A Story of Capturing, Collaborating, and Caring: Lessons Learned During the COVID-19 Crisis

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#HCBS2020
Today’s Presenters

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Goals

• Review how state, public, and private entities can collaborate quickly to adapt to a crisis

• Share data on how family caregivers are an asset to healthcare at the state and local levels

• Demonstrate how technology/innovation is a game changer

• Discuss care models broadly

• Review impact on families / healthcare system
Today’s Presentation

• Coronavirus: Unchartered Waters
• The State of Indiana’s Response
• Partnership & Innovation
• The Role of Family Caregivers
• Takeaways

Housekeeping Reminder
Panelists will share data/slides over next 45 mins. We will reserve time for Q&A so if you have questions, please place in the Zoom chat stream at bottom of your screen and we will address at end of presentation.
AARP report says nursing homes need more resources, scrutiny in pandemic

Advocates say data raises questions about assisted living; trade group says the problem is COVID-19

For those needing in-home care, a dire decision amid a pandemic
Coronavirus: Impact to NF Admissions

National Investment Center for Senior Housing & Care (NIC)

- Skilled nursing occupancy dropped to 78.9% at the first peak of COVID-19 in April
- Down from 84.4% in April, 2019
- Down from 84.7% in February, 2020
- Lowest level since NIC started gathering the numbers in 2012
States Are Implementing New Medicaid Policies to Respond to COVID-19

• Making it easier to get HCBS: Permitting virtual assessments, Modifying processes for LOC evaluations, extending reassessment and re-evaluation dates

• Expanding Services and Settings: allowing HCBS in alternative settings, adjusting service limits, adjusting PA’s, adding services to address emergencies

• Strengthening the HCBS Workforce: extending paid family caregiver limits, increasing payment rates, making retainer provider payments
Better Integration of Family Caregivers

Family caregivers are responsible for producing **80% of the total estimated economic value** of community-based long-term services and supports for older adults\(^1\)

RAND Health, in partnership with Seniorlink and others, recently published a **whitepaper** outlining barriers that limit family caregiver integration and identify key policy opportunities that can help to facilitate change.

The report shows that successful integration is key in improving health outcomes in older adults.

**Key Findings**

- Myriad benefits to integrations
- Barriers to entry, but workable
- Improved outcomes
- Appendix K / Additional flex at state level yielding new opportunities

\(^1\) “Supporting Family Caregivers of Older Americans,” New England Journal of Medicine, December 29, 2016
Why Caregiver Work Effort Matters

Population Requiring LTC Services (lives, millions)

- 2000: 15M
- 2050: 27M

+80%

Significant Spend

- Medicaid 1: $496B
- Medicare 2: $619B
- Unpaid 3: $522B

Impact of Family Caregiver Involvement

- 30% fewer ER Visits
- 50% lower Hospital Utilization*

“We find that family involvement significantly decreases Medicaid utilization.”

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Orbiting the Giant Hairball

Orville Wright did not have a pilot's license.
Proactivity Re: Appendix K

• Amendments to Support Waiver Providers

• Amendments to Support Waiver Care Managers

• How Appendix K Supports Hoosiers
High-Risk Emergency Response Plan

Connecting with Indiana’s Most Vulnerable Population

• Identification of “at risk” diagnoses

• Identification of high risk waiver participants

Collaboration with Local Area Agencies on Aging

• A list of high risk response participants within each area agency was provided to each of the 15 local area agencies on aging.

• All “at risk” participants received wellness checks based on level of need determined.

<table>
<thead>
<tr>
<th>Level 1: Stable</th>
<th>Definition</th>
<th>Minimum Frequency of Remote Wellness Check</th>
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<tbody>
<tr>
<td></td>
<td>- Participant has identified a caregiver; and - Participant/caregiver has identified no change in participant’s health status and care plan</td>
<td>Once every two weeks</td>
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<tr>
<th>Level 2: Unstable</th>
<th>Definition</th>
<th>Minimum Frequency of Remote Wellness Check</th>
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<tbody>
<tr>
<td></td>
<td>- Participant is not able to identify a caregiver; or - Participant has identified a change in health status and/or care plan</td>
<td>Once every 72 hours until stable</td>
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<tr>
<th>Level 3: Unreachable</th>
<th>Definition</th>
<th>Minimum Frequency of Remote Wellness Check</th>
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<tr>
<td></td>
<td>- Participant is unable to be reached by phone every day for at least 3 days in a row; and - Participant’s caregiver (if applicable) is unable to be reached by phone; and - The care manager has left at least one voicemail for the participant (and caregiver if applicable) describing how the participant/caregiver can contact the care manager.</td>
<td>The participant should be removed from the “AAA Participant Triage List” once all required contact attempts have been fulfilled AND the care manager has pursued the considerations outlined on page 3 under “Considerations prior to assigning a participant Level 3: Unreachable.”</td>
</tr>
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Note: Care managers should make contact attempts at various times throughout the day.

The participant should be removed from the “AAA Participant Triage List” once all required contact attempts have been fulfilled AND the care manager has pursued the considerations outlined on page 3 under “Considerations prior to assigning a participant Level 3: Unreachable.”

Once a participant is categorized as Level 3: Unreachable, an incident report should be submitted to the DART Incident Reporting Management System. For these Level 3 participants, AAAs should also email the incident report to the Provider Team within the Division of Aging at AAA.inquiries@fsca.in.gov.
Indiana LTSS Snapshot / # of Family CGs

SFC Annual Expenditures Indiana A&D Medicaid Waiver

SFC Monthly Expenditures Indiana A&D Medicaid Waiver

1. Providers have six months to claims, so numbers are not necessarily final.
2. 2021 expenditures are an estimate.
Looking Forward: Caregivers

- Identifying informal and formal caregivers
- Create a strategic awareness campaign to connect caregivers with services as well as other caregivers.
- Megaphone that caregiver supports exist.
- Develop and implement caregiver training program.

Caregiver Burnout: When all-in dedication takes a toll on physical and mental health, it’s time to step back and ask for help
Moving Forward: Assessing Loneliness

UCLA’S Three-Item Loneliness Scale

There are three dimensions of loneliness that are addressed in UCLA’s Three-Item Loneliness Scale: relational connectedness, social connectedness and self-perceived isolation.

The questions are:
1. How often do you feel that you lack companionship?
2. How often do you feel left out?
3. How often do you feel isolated from others?

The Loneliness Scale captures the following response categories:
1) Hardly ever, 2) Some of the time and 3) Often.

How to score and interpret resident results

In order to score a resident’s answers, each responses should be scored as follows:

<table>
<thead>
<tr>
<th>Response</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hardly Ever</td>
<td>1</td>
</tr>
<tr>
<td>Some of the Time</td>
<td>2</td>
</tr>
<tr>
<td>Often</td>
<td>3</td>
</tr>
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The scores for each individual question can be added together to give a possible range of scores from 3 to 9. Researchers in the past have grouped people who score 3–5 as “not lonely” and people with the score 6 – 9 as “lonely.”
AIHS Adaptation During COVID

Nutrition Program
• Increase Meals at delivery (traditional and shelf stable)
• Allowed for double capacity in the program
• Provided no-contact drive thru meal service (Grab n’ Go)
• Served 98,340 Grab n’ Go meals through September 28th

Partnership with IU School of Medicine Fort Wayne
• Additional telephonic support provided for hi-risk individuals

Telehealth
• Implemented doxy.me technology
• Distributed GrandPad devices
Title III Funds for Caregivers

The Shift to Virtual

1. Support Groups
2. Training
3. Evidence-based Programming
**Surveys and Screening**

**Finding Best Technology**
- Doxy.me
- GrandPad

**Improving Offerings**
- Comfort using platform/device
- Improvement of services
- Level of connectivity
- Use of extra features (GrandPad only)
Caregiver Homes from Seniorlink
Home-Based Model of Care

Our Care teams are comprised of nurses and care managers who:

• Develop and manage person centered care plans

• Utilize evidence based coaching protocol to educate caregivers

• Support caregivers and coordinate community-based services

• Interact daily through VELA – HIPAA secure app

• Monitor and support the environment so the consumer and caregiver can live happier, healthier, and longer in their home.

200+ families supported by CGH & AIHS
Caregiver Homes from Seniorlink
Powered by Vela

Vela is a HIPAA-secure app that allows care teams, consumers and caregivers to seamlessly communicate and coordinate care, resulting in high-quality, person-centered care delivered at scale.

**Vela:** Caregivers interact with their Care Team sharing real time updates

- Send and receive text messages and images to share information and communicate
- Access a shared calendar to easily schedule and view appointments, events and tasks

**Vela Pro:** Care Teams manage assigned caseload

- Receive real-time alerts to stay informed of changing consumer health and incidents
- Provide educational content based on the care needs of the consumer or caregiver

Vela Provides Enterprise Level Security and Professional User Configuration for Managing Case Loads
AIHS + Caregiver Homes: The First 90 Days

**381** total AIHS messages sent

**81** Collaborative Care Team Conversations

**23** AIHS Initiated Conversations

**58** Caregiver Homes Initiated Conversations

### AIHS Initiated

- **Referral**: 5 messages
- **In Vela**: 0 messages
- **Document**: 0 messages
- **Information exchange**: 1 message
- **Change in Level**: 2 messages
- **Respite Stay**: 0 messages
- **Hospitalization**: 0 messages

### CGH Initiated

- **Documents**: 25 messages
- **Status Update**: 2 messages
- **Hospitalization & dates**: 4 messages
- **Welcome and check-in**: 3 messages
- **Referrals**: 18 messages
AIHS & CGH Pro Messaging & Collaboration

Messaging Themes

- Welcome to Vela: 36%
- Document/File Share: 16%
- Referrals: 14%
- Hospitalization & Respite: 22%
- Status Update: 12%
Andrea, see attached Quarterly Report summary for Consumer. We had a nice visit today. I am wondering if you can complete a level assessment for her. Caregiver reported that she is providing increased support with ADL care needs.

Yes, I can do that. She was still at a level 2 in July when I did her annual. I'll give her a call and will send you an updated LOS if there are any changes.

Thanks Andrea. I appreciate it. Also, Shane from Rehab Medical is going to her home on 8/27 to fit Consumer for a chair.

Great news! Nice to see progress so quickly.

Can you tell me the dates of Consumer’s most recent respite stay? I don't believe I have it documented. I left Caregiver a voicemail and text but have not heard back yet. Thanks!

Hi Lori, dates were 7/3-8/8.

I confirmed with the nursing facility and entered her interrupt and restart 7/31-8/8. Thanks!
AIHS CARE MANAGER:
Yes. I recently made the referral to advanced care connections because the VA has been closed and I think he just wanted to have someone to check in with. Her last name is ______.
I do not know anything about the hospital bed. He has told me about the power wheelchair. At one point, he asked me to assist with this and I explained I would need a script to make the referral and then when I talked to him he said it was going through the VA. He never mentioned anything to me about private pay. I am doubtful about that as well. Let me know if you need any assistance in following up with any providers. I also have _______ cell phone number if you need.

CGH CARE MANAGER:
Hi Katie, I just got off the phone with Caregiver and Care Recipient; Care recipient is new to me and wanted to clarify some things in his file-

1.) He reports that he is now receiving primary care through Advanced care connections and Lindsey is his NP- Do you know her last name by chance?
He also reports that she is trying to get a new hospital bed for him - Possibly through NuMotion - Do you know anything about that?

2.) He reports the VA will be supplying him with a new power wheelchair in September- He said something about private pay - Do you know any details of this? Certainly can’t see him fully paying for that with VA AND Medicaid benefits? If not, that’s fine, I will follow up on the delivery and update his goal I was just curious.

Thanks ever so!!
Lightning Round

Actual Indiana lightning!
Thank you

Reach out for more information

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