Medicaid Managed Care Ventilator Services

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Topics

• Service Coordination
• Money Follows the Person
• Hospital Transition Teams
• Sustaining Community Members
• Services and Authorization
• Tools that Promote Success
Overview

• People do best in home environment
• Each person has their own unique care needs
• Primary importance is health and safety
• Use of professional staff for training and education is key.
• Flexibility to make services adjustments to address individual care needs promotes success
Service Coordination

Roles & Program Goals

(With respect to clinically complex and ventilator dependent members)

Service Coordination is an integral service and the main feature of the STAR+PLUS program
The goals of the Service Coordination Program are to:

- Ensure long term services and supports (LTSS) and clinical programs are in place according to members wants and needs
  - Accomplished through a comprehensive approach that includes assessments targeting functional, medical, behavioral and social needs
- Support members desires to live in the least restrictive setting as possible
Level 1 Service Coordination

- **Level 1 Service Coordination** includes members:
  - Who receive services under the Home and Community Based STAR PLUS waiver services
  - Residing in nursing facilities (except for nursing facility members on hospice)
    - If a nursing facility resident is receiving hospice services, the MCO SC must make at least two telephonic service coordination outreach contacts annually.
  - Who have a severe and persistent mental illness (SPMI) diagnosis
  - Who have complex medical needs
- MCOs must provide Level 1 Members with a single identified person as their assigned Service Coordinator.
- All Level 1 Members residing in the community must receive a minimum of two face-to-face service coordination visits annually.
  - Nursing facility residents receive a minimum of four required face-to-face visits annually.
    - Visits include assessing viability of return to the community
  - Members with SPMI must receive one telephonic service coordination contact annually in addition to the minimum of two annual face-to-face service coordination contacts.
Nursing Facility Service Coordination

Service Coordination for nursing facility residents includes:

- Identifying and addressing residents’ physical, mental or long term needs
- Ensuring that care is holistically integrated and coordinated
- Finding ways to avoid preventable hospital admissions, readmissions, and emergency room visits, most importantly benefitting the members
- Finding providers to address specific needs
- Coordination of resident transitions to the community
  - Work with resident, family, nursing facility staff, and relocation contractors to arrange for community based supports (e.g., housing, utilities, legal) and services (e.g., medical transportation, home health, durable medical equipment)
  - Coordinate services with Medicaid and Medicare providers
Service Coordination: Transition planning

Prior to relocation to the community, the MCO Service Coordinator ensures that:

- Interdisciplinary discharge planning meeting occurs prior to NF discharge
- Residents and members of their informal support system are trained on care tasks and equipment usage while still in the facility
  - Evidence of return demonstration should be documented
- Follow up appointments are scheduled, all needed services are in place, and equipment is ordered, set up and tested prior to relocating member
- Specialty services and trained providers are in place
Service Coordination: Community Placement

Once the ventilator dependent individual has moved to the community, the MCO Service Coordinator ensures that:

- Services and equipment have been coordinated and delivered in a timely manner
- Expedited authorizations for the PAS attendant training are processed
- Higher attendant hours are approved to accommodate the transition and training of the attendant
- Back up Plan has been documented and put into place.
  - Back up generators/battery packs for ventilator
  - Service back up plan in the event of the attendant not showing up
- Durable Medical Equipment (DME) Company has a 24 hour on call Respiratory Therapist or Registered Nurse available
- Skilled nursing visits are “front loaded” to teach, train, and monitor
- Physical Therapy is in place to train informal supports on transfers and mobility related activities in the members home environment, evaluate for additional medically necessary DME, and perform a home safety evaluation
- Frequent follow up calls/visits by the Service Coordinator to evaluate service needs and supports
Money Follows the Person

Transitions from Institutions to the Community
Goals for Transitions

- Promote independence
- Focused on Person Centered Care
- Offer the least restrictive environment
- Ensure health and safety
- Minimize reinstitutionalization
- Educate member/family to make informed decisions
Transitions from Institutions to Community

Nursing Facility Residents who desire relocation to the community and/or request assistance to transition may be identified in several ways including:

- Individuals referred from the state Program Support Unit
- Minimum Data Set (MDS) Assessment, Section Q
- During a quarterly face to face assessment with the resident by the MCO Service Coordinator
- During interdisciplinary care plan meetings
- At admission, when initial nursing and social service assessments are completed
- NF social worker or other nursing facility staff
- Family/Friend/Representative
- The NF Ombudsman
- Relocation Specialist
- During a hospital stay

A request to transition may be made at any time by contacting the MCO Service Coordinator.
Transition Team Members

- Service Coordinator leads the transition process
- Member, family, legal representative, and others identified by the member
- Nursing Facility interdisciplinary team, including therapy staff
- Physician or physician extender
- Relocation Contractor
  - Community Agencies who may support the success of the transition
  - MCO Medical Director, as needed
  - Ombudsman, if involved
  - Local authority, if applicable
  - Other ancillary providers as needed (i.e., hospice staff, psychologist, respiratory therapist)
Core Steps to Transition

- Exploration of the individual’s desires and preferences
- Each transition is treated individually: unique and specific to the member’s needs
- Coordination is a key principle to ensuring a successful transition.
- Assessment to evaluate the members:
  - Cognitive and Functional abilities
  - Informal Support Systems
  - Housing Plan
  - Medical Services
  - Home visit to assess home environment and possible barriers to transition
  - Community Service and Support Needs
MCO: Transitioning to Discharge

Formal and Informal discussions including:

• Discussions with the member/family/involved others
• Nursing Facility Interdisciplinary Team
• Community Transition Teams
• Internal Interdisciplinary Team

Member, family, legal authorized representative and caregivers are educated on the process and service array in order to make an informed decision related to return to the community throughout the process.
Service Coordination following Community Reintegration

The MCO Service Coordinator is responsible for:

- Ensuring all needed equipment is delivered on the day that the member moves to the community
- A handoff from NF SC to Community SC to ensure continuity of member's care
- Providing contact information to the member and their support system to reach the identified Service Coordinator, the agency, other service providers and community resources as needed
- Conducting a follow up visit within 14 days after relocation or sooner depending on member’s needs
- Contacting the PCP and specialists to coordinate/collaborate services
- Completing required home visits to assess for changes in condition.
- Making all necessary referrals to meet preventative and interval physical and mental health needs
- Educating, monitoring, and identifying the complex needs for our members receiving ventilator services
Hospital Transition Teams
From Hospital to Home
Hospital to Home: Care Management

• Discharge Planners and Concurrent Review clinicians meet and collaborate with member/family and other health care professionals to review home care and equipment needs.
• Members on ventilators receive intensive service coordination and transition services to ensure community success and reduce likelihood of readmission.
• Education and training needs are identified during hospitalization.
• Expectations concerning home care and training needs are determined using a Person Centered approach prior to leaving the hospital.
Hospital to Home: Planning for Care and Equipment Needs

• Discharge planners and case managers evaluate equipment needs and ensure proper equipment is delivered to the home.

• A home assessment is conducted to ensure removal of barriers and a safe environment for ventilator needs.

• Attendant hours are established or reviewed for adequate coverage to provide quality care (attendant hours may increase temporarily after a hospitalization or temporary change in condition).

• Home health services put in place as ordered by the Primary Care Provider (skilled nursing visits/ongoing attendant education).
Hospital to Home: Planning for Education Needs

- Ongoing education during hospitalization through discharge planning
- Member/family training on activities related to ventilator care during hospital stay with opportunities for return demonstration
- Follow-up education at home with home health agency (recommend more than one attendant/informal support with knowledge of ventilator use)
- Backup plan in place to include Durable Medical Equipment and attendant services that meets the needs of the ventilator dependent member
Hospital to Home: Intensive Care Management

- Case Managers/Service Coordinators review precipitating factors: situations or conditions that led to hospital admission
- “Red Flag” management: Identify triggers and behaviors related to condition (when to contact physician)
- Medication management: reconciliation of post-discharge medications
- Follow up: ensure coordination of care through member’s PCP
- Specific education on disease condition and disease management
Barriers to Relocation

- Member or their legal guardian does not desire relocation
- Housing availability
- Lack of support to ensure for the health and safety of the member receiving ventilator services
- Medical Instability warrants frequent medical interventions that cannot be supported
Tools for Success

- Discharge planning begins at admission
- Each individual receiving ventilator services is unique, as are their care needs
  - Person Centered Approach is used during discharge planning to identify members’ needs and incorporate their preferences into their individualized Plan of Care
- It takes a team
- Ability to flex services based upon individual need
- Home Safety Visits
- Services and other resources identified are based upon individual need and are coordinated by the team to make all transitions a smooth

Communication + Ongoing Coordination = Successful Transition
Service Delivery

Sustaining & Supporting Community Living
Service Delivery Models

- Agency Option
- Service Responsibility Option
- Consumer Directed Option
Service Array

- Personal Attendant Services
- Skilled Nursing
- Therapy
- Minor Home Modifications
- Respite
- Protective Supervision
- Adaptive aids, medical supplies and specialty DME
- Dental services
- Employment Assistance and Supported Employment
The Attendant

- Must be 18 years of age
- Cannot be a spouse or legal guardian of a child
- Providers may reside in the home of the member in STAR+PLUS programs
- Family may be the paid service provider in STAR+PLUS programs
- Provide tasks purchased from the Person-Centered functional assessment
- Training by the employing entity
  - Agency model
  - Consumer Directed Services model
Service Authorizations

- MCOs contract with Home Health and DME providers that offer ventilator services and equipment
  - DME show families how to use equipment
  - Home Health providers are used for additional training
  - Home Health agencies have on call staff to troubleshoot
- Service authorizations are effective for one year
- Service authorizations are renewed/generated with annual reassessments or with a change of condition
Questions