Care Manager Meeting Highlights 08/23/2018

Handouts from presentations are attached to email and on website (handouts and highlights under Care Manager User Group, handouts also under Care Manager Resources)

Objective: Provide a setting for Care Managers (CM) to

- **Connect with other CMs**
- **Gather supportive and helpful information**
- **Share resources and information about upcoming events and other information (training, documentation, etc.).**

Agenda:

3:00 – 3:10pm	**Welcome and introductions by Kris Elliott, NPO Quality Director**
3:10 – 4:30pm	**Skilled Nursing Facilities (SNFs) present on Direct Admits and Respite Care:** • **Heidi Leupnitz from Medilodge GTC and Leelanau** • **Carrie Delk from Grand Traverse Pavilions** • **Sharon Appicelli from Manistee County Medical Care Facility**
4:30 – 4:45pm	**Discussion**

Kris: NPO has worked with Manistee, Traverse City, and Petoskey-area SNFs for the last three years to hold regular meetings. Many topics have been discussed such as advance care planning, dementia, ADT usage in a SNF, SNF data best practices, and so on. One hope of the collaboration was a reduction in ED and Hospital admissions from SNFs. In this time, CMS adopted related measures which also impact SNF Star Ratings (based on a five-star scale).

SNFs have shared questions and concerns with NPO and the current co-project with Munson Case Management helps improve the discharge process from MMC to the SNFs, Kris said.

Kevin DeBruyn, LMSW of Adaptive Counseling shared two Direct Admit to SNFs scenarios he has encountered at the PCP level:

1. Pt. hospitalized for 3-night qualified stay, returned home, and later struggled and needed to enter SNF within 30 days of discharge.

   Kevin noted two State-required tests: PASARR 3877 Level 1 Mental Health Screening, which can be conducted by social workers or nurses, and PASAAR 3878 Level 2 Pre-Admission Screening for Mental Health and Dementia (for TC, this is conducted by the OBRA Office).

   A "yes" on Level 1 requires a Level 2.

2. Pt. or family-initiated admit to SNF due to increased physical or mental debilitations, but no 3-night qualified stay had taken place.

This admit can be trickier, Kevin said, because pt.'s insurance(s) may not cover. There are some which will, such as Long-Term Care insurance, but having this type is no guarantee of coverage. Respite or assisted living may also be options that can help.

Representatives from SNFs then spoke. Each went through the admission process (repetitive details not noted for last two speakers) and forms and all emphasized that Care Managers should just feel free to call with ANY questions!

<u>Guest Speaker Heidi Leupnitz, administrator of Medilodge of GTC, TC, and Leelanau</u>

Direct Admit— Medilodge

> "A lot of people think the only way they can come to us is by going to the hospital and getting referred to us, and that's not the case. We can do most of it through the physician office or from home; the trick is for Medicare, you must have that 3-night qualifying stay. But if they had Medicare and Medicaid they still wouldn't have to go back to the hospital because we can take their Medicaid benefits and see if they fit through a Medicaid door."

If a pt. is within a 30-day window of their 3-night qualifying hospital stay, they can often be admitted from home, Heidi shared.

- She shared an Admission from Home checklist of necessary documents for admit to a SNF. (See Attachment).
- Heidi said that OBRA voluntarily admits to being behind in processing. A 3878 Level 2 is conducted by OBRA at the patient's home, and sometimes can be the delay in getting the patient situated because this visit must be initiated with a call to OBRA. May be able to avoid if patient has dementia.

Heidi's Info for Care Managers —Medilodge makes follow up calls post discharge from the SNF at 72 hours, one week and two weeks post discharge to see if the patient is succeeding at home and to see if they need to return to the SNF or require assisted living or an AFC home.

- Care Managers are welcome to call Medilodge for patients post-discharge from a 3-night stay to provide this same information if reported to a Care Manager during the patient's one-week follow-up visit at the physician office.
- Medilodge's therapy team, medical director, and nursing department drive the discharge decision process and determination regarding lengths of stay.
- Heidi shared that she's witnessed coverage problems when the hospital codes the first three nights of a stay as "observation inpatient" and then codes the subsequent overnight as regular inpatient. The impact of using this billing identifier is that it prevents patients from using their Medicare benefits for a three-night stay.
- Heidi did invite all to come tour the facility.
- If any questions, just call!

Respite Care – Medilodge — Respite stays are open to any patient, including those in Hospice Care.

- Families can call Medilodge's Holly Gribble from Admissions directly to initiate Respite Care (See attachment).
- Private Pay can stay any number of days. Cost is $292/night
- VA respites allow for longer than five days, she said.

- Medicare does require 3-night stay within past 30 days.
- Many other payers have respite benefits, including even monthly respite care. Medicare Advantage and some HMO (Medicare Plus Blue, Priority Medicare) plans may not require a 3-night stay but will require a prior authorization (PA) for services. Heidi said she has experienced one to two-day waits on the PA. Sometimes it has even been same-day.
- If the pt. has Medicaid, Medilodge can see if the patient fits through the corresponding "door" for respite coverage
- Have specific respite rooms including a calming room.

Guest Speaker Carrie Delk, Admissions Coordinator, Grand Traverse Pavilions (GTP)

Direct Admit — GTP "Bed availability" determines most patient's success for admission

- GTP can assist patients who have MA plans with locating the required PT / OT notes to generate Prior Authorizations for service, but to date, GTP has not direct admitted a pt. with an MA plan. These complex plans often differ in what will be accepted for PA submission. Some require the PT / OT completion within the prior three days, some not, Carrie said.
- **Important aside to note –** Many patients will go to the ER to initiate the assistance they desire for set-up of a nursing home admission because it can be faster or less difficult for them, Carrie shared. The ER method may be interpreted as faster by the patient, but Kris and Kevin identified this action as undesirable since it is disorienting for patient and adds unnecessary costs for the patient.

It is important to communicate that when available, patients should utilize their PCPs and care managers for help with the admissions processes as they pertain to coverage and coordination, Kevin requested.

- Assisted living nursing home houses respite care area. Deb Nichols at GTP handles Respite Care as part of the Cottages 231-932-3641.

Guest Speaker Sharon Appicelli from Manistee County Medical Facility

Direct Admit — Manistee County Medical Facility Receives request for admit calls from case managers of PCP offices and from families.

- Requires a signed most-recent progress note and signed H&P within 24 hours of admission period
- Generally, has been able to admit the next day
- Direct admit from home requires her to coordinate with social work to determine if OBRA will need to do their screening prior to admit.
- She does obtain therapy notes from home health providers and has had these notes count toward obtaining MA coverage for some pts.
- Reiterated that Care Managers should just call for assistance to help make the direct admit from home process smooth.
- Controlled substances require a separate paper script (for example clonazepam, Norco, tramadol)

Respite Care — Manistee County Medical Facility

- Private pay = $260-S275/day depending on the room where the patient is placed. Includes OTC meds.

Wrap-up discussion with Kris Elliott/ Terese Henley / Natalie Harter / Kevin DeBruyn

RSVP'd but did not attend meeting: Villa, Maple Valley and Meadowbrook

- Frequently revisit SNF admit and respite information and options for the patient because life circumstances can quickly change.
- Sit down and work through forms, information and options with a pt., which can change the pt.'s would-be "crisis-mode," or "emergency" approach to the process to a calmer more proactive approach.
- Connie at Alliance for Senior Housing (https://allianceforseniorhousing.com) is a useful asset in determining the kind of care a patient needs and where openings are. She also can help set up for respite at assisted living homes. Call: 888-816-4040 or 231-263-4040
- Respite care services also are available at other facilities such as Culver Meadows and Victorian Inn
- Visit facilities to learn the most about them
- GoodRx (https://www.goodrx.com/) App has a Tips section at the top of the App where people with commercial insurance may be able to receive a coupon to cover their copays or learn about programs for help.
- Suggestion of a Care Manager e-mail for care managers working by themselves, to have a quick place to jot a question to each other.

Kris and Kevin thanked attendees for coming, and for their willingness to participate in the discussions.

Next Meeting:

The planned November 8 meeting is cancelled as NPO will be hosting a 3-hour educational session on Dec 12 from 1P-4P at the Park Place. Dr. Lori Zeman from the Practice Transformation Institute (http://www.transformcoach.org/) will be presenting in-depth Motivational Interviewing with opportunities for role playing to practice. RSVP at https://attendee.gotowebinar.com/register/2259509983712204546

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