PROBARI

PathWays FOR AGING

Coordinator NH Re-Entry

03/13/2025

IHCA INCAL

Probari Updates

- **Regular meetings with FSSA**
  - Collaborating on updates to the Coordinator Manual
- **Recurring meetings with all three MCE's**
  - Training Coordinators on re-entry goals and tasks
  - Working through questions to the FSSA
- **Presenting at Trade Org conferences on coordinator re-entry plan**
  - IHCA - Today
- **Collaborating with FSSA, Trade Orgs, NHs and MCEs**
  - Coordinators are authorized to request EMR Access
  - Unable to reach and issues are being addressed at corporate and facility level

Timeline

January - July 2025

United Healthcare

Humana

Elevance Health

Probari Education

Coordinators receive training on approach and best practices to re-enter the nursing homes.

Facility Calls and Visits

Coordinators begin to call facilitates to make introductions and schedule a time to come to the facility.

Facility Data Access

Coordinators meet with the facility to determine what level of data access they will have to complete assessments

Assessments Begin

Coordinators will start conducting assessments on their members to identify services and a potential transfer (with collaboration of the facility.)

Assessment Completion

As of today, assessments are to be completed by July 1st. This is subject to change by FSSA.

Instructed Coordinator Approach

Facility Calls	Facility Visits	Facility Data Access

• Connect with ED or DON
• Goals of call:
  ○ Introduce themselves
  ○ Schedule time for an in-person meeting
  ○ Exchange contact formation
• If ED/DON not available, they will obtain email and follow up electronically
	• Introduce themselves to leadership team and staff:
	  ○ DON, Social Services, MDS, Business Office Manager.
	• Reconcile rosters with business office
	• Meet residents if available
	• Will not be doing assessments
		• Visit reminder email to facility point person
		• Set context for purpose and goals of conducting assessments
		• Review types of data elements helpful for assessments
		• Determine level of EMR access
		• Send a follow-up email summary

Facility Welcome Packet

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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:**

Facility Data Packet

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Facility Data Packet

EMR Access for Coordinator Assessments

PathWays for Aging Program Overview

PathWays is a statewide initiative shifting Medicaid from the State of Indiana (for people over age 60) to managed care companies. As part of this program, Care Coordinators are responsible for assessing the resident to identify additional services under their insurance plan and enhance the resident's plan of care.

Coordinator Assessment - *Commonly Asked Questions*

Who does the assessments?	What is the purpose of the assessments?
Nursing Home dedicated Care Coordinators from Anthem, Humana, and United Healthcare	• Collect information on resident needs and condition • Support the facility with securing services for PathWays residents • Help explain benefits to residents and their families • Assist with the planned transition of residents back to the community. ○ NOTE: A resident transition will not occur without the collaboration of the facility and the confirmation of a safe plan.
What are assessments not used for?	**What are the types of assessments?**
Assessments are not used for reimbursement and will not be used to deny residents' services.	• HNS - Health Needs Assessment • CHAT - Comprehensive Health Assessment Tool • Brief CHAT - shortened version of the CHAT

Steps for Facility Staff:

1. Identify how your facility is handing EMR access for Coordinators
   a. Ask corporate leadership if the level of EMR access will be the same under your corporation or will be determined and unique to each facility
2. Have your Coordinator sign a Data agreement to access the EMR
3. Guide your EMR specialist to provide the agreed-upon level of EMR access
   a. Examples: Full EMR access, isolation of EMR tabs, PathWays residents under a specific payer
4. Communicate data capabilities to the Coordinator so there is a mutual understanding of how much the assessment can be completed prior to interviews

Choosing your Coordinator's EMR Access Level:

The table below highlights helpful EMR data elements for the coordinator to complete their assessments. Access to more information in the EMR allows the coordinator to complete more of the assessment and learn more about the resident before interviews. The coordinator will still need to assess the resident face-to-face, but more information ahead of time would reduce the number of questions and time for staff and residents. Discuss with leadership to determine what EMR elements you are comfortable providing your coordinator in addition to your MDS.

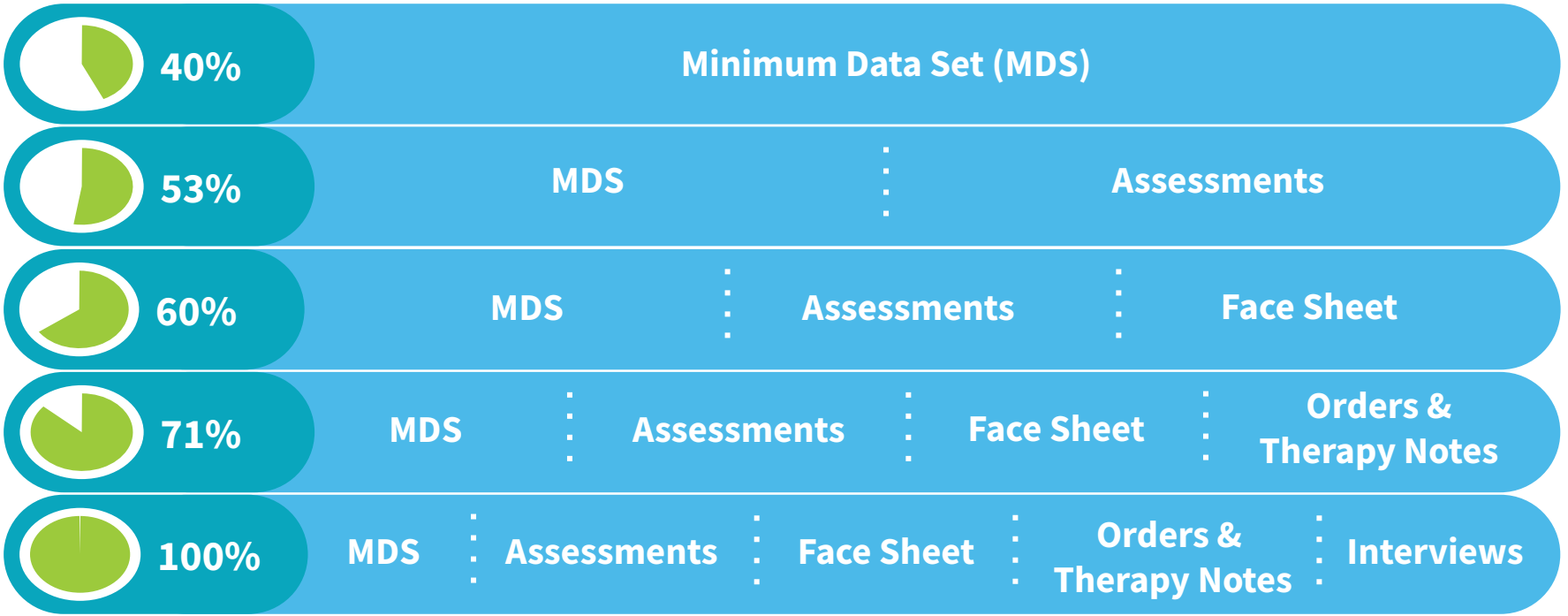
Assessment Completion	EMR Data Elements
	Minimum Data Set (MDS)
40 %	• A great starting place for your coordinator • The MDS will help coordinators complete about 40% of the residents' assessment
	MDS | Assessments
53 %	• Access to these EMR data elements will help coordinators complete 53% of the residents' assessment
	MDS | Assessments | Face Sheet
60 %	• Access to these EMR data elements will help coordinators complete 60% of the residents' assessment
	MDS | Assessments | Face Sheet | Orders & Therapy Notes
71 %	• Access to these EMR data elements will help coordinators complete 71% of the residents' assessment
	MDS | Assessments | Face Sheet | Orders & Therapy Notes | Interviews
100 %	• To finalize the assessment, coordinators will need to conduct discussions with residents and families with the guidance of the facility.

Other helpful data options to provide your coordinator:

- Progress and Provider Notes
- Census
- Administration Records
- Behavior/Mental Health Records

Productivity Based on Access Level

Full CHAT



Coordinator Re-Entry Troubleshooting

Approach

- Asking coordinators to leave their information with facility and let Probari know
- Probari reaches out to corporate NH contacts and then at the facility level
- Probari works to connect coordinator and right NH point persons

Common Barriers

- Facility unable to be reached
- State Surveys
- Miscommunication or Missed Communication
- Confusion regarding Medicaid Waiver Waitlist
- Concerns about administration changes with state

FSSA Updates in Discussion

- Frequency and trigger of coordinator assessments
- Completion of first member assessments
- Coordinator caseloads
- Coordinator NH Tools

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
- Other Issues

Questions?

APPENDIX

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)