.), facility transfers, and State partners.

How does the Service Coordinator Fulfill their Role?

Consistent contact with the Participant, Planning Team Members, and the Facility

- Contact is required at least every quarter with the Participant, with at least two of those contacts being face-to-face.
- Contact is also established at the request of the Participant (or Power of Attorney), the Nursing Facility, or when a Trigger Event occurs.
- Service Coordinators will also reach out to and work with the Nursing Facility staff (Director of Nursing, Business Office, Social Workers) for service planning purposes, eligibility concerns, and for updates as needed.

Development of Person-Centered Service Plans

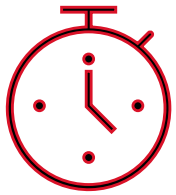
Person-Centered Service Plans

Capture the Participant's current diagnostic history, health status, preferences, services, barriers, and goals.

Are completed face-to-face with the Participant.

Are developed with input from the Participant, the Participant's Authorized Representative, Power of Attorney or Legal Guardian (if applicable), nursing facility staff, and any other individuals that the Participant chooses.

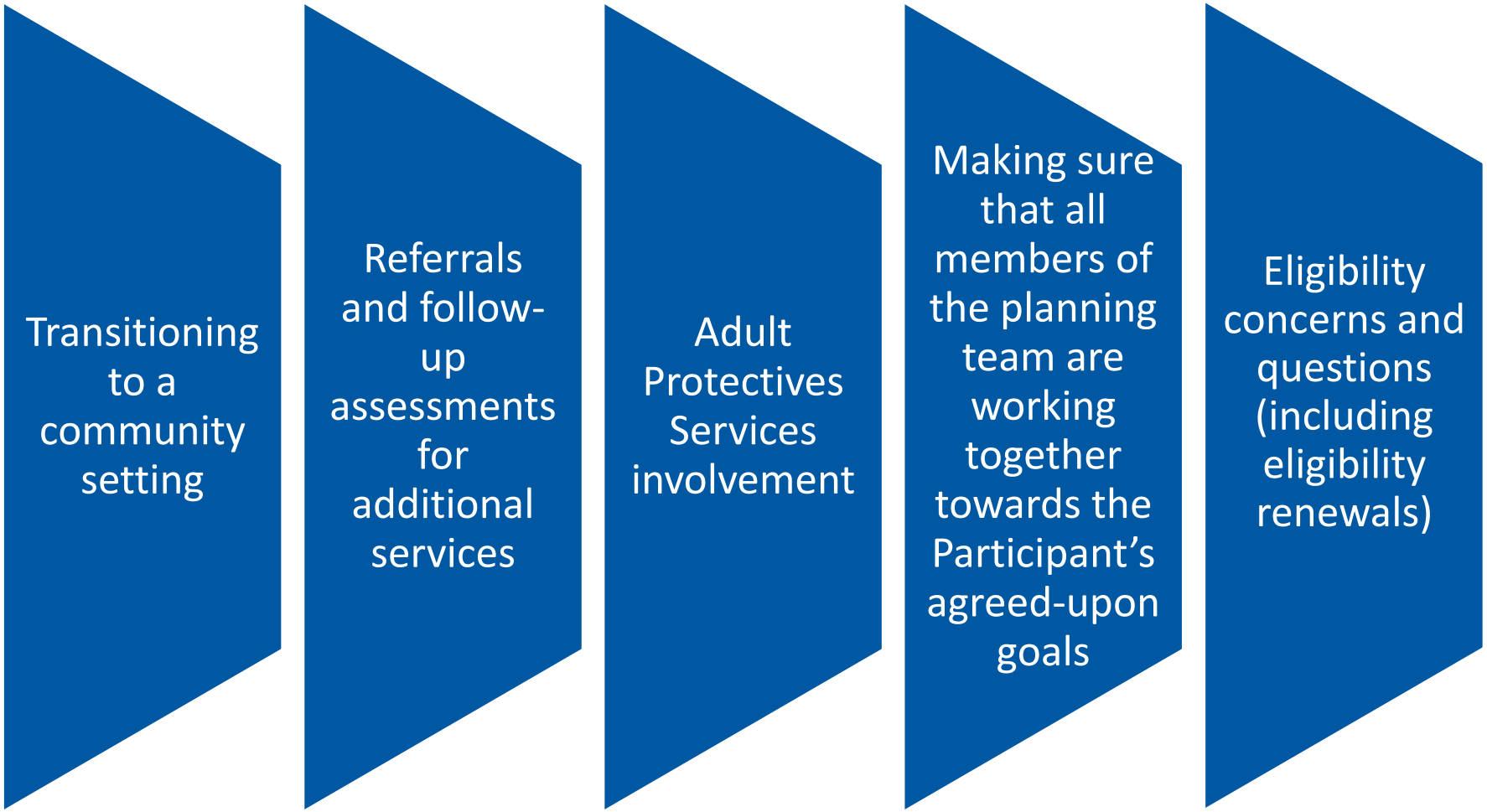
Access to Electronic Health Records is not required, but it allows for a more comprehensive plan to be built by the Service Coordinator with minimal preparation by the nursing facility staff. Electronic Health Records also serves as a data source for accurate, up-to-date information regarding medications, diagnoses, and health status.



CHC Managed Care Organizations (MCOs) are required to complete the initial orientation within thirty (30) days of the new **Participant's start date with the CHC-MCO**.

Advocating for Participants

- Service Coordinators can assist with advocacy for Participants and their Authorized Representatives.
- Advocacy can occur for some of the following reasons:



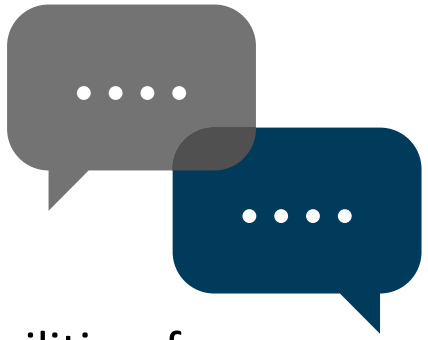
Transition to the Community

- Service Coordinators assist with facilitating transition to the community with internal and external teams.
- Service Coordinators complete a Comprehensive Needs Assessment to identify Participant needs and preferences, including the identification of and referral to Home and Community-Based Services (HCBS).
  - HCBS benefits include but are not limited to:
    - Personal Assistance Services (PAS)
    - Home Delivered Meals (HDM)
    - Personal Emergency Response System (PERS)
    - Adult Day Program
    - Specialized Medical Equipment

- Additional services often utilized with Nursing Home Transition:
  - Community Transition Services
  - Home Modifications
  - Complex Case Management

Referrals and Outreach

- Service Coordinators often serve as the “go to” for additional services.
- The need for additional services is typically captured during the initial, annual, or trigger Comprehensive Needs Assessment, but Service Coordinators are available to assist with referrals at any time.
- As necessary, additional services to Participants residing in a nursing facility long term may include:
  - Behavioral health support
  - Specialty medical equipment
  - Specialized services (such as community integration)



- Service Coordinators are available to assist with referrals to other facilities, for example, when more specialized care is needed, or in the event of a facility closure.
- Service Coordinators can reach out to the Ombudsman or other State partners as needed.

Questions?

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August 7, 2024
Presenter: Sarah Hall - Manager, Service Coordination

Background

PA Health & Wellness (PHW) has Service Coordinators (SCs) assigned in 607 nursing facilities statewide, serving over 13,600 participants

- The maximum caseload ratio for SCs serving participants in nursing facilities is 1:225
- Population consists of participants eligible for Medicaid Long-Term Care (LTC) and participants dually eligible for Medicare and Medicaid
- In addition to PHW SCs, we partner with 3 Service Coordination Entities (SCEs) with nursing facility caseloads

Service Coordination Lifecycle

01 Participant Assignment

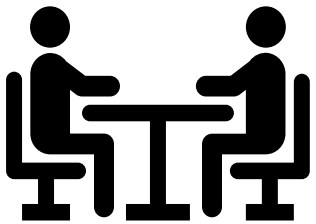
- ✓ Assign to SC/SCE based on membership type, location, caseload numbers

02 Initial Assessment

- ✓ Orienting participant to PHW
- ✓ Creating a Person-Centered Service Plan (PCSP) for goals, needs, and services
- ✓ Review for care plan appropriateness

03 Visit Documentation

- ✓ Collection of required paperwork
- ✓ Timely documentation
- ✓ Chart reviews



04 Ongoing Assessments

- ✓ 2 Face to Face visits required per year
- ✓ Quarterly outreaches
- ✓ Annual reassessment
- ✓ Trigger event visits
- ✓ Referrals and advocacy as needed

Role of the SC

Nursing Facility Assignment

- SC to nursing facility (NF) ratio varies depending on the PHW population to build a caseload of no more than 220 participants per SC.
- SCs create their schedule to visit their assigned NFs and may meet with several participants any given day.

Person-Centered Planning

- Outreach to hospitals to assist with discharge planning and follow up with participant after hospitalization.
- Meet face-to-face with participants and involve their Person-Centered team to develop comprehensive PCSPs to include current health status, services, needs, and goals.
- Advocate and ensure that all members of the multidisciplinary team are on the same page, working together towards the participant's agreed-upon goals.

Advocacy

- Educate the participant on the option to transition to a community setting and assist with the transition.
- Make referrals and follow-up assessments for additional medically necessary services.
- Serve as a point of contact for participant and follow-up to ensure they are receiving quality care.

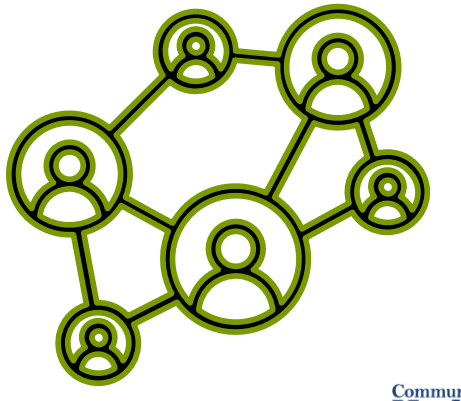
Referrals and Outreach

- SCs often serve as the “go-to” for additional services and support.
- The identification of additional medically necessary services is typically captured during the annual and/or initial assessment, but SCs are available to assist with referrals at any time.
- NF staff are also encouraged to contact the SC on behalf of the participant if they identify a need.
- Additional services while residing in an NF long-term could include:
  - Behavioral health support
  - Specialty medical equipment
  - Specialized services

- SCs can reach out to the Ombudsman or other supports as needed.
- SCs are the point-person for escalations involving the participant. Our Complex Care Team and Transitional Care Teams can assist with complex medical and care needs of participants, finding the best location placement, guarantee compliance of critical incident investigation and outcome, and ultimately ensuring the participant’s health and safety.

Transition to the Community

- SCs assess and assist with Nursing Home Transition (NHT) if the participant is interested in returning to a community setting.
- SCs will conduct a comprehensive needs assessment, including the identification of and request of home and community-based services (HCBS).
- SCs collaborate with participants and their care team, Medical Directors, and NF staff to evaluate the needs of participants and help develop a safe discharge plan.
- PHW engages Housing Specialists to find appropriate community settings that could meet the housing goals of the participants.
- PHW may offer additional services to support an NHT such as:
  - Community transition services
  - Home modifications
  - Complex case management
  - Assistive Technology assessments



Success Story

- “John” is a 51-year-old male diagnosed with a cognitive impairment and cerebral palsy. He currently resides in a Peer 13 Group NF. He has been there since 2011 following the death of his mother. He has two older siblings (both in their 70’s). His brother has partial guardianship.
- John has never lived alone. He resided with his mother until he was 38 years old and then went to live at the facility.
- PHW coordinated transition activities with Roads to Freedom including the inclusion of a peer advocate.
- PHW teams have assessed and visited with John on site. We have found that with support we can help him to be successful in the community.
- In coordination with Roads to Freedom, PHW is working closely with the Center for Independent Living (CIL) to support NHT efforts including early preparations for John to understand his choices including community choices and daily activities when he leaves the facility.
- John has expressed wanting to volunteer at the CIL, get a job at a radio station answering the phone and to join a bowling league.
- John has limited life experience as a decision-making adult and will benefit from a peer advocate as well as extended community integration supports.
- PHW has moved forward with the warm hand-off to a community-based SC so that they can begin building their relationship with John. At this writing, John is on a waiting list for housing in his chosen county and on-going internal Transition meetings are occurring.

Success Story

"John's" experience has fostered a concern about the number of people currently living in Peer 13 facilities and the appropriateness of these placements. PHW LTSS leadership will be engaging service coordinators assigned to these facilities to join them in personally meeting all Peer 13 PHW residents over the next several months. We are also engaging the CILs to assist with providing peer advocates for any participant expressing a desire to live independently.

Questions 

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August 7, 2024

Marissa Ables Dawson
Senior Director, Strategic Initiatives and Clinical Programs

Nursing Facility Service Coordinators

- UPMC Nursing Facility (NF) Service Coordinators (SC) are responsible for supporting the Participants that we serve who are residing in a NF setting for long term care.

- We assign one NF SC to each NF, which helps us to ensure consistency, relationship building, and support our person-centered process.

- *Note – Some larger facilities have multiple NF SC assigned to support Participants

UPMC NF SC Best Practices

- Relationship Building Efforts. NF SC meets with Social Worker, Director of Nursing, and Administrator during in-person visits to keep updated on staffing or facility changes

- NF SC explains their role and how/when the facility should contact UPMC Service Coordinator

- NF SC completes coordination activities and all needed outreach and monitoring. At a minimum, the NF SC outreaches to each NF Participant once every three months and documents any new needs and concerns. At least two of these outreaches each year are completed in-person. A NF comprehensive needs assessment is completed during an in-person visit.

UPMC NF SC Best Practices, continued

- SC shares invitations to weekly Learning Network webinars and attend webinars to learn best practices in real time with NF staff

- When participant issues are identified, SC approaches the NF leadership first to inquire about the facility knowledge of the issue, gather their response and additional details, and help advocate for the participant's preferences and needs to get addressed

- UPMC CHC NF Quality of Care (QOC) Roundtable

Monitoring of NF Activities

- Monitor for completion of facility related processes and services
  - Pre-Admission Screening and Resident Review (PASRR) Process
  - Specialized Service Delivery
  - Participant Rights
  - Patient Pay Liability
  - Personal Care Accounts
  - Other Identified Processes

- Identify and ensure the provision of PASRR specialized services to individuals residing in NF, and at a minimum, provide community integration, peer counseling/support groups, training and transportation needed to access these specialized services.

Transitions to the Community

- Promote care in the least restrictive and most appropriate setting based on the Participant's condition and prognosis

- Identify Participants wishing to transition back to the community.

- Work collaboratively with our Nursing Home Transition (NHT) providers, NF staff, and care managers to address any barriers to ensure that the Participant's pre and post transition needs are met.

Meeting Participant Needs

- Promote wellness and preventative care including routine medical exams, therapies, and treatments as needed.

- Ensure NF services are conducted in a manner that promotes each Participant's preferences and goals

- Ensure that all Participants functional, physical, and behavioral needs are being met.

- Identifying and ensuring provision of alternative methods of communication for those that are unable to speak but can communicate through another method.

Meeting Participant Needs, continued

- Identify health and safety concerns and assist with complaints that need to be raised to the NF, Ombudsman, Older Adult Protective Services/Adult Protective Services, and Department of Health.

- Review for and help find ways to avoid hospital admissions, readmissions, or emergency services utilization.

- Monitor access to care and assist, as needed, for referrals to providers or specialists, including transportation needs outside of the NF.

- Coordinate and assist with obtaining external behavioral health services as needed.

Confidentiality and Compliance

- Ensure compliance with all state and federal regulations and guidelines in day-to-day activities.

- Maintain confidentiality and adhere to Health Insurance Portability and Accountability Act (HIPPA) requirements.

- Perform in accordance with system-wide competencies/behaviors and other duties as assigned.

UPMC CHC NF Quality of Care (QOC) Roundtable

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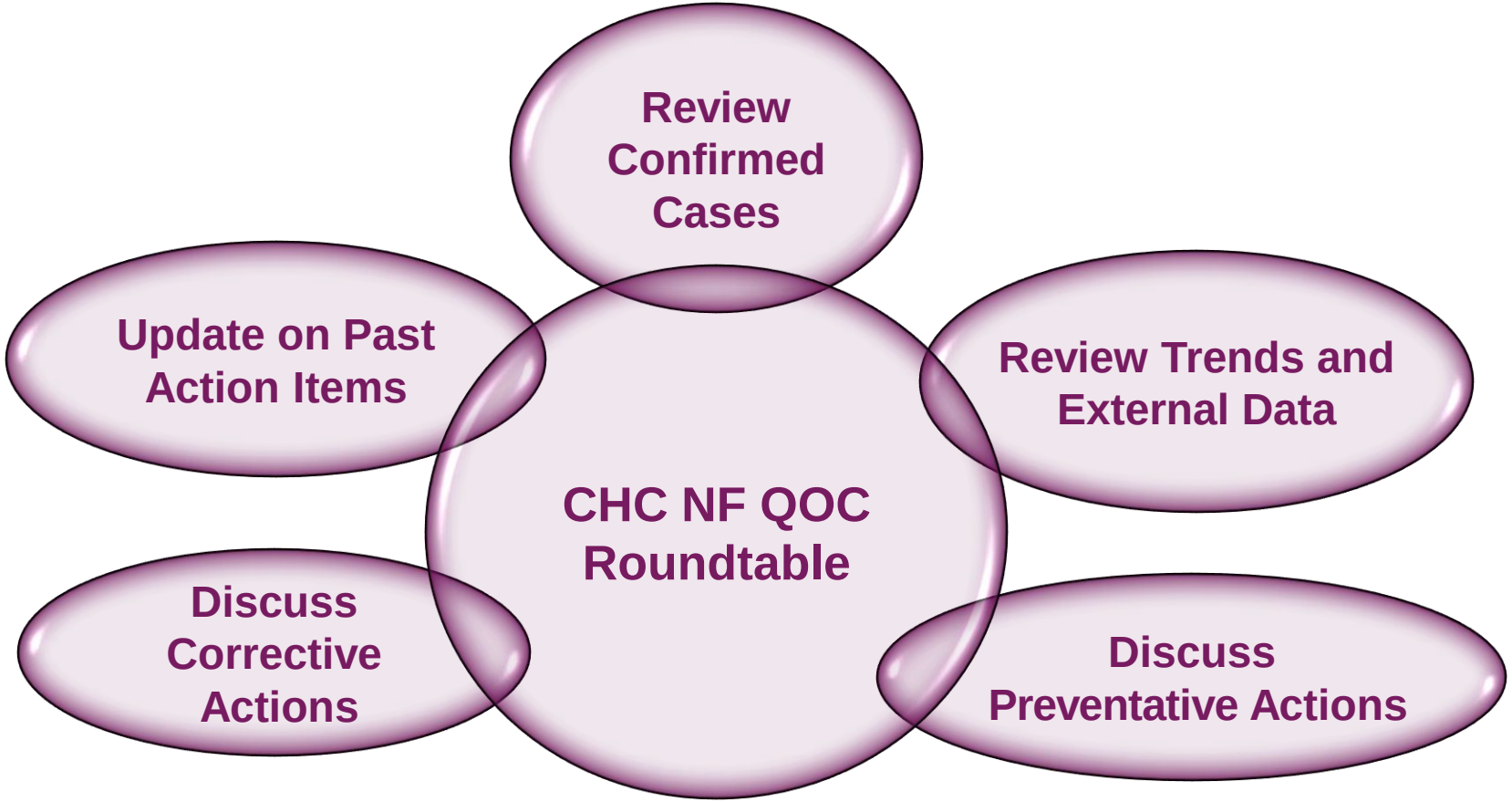
Internal interdisciplinary team who:

- Review/vote on NF QOC Cases, corrective action, and follow up actions
- Review Nursing Facilities investigations or events from media stories and plan clinical audits of participants and Health/Safety checks by NF SCs
- Discuss educational topics for NF Learning Collaborative or other technical assistance opportunities
- Recommend NF SC process improvements based on findings and trends

Visual - UPMC CHC NF QOC Roundtable



UPMC CHC NF QOC Roundtable Staff

- Ancillary Network Representative
- Clinical Manager
- Quality QOC Representative
- NF SC Assigned
- NF SC Statewide Manager
- Associate Vice President LTSS
- CHC Medical Directors
- Quality Medical Director or Senior Quality Director
- CHC Registered Nurse QOC; Project Manager present QOC Case with recommendations
- CHC Quality Director and Program Director Facilitator

NF QOC Roundtable-Driven Improvements

- Increased training to NF SCs on chemical restraints (what to monitor, question, & report) along with other focused topics.

- Red Flag Calls held when a larger NF issue is identified to quickly assess the facilities past issues and public ratings, triage the participants most at risk, and recommend action items and responsible parties for following up.

- Increased education and opportunities for NFs to participate in Learning Collaborative and receive topic-specific support where available.

- Collaborating with a Nursing Facility Association-led training series to increase NF participation.

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Questions?

Thank you