LTSS/CFC Medicaid Pathway
Ideas/Recommendations to Improve Performance and Outcomes
August 31, 2016

Discharge of Nursing Home residents to community

1. Training of nursing home staff to identify candidates for discharge and facilitate discharge planning process
2. Timeliness and adequacy of options counselling
3. Timeliness and adequacy of HCBS case management services in planning and addressing multiple elements in transitions
4. Finding and securing suitable housing - affordable and accessible
5. Timeliness and availability of home "accessibility" inspection for adult family care homes
6. Need interdisciplinary care management team that is "person-directed" and reimbursed for its services
7. Provide NH staff with consultation on mental health needs
8. Improve access to mental health and substance abuse treatment services
9. Process for assessing need for Care Transitions assistance

Transition from Nursing Home to HCBS

1. Critical team members need to be there on day of discharge from NH
2. Need clinical, DME, and medication management on day one of HCBS
3. Case management via interdisciplinary team needs to be better coordinated and more intensive during transitions. Ability to call on specialized providers (i.e., brain injury) as needed to supplement the interdisciplinary team.
4. Use of risk mitigation tool
5. Address causes for re-institutionalization
6. Improve access to mental health and substance abuse treatment services

HCBS Services

1. Need interdisciplinary care management team (inclusive of primary care and provider with disability specific expertise, as needed) that is "person-directed" and reimbursed for its services, consistent with the Model of Care. (Includes client and, if preferred, paid caregiver.)
2. Need comprehensive, individualized, person-centered Care Plan, consistent with HCBS rules and the Model of Care.
3. Expand CFC to allow for more people being served in HCBS by offering a shared savings incentive
4. Use of risk mitigation tool.

5. Need for IT infrastructure to support coordinated communication among agencies.
6. Improve coordination/integration between CFC and 'traditional' Home Health Agency services, including hospice
7. Invest in mental health prevention services
8. Improve medication management
9. Improve health promotion efforts for nutrition and exercise, and disease prevention efforts for obesity, diabetes, and other chronic conditions
10. Improve training and support for individuals and families who self-manage paid caregivers
11. Improve knowledge/skill and ability of case managers, paid caregivers, and unpaid caregivers in understanding and addressing dementia, cognitive impairment, substance use, depression and other mental illnesses
12. Improve assessments of dementia, cognitive impairment, substance use, depression and other mental illnesses, and caregiver support needs
13. Improve access to mental health and substance abuse treatment services
14. Grow hospice services. Use the All Payer Model to have "open hospice" paid for by Medicare
15. Fund preventive in-home VNA visits to monitor at risk individuals between episodes of acute care.

<u>Moderate Needs Group</u>

1. Integrate three separate CFC Moderate Needs Group funding streams (with separate allocation formulae and application processes) into one integrated funding stream using one application process.
2. Improve access to mental health and substance abuse treatment services