Western Reserve

Area Agency on Aging

MyCare Ohio, CareSource

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Clinical Manager

Learning Objectives

- Have an understanding of Case Management, Adult Disability & Resource Center and Transition Care Coordination activities Pre-Pandemic and the shift to operate during the COVID-19 Pandemic.

- Have an understanding of operational challenges for managing clients, employees and programs during the COVID-19 Pandemic.

Care Management Programs

Six Care Management (CM) or Waiver Service Coordinator(WSC) Programs

- Passport/ Assisted Living Waiver-CM
- Ohio Home Care Waiver-CM
- SRS-CM

MyCare Ohio

- United- WSC
- Buckeye-WSC
- CareSource- CM & WSC

Care Management Programs

Population Demographic

- Dual eligible-Medicare & Medicaid
  - Under 60
  - Over 60
  - Disabled
- Five county service area
  - Cuyahoga, Geauga, Lake, Lorain & Medina
  - Urban & Rural

MyCare CareSource Team

Staff:

- Clinical and Operations Manager
- 5 Supervisors
- 6 Teams of 57 Care Managers
- One team dedicated to under 60 population

Support Staff:

- 3 LPNs
- 4 Clinical Case Assistants

MyCare CareSource Team

Role includes:

- General Care Management
- Waiver Service Coordination
- Transitions of Care
- Advocacy

MyCare CareSource Team

Role:

General Care Management

Waiver Service Coordination

Transitions of Care

Advocacy

Collaboration:

ADRC

Job Family Services

MCO

Doctors

All Providers

Consumer and Family

A Day in the Life…

Multiple priorities:

- Phone calls
- Visits
- Documentation

Consumers:

- Addressing everyone's needs
- Prioritizing needs
- Managing multiple requests

Follow up:

- Providers
- Members
- Family

Commute:

- Home Visits
- Weather
- Traffic

A Day in the Life…

Stop…

- Look- home observation
- Listen- read between the lines
- Advocate-APS, family, providers, insurance

A Day in the Life…

Care Manager's Role:

- Field
  - **Documentation**
- Follow up
  - **Documentation**
- Collaboration
  - **Documentation**

And then came…

Changes – COVID-19

How did we adjust?

- Telephonic Case Management
  - Perceptions
  - Reality
- Needs of the CM and support staff to work from home
- Needs of the consumer
- Rules and Regulations

Adjustments

- Questions
- Re-balancing priorities
- Safety First
    - Member
    - Care Manager

Today

Lessons learned

- Telephonic Case Management may not be as easy as it looks
- There's an art to really reading between the lines
- Emotional and Mental Health of all involved
- Re-learning the job

Before vs. During

Personal Experiences…

Survey:

- Target Audience

  All staff in most departments

- Questions

Professional Challenges

Personal Challenges

Consumer Challenges

Emotional Health

Personal Experiences

Common themes:

- Time management
- Personal Care
- Isolation/Depression
- Senses
- Work/Life Balance
- Being creative

Personal Experiences…of note

Professional Challenges

- "I have had no issues with telehealth. Visits were successful and members expressed thanks for offering a service that makes them feel safe and cared for. Tone/delivery, projecting warmth, and thanking the member are some of the ways I connect during cold calls, making it easier to develop rapport"

Managing Challenges

- "Lots or walks and car rides"

In Summary

Case Management

Western Reserve

Area Agency on Aging

Adult Disability & Resource Center

Theresa Foster, RN/LSW

Director of ADRC

Aging & Disability Resource Center

- The ADRC, also known as the **Front Door,** is the **first point of entry** for individuals seeking:
  - Information & referrals to **community resources**,
  - Acquiring **Medicaid Waiver services** and
  - **Nursing Home placement** into Medicaid Certified Nursing Facilities.

Aging & Disability Resource Center

- **WRAAA's ADRC** is comprised of **four** separate units or functions:
  - **Screening/Intake** or Resource Center
  - **Pre-admission Review** (PAR) for NF Placement
  - **Assessment**
  - **Home Choice**

Aging & Disability Resource Center

- **Resource Center/OBLTSS**
  - **9** full-time staff Resource Center Specialists in our call center.
    - Provide **information & referrals**
    - Schedule **waiver assessments**
    - Provide **community presentations and outreach—On hold since COVID**
    - Provide and lead **Evidence-based health promotion programs** like Health U and Matter of Balance**—On hold since COVID**

Aging & Disability Resource Center

What's changed OBLTSS/Intake?

- Community Needs-
  - **Food Insecurity** significantly increased
    - Accessibility over financial
  - **Housing assistance** requests doubled
    - Safety concerns directly related to COVID and not financial.
  - **Social Isolation**--
    - Lack of access to technology
    - Fear of interacting in person

Aging & Disability Resource Center

What's changed OBLTSS/Intake?

- Community Needs-Benefits
  - Increased efficiencies for community
    - Real time <24 hour response
    - Care Act infused additional $$
  - New Partnerships and referral sources
    - Cleveland Food Bank Direct referral, Circle of Food, BBF and applying for SNAP.
    - Local housing resources
    - Telephone Assurance Program
    - Connection to virtual programs

Aging & Disability Resource Center

PAR (Pre-Admission Review) Responsibilities:

- Anyone seeking admission into a **Medicaid Certified Nursing Facility**, regardless of payment source, is subject to having Pre-admission Screen (PAS) requirements met.
  - Exceptions can be made to PAS requirement above called Hospital Exemption:
  - Post hospital discharge anticipated to last 30 days or less
- Change of Vendor requests:

  An individual enters NF under Medicare or private insurance for skilled rehabilitation and either runs out of Medicare days or is staying in NF long term. (Medicaid pay)

Aging & Disability Resource Center

What's changed in PAR?

- Increased efficiencies for consumers and submitters
  - New workflow processes
    - Little to no printing
    - Scanners distributed to all staff
  - Electronic records more easily accessible
    - Faster turnaround for MD orders and Medicaid determinations.
- Improved work-life balance for this group**
  - Increased satisfaction and overall performance

Aging & Disability Resource Center

- **CRC (Community Resource Consultants) a.k.a. Assessment**
  - **Twenty-two** RN's or LSW's conduct in-person assessments to determine eligibility for Nursing Facility level of care programs.
  - **Types** of assessments:
    - **PASSPORT and Assisted Living Waivers:** WRAAA determines all non-financial criteria as outlined in the Ohio Administrative Code.
    - **MyCare Ohio Levels of Care:** WRAAA determines if individuals meet the required institutional level of care (ILOC) for dual eligible (Medicare + Medicaid)
    - **PACE/RSS:** PACE—Program for All Inclusive Care of Elderly/Resident State Supplement (Group Home supplement)
    - **NF LOC:** WRAAA determines if an individual meets nursing home level of care.
    - **LTCC:** Long Term Care Consultations provide options for LTC planning

Aging & Disability Resource Center

- **CLS (Community Living Service)**
  - CLS is a “pre-screen” to determine if long-term Nursing Home residents have the ability, desire and supports to transition out of NF and back to the community.
  - Outcomes can be continued NF placement, Community referrals or referrals to Home Choice
- **Home Choice (HC)**
  - Home Choice provides in-person assessments for individuals residing in NF’s who wish to return to the community.
    - NF residents are connected to a Transition Coordinator (TC) in the community
    - TCs assist with finding housing, purchasing household items, transportation, and etc.
    - TCs follows the individual for 30 post NF discharge.

Aging & Disability Resource Center

What's changed in Assessment/Community?

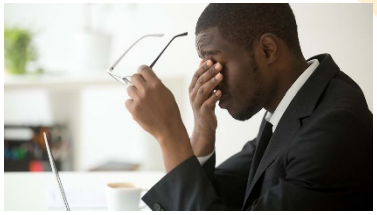
- **In-person to Telephonic assessments CHALLENGES**
  - Lengthy interviews via phone; more collateral contacts required
  - Potential health, safety and environmental concerns not being identified—reliant on providers for identification
  - Mailing packets, follow-up, re-mailing. Delayed enrollment if paperwork not returned

- **In-person to Telephonic assessments BENEFITS:**
  - Improved access—less than 4 days to receive assessment
    - Quicker enrollment if eligible
  - Increased family participation via phone vs. in-person
  - New and improved interview skills due to no observations of person or environment (trainings provided)

Aging & Disability Resource Center

What's changed w/ ALL Staff and how WRAAA responded?

- **Emotional**—Fatigue, burnout, and even guilt taking PTO.
  - Prioritizing self-care and encouraging time off
  - Promoting resources from HR
  - Offering zoom happy-hours, staff birthday zooms and etc.
- **Work-life Balance—home** schooling children, child care
  - Offer more flexibility including flexible schedules
- **New Technology needed**
  - Paying for highest speed internet and cell phones
  - Deliver printer/scanners/desk phones/supplies to homes
- **Training and new skills obtained**
  - Interview skills trainings
  - Cross-training of clinical staff to address volume shifts
- **Streamlined processes and internal efficiencies**
  - Will stay with us post-COVID!



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Area Agency on Aging

Transition Care Coordination

Mary Lipovan, MBA, MSN, RN
Director of Culture Change & Special Projects

Transition Care Coordination

30 Day* Program for Client's after a hospitalization

- Built on evidenced based model
  - Care Transition Intervention Model (previously known as the Coleman Model)
  - Confirms PCP and Specialist appointments post hospitalization or long term facility stay.
  - Identifies Red Flags-behaviors leading to previous hospitalization
  - Medication Reconciliation & Personal Health Record

Transition Care Coordination

30 Day* Program for Client's after a hospitalization

- **Provides:**
  - In home assessment for the managed care partner
    - 14 meals after initial hospitalization
    - Referral to a MCO Case Manager
  - Links back to WRAAA services and ADRC
  - Links to Partner agency services

Transition Care Coordination

Challenges transitioning to telehealth:

- Encouraging Staff and Client's to use video options
- No longer seeing the Client's environment
- Rely on the Client to read medications
- Cost of not meeting face to face:
  - Providing handout materials
  - Addressing social isolation
  - Meeting Vendor expectations
- Managerial emotional support for Staff

It’s Real

Transition Care Coordination

Challenges transitioning to telehealth:

- Managerial dedicating time and resources to emotional support for Staff
  - Zoom fatigue is real…
  - Prioritizing self-care and an end of the work day
- Actively promoting and making time to use agency resources for Staff and Clients
  - Ease@Work
  - Local resources and services

Questions???

Questions?

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Thank you!