

# The Power and Possibility of PASRR Webinar Series

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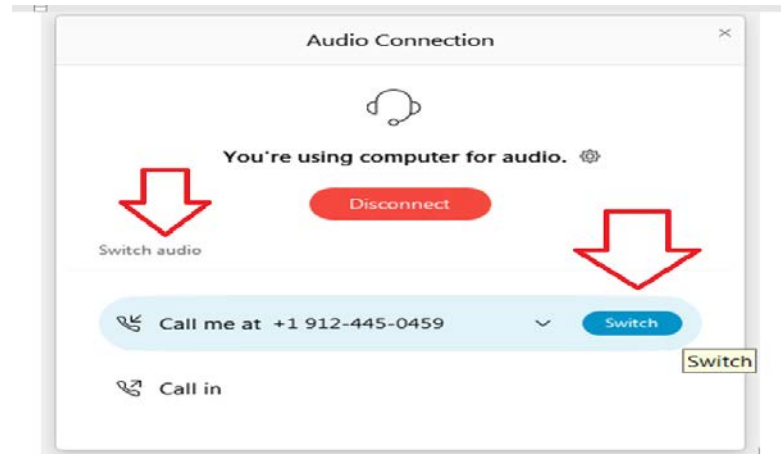
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# Partnering for Quality of Care – State PASRR Authorities and Nursing Facilities



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**POWER AND POSSIBILITY OF PASRR WEBINAR SERIES**



## Webinar Goal

**This webinar will help attendees understand how state Medicaid/Mental Health/Intellectual Disability PASRR Authorities and Nursing Facilities can effectively partner to advance quality of care for nursing facility residents with PASRR conditions.**

## Learning Objectives

- Understand the definition of quality of care and the core components that contribute to quality of care.
- Understand the federal PASRR and Nursing Facility regulations that focus on quality of care.
- Understand the regulations that link state PASRR authority and Nursing Facility quality of care interests.
- Understand the role state PASRR authorities play in helping Nursing Facilities develop and maintain quality oriented plans of care.
- Understanding the role state PASRR authorities and Nursing Facilities have in promoting continuity of care during the nursing facility stay and upon transition to the community.

# Setting the Webinar Foundation- Quality of Care

## What does Quality of Care mean?

- Group discussion - a primer for our learning objectives

# Quality of Care



**WHAT IS IT?**

**WHY ARE PARTNERSHIPS IMPORTANT  
TO QUALITY OF CARE?**

## Quality of Care: What is it?

“The U.S. [Institute of Medicine](#) (IOM) defines ‘quality’ as: the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.”

What this really means is that each individual should receive the best possible health care available every time services are needed.

From - [Agency for Healthcare Research and Quality](#), U.S. Department of Health and Human Services



## Why are partnerships important to quality of care?

**“Multipronged, integrated approaches are needed to further the quest for sustainment of high clinical quality in NF care. In addition to setting a tone for attainment of clinical quality, leadership should champion adoption of practice standards, quality initiatives, and evidence-based guidelines.”**

**PASRR Authorities and Nursing Facilities  
each play a vital role!**

From - [“Quality Clinical Care in Nursing Facilities” – Journal of Post Acute and Long Term Care Medicine, October 2018](#)

## A PASRR/NF Partnership – Three Key Considerations

- Dialogue between state authorities, hospital and nursing facility prior to admission.
- Personalized goals of the nursing facility resident that build upon PASRR recommendations.
- A dynamic process and continued dialogue as the needs of the resident change.

# The Quality of Care Formula



# Quality of Care – A Shared Responsibility



**PASRR REGULATIONS**

**LONG TERM CARE FACILITY  
REGULATIONS**

## PASRR Regulations: A Focus on Quality of Care

### **§483.112 Preadmission screening of applicants for admission to NFs.**

- (a) ***Determination of need for NF services.*** For each NF applicant with MI or IID, the State mental health or intellectual disability authority (as appropriate) must determine, in accordance with §483.130, whether, because of the resident's physical and mental condition, the individual requires the level of services provided by a NF.
- (b) ***Determination of need for specialized services.*** If the individual with mental illness or intellectual disability is determined to require a NF level of care, the State mental health or intellectual disability authority (as appropriate) must also determine, in accordance with §483.130, whether the individual requires specialized services for the mental illness or intellectual disability, as defined in §483.120.

# Regulatory Language for Quality of Care Partnership Mental Illness

## **§483.120 Specialized services**

(a) *Definition*—(1) For mental illness, specialized services means the services specified by the State which, combined with services provided by the NF, results in the continuous and aggressive implementation of an individualized plan of care.

## Specialized Services Plan of Care – MI

- (i) Is developed and supervised by an interdisciplinary team, which includes a physician, **qualified mental health professionals** and, as appropriate, other professionals.
- (ii) Prescribes specific therapies and activities for the treatment of persons experiencing an acute episode of serious mental illness, which necessitates **supervision by trained mental health personnel**; and
- (iii) Is **directed toward diagnosing and reducing the resident's behavioral symptoms** that necessitated institutionalization, improving his or her level of independent functioning, and achieving a functioning level that permits reduction in the intensity of mental health services to below the level of specialized services at the earliest possible time.

# Regulatory Language for Quality of Care Partnership- Intellectual Disability

## **§483.120 Specialized services**

(2) For intellectual disability, specialized services means the services specified by the State which, combined with services provided by the NF or other service providers, results in treatment which meets the requirements of §483.440(a)(1)



## §483.440(a)(1).

Condition of participation: Active treatment services.

- (a) *Standard: Active treatment.* (1) Each client must receive a continuous active treatment program, which includes aggressive, **consistent implementation of a program of specialized and generic training, treatment, health services and related services** described in this subpart, that is directed toward—
  - (i) The acquisition of the behaviors necessary for the client to function with as much self determination and independence as possible; and
  - (ii) The prevention or deceleration of regression or loss of current optimal functional status.

# Long Term Care Facility Regulations A Quality of Care Focus



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## Regulatory Language – Quality of Care

- **§483.40 Behavioral health services.**
- Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders.
  - a) The facility must have sufficient staff who provide direct services to residents with the appropriate competencies and skill sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with §483.70(e).

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## Regulatory Language – Quality of Care

### **§483.40 Behavioral health services, continued**

- a) (cont.) These competencies and skills sets include, but are not limited to, knowledge of and appropriate training and supervision for:
- Caring for residents with mental and psychosocial disorders, as well as residents with a history of trauma and/or post-traumatic stress disorder, that have been identified in the facility assessment conducted pursuant to §483.70(e), and
  - Implementing non-pharmacological interventions.
- b) Based on the comprehensive assessment of a resident, the facility must ensure that—
- A resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder, receives appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being;

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## Regulatory Language – Quality of Care

### **§483.40 Behavioral health services, continued**

- c) Provide the required services, including specialized rehabilitation services as required in §483.65; or
  - Obtain the required services from an outside resource (in accordance with §483.70(g) of this part) from a Medicare and/or Medicaid provider of specialized rehabilitative services.
- d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident

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# Facility Assessment

## §483.70 Administration

A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.

- (ii) The care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population;
- (iii) The staff competencies that are necessary to provide the level and types of care needed for the resident population;

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# Long Term Care Facility Regulations Plan of Care



## **CARE PLANNING FOCUS ON THE PERSON, NOT THE DIAGNOSIS**

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# Discharge Planning

## Safe Discharge Planning and Level II Specialized Services

- **CMS Definition of a Safe Discharge and Regulatory Guidance to Nursing Facilities**
  - **Does not unexpectedly admit to an acute care hospital within 30 days of discharge from NF**
  - **Does not unexpectedly readmit to a NF within 30 days of discharge from the NF**
  - **Does not unexpectedly die within 30 days of discharge from the NF**

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# Discharge Planning

## Safe Discharge Planning and Level II Specialized Services

- Implications to Nursing Facilities when an unsafe discharge takes place
  - ✦ Five Star Rating
  - ✦ Regulatory Compliance
  - ✦ Acute Care Impact

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## Quality Oriented Care Plans – Person Focused

### §483.21 Comprehensive person-centered care planning.

- (a) *Baseline care plans.* (1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must—

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# Quality Oriented Care Plans – Person Focused Continued

## **§483.21 Comprehensive person-centered care planning (cont.)**

- (i) Be developed within 48 hours of a resident's admission.
- (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to:
  - (A) Initial goals based on admission orders.
  - (B) Physician orders.
  - (C) Dietary orders.
  - (D) Therapy services.
  - (E) Social services.
  - (F) **PASARR recommendation, if applicable.**

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# Integrating PASRR Level II Recommendations Into The Care Plan

- **Making the Care Plan Person Centered**
  - Level II recommendations/limitations
  - Care Plan development prior to admission
  - Goals of the resident and how staff will assist
  - Staff Training (Facility Assessment)
  - Physician Orders
  - Resident Assessment
  - Resident Choice - Quality of Care
  - Care Plan Updates

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# The Quality of Care Partnership



## **AN ONGOING LTCF AND STATE AUTHORITY DIALOGUE: THE RESIDENT REVIEW**

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# Resident Review Quality of Care Connections

## **§483.20 Resident assessment**

- Within 14 calendar days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition.
- A “significant change” means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both

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# Resident Review Quality of Care Connections

- CMS recommends that states use [Section 2.6 of the MDS 3.0 Version 1.15 Manual change of condition protocol](#).\*
- If the MDS indicates suspected MI and/or ID, the NF must notify the Medicaid agency or its designee, which must then arrange for a Level II Resident Review (RR).
- If the MDS indicates a significant change in condition, the NF must notify the Medicaid agency or its designee, which must then determine whether the change in condition data support the need for a RR.
- \*From PTAC FAQ [“When does a Level II evaluation need to be conducted?”](#) - July 2018

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# Long Term Care Facility Regulations Discharge Planning



## **CONTINUITY OF CARE SPECIALIZED SERVICES**

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# Level II Recommendations, the Nursing Facility, and Discharge Planning

## Discharge Options are Greater than Ever

- Olmstead Act / Money Follows the Person
- Home Health
- Home and Community Based Services

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# The Decision Maker

- Resident Rights
- Person Centered Care and Choices
  - The resident/resident representative is the final decision maker on whether to have specialized services, care plan guidance, and physician input integrated into his or her life.

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# Specialized Services and Discharge Planning

## §483.130 PASARR determination criteria

- (4) *May choose to remain in the NF even though the placement would otherwise be inappropriate.* Any NF resident with MI or IID who does not require the level of services provided by a NF **but does require specialized services and who has continuously resided in a NF for at least 30 consecutive months before the date of determination** may choose to continue to reside in the facility or to receive covered services in an alternative appropriate institutional or noninstitutional setting.
- **Wherever the resident chooses to reside, the State must meet his or her specialized services needs.** The determination notice must provide information concerning how, when, and by whom the various placement options available to the resident will be fully explained to the resident.

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## Specialized Services and Discharge Planning - continued

(5) *Cannot be considered appropriate for continued placement in a NF and must be discharged (short-term residents). **Any NF resident with MI or IID who does not require the level of services provided by a NF but does require specialized services and who has resided in a NF for less than 30 consecutive months must be discharged in accordance with §483.15(b) to an appropriate setting where the State must provide specialized services.***

- The determination notice must provide information on how, when, and by whom the resident will be advised of discharge arrangements and of his/her appeal rights under both PASARR and discharge provisions.

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# The Quality of Care Formula

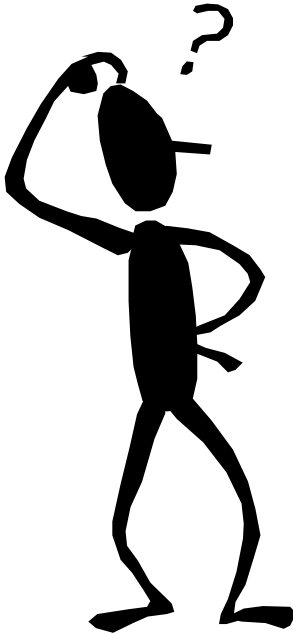


# The Nursing Facility & State PASRR Partnership

- Establish a dialogue – the interest and recognition of value is likely to be high.
- Clarify roles and expectations – shared understanding minimizes the risk of balls getting dropped.
- Identify the essential resources or the gaps – specialized rehabilitation and specialized services in particular.
- Identify the additional resources that can support your shared goals – Money Follows the Person (MFP), Waivers, MCO entities
- Establish a clear communication process – who are your primary liaisons.
- Promote ongoing collaboration – meetings/calls/joint strategy sessions.

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# QUESTIONS



# THANK YOU



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