Harford County Health Department

Care Coordination Services

2/20/18

Public Health
Prevent. Promote. Protect.
Harford County Health Department

Who we serve...

- Harford County residents
- All ages across the lifespan
- Medicaid, a Qualified Health Plan, Medicare, Commercial Insurance recipients or the uninsured

Who we serve...

- Anyone needing help finding a doctor, navigating the healthcare and community resource system or needing assistance remaining in the community

Overview of the Care Coordination Programs

Care Coordination Plus (CC+)

Hospital Outreach (HOP)

Adult Evaluation Review Services (AERS)

Nurse Monitoring (NM)

Care Coordination Plus (CC+)

is the Primary Point of Entry at the health department for clients in need of significant care coordination

Care Coordination Plus (CC+)

--a rapid referral program for Harford County residents whose health needs extend beyond traditional medical care

Care Coordination Plus (CC+) Program

- funded by Maryland Community Health Resources Commission
- in partnership with Healthy Harford WATCH (Wellness Action Teams of Cecil and Harford County)

Care Coordination Plus (CC+) Program

Eligibility Criteria

- Harford County resident
- All ages across the lifespan
- Have Medicaid, a Qualified Health Plan, Medicare, Commercial Insurance or are uninsured
- Need help finding a doctor or navigating the system

Care Coordination Plus (CC+) Program

What services we provide…

- Assistance in applying for health insurance
- Assistance in navigating your insurance benefits
- Linkage to clinical safety net services
- Help with coordinating community agencies's resources such as housing, transportation

Care Coordination Plus Program

What services we provide…

- Help with accessing community mental health services
- Referral to other Health Department Programs

Care Coordination Plus (CC+) Program

- Assistance and services offered to all household members

- Peer Recovery Specialist services provided in the hospital and in the community

Care Coordination Plus (CC+) Program

- CC+ services provided by phone, in the home or wherever the individual would like to meet within the county
- CC+ services provided at no cost
- In person or telephonic interpreter services provided to limited english speaking individuals

Care Coordination Plus (CC+) Program

Referrals made by….

- calling

telephone 410-942-7913

- completing referral form and faxing

fax 443-502-8976

Contact Person: Kim Proutt RN, Care Coordinator

Care Coordination Plus (CC+) Program

A Care Coordination Plus (CC+) referral is the Gateway to …

- Hospital Outreach Program (HOP)
- Adult Evaluation Review Services (AERS)
- Nurse Monitoring (NM)

Hospital Outreach Program (HOP)

Eligibility Criteria

- Medicaid recipients over the age of 18
- Currently or recently hospitalized
- At risk of long term care

Hospital Outreach Program (HOP)

What services we provide…

- Provides discharge-planning and monitoring services to Medicaid recipients in acute, sub-acute, and long term care facilities

Hospital Outreach Program (HOP)

- Help Medicaid individuals in the hospital and long term care facilities transition back to the community
- Provides information and assistance with community support services
- Services provided by a registered community health nurse

Hospital Outreach (HOP)

HOP Services include…

- Hands on assistance with applications such as food assistance, energy assistance, meals on wheels, transportation, senior housing
- Assistance with completing Advance Directives

Hospital Outreach Program (HOP)

- Medication reconciliation
- Disposal of expired medications if requested
- Education on “red flags” of disease
- Encourage family attendance during home visit
- Home visits made by appointment

Hospital Outreach Program (HOP)

Services we provide…

- interRAI level 1 screen

- Referrals to partnering agencies such as Office on Aging, Community Action Agency, and Maryland Access Point

Hospital Outreach Program (HOP)

- Referrals to other HCHD Programs such as AERS, MCHP, Administrative Care Coordination, Behavioral Health, Cancer Screening and Tobacco Cessation Programs

Hospital Outreach Program (HOP)

Services we provide…

- Referrals to Faith based community assistance such furniture, rental assistance, prescription assistance
- Referrals for durable medical equipment such as Lions Club
- Deliver borrowed durable medical equipment

Hospital Outreach Program (HOP)

Services we provide…

- Monitor that post hospitalization PCP appointments are made and kept
- Reinforce importance of specialty healthcare appointments and follow-up
- Connect individuals with support groups such as NA, AA, Grief and Caregiving Groups
- Provide Naloxone training in the home

Hospital Outreach Program (HOP)

Services are provided...

- by phone, in the home, in the hospital, in subacute and long term care facilities or wherever the individual would like to meet within the county
- at no cost

Hospital Outreach Program (HOP)

Services we provide…

- In person or telephonic interpreter services provided to limited english speaking individuals
- Referral to Living Well Classes and other disease specific classes such as diabetes, CHF, COPD that are provided by the community hospitals and partner organizations

HOP

How do you refer to HOP?

- Make a referral by using the CC+ referral

Adult Evaluation & Review Services (AERS)

AERS

What is AERS?

- A state mandated program
- Located in each county in Maryland
- Aims to help county residents to remain safe at home (or in the 'least restrictive environment' suited to their needs) by connecting them with services and supports that can foster their independence and personal well-being

AERS Staff

- AERS staff consists of registered nurses and licensed social workers.

- Psychologist and psychiatrist consultation is also available if needed.

AERS

What Programs Need an AERS evaluation?

- •Community Personal Assistance Services
- •Community First Choice
- •Medical Day Care Waiver
- •Home and Community-Based Options Waiver
- •Various programs from the Office on Aging (via Office on Aging)
- •Nursing Facility Placement from a home/community setting
- •PASRRs

AERS

Preadmission Screening and Resident Review Services (PASRR)

AERS staff evaluates individuals seeking placement in a nursing facility who have, or are suspected of having, a diagnosis of mental illness, an intellectual disability, or both. The staff also evaluates individuals, currently residing in a nursing facility, who screen positive for mental illness, a developmental disability, or both, and demonstrate a significant change in their physical or mental condition as defined in federal regulations. A psychiatrist or psychologist participates in the evaluation as appropriate.

AERS-PASRR

- •Referrals for PASRR generally come from hospitals or nursing facilities.

- •Prior to the referral, an identification screen must be completed. This screen will identify the referred individual as one who has a diagnosis of, or is suspected of having a mental illness, and/or an intellectual disability.

AERS-Medicaid Programs

Popular services include:

Community Personal Assistance Services

- Personal Care
- Support Planning (case manager)
- Nurse Monitoring

Community First Choice

- Personal Care
- Medical Alarm
- Home Delivered Meals
- Environmental Assessment
- Accessibility Adaptations
- Medical Day Care

Community Options Waiver

Community First Choice Services
+
Assisted Living

AERS-Medicaid Programs

InterRAI assessment tool

- International standardized tool
- Identifies functional, medical, and social issues that are limiting
- Identifies unmet and unrecognized needs
- Pediatric form for individuals under 18 years old.

AERS

What kinds of questions does AERS ask?

- Overall health history
- Current diagnoses
- Mood & Mental Health
- Social & Family Supports
- Environmental Concerns
- ADL & IADL needs
- Client concerns & wishes
- After the assessment, the assessor will make recommendations in a Plan of Care to meet the needs of each individual evaluated.

AERS-How do I make a referral?

Community First Choice

Call 410-942-7999 with client demographic information and MA number.

Refer to Care Coordination Plus.

PASRR

1. Call 410-942-7999 to let AERS know that you have a positive PASRR screen and the background information on the client and discharge plan.
2. Fax PASRR Screen to 443-502-8976.

AERS

What happens when I make a referral?

- •A registered nurse or social worker will be assigned to the case.
- •They will call the client or point of contact to set up the visit.
- •AERS services are voluntary. For home visits, client must be agreeable to allow us into their home and participate in the assessment.

AERS

What happens after an evaluation?

Medicaid programs

- A determination letter will be sent to the client regarding their eligibility.
- If eligible, a support planner will reach out to the client to review AERS recommendations and proceed with the implementation of the plan of service.

Nurse Monitoring (NM)

Eligibility Criteria… Steps that need to be in place before Nurse Monitoring services begin...

- Medicaid eligible
- Enrolled in Long Term Services and Supports (LTSS)
- Meets Nursing Facility level of care or CPAS LOC based on interRAI level 2 assessment completed by AERS staff

Nurse Monitoring (NM)

Eligibility Criteria… Steps that need to be in place before Nurse Monitoring services begin...

- Has selected Supports Planning Agency and a supports planner who helps develop a plan of service including personal care assistance

Nurse Monitoring (NM)

Eligibility Criteria… Steps that need to be in place before Nurse Monitoring services begin...

- Has selected a Residential Service Agency (RSA) to provide assistance with Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs)

Nurse Monitoring (NM)

Eligibility Criteria… Steps that need to be in place before Nurse Monitoring services begin...

- Has an approved plan of service which includes Nurse Monitoring by the HCHD
- Enrolled in one of the following programs Community Personal Assistance Services (CPAS), Community First Choices, Home and Community Based Options Waiver

Nurse Monitoring(NM)

- Available to all ages across the lifespan who need assistance with activities of daily living including personal care

- Must reside in home in Harford County

Nurse Monitoring(NM)

Purpose of Nurse Monitoring Services …

- Provide Nurse Monitoring to monitor the health and safety of the participant

Nurse Monitoring (NM)

Nurse Monitoring activities by the RN…

- contact with the participant at a minimum of every six months, with at least one in-person home or workplace visit every twelve months to review participant's status

Nurse Monitoring (NM)

Nurse Monitoring activities by the RN…

- Additional NM visits may be conducted at greater frequency based on participant's medical condition

Nurse Monitoring (NM)

During Nurse Monitoring visit the Nurse Monitor...

- Completes the Nurse Monitor Assessment to determine any significant health change
- Conducts medication review

Nurse Monitoring (NM)

During Nurse Monitoring visit the Nurse Monitor...

- Assesses quality of personal assistance services such as timeliness of care giver
- Determines adherence to plan of care by RSA caregiver
- Reviews the Medication Administration Records (MARS) completed by CMT

Nurse Monitoring (NM)

During Nurse Monitoring visit the Nurse Monitor...

- Review participant assessment completed by the RSA RN
- Determines the need for discharge from personal care services or referral to other services

Nurse Monitoring (NM)

During Nurse Monitoring visit the Nurse Monitor...

- Reviews RSA documentation of provision of personal assistance services and follows up with RSA if RSA documentation is not available in home

Nurse Monitoring (NM)

After the NM Visit the Nurse Monitor…

- Communicates with Support Planner for clarification and updating purposes such as referrals needed, issues with RSA or regarding the need for additional personal assistant hours
- Completes Reportable Event, APS referral if indicated

Nurse Monitoring(NM)

Current staffing: 7 RNs

COMAR Regulations

CFC - 10.09.84

CPAS - 10.09.20

RSA - 10.07.05

NM