IHCA INCAL

Regulatory Roundup

Monthly Webinar for Long-Term Care Professionals

IHCA.org/regulatory-roundup

PRESENTERS

Lori Davenport
Indiana Health Care Association

Team Members from
Indiana Department of Health

January 9, 2025

1

IHCA INCAL

Today's Agenda

- Upcoming Education – Katie
- Regulatory Roundup February 13, 2025 – Indiana Department of Health – New Survey Guidance
- Coordinator NH Re Entry – Russ Evans – Probari
- New LTC Acute Respiratory Illness Reporting Requirements – Lori Davenport, IHCA

IHCA.org/regulatory-roundup

2

2025 Upcoming Education

- Jan 15: NAB Exam prep course (live online), details HERE
- Starting Jan 21: Reducing Litigation Risks in SNF/AL (webinar series), registration is open, purchase the entire 12 month series and receive a discount
- Starting Jan 29: 5-Star Work Plans (6-part webinar series), registration is open
- Feb 5: Indiana HFA/RCA Exam prep course (live online), details HERE
- Feb 6-7: **Emergency Preparedness/Disaster Summit** (in-person), registration is open
- Starting Feb 12: Social Service Designee (SSD) course (live online), details HERE
- Feb 27: QIDP course (in-person), details HERE

3

New LTC Facility Acute Respiratory Illness Reporting

- CMS issued new requirements on 1/2/2025 that went into effect January 1, 2025.
- (CMS) recently released QSO-25-11-NH Long-Term Care (LTC) Facility Acute Respiratory Illness Reporting Requirements, which replaces QSO-20-29-NH Interim Final Rule Updating Requirements for Notification of Confirmed and Suspected COVID-19 Cases Among Residents and Staff in Nursing Homes.

4

What you need to know

- January 1,2025 nursing homes must electronically report information about COVID-19, influenza, and RSV weekly to the Centers for Disease Control and Prevention's (CDC) National Health Safety Network (NHSN), which includes:
- Facility Census
- Resident vaccination status for COVID-19, influenza, and RSV
- Confirmed resident cases of COVID-19, influenza, and RSV (overall and by vaccination status) and
- Hospitalized resident with confirmed cases of COVID-19, influenza and RSV (overall and by vaccination status).

5

Resources

- Slide deck from training on January 7 in today's handout.
- Training session resources:

Long-Term Care Respiratory Pathogens: Resources | NHSN | CDC

6

Next Monthly Regulatory Roundup

February 13, 2025
New Survey Guidance
Indiana Department of Health

Listing of 2025 dates: https://www.ihca.org/regulatory-roundup/

7

PROBARI

PathWays FOR AGING

Coordinator NH Re -Entry

01/09/25

IHCA INCAL

Probari Updates

- **Weekly meetings with FSSA**
  - Collaborating on official memo to send to Nursing Home Trade Orgs
- **Recurring meetings with all three MCE's**
  - Training Coordinators on January re-entry goals and tasks
- **Presenting at Trade Org conferences on coordinator re-entry plan**
  - LeadingAge - Thursday (1/30/25)
- **Collaborating with FSSA, Trade Orgs, and MCE's on a data resolution**
  - Determining best option for Data needs by February 1, 2025 (EMR read-only access, Third Party Solution, Secure Email, etc.)

MCE Coordinator Expectations

- Re-entry will happen in January 2025
- Coordinators will have access to certain data elements
- Coordinators will have access to residents
- Coordinators are collaborators, NOT auditors and do not report to the state
- Coordinators should work alongside facility to serve best needs of the resident (not a program to get people out of the building)

Objectives of the Coordinator Program

- Collaboration between MCE and facility on member care
- Establish baseline information on members for enrollment
- Identification of opportunities for new resources for members
- Advocacy for member to MCE
- Support for facility regarding MCE coverage

Coordinator Responsibilities

- Initial Assessment - HNS and brief CHAT
- Quarterly visit to each member of the facility
  - Care Plan review
  - Touchpoint with facility care team
  - Loneliness assessment
- Regular member updates to the facility staff
- Contact for questions based on member benefits and questions
- Facilitate coordination for any new member admissions

Timeline

JANUARY | **FEBRUARY - JUNE** | **JULY**

- Coordinators will call Facilities (LTC Listing) beginning next week (1/13/25)
- Coordinator Goals
  - Reintroductions
  - Schedule time to visit facility in January
  - Reconcile resident rosters
  - Meet residents and staff
- No data and assessments will be necessary at this time

Timeline

- Data exchange between Coordinators and Facility will be resolved
- Coordinator Goals
    - Schedule time to visit facility
    - Conduct HNS and Brief Chats for assigned residents

Timeline

JANUARY | **FEBRUARY - JUNE** | **JULY**

- Coordinator Goals
  - Continue HNS and Brief Chats
  - Complete assessments by July 1st

Coordinator Approach in January

- **Introductory Calls**
  - Connect with ED or DON
  - Goal of call
    - Introduce themselves
    - Schedule time for in person meeting
    - Exchange contact formation
  - If ED/DON not available, they will obtain email and follow up electronically

- **Onsite Visits**
  - Introduce themselves to leadership team and staff
    - DON, Social Services, MDS, Business Office Manager, etc.
  - Reconcile rosters with business office
  - Meet residents if available
  - Will not be doing assessments

PathWays FOR AGING

Facility Welcome Packet

About Your Coordinator

What is the main benefit of this program?

Care Coordinators will partner with the facility to work with residents, families, and care team members. They will review charts and collect information to develop and **enhance the residents' care plan**.

Who are Care Coordinators?

The **Care Coordinator** will assess long-stay residents and follow up to fulfill the identified services in the resident's assessment under their insurance plan. The MCE will likely assign one Care Coordinator per building. Short-stay residents who come from the community may have their own coordinator who will collaborate with facility staff and the facility-assigned coordinator while that resident is in the building.

Look for employees with MCE Name Badges– They will most likely be spending time with residents. They may ask you for information about residents that you take care of.

What can staff expect from Care Coordinators?

They will:

- Collect information on resident needs and condition
- Support the facility with securing services for residents
- Help explain benefits to residents and their families
- Assist with the planned transfer of residents back to the community

They won't:

- Provide resident care, despite having a clinical background

Important Contact Information:

	Name	Email	Phone
Coordinator			
Supervisor			

Next Planned Visit:

Date: **Time:**

Facility Welcome Packet

How to work with the Care Coordinator

PREPARE FOR VISIT

- Complete Preferences page during your meeting with your Coordinator to ensure scheduled visits coincide with resident and facility availability
- Review list of residents to be seen by Care Coordinator
- Indicate any concerns or additional information you may have on particular resident situations

STAY INFORMED

- Care Coordinator will first meet with the member, then based on facility preferences will meet with designated facility representative to discuss the member visit
- Collaborate with Care Coordinator on any care plan adjustments
- Discuss any new advance care planning information
- Discuss any new pertinent information

ANTICIPATE MEMBER SERVICE PLAN NEEDS

- Prepare questions regarding benefit documentation
- Identify potential services for the resident

Facility Welcome Packet

Meeting Summary

Instructions:

1. Fill out Information below with the facility point person
    - If Point Person requests a copy, ask if you can make a copy in the facility
2. Give pages 1 and 2 of Welcome Packet to facility point person along with your business card
3. After the meeting, email a summary of the information below to Point Person along with your agreed-upon next meeting date.

Facility Name:

Corporation (if applicable):

Meeting Date and Time:

	Name	Email	Phone
Point Person			
Backup Contact			

Best time for working with residents in the facility:
Best time and method of communication with point person:
Other Notes from Introductory Meeting:

Next Planned Visit:

Date: **Time:**

Data Needs

For Assessments and Collaboration

Minimum Data Set (MDS)	Care Plans	Face Sheet	Recent Events
○ Medication list ○ Diagnosis List ○ Allergies ○ Immunizations ○ Updated Functional status	○ Focus ○ Goal ○ Intervention	○ HCR ○ POA ○ Next of kin	○ Procedures ○ Diagnostic results ○ Other provider visits

Residents Identified by FSSA for Potential Transitions

- Residents who qualify for the Medicaid Waiver
  - MCE Transition Coordinators are required to reach out to resident / family and facility (if applicable)

- Coordinator goals for identified residents
  - Work with facility to assess if transfer is suitable
  - If suitable, collaborate with facility through discharge (supplement, not override the facility discharge effort)

When Barriers Arise

Probari Assistance

- Probari will collaborate with IHCA and MCE to resolve barriers
- Contact Information:
  - Phone: 317-804-4102
  - Email: Outreach@probarisystems.com

Call in Examples

- No Coordinator phone call
- Unscheduled Coordinator facility visit
- Coordinator request for data during the month of January
- Other Issues

Questions?