Person-Centered Care

Indiana PathWays for Aging

2024 IHCP Works Annual Seminar

Humana.

Introduction

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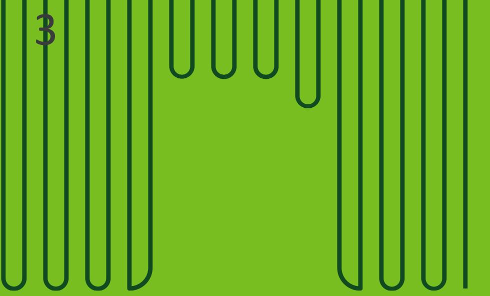

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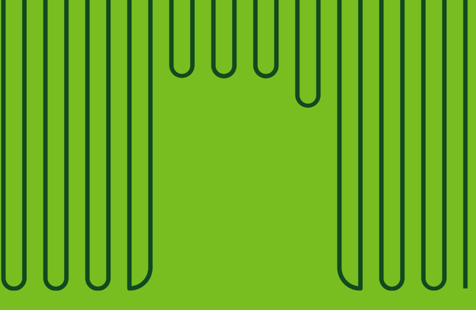
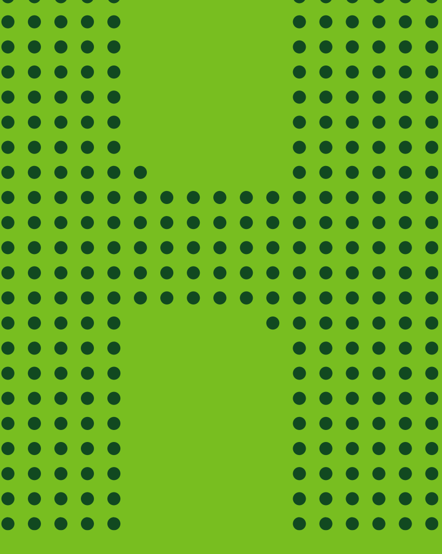

Provider Engagement Teams

Humana Healthy Horizons in Indiana PathWays for Aging Long-Term Services and Supports/Home and Community-Based Services Provider Representatives Map

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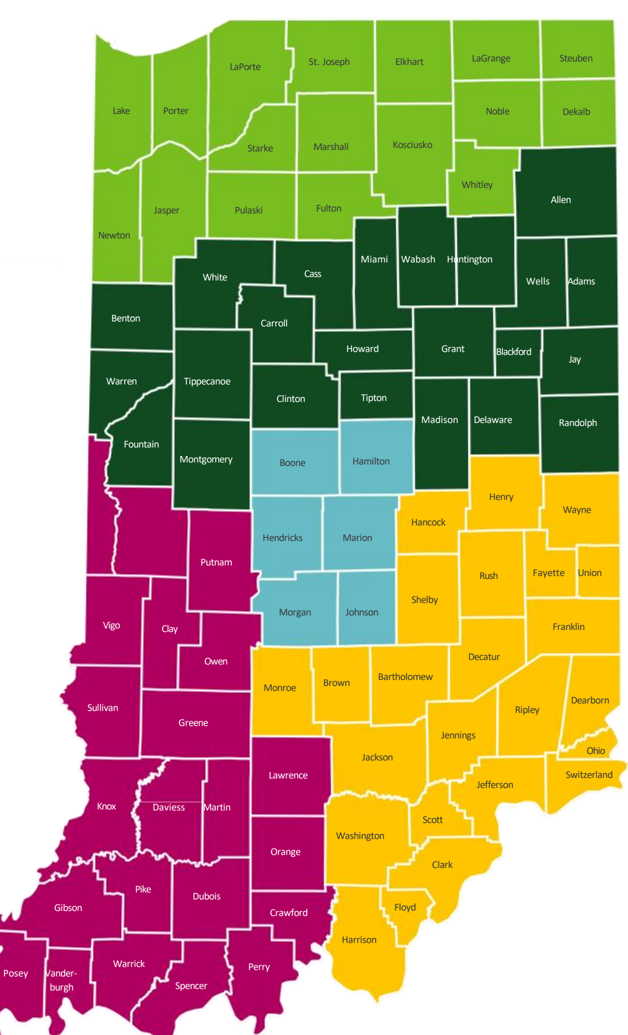

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Humana Healthy Horizons in Indiana PathWays for Aging Behavioral Health, Physical Health, and Nursing Facility Provider Representatives Map

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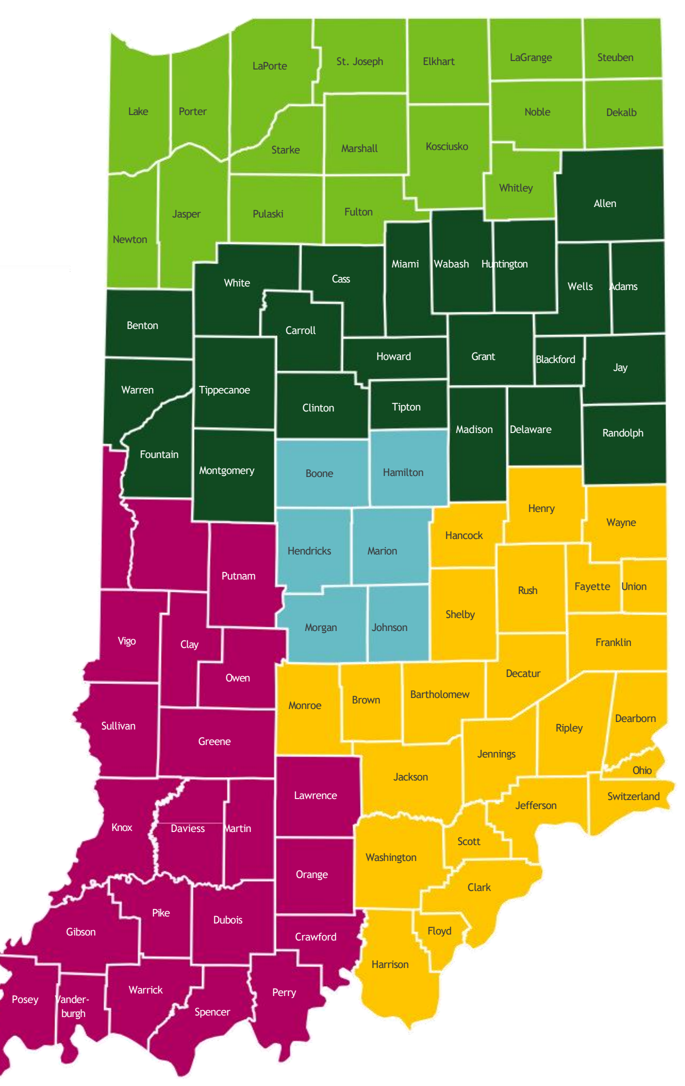

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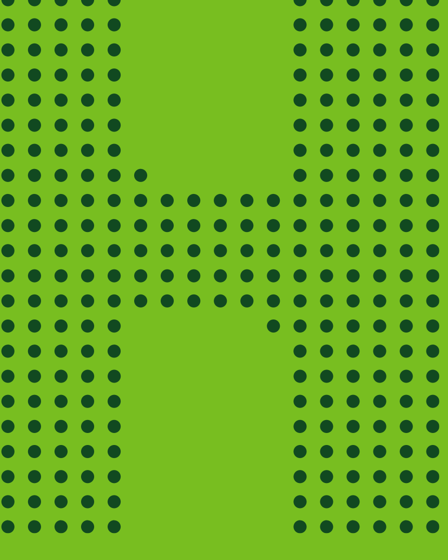
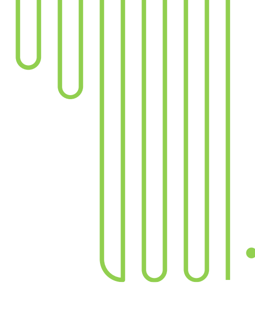


Goals for PathWays



Goals for Indiana PathWays for Aging Program

- When possible, **divert** individuals from long-term nursing facility stays using a **person-centered approach**.

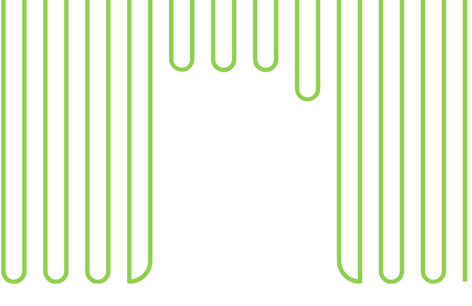
- Ensure **member choice, protections, and access to services**; promote **caregiver support and skill development.**

- Emphasize **communication, training, and collaboration with network providers** to ease administrative burden and help accomplish program goals.

- Align incentives across the delivery system with **improved health** and **quality of life outcomes.**

- Deliver **cost-effective and accountable coverage**; Leverage **data** to make **informed** program and care **decisions**.

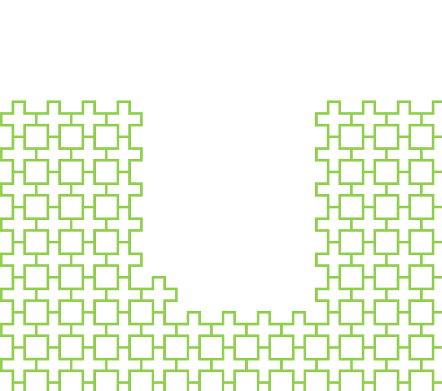
- Understand, measure, and address **health inequities** in care and access; promote primary and preventive care.

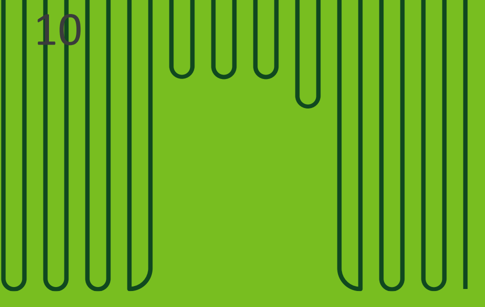


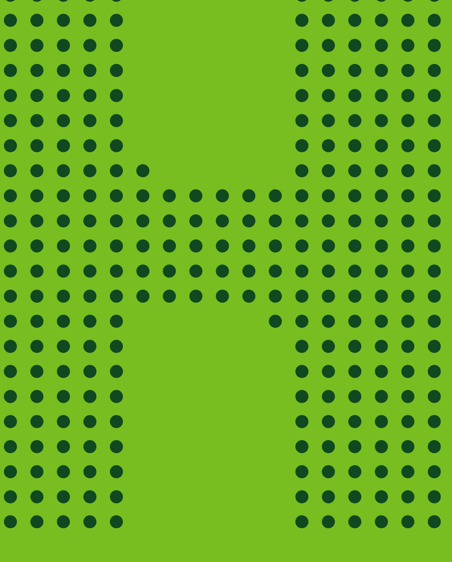
Goals for Indiana PathWays for Aging Program Cont.

- Ensure the **appropriate use** of health care and behavioral health services.

- Develop informed health care consumers by **increasing health literacy** & providing **price and quality transparency.**
- Encourage **quality, continuity,** and **appropriateness** of medical care; Develop innovative member and provider **incentives**.
- Develop innovative **utilization management** (UM) techniques that incorporate member and provider education to facilitate the right care, at the right time, in the right location.
- Engage in provider and member outreach regarding **preventive care, wellness, and a holistic approach** to services.
- **Expand** the **Home and Community-Based** provider network, especially in **rural** areas.







Person-Centered Care

Person-Centered Care Overview

- Managed Care Entities will use a Person-Centered Services and Supports framework when developing a member's service plan and authorizing HCBS Services.
- Service Plan development and delivery to occur in a manner that is participant-driven, involves caregivers, and addresses social determinants of health.
- Within 30 calendar days of the member's enrollment date, Humana will conduct the Comprehensive Health Assessment (CHAT). Members that meet Nursing Facility Level of Care (NFLOC) will also receive a CHAT within 30 days.
- A person-centered approach can also be done for the non-NFLOC members. At that point, a brief chat is completed within 90 days, along with the Individual Care Plan (ICP).
- A Person-Centered Care and Service Plan (PCSP) is developed with the member in conjunction with the member's Interdisciplinary Care Team including the caregiver, providers, and Care and Service Coordinator.

Person-Centered Care Overview Cont.

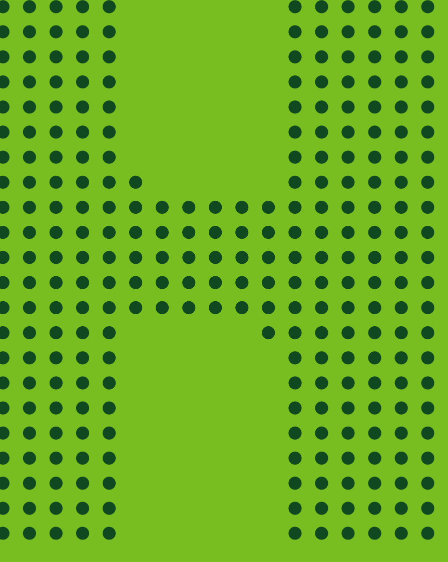
Care Coordinators develop a comprehensive ICP with the member to guide self-identified goals and integrates their physical health, behavioral health, and ancillary care plans.

All members will be assigned a Care Coordinator at time of enrollment.

Service Coordinators develop a comprehensive Service Plan (SP) to coordinate natural supports, social, functional, educational, and housing service needs, goals, interventions, and outcomes.

Members that meet NFLOC will also have a Service Coordinator.

If member meets NFLOC and lives in a nursing facility, the Care Coordinator will also serve as their Service Coordinator.



What Matters?

What Matters?

What is "What Matters"?

- The goal is to increase awareness of critical issues in the members' lives to create a personalized plan of care.
- The Institute for Healthcare Improvements (IHI) and other organizations have encouraged Providers/Health plans to ask members and caregivers “What Matters” to inform them of their care needs to include Advance Directives and End-of-Life care.
- This approach helps to align the care with the member’s decisions with their health care goals and outcomes.
- These conversations are ongoing and begin with the initial contact, changes in health care needs and status, major life events and throughout the course of the member’s journey.
- More information located here: "What Matters to You?" Conversation Guide for Improving Joy in Work | Institute for Healthcare Improvement (ihi.org)

What, Why, and Who

What

FSSA managed Indiana Health Coverage Program for Hoosiers aged 60 and older who are eligible for Medicaid.

Why

Member Choice, person-centered care, access to services, align incentives, leverage data, understand inequities, promote primary and preventive care

Who

Medicaid, Medicare, Dual-Eligible Aligned and Unaligned

What Matters – Assessing Needs

What is covered in “What Matters”?

- Aligns each member’s goals and preferences to their health, environment, and end of-life decisions .
- Health outcome goals related to the activities and values of importance to the member.
- Guidance to sustain improved health outcomes.
- Care preferences are services the member agrees or disagrees to receive such as medications, self-management tasks, testing, and procedures.

- Medication
  - If necessary, age-friendly medications that do not interfere with ‘What Matters” to the member.

- Mentation
  - Prevent, identify, treat, and manage dementia, depression and delirium across care settings.

- Mobility
  - Moving safely every day to maintain a function and aligns with what matters to the member.

- Advance Directives
  - What are the end-of-life wishes, how are they expressed and aligned to their needs.

What Matters – Addressing Gaps

When do these conversations start?

- Initial Assessments/Visits, Annual Wellness Visits, and Scheduled Visits
  - Great Opportunity to continue the "What Matters" conversation and assess new gaps and needs.
  - What is important to you today? What are our goals for the next 3 or 6 months? What do you worry about?
  - What is one thing about your health care you most want to focus on?

- New Diagnosis or Change in Health Status
  - Assess new gaps in healthcare needs.
  - Revisit the member's health direction and assist with health requests.
  - What makes tomorrow a great day for you? What else would you like us to know about you?

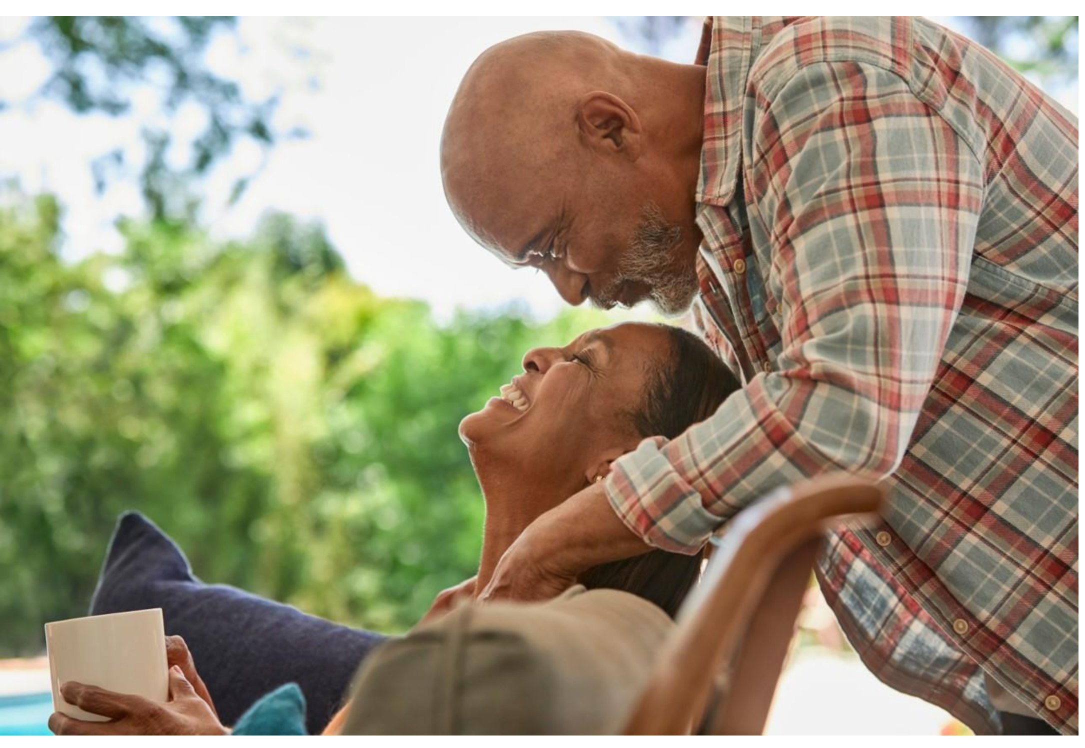
- Life-Stage Change
  - Assess differences in the direction of the member's needs.
  - Impact the needs of the member by assessing additional services that may be needed.
  - What are some of the goals you hope to achieve on or before your birthday?

What Matters – When do Conversations Start?

When do these conversations start?

- Life-Stage Change
  - What are your most important goals now as you think about the future with your health?
- Chronic Disease Management
  - Explores potential needs and services to assist the member's health condition
  - How best do you learn? Listening to someone, reading materials, watching a video?
  - What things about your health care do you think aren't helping you and you find too bothersome or difficult?
  - Is there anyone who should be part of this conversation with us?
- Inpatient Visits- Hospital, Nursing Home, Skilled Nursing Facility
  - Revisit the "What Matters" conversations and assess health status to assist to transfer to a home setting and discuss follow up care and services
  - What can help you at home? What services do you need at home?

What Matters - Assessing Needs



When do these conversations start?

- Nursing Judgement
  - The nurse forms a clinical decision based on the member’s condition and needs while utilizing elements of the nursing process - Assessment, Diagnoses, Planning, Implementation, and Evaluation
  - What are your most important goals if your health worsens?
  - What are your fears or concerns for your family?
- Review the "What Matters" to assist the member with their individualized needs.
  - Humana has a holistic approach to health care
  - Document your work and what matters to the member in the care plan

Hospice

Advance Care Planning and the role of Care Coordinators

- Encourage residents to communicate with their family and medical provider about their goals and preferences for care

- Educate residents and families about the importance of documenting goals of care and appointing healthcare decision makers

Continuity of Care Requirements

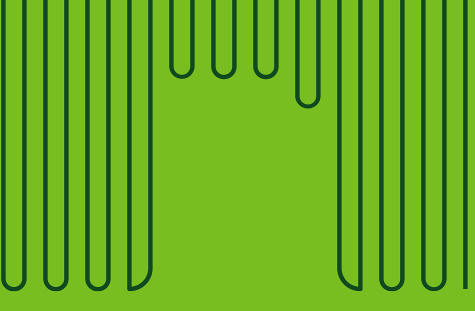
To avoid disruptions in care and services as members transition, we collaborate with our internal programs and external entities to achieve continuity of care and coordination of medically necessary healthcare services.

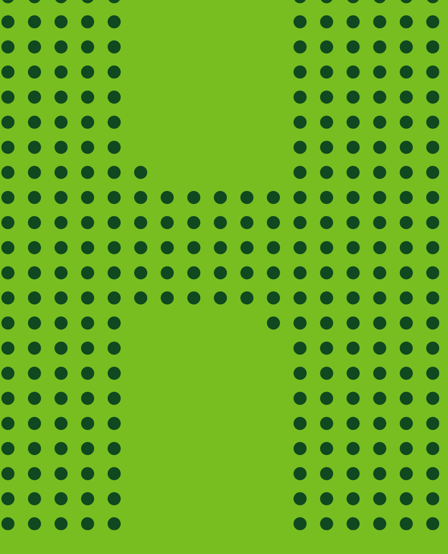
We apply scalable resources to ensure a consistently smooth transition in all care settings across programs and continuation of medically necessary services in compliance with Indiana-defined timelines:

- We provide 90 calendar days of continuity of care for authorized services and choice of providers during the first year of the program.

- When we receive members from another MCE, fee-for-service (FFS) or commercial coverage, we will honor the previous care authorization for either the first 90 calendar days of enrollment or the remainder of the prior authorized dates or services, or until the approved service units are exhausted. This is determined by whichever date comes first.

- For transition between programs, we honor the care plan approved by the FSSA or previous MCE for 90 calendar days from the enrollment date.





Transitions

Community Transitions

A “**transition**” is the movement of a member from one care setting to another as the member’s health status changes.

A **Community Transition Program** is designed to facilitate the transition of individuals from institutional settings back into their communities.

The program aims to enhance **independence**, improve **quality of life**, and promote **community integration.**

Community Transitions

- A “care setting” refers to the location where a member receives health care and health-related services.
- In any setting, a designated practitioner has ongoing responsibility for a member’s medical care.
- Settings include, but are not limited to, home, home health care, acute care, skilled nursing facility, custodial nursing facility, rehabilitation facility and outpatient/ambulatory care/surgery centers.

Community Transitions – Continued

- Facility assessments
- Verbal communication
- Referrals
- Communication between Care/Service Coordinator and Transition Coordinator (Interdisciplinary Care Team/ICT)

Transition Coordinator

- Review alerts, current care setting, high risk member data and member profile to begin transition planning
- Complete Transition Assessment
- Create Transition Plan
- Update Plan of Care with Member and Caregiver to add “Transition Goal”
- Supports Care Coordinator during an on-site evaluation of the physical residence within 3 days of transition and meet with the member’s family or other informal caregiver who will be residing with the member
- Complete Transition Service Plan with Member and support
- Discuss housing preferences with the member and make referrals to a housing specialist
- Complete monthly telephonic or in-home visits with the member for the first 90 calendar days

Ways to Contact*

Email:

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- **INPathwaysLTSSUM@humana.com**
- **INPathWaysServiceCoordination@humana.com**
- **INMedicaidProviderRelations@humana.com**

Phone:

- Members in need of care management assistance can call **866-274-5888** Monday – Friday, 8 AM – 8 PM EST

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