

The Role of Long-Term Care Ombudsman Programs in HCBS

Two States Share their Experiences & Collaborative
Approaches to Addressing Challenges

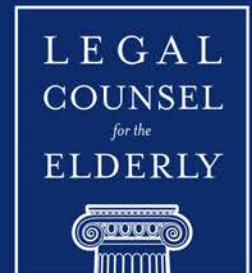
Office of the D.C. Long-Term Care Ombudsman

Sheila Pannell, Ombudsman Specialist

Albert Reed, Ombudsman Specialist

Walter Williams, Ombudsman Specialist

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OF SENIORS IN WASHINGTON, DC



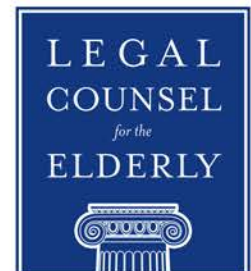
Overview of the DC Long-Term Care Ombudsman Program

The District of Columbia Long-Term Care Ombudsman Program (DCLTCOP) was established in 1975 to protect the rights of Long-Term Care residents.

The program is an advocate and resource for more than 7,000 District residents in licensed nursing facilities (NFs), assisted-living residences (ALRs), community residential facilities (CRFs), and persons receiving services in the community through the Elderly and Persons with Physical Disabilities (EPD) Medicaid Waiver

- 18 nursing facilities with 2,582 beds
- 12 ALRs and 109 CRFs with 1,576 beds
- Over 3,100 EPD waiver recipients

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Ombudsman Role

- Visit residents, upon their request, to assess their quality of life and quality of care
- Investigate and resolve complaints for/on behalf of residents
- Resolve issues with home health providers and case managers
- Ensure Resident's Rights are protected
- Report violations to appropriate authorities
- Educate residents, their families, stakeholders, and significant others regards to their rights and good care practices
- Monitor and make recommendations on D.C. laws, regulations, and policies that affect the D.C. Medicaid beneficiaries receiving EPD Waiver Services

History of D.C.'s Home and Community Based Services Program

Mission: To EMPOWER residents to understand their rights, voice their concerns, find solutions to problems, and help to obtain legal services.

Launched in October 2012, to become The District of Columbia Long-Term Care Ombudsman Program (DCLTCOP), Home and Community-Based Services Program

DCLTCOP works closely with the Legal Counsel for the Elderly, and the D.C. Office on Aging as part of the **Senior Service Network**

Services include:
Advocacy for individuals enrolled in the D.C. Medicaid Elderly and Persons with Physical Disabilities (EPD) Waiver Program

Overcoming Challenges through Collaboration and Education

Department of
Healthcare
Finance (DHCF)

Case Managers

Home Health
Agencies (HHA)

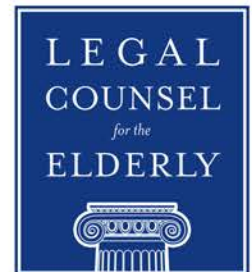
D.C. Office on
Aging

Department of
Human
Resources

Legal Counsel
for the Elderly

- Educate HHA and Case Management Agencies on Diversity
- Educate the community and residents about the usage of medical marijuana
- Ombudsmen are mediators for complaints against Home Health Agencies, and/or Case Management Agencies

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Key Partnerships / Resources to Address Community Challenges

D.C. Department on Aging:
Aging and Disability Resource Center

D.C. Long Term Care Coalition

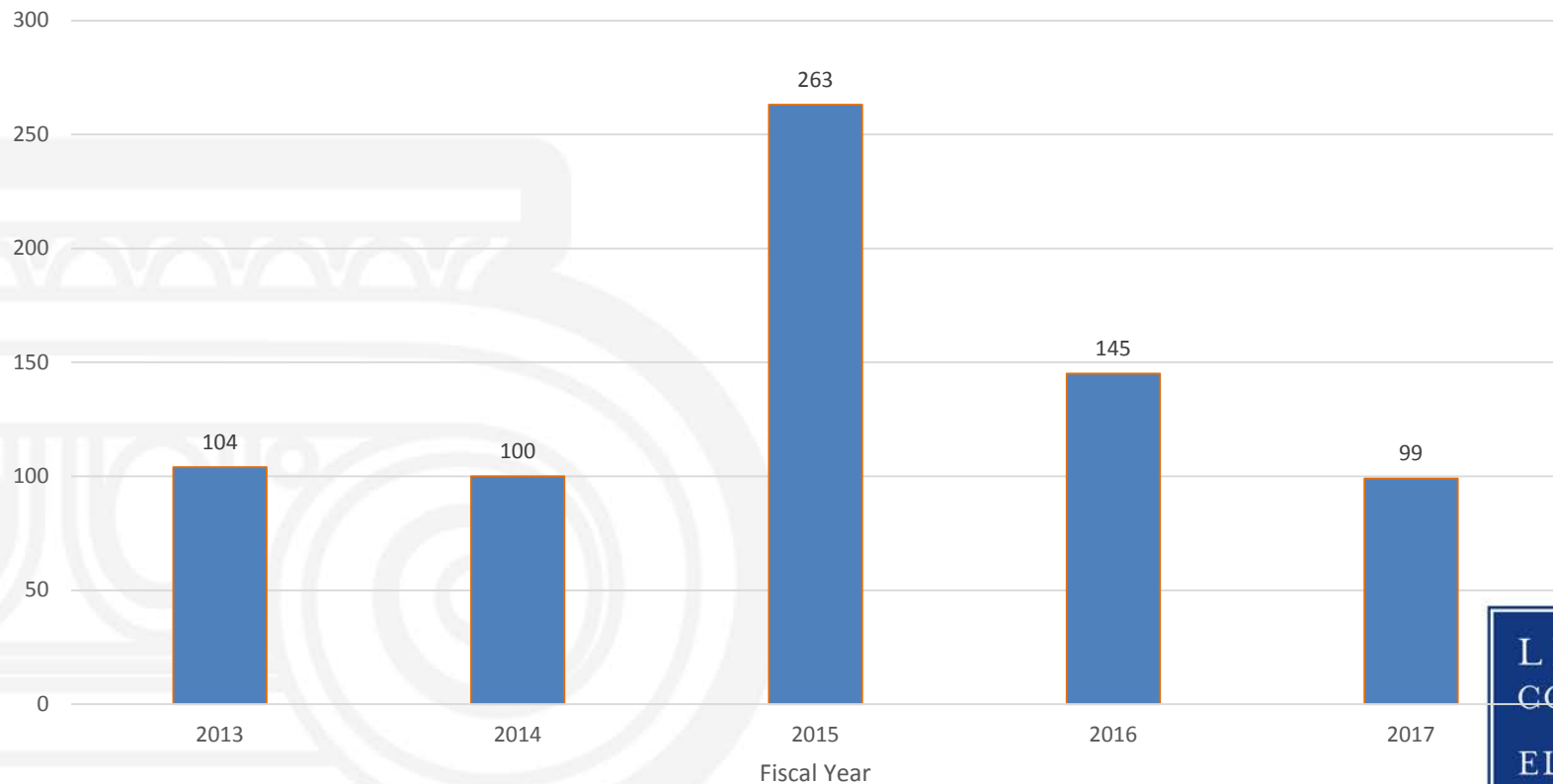
Money Follows the Person

- Ombudsman attend monthly meetings to address, discuss, and resolve programmatic concerns.
- Ombudsman staff attend special meetings for specific projects, ie: assessment tools, and person centered plans
- Ombudsman attend monthly case management meetings to keep abreast of community resources

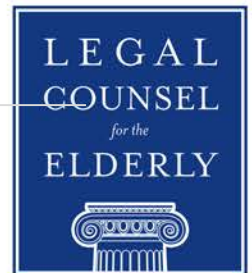
Closed Home Care Complaints

2013 - 2017

D.C. Office of the Long Term Care Ombudsman
Closed Home Care Complaints



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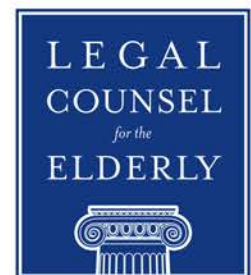


Outreach Strategies

- Conduct in-service training to case management agencies.
- Conduct monthly training to DCOA Ambassador volunteer program
- Conduct in-service training to nursing home ombudsman volunteers.
- Outreach community activities with, churches, community centers, and senior housing.



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Resources:

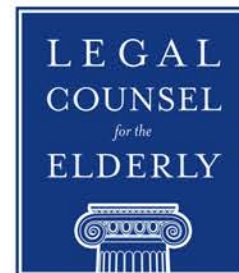
National Consumer Voice

<http://theconsumervoice.org/>

National Long-Term Care Ombudsman Resource
Center

<http://ltcombudsman.org/>

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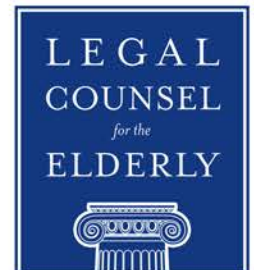
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The Role of Long-Term Care Ombudsman Programs in Home- and Community-Based Services (HCBS): Two States Share Their Experiences and Collaborative Approaches to Addressing Challenges

2018 HCBS Conference, Baltimore, MD
August 29, 2018

- Administration for Community Living/Administration on Aging (ACL/AoA) - Introduction
- NORC at the University of Chicago – Overview and Findings from the National Evaluation of the Long-Term Care Ombudsman Program (LTCOP)
- Office of the D.C. Long-Term Care Ombudsman
- Virginia Office of the State Long-Term Care Ombudsman



The Role of Long-Term Care Ombudsman Programs in HCBS:

Overview and Findings from the National Evaluation of the LTCOP

2018 HCBS Conference
August 29, 2018

Kim Nguyen, PhD
Sarah Downie, MPP
NORC at the University of Chicago

National Evaluation of the LTCOP

Overview of LTCOP

- A long-term care ombudsman is an advocate for residents of long-term care facilities
- National program administered by ACL
- Each state has an Office of the Long-Term Care Ombudsman
 - 53 programs, including Guam, Puerto Rico, and Washington DC. Each Office is led by a State Long-Term Care Ombudsman.
- Relies on large volunteer workforce to maintain a presence in facilities throughout the country

Overview of LTCOP

- As authorized by the Older Americans Act (OAA), the Long-Term Care Ombudsman Program (LTCOP) has the following responsibilities nationally:
 - Identify, investigate, and resolve complaints made by or on behalf of residents of long-term care facilities
 - Provide information to residents, families, staff
 - Advocate for systemic changes to improve residents' care and quality of life

Evaluation Team

Process Evaluation and Special Studies Related to the LTCOP

- NORC at the University of Chicago (NORC Chicago)
- National Consumer Voice for Quality Long-Term Care (Consumer Voice)
- Brooke Hollister, PhD, University of California, San Francisco
- Helaine Resnick, PhD, Resnick, Chodorow & Associates
- William Benson, Health Benefits ABCs
- Human Services Research Institute (HSRI)

Background

Overview of National Studies on the LTCOP

- 1993-1995: Institute of Medicine (IOM) completed the first national evaluation of the LTCOP.
- 2011-2013: NORC and its partners developed a comprehensive evaluation design of the LTCOP.
- 2015-2018: NORC and its partners are conducting a process evaluation of the LTCOP.
- 2018-2021: NORC and its partners are conducting an outcome evaluation of the LTCOP.

Research Questions

Process Evaluation and Special Studies Related to the LTCOP

- How is the LTCOP structured and how does it operate at the local, State, and Federal levels?
- How do LTCOPs use existing resources to resolve problems of individual residents and to bring about changes at the facility and local, State, and Federal levels that will improve the quality of services available/ provided?
- With whom do LTCOPs partner, and how do LTCOPs work with partner programs?
- How does the LTCOP provide feedback on successful practices and areas for improvement?

Data Collection

Process Evaluation and Special Studies Related to the LTCOP

■ Round 1 Data Collection (2017)

■ Telephone Interviews

- Federal Staff (5) ✓
- Stakeholders (19) ✓
- State Ombudsmen (53) ✓

■ Round 2 Data Collection (2018)

■ Online Surveys

- State Ombudsmen (98% in 53 states) ✓
- Local/Regional Ombudsmen – Leads (@ 80% in 27 states) ✓
- Local/Regional Ombudsmen (@ 63% in 27 states) ✓
- Volunteers (@50% in 26 states) ✓

Data Collection

Round 2 Local Data Collection (27 States)

AoA Region

1	2	3	4	5	6	7	8	9	10
ME	NJ	DE	FL	IL	LA	IA	ND	AZ	AK
RI	NY	VA	KY	IN	NM	NE	SD	CA	WA
			TN	OH				HI	
			SC	MN				NV	
				WI					

Outcome Evaluation

Upcoming Data Collection

- Longitudinal Study
- Interviews, Surveys, Focus Groups
- Case Studies

LTCOP Role in HCBS

Population Served

Board & Care / Assisted Living / Similar Facilities

- Federally-mandated population: long-term care facility residents
 - OAA requires LTCOP to serve individuals who reside in long-term care facilities—defined as:
 - Nursing facility (NF)
 - Board & care (B&C) facility
 - Any other adult care home, including an assisted living (AL) facility, similar to a nursing facility or board & care facility
- [OAA, Sec. 102(35), Sec. 712]

Population Served

In-Home Services

- **17 state LTCOPs reported having the authority to serve individuals who receive long-term care services in their own homes.**
 - The OAA does not authorize the LTCOP to serve individuals who receive services in their own homes so federal OAA funds cannot be used to serve this population. However, some states have chosen to serve in-home consumers using state funds or other sources of funding.
- As revised in 2016, the OAA authorizes LTCOPs to serve residents who are transitioning from a long-term care facility to a home-care setting “when feasible.”

Sources: NORC 2018 survey of state long-term care ombudsmen; OAA Sec. 712(a)(3)(I)

Number of Facilities Served

2016	Licensed Facilities	Beds	Beds Per Facility
Board & care facilities*	59,189	1.37 million	23
<i>Nursing facilities</i>	16,372	1.71 million	104

- Over three times more B&C/AL facilities compared to NFs but fewer beds per facility
- Fewer B&C/AL beds overall, but the gap has been narrowing over time
 - NF beds decreased by 2% from 2007 to 2016, while B&C/AL beds increased by 23%

Data: NORS, 2016

**Includes board and care, assisted living, and similar facilities, only those covered by the LTCOP as required by the OAA*

Responsibilities

- LTCOPs have the same responsibilities in B&C/AL facilities as in NFs
- In some states staff serve all settings, while others have staff dedicated to HCBS settings
- Regulations governing HCBS settings vary across states. The level of regulation of these settings can impact the ability of ombudsmen to advocate on behalf of residents
 - Federal HCBS settings regulations issued in 2014 are being phased in with full compliance required by March 17, 2022. These regulations impact settings that serve Medicaid beneficiaries.
 - Some B&C/similar homes are unlicensed

How do LTCOPs serve HCBS consumers and what are the strengths & challenges?

Findings from Interviews and
Survey of State Long-Term Care
Ombudsmen and NORS data

Visits to B&C/AL Facilities

- State LTCOPs visit B&C/AL facilities routinely and/or in response to a complaint
- Half of states visit most or all B&C/AL facilities at least quarterly (on average)

Average frequency of visits made to most or all board and care homes by statewide program

	Frequency (# of states)	Percent
Monthly	8	15%
Quarterly	18	35%
Twice a year	3	6%
Annually	6	12%
Other	17	33%

Data: SLTCO Survey

Visits to B&C/AL Facilities

- On average, State LTCOPs do not visit B&C/AL facilities as frequently as nursing facilities.

	Nursing homes		Board & Care Homes	
	Survey	NORS*	Survey	NORS*
Have Statewide goals	88%		83%	
Goals are at least quarterly	78%		66%	
Goals include visits in response to a complaint	30%		32%	
Ability to visit most or all homes on a quarterly basis, on average	76%	67.5%	50%	27.5%

**% of facilities visited at least quarterly, not in response to a complaint*

Data: SLTCO Survey (2018), NORS (2015)

Visits to HCBS Settings - Challenges

Data: SLTCO Interviews/Survey

- **Program Capacity: Regular facility visits limited in many states due to lack of resources**
 - Many programs struggle to visit all B&C/AL facilities quarterly and to conduct non-complaint-related visits. Barriers to regular visits include staffing, distance of facilities.
 - In some cases, programs reported prioritizing some facility types over others given limited resources, such as visiting nursing homes more frequently than assisted living facilities.
 - 67% of state ombudsmen reported that regular B&C/AL visits not carried out as fully as they would like due to a lack of resources. 50% of state ombudsmen reported this for nursing home visits.

Resolving Complaints in B&C/AL Facilities

Data: SLTCO Survey

- State Long-Term Care Ombudsmen were asked about complaint resolution in B&C/AL facilities:
 - most effective at resolving: “Autonomy, choice, preference, exercise of rights, privacy” - 54% (28 state ombudsmen)
 - most challenging to resolve: “Admission, transfer, discharge, eviction” – 40% (21)
 - takes up most of program’s time: “Admission, transfer, discharge, eviction” AND “Autonomy, choice, preference, exercise of rights, privacy” – each 31% (16)

Types of Complaints – B&C/AL Facilities

Data: SLTCO Survey

Broad Complaint Categories	NORS 2016	Most Effective	Most Challenging	Takes up Most Time
Care	18%	2 (12%)	3 (13%)	3 (15%)
Environment	13%	0%	0%	2%
Autonomy, choice, preference, exercise of rights, privacy	11%	1 (54%)	5 (8%)	1 (31%)
Abuse, gross neglect, exploitation	8%	2%	4%	5 (6%)
Dietary	7%	5 (4%)	0%	2%
Admission, transfer, discharge, eviction	6%	4 (8%)	1 (40%)	1 (31%)
Activities and social services	6%	5 (4%)	0%	0%
Staffing	5%	0%	4 (12%)	0%
Policies, procedures, attitudes, resources	4%	5 (4%)	2 (19%)	4 (8%)
Access to information by resident or resident's representative	3%	3 (10%)	0%	0%

Regulations – B&C/AL Facilities

Data: SLTCO Survey

- Almost one-fifth of SLTCO report that “Policies, Procedures, Attitudes, Resources” is the most challenging type of complaint (second highest complaint category)
- Sufficiency of board and care regulations to advocate for residents:
 - 42% report guidance is sufficient
 - 44% report guidance is a mix, depending on the type or size of the setting
 - 12% report that guidance is not sufficient

LTCOP Relationships with Facilities/Providers

Data: SLTCO Survey

- When asked about the effectiveness of their statewide program's relationship with HCBS providers, most ombudsmen reported that either a majority or some relationships are effective.

	Board and Care (N=51)	In-Home (N=17)
Majority of relationships effective	39%	25%
Some relationships effective	49%	56%
A few relationships effective	12%	19%
No relationships effective	0%	0%

LTCOP Relationships with Facilities/Providers

Data: SLTCO Survey, Interviews

- Ombudsmen reported more effective relationships with nursing homes compared to board & care facilities and compared to in-home care providers

	<i>Nursing Homes</i> (N=51)	Board & Care Facilities (N=51)	In-Home Providers (N=17)
Majority of relationships effective	51%	39%	25%
Some relationships effective	47%	49%	56%
A few relationships effective	2%	12%	19%
No relationships effective	0%	0%	0%

Successful practices

- **Strong relationship with licensing and survey agency**
 - In one state, some B&C homes have been found to be operating illegally without a license. The LTCOP meets regularly with the survey agency about issues related to these homes, including the relocation process when homes must be closed. In addition, the agency attends the LTCOP annual statewide training and shares facility trends.
- **Mental health training**
 - One LTCOP works closely with the state mental health agency on training for ombudsman staff and advocating for mental health training for staff in residential care facilities where staff have limited knowledge of these issues.

Source: SLTCO Interviews

Sources

- NORC Survey of State Long-Term Care Ombudsmen (2018)
- NORC interviews with State Long-Term Care Ombudsmen (2017)
- National Ombudsman Reporting System (NORS) data (2016)
- The National Long-Term Care Ombudsman Resource Center, “State Funding Support for Assisted Living Facilities” (July 2014).
- Greene, Lepore, et al. ASPE. “Understanding Unlicensed Care Homes: Final Report” (September 2015).

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Thank You!

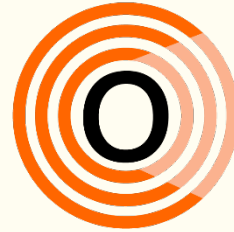


NORC
at the UNIVERSITY of CHICAGO

 insight for informed decisions™



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office of the state
OMBUDSMAN
LONG-TERM CARE

The Role of Long-Term Care Ombudsman Programs in HCBS: Two States Share their Experiences and Collaborative Approaches to Addressing Challenges

Virginia Office of the State Long-Term Care Ombudsman

National Home and Community Based Services Conference
August 2018

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Evolution of Virginia's LTOCP Role in HCBS

“STARTERS” & “NON-STARTERS”:

1982' Statutory jurisdiction – one of a few states

- No commensurate funding
- Existing resources stretched

Limited public awareness

- Focus on education/prevention



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—
NATIVE SERVICES



And then along comes Ma- (naged Care)



.....So when you come to a fork in the road....



Not as simple as “Take it”!

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It **STARTED** with a **QUESTION**,...

Is there a **NEED**



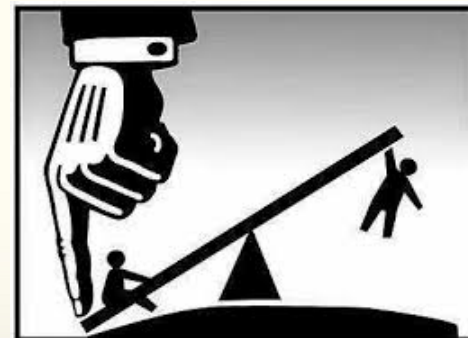


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NEED?

- **HC Reforms/** Changing landscapes
- **Untested** systems
- Bulging State **Medicaid** Budgets
- **\$\$ Bottom line** drivers **\$\$**

Consumers at risk in a system
under extreme pressures





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Crisis/Opportunity



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Yin Yang: Crisis/ Opportunity

+

- More **Holistic** Care-
Prevention, wellness
- **Care Coordination**
- **Simplify: ONE CARD** –
Integrated payment
- Support/advice
- Plan **EXTRA'S**

-

- **Access/ Choice**
- **Assignment** problems
- **Confusion/frustration**
- **'Glitches'**
 - Authorizations/payment
 - Continuity of care
 - Care Coordination
problems

And then another Question: To be or not to be.....

Are we the ones to do this?

- ❖ Already 'in':
 - Transitions & Home care cases
- ❖ **Non-static** population & **overlap**
- ❖ **Person-centered** care - - requires



Person-centered...ADVOCACY!



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Cautionary Flags

- Losing **FOCUS**
- **Uncharted** territory
- **No template/** model
- **Unpredictability**
 - Numbers served & Time required
 - Resource needs & availability – now & future
 - Potential effectiveness





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Adding it all together: **AAA**

- **A**lignment Of **M**ission
- **A**nalogous population
- **A**dvocacy is central
 - **I**ndividual Advocacy
 - **S**ystems Advocacy





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REALITY OF TOUR TIMES

Health care reform is here to stay - - coming fast
and coming strong....



Get on or get off the tracks...

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Timing ^ Opportunity





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The **FUTURE** is (shaped) **NOW**

- **ACCESS** at ground floor
- Forming new **PARTNERSHIPS**
- **SYNERGY** for systems change
- **LOCUS** of decision-making
- **HIGH STAKES** for our recipients we serve





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Opportunity knocking ...

2013 Medicare/ Medicaid Financial Alignment / Integrated Care



- CMS signed an agreement with Virginia's Department of Medical Assistance Services (DMAS) to test a new model for providing Medicare-Medicaid enrollees with a more coordinated, person-centered care plan. This new initiative – was branded Commonwealth Coordinated Care (CCC).
- DMAS's proposal to CMS for CCC included an ombudsman component.





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CNS: “Support for Demonstration

Ombudsman Programs



- CMS grants: “Support for Demonstration Ombudsman Programs” – to ensure beneficiaries had access to person-centered assistance in resolving problems related to the Demonstration.
- Virginia - one of five original Demo Ombudsman Programs funded.





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Building on a Solid Model



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LONG-TERM CARE

MISSION
MODEL
MANDATE





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Structure & Role of the CCC Ombudsman Program

Expanded the Virginia Long-Term Care Ombudsman Program to build on the existing network of 21 programs and 32 local ombudsmen.

Developed a new component of regional “Coordinated Care Advocates” to provide problem-solving and advocacy services to CCC enrollees who live in the community.

Together, local ombudsmen and CCC Advocates assist enrollees to resolve problems with care or services they receive regardless of where they live.





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CMS Mandate: Advocate Role

- Ensure beneficiary **access** to person-centered assistance
- **Inform** states, plans, CMS, and other stakeholders of beneficiary experience with CCC
- **Make recommendations** to improve systems, policies, services, access, etc.



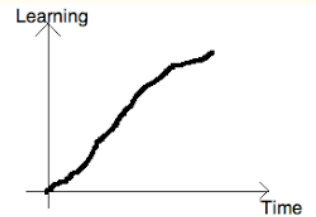


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Early Lessons & Challenges - CCC

COMMUNICATE - COMMUNICATE - COMMUNICATE

- **Best communication strategies** with this population - **HUGE LEARNING CURVE**
- **Unexpected challenges** in ensuring understanding on part of providers as well as beneficiaries





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Challenges & Opportunities...

- New **LANDSCAPE**
- New **POPULATIONS**
- New **COMPLEXITIES**
- New **RULES**, regulations,
contracts, measures





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“New” PARTNERS



- + CMS
- + MCO's
- + Enrollment Broker
- + Home Care Provider. groups
- + Behavioral Health
- + Transportation Vendors
- + Payment intermediaries





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And a 'HONEYMOON PERIOD'



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Expanded Relationships

- Medicaid Agency (DMAS)
- Nursing Homes & Assisted Living
- CILS
- Physicians
- Hospitals
- Pharmacies





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CCC Transition to MLTSS

- **2017** – Virginia launched statewide Medicaid Managed Care (mandatory)
- ❖ CNS mandate: States implementing Medicaid managed care must provide for a **Beneficiary Support System**
- ❖ OLTCO'S CCC Advocate Program (Duals Demo) transitioned into Advocate role for statewide Medicaid Managed Care.





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CCC → CCC Plus

5 of the 6 regions

Optional Enrollment

3 Health plans across 5 regions

Full Dual adults; including NF and
EDCD HCBS Waiver

Coordination of Medicare benefits
through same Medicare-Medicaid
Plan

Continuity of Care period was 180
days

6 regions

Required Enrollment

6 Health plans in 6 regions

Duals/non-duals,
children/adults, NF and 5 HCBS
Waivers

Coordination of Medicare
benefits through companion
DSNP or MA Plan

Continuity of Care period is 90
days





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Scope of Work

- **Access Point** for MLTSS complaints/concerns
- **Outreach** to CCC+ Beneficiaries
- **Education** – Inform beneficiaries regarding overall rights, Grievances & Appeals process
- **Systems Advocacy** - Provide Department for Medical Assistance Services (DMAS) with recommendations regarding Systemic Issues





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Advocate Services in HCBS Settings

- Investigate beneficiaries' complaints regarding MCO/managed care system - Advocate is in an independent role; 'connects the dots' for resolution of beneficiary problems; elicits cooperation from multiple stakeholders – MCO's DMAS, providers; Escalates issues as needed.
- Collaborate with Community Groups/Stakeholders to provide education and outreach about role, CCC+ rights and protections – across all settings.
- Assist health providers and stakeholders with CCC+ issues – to include MCO vendors and health providers from a variety of settings.





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Advocate Services in HCBS Settings

- Work with Care Coordinators – to refer member needs and report time-sensitive changes/transitions.
- Supported Decision-Making Role – Provide independent support and assistance with MCO changes / work with local LTC Ombudsman to support member and resolve issues.
- Work with regional AAAs, VICAP, CILs, LTC Ombudsmen, and local CSBs to report systemic issues and receive feedback about Medicaid managed care.
- Collaborate with hospital staff, local physician offices, pharmacies and adult day staff to address CCC+ issues and beneficiary access issues.





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Advocate Services in HCBS settings

- Assistance with CCC Member Experience & Quality of Life Survey – face-to-face interaction with NF members – follow up with requests in and out of NF's.
- Facility Closure – Communicate with Care Coordinators, NF staff and other community or health partners to ensure Member rights are met.
- Stakeholder – Collaborate for education, beneficiary problem-solving and feed-back.
- CCC Advocates serve both Members and Providers with Systems Issues and Problem Resolution.





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Examples of the Types of Issues that CCC Plus Advocate May Address

- Enrollment & Disenrollment
- Continuity of Care
- Coordination of Benefits
- Access to covered benefits, urgent needs, prescription drugs, behavioral health care and long-term services and supports
- Timeliness of Plan responses to Member questions and Needs
- Questions about bills, care coordination, and Plan benefits
- Information and Assistance with Grievances and Appeals





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Advocate Case Examples

- Example 1 – Case Management

Example 1 highlights Advocate work outside a LTC community and some case work with MCO Care Coordinator. At a DMAS Town Hall community meeting (pre-enrollment) an Advocate met parent of child with multiple disabilities and medical needs who was enrolled in CCC Plus 9/1. There was extensive case work prior to his enrollment due to the complexity of needs. The Coordinated Care Advocate assisted this parent and Mom with understanding the options and how she could change plans for her child. There was a great deal of fear and concern voiced to the Advocate because of the many services and supports that needed to be in place – some of those life-sustaining such as breathing treatments, highly specialized medications, DME, etc.

Because of some denials for essential supplies even prior to enrollment in CCC Plus the Advocate contacted DMAS for some intervention.

One of the more important aspects was the Advocate work with Care Coordination Supervisor to be sure that this member/family would be connected immediately upon enrollment with a specialized Care Coordinator. Because of the urgency of need, and because no breaks in services and equipment availability could occur especially with life sustaining equipment, the Advocate followed up and checked to see that someone had been assigned and this case would be prioritized.





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Example 2 – Intervention/Problem Resolution

Initial request for Advocate assistance came from a Social Worker at a local Department of Social Services. She had been attempting to assist one of her clients (CCC member) who lives in an Assisted Living Facility (ALF). Even after numerous attempts she had been unable to get outstanding bills paid to the member's physician, and the member was being told he could no longer see his physician because she was out of network.

CCC Advocate traveled to the ALF and learned from the Administrator that there were 10 other residents who were experiencing some or all of the following issues: had never met or spoken with a Care Coordinator, were on a list of residents who would no longer be able to see their physician of choice due to the physician(s) being out of network, continuity of care protections were not adhered to, transportation services unavailable, and outstanding bills had not been submitted to Claims for payment.

CCC Advocate was told that in some cases CCC plan representatives would call to speak with residents, but when a resident was not capable of communicating there would be no further contact. In most of these cases the residents had no known family; so they were, in effect, left with no or very limited Care Coordination through their CCC plan.





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Case Example 2; Continued

Intervention: CCC Advocate called contacts at all managed care plans and learned who the Care Coordinators were for these individuals. Care Coordinators subsequently made contact with the members, family members and ALF Administrator, either face-to-face or telephonically. CCC Advocate had multiple contacts with plan representatives, ALF Administrator, local department of social services worker, and family members when identified. These efforts were critical to over coming the communication obstacles that stood in the way of effective care coordination.

Some plan members had chronic health conditions, and were in need of behavioral health support, etc. The Care Coordinator is an essential connection to crucial services and care. Also, some ALF administrators were unaware of what should be provided and available to members through their plans. In summary, the Advocate worked with members, care coordinators, and multiple providers to resolve member payment issues and access care coordination and needed health services through their managed care plans. The Advocate's work helped unlock the gears so that the members could benefit from the advantages of care coordination.





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Challenges/Lessons Learned

- **Understanding of the Advocate role**
 - ✓ Unique role of a conflict-free Advocate
 - ✓ Advocate training for Medicaid staff, Maximus staff, Care Coordinators, and MCO staff for understanding and to ensure members have access to independent advocates.
- **Education, Education, Education (Beneficiaries & Providers)**
 - ✓ One of the biggest challenges/Constant education needed/critical for problem resolution and beneficiary assistance.
- **Care Coordination – Critical Component**
 - ✓ Understanding of the role and function by members and providers
 - ✓ Involvement during transitions





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Challenges/Lessons Learned

- **Supported Decision-Making Role**
 - ✓ Members in LTC communities needed assistance with navigation and enrollment choices/decisions
 - ✓ Advocates met face-to face or communicated directly with members for impartial assistance.
- **Navigation and Enrollee Protections**
 - ✓ Understanding of Continuity of Care and Coordination of Benefits
- **Nursing Home Closure**
 - ✓ CCC Care Coordinators and Advocates assisted 60 residents find alternative nursing home or community options/provide beneficiary assistance.



Challenges/Lessons Learned

- **Reaching enrollees in ALFs and NFs**
 - ✓ Assistance with CCC Member Experience & Quality of Life Survey – face-to-face interviews at 24 nursing facilities/180 residents.
- **Specific Complaint Codes for Reporting and Monitoring Trends & Issues**
 - ✓ Establish Reporting Guidelines and Procedures Early
 - ✓ Develop specific data elements and report monthly Medicaid/MCOs
- **Member Feedback**
 - ✓ Hold listening sessions, stakeholder regional meetings, hold monthly webinars with stakeholders and provide targeted community education and outreach.
- **Serving both Members and Providers**
 - ✓ Found both needed assistance with beneficiary issues and systems issues.



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