2.10.6.3 Case 3: An enrollee who is a 65-year-old Medicare-eligible male with a history of schizoaffective disorder…

Omar, age 65
Our approach to Omar's care focuses on helping him transition to the least restrictive setting of his choice and successfully manage his conditions in the community with the support of covered and non-covered services. Through Omar's multi-disciplinary care team, his Humana Case Manager coordinates his care with his other payers and providers, including his Assertive Community Treatment team, Permanent Supportive Housing (PSH) supports, and nursing facility staff.

Omar joins Humana as a nursing facility (NF) resident with a history of complex behavioral health (BH) and physical health needs. Due to Omar's BH conditions, history of psychiatric admissions, and NF residency, we identify him as an enrollee with special health care needs (SHCN) who will benefit from Tier 3 case management. Shortly after Omar's enrollment in Humana, we are notified by the Louisiana Department of Health (LDH) Transition Coordinator that he also requires transitional case management.

Humana has extensive experience managing the care of Medicaid and dual eligible NF residents; today, we serve more than [redacted] residents of institutions or with an institutional-equivalent level of care through our Medicaid plan in Florida. Under our care model, we assign the same Case Manager (CM) to manage all Humana enrollees in a single NF to promote strong relationships with NF staff and coordination of care for our NF residents. As all NF residents in Louisiana will be assigned to an MCO for specialized BH (SBH) services and non-emergency transportation (NET) only, we will assign licensed mental health professionals (LMHP) to serve as our NF-designated CMs.

After receiving notification that Omar has been identified for case management, Donna (the Humana CM serving his NF) meets with the facility social worker, charge nurse, and other NF staff to review his current treatment plan and services. In addition, Donna finds out if Omar has an authorized representative who should be invited to any case management meetings, and determines his preferred language. Donna then meets with Omar in person to introduce herself and learn more about him, his needs, and his preferences. Donna also educates Omar about what case management entails and completes the Health Needs Assessment (HNA) at this time. From our experience serving NF resident populations, we recognize that face-to-face contact better facilitates the completion of initial screenings; therefore, we will conduct a face-to-face visit with all Humana enrollees who are NF residents to complete the HNA.

During her CM training, Donna learned the principles of cultural sensitivity and motivational interviewing. She applies these to her initial and ongoing contacts with Omar. Donna works to build a personal connection with Omar to support their relationship; in this case, they connect over their love of jazz music. If Omar prefers to communicate in a language that Donna does not speak, Donna invites a Humana Community Health Worker (CHW) who is fluent in Omar's language to participate in Omar's case management meetings or uses our interpretation service to facilitate communication.

Omar's Assessment and Care Plan

After Omar agrees to participate in case management, Donna schedules another face-to-face meeting with him to complete the comprehensive assessment and his care plan. This meeting also includes his chosen supports and facility staff. With his consent, Donna reviews Omar's case file, historical claims, Minimum Data Set (MDS), and Preadmission Screening and Resident Review (PASRR) to gain more insight into Omar's medical history, current and needed services, available supports, and overall well-being. She notes Omar's recent PASRR Level II result, which indicates that he is not in the least restrictive setting. As Omar has reached the age of Medicare eligibility, Donna verifies his Medicare plan and asks permission to contact his Medicare CM (if assigned). If he has not yet enrolled in Medicare, Donna helps him contact a local agency to understand his options and to enroll.

Donna applies the principles of person-centered planning to develop Omar's care plan, capturing his preferences, strengths, priority needs, goals, and current and needed services. She also explores how cultural preferences may

impact how he engages in healthcare, including how it may impact his understanding or perceptions of his conditions or ability to communicate with providers. During the assessment, Omar reports that his primary goal is to transition out of the NF and return to his former apartment. Donna shapes his care plan around this goal by identifying those services and supports (detailed in Table 2.10.6.3-A) that can prepare Omar to transition from the NF. Donna encourages Omar to share successes that he has experienced over the past couple of years and to identify those elements that may support him in his transition to the community, such as his motivation to live independently and his ability to avoid a psychiatric hospitalization for the past several months. To determine those interventions that can best help Omar, they also discuss the treatment strategies that have not worked in the past and barriers to a successful transition that must be overcome, including his estrangement from his family and his past eviction.

Donna and Omar agree on the individuals who will participate in his multi-disciplinary care team (MDT). These include: Omar, Donna, Omar's support system, the NF social worker, Omar's primary care provider (PCP) or the facility medical director, Omar's BH provider or facility psychiatrist, the LDH Transition Coordinator, a Humana Transition Coordinator, a Humana Housing Specialist, and Omar's CM from his other payer (if applicable). If Omar prefers to communicate in a language other than English, Donna includes an interpreter to ensure Omar's understanding and full participation. During their regular meetings, his MDT – led by Donna or a CM assigned by his PCP or BH provider – reviews his care plan, monitors his progress towards his goals, and collaborates to develop ideas and recommendations for services that can help him achieve his goals and experience a successful community transition.

Linking Omar with Appropriate Housing

We intend to form medical-legal partnerships with Louisiana organizations – [redacted] – to develop strategies to reduce eviction rates.

Humana honors our enrollees' choice of residence whenever possible, while preserving their safety. To help him achieve his goal of moving into his former apartment, Donna [with the support of our Louisiana Medicaid Housing Specialist and Permanent Support Housing (PSH) liaison] works with Omar to help him complete his application. Through the pre-tenancy supports provided by PSH, Omar may be able to move back into the apartment from which he was previously evicted and receive supports to prevent decompensation upon return to the community. With Omar's permission, Donna contacts his previous landlord to see if there are opportunities to allow Omar to move back in. If this is not possible, Donna works with our Housing Specialist and Omar's LDH Transition Coordinator to identify suitable housing options. Donna also collaborates with the Social Determinants of Health (SDOH) Coordinator counterpart on her Comprehensive Care Support (CCS) team to link Omar with eviction diversion supports and independent living courses that can help Omar successfully remain in the community upon transition. In addition, Donna works with Omar's MDT to coordinate services that will stabilize his BH conditions when in the community. If Omar qualifies for a home- and community-based services waiver and is interested in accessing these services, Donna works with Omar, his supports, and his other payer (as applicable) to coordinate the application process.

Coordination with Omar's Other Payer

Humana operates the largest Medicare Advantage (MA) plan in Louisiana, with [redacted] enrollees, including [redacted] in Dual Eligible Special Needs Plans (D-SNPs).

In addition to Donna's role coordinating Omar's SBH and NET services, she serves as an advocate for Omar with his other payer. This includes ensuring that Omar receives necessary physical health and basic BH services through Medicare. For those who are dually enrolled in Humana Medicaid and Medicare Advantage (MA), we have designed our systems and procedures to facilitate seamless coordination of care across payers. Our integrated clinical platform, Clinical Guidance eXchange (CGX), enables both our Medicaid and MA CMs to view Medicare and Medicaid providers, care plans, claims, and authorizations. If Omar is enrolled in an unaligned Medicare plan, we are no less committed to maintaining open and active communication channels. With Omar's permission, Donna initiates contact with the plan to determine if Omar has an assigned CM, to share her own contact information, and to invite a representative of the plan to participate on Omar's MDT. With his permission, we supply Omar's Medicare plan with access to the results of all assessments and a copy of his care plan. Donna may participate in discharge and transition planning with the Medicare plan as requested. Donna also actively works to coordinate

services with Omar's Medicare PCP by inviting them to join Omar's MDT. This coordination is particularly important if he is enrolled in a Medicare FFS plan, as these enrollees often do not have a single contact for plan case management.

Table 2.10.6.3-A summarizes Omar's goals, priority needs, and interventions for the period before his transition to the community. As Omar is enrolled in our Medicaid plan for SBH services and NET only, his care plan focuses on coordination and integration of services, per Section 2.7.10.1 of the Model Contract.

Table 2.10.6.3-A: Omar's Goals, Priority Needs, and Interventions

Goal	Priority Needs	Interventions
Increase Omar's ability to conduct activities of daily living (ADL)	Donna administers the BH screening tools that are part of our comprehensive assessment to assess Omar's anxiety, thinking, and mood. Donna's review of Omar's NF care plan revealed that Omar's anxiety level, in combination with his pain and weakness, is contributing to his difficulty performing tasks. As Donna reviews ADLs during the assessment, Omar states that his chronic pain and subsequent weakness has limited his ability to move around the NF without support. In addition, Omar states that he cannot carry out a number of tasks because he does not know how to complete them without help.	Donna documents services to support Omar's ability to conduct his ADLs in preparation for his transition, including: Treating Omar's anxiety: The MDT discusses Omar's anxiety specific to his ADLs, including any needed adjustments to his treatment plan to prepare him for his move to the community. Upon recommendation of the MDT, Donna arranges cognitive behavioral therapy (CBT) services for Omar, recognizing its ability to treat both his anxiety and chronic pain. Addressing chronic pain and weakness due to unspecified neuropathy: Donna coordinates with Omar's payer of physical health services and providers to ensure that Omar has any durable medical equipment (DME), physical or occupational therapy services, and pain management services to assist with ADLs and address his limited mobility. In addition, Donna educates Omar on Humana's value-added benefits (VAB) for pain management (including chiropractic care, massage therapy, and acupuncture), helps him find a nearby provider (if interested), and arranges transportation. Recognizing their importance to the health of our enrollees, we will cover our pain management VAB and associated transportation for all Humana Medicaid enrollees, regardless of eligibility category. Helping him gain confidence in ADLs: Donna helps Omar access independent living courses and support groups through his area's Center for Independent Living.
Manage Omar's BH needs	During the BH comprehensive assessment, Donna asks questions to understand Omar's current BH treatment plan; his current symptoms, and whether he thinks his treatment plan is helping him manage his conditions; and his BH history, including his past suicide attempts and psychiatric hospitalizations (as documented in his NF case file).	Donna includes Omar's current BH services, as well as those noted on his PASRR, in the care plan. Donna assists with appointment scheduling and transportation to support adherence with his treatment plan. Based on his BH history and historic medication non-compliance, his MDT recommends that Omar receive supports from an Assertive Community Treatment (ACT) upon transition to the community. Donna facilitates the referral to the local ACT team serving Omar's area. In addition, as suggested by Omar's MDT, Donna helps Omar enroll in an intensive outpatient program (IOP), which Humana will cover as an in lieu of service. [redacted] Donna works with Omar and the rest of his MDT to update his crisis plan, with the aim of preventing and mitigating any decompensation of his BH conditions that may accompany his transition to the community. His BH crisis plan includes identified triggers; steps to mitigate his triggers; and contact information for

Table 2.10.6.3-A: Omar's Goals, Priority Needs, and Interventions		
Goal	Priority Needs	Interventions
		our Louisiana-based BH Crisis Line (operated by [redacted], his BH provider, and his ACT team. With Omar's permission, the plan is shared with his BH provider, ACT team, and our BH Crisis Line. Our BH Crisis Line will refer to Omar's crisis plan if Omar calls for assistance.
Manage his chronic pain and weakness	Although Omar does not receive his physical health services through Humana Medicaid, Donna nevertheless works with Omar to support management and treatment of his high blood pressure, chronic pain, neuropathy, and other physical health conditions. Donna's support includes coordination with his other payer and monitoring the impacts of his physical health needs on his BH conditions.	Donna documents Omar's treatment plan for his physical health services, including medications and providers. As needed, Donna coordinates with Omar's other payer to ensure that he is engaged with his PCP on an ongoing basis. Under our integrated disease management-case management approach, Donna provides condition-specific education that complements Omar's care and treatment plans and aligns with his cultural preferences. Donna draws from our Healthwise library to provide information that matches Omar's health literacy level and stage of change, in accordance with the Transtheoretical Model of behavior change. As needed, Donna works with Humana's Concierge Service for Accessibility to translate educational materials into Omar's language of choice or otherwise customize the materials to any accessibility needs.
Prepare Omar to live in the community	Donna reviews Omar's SDOH needs for his move to the community, including housing, food, household items, social interaction, transportation, and training on independent living.	Using the [redacted] Donna links Omar with resources, such as the Salvation Army, to provide needed living items when transitioning (e.g., household goods). Donna also arranges the delivery of ten meals upon Omar's transition through Humana's added benefits, with linkage to other community resources to provide ongoing food assistance (if needed).

Omar's Transition from the Nursing Facility

Donna regularly visits Omar in the lead-up to his transition from his NF, tailoring the contact frequency to his acuity level. She maintains contact with the NF social worker, who keeps her up to date on Omar's care and any changes in his condition. As needed, Donna coordinates with Omar's other payer to transition his care to community providers by sharing Omar's care plan (with permission), including them in the MDT, and scheduling initial appointments.

Once Omar has secured housing through PSH or an alternative option located by Humana's Housing Specialist, he transitions from the NF. After transition, our Housing Specialist continues to coordinate with Omar's ACT housing specialist to ensure that we have addressed Omar's housing needs. Donna visits Omar the next day to confirm that he is receiving the services detailed on his transition plan of care, including those arranged through community resources, and to check on his general well-being. Donna continues to engage Omar at a frequency that is appropriate for his acuity level and matches his preferences. She monitors compliance with his plan of care; coordinates care between his ACT team, PSH supports, other payer (if applicable), and providers; and responds to any emerging needs. To promote coordination and reduce overlap, Omar's ACT team joins his MDT (with his permission), and the ACT CM becomes the MDT's lead CM. Under the leadership of the ACT CM (and with Donna's support), his MDT revises his plan of care to capture Omar's needs, goals, and interventions for his life in the community, summarized in Table 2.10.6.3-B.

Table 2.10.6.3-B: Omar's Goals, Priority Needs, and Interventions Post-Transition to the Community		
Goal	Priority Needs	Interventions
Maintain compliance with his medications	Omar and Donna discuss factors influencing Omar's historical non-compliance and strategies that Omar believes may help him remain compliant after leaving the NF.	In addition to medication adherence support provided by the ACT team, Donna works with Omar's Medicare plan and PCP to arrange home health services in support of medication adherence (as recommended by his MDT). If Omar continues to display patterns of non-adherence, Donna notifies his BH provider to discuss next steps. These may include switching Omar to a long-acting injectable (LAI) antipsychotic. [redacted]
Reconnect with his family and build connections in the community	Recognizing that an individual's health status is affected by a myriad of factors outside of their treatment plan, our assessment includes an evaluation of our enrollees' non-health-related goals. Omar reports that he would like to reconnect with his family. Donna and Omar discuss the factors that led to the separation and what may lead to reconciliation.	As an organization, Humana is committed to tackling the issue of social isolation among older adults. Together with Omar's ACT peer support specialist, Donna helps him identify steps he can take to reconcile with his family. To support community connections and build Omar's confidence in social situations, Donna teaches Omar how to use his nearby Humana Neighborhood Location to receive assistance and attend classes. She also uses the [redacted] to identify support groups and other social opportunities that align with Omar's interests and any cultural preferences that Omar has expressed. In addition, Donna suggests that Omar access a gym membership through Humana's added benefits, as it can both provide socialization and help him stay physically active.
Address SDOH needs	Donna evaluates Omar's SDOH needs for his new setting during each re-assessment. Donna stays in close contact with Omar's ACT team and uses her own face-to-face visits with Omar to look for indicators of SDOH needs (e.g., a clean house with working locks).	Donna uses the [redacted] to identify resources that can address Omar's SDOH needs (including eviction diversion support) and coordinates these with his PSH coordinator. She notes these resources on Omar's plan of care and follows up after referral to ensure that Omar has accessed the resource and that it is meeting his needs. If Donna identifies a complex SDOH need, she may engage the SDOH Coordinator on her CCS team to provide additional support.
Understand and appropriately use ED alternatives	Before Omar entered the NF, he had frequent ED visits for both physical health and BH causes. Donna and Omar identify the drivers of these visits, such as insufficient condition management, lack of awareness of ED alternatives, or inability to access ED alternatives.	Donna works with Omar's other payer to identify their available supports for ED diversion and notes these on the plan of care, along with Humana-facilitated interventions, including: providing a list of nearby urgent care centers that are in-network for his physical health payer; offering a refrigerator magnet that lists contact information for our Nurse Advice Line (NAL), BH Crisis Line, Donna, and his ACT CM; and facilitating ongoing education on chronic condition management through the use of our health education library and with Donna's support.

Donna continues to provide Tier 3 case management for at least 90 days following transition, recognizing that this is the most crucial timeframe for enrollees returning to the community. After 90 days, Omar may be re-stratified as Tier 2 depending on his progress. As a member of the Department of Justice (DOJ) Agreement Target Population, Omar receives Tier 2 or Tier 3 case management for at least twelve 12 months after transition. Donna continues to work with Omar for as long as he is enrolled in case management, with the ultimate goal of transitioning him to Tier 1 case management.