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The Current Climate of PASRR

Trends in Quality and Person-Centered Care

Topics of Discussion

- Understanding PASRR
- Trending shows states are increasing their focus on PASRR; what does your state need to keep up/surpass
- Avenues where PASRR is effective and affecting positive change both on the individual level and the macro level
- Implementing and Maintaining Quality in PASRR
- Common barriers for states and effective strategies
- Person-Centered Care, Best Practices, and Systems Approach
- PASRR Resources

Understanding PASRR

- The Omnibus Reconciliation Act of 1987 (OBRA), Public Law 100-203, Section 4211 (c)(7), and Americans with Disabilities Act (ADA) 1990.
- Changes to the 42 CFR 483.1 on October 4, 2016 containing requirements that nursing homes must meet to participate in Medicare and Medicaid.

Reflects an enduring undercurrent of concern among advocates about institutionalization of individuals with mental illness, or intellectual/developmental disabilities and related conditions.

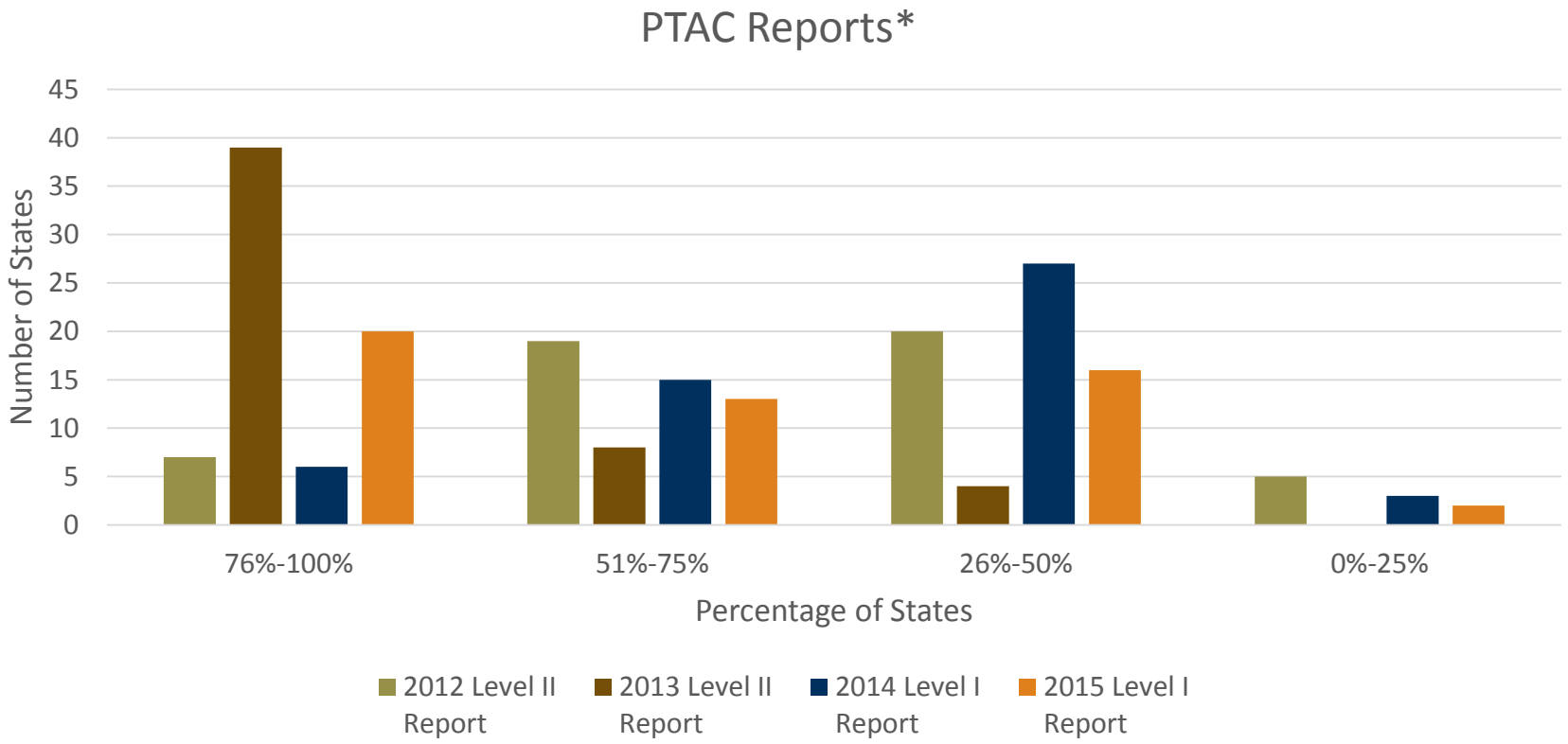
Understanding PASRR

- The overarching goal of PASRR is to ensure that individuals are not inappropriately placed in nursing homes for long term care when they can be better served in a community setting.
- PASRR can be used to help states “rebalance” or ensure that they are moving away from institutional care and moving toward strategies that ensure individuals with disabilities are able to be supported in community and integrated settings.
- Effective PASRR programs use person-centered care planning to ensure that personal goals and preferences are met.

Understanding PASRR

- **Level I**
  - A Level I PASRR screen determines whether an individual referred for admission into an NF has or is *suspected* of having an SMI and/or an ID diagnosis.
- **Level II**
  - The Level II PASRR is an individualized, in-depth evaluation of the individual, including confirming or ruling out the suspected diagnosis and determining the need for Nursing Facility (NF) services. If an NF is the most integrated setting appropriate to meet the individual's long-term care needs, the Level II PASRR should also evaluate what specialized rehabilitative or specialized services, if any, are needed.

Trend shows states are increasing their focus on PASRR

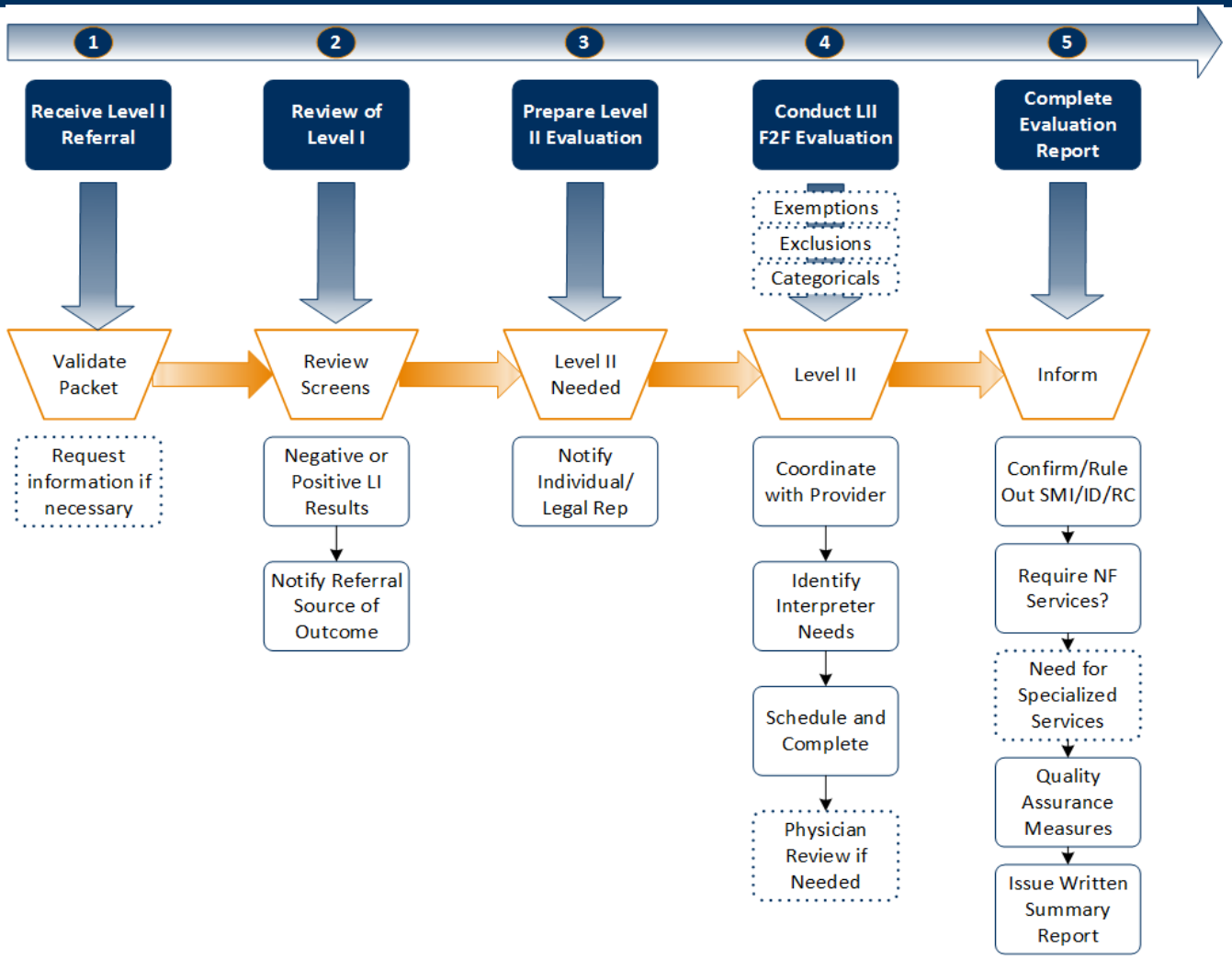


**National PASRR Policies and Procedures Review.* PASRR Technical Assistance Center, June 12, 2012,
Review of State PASRR Policies and Procedures. PASRR Technical Assistance Center, September 10, 2013,
2014 PASRR National Report. A Review of Preadmission Screening and Resident Review (PASRR) Programs, PASRR Technical Assistance Center, August 28, 2014, and
2015 PASRR National Report: A Review of Preadmission Screening and Resident Review (PASRR) Programs, PASRR Technical Assistance Center, December 2015.

Take Away on PASRR Trends

- Where did your state fall and what does your state need going forward?
- Is your state ready to go beyond compliance with the current Federal Regulations?
- Does your state PASRR program support person-centered and continuous care, integrated living, and home and community based service options?

Typical PASRR Workflow



PASRR at the Micro and Macro Levels

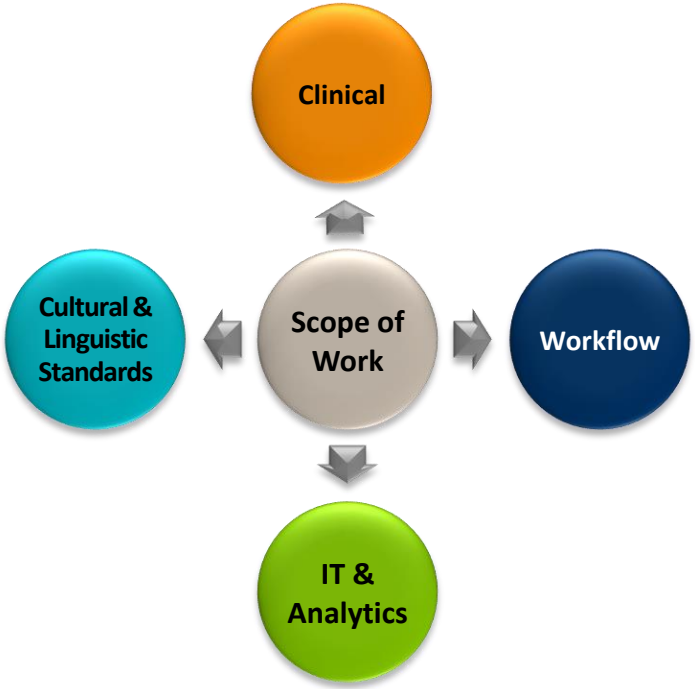
- State- and Agency-wide Collaboration
  - Involves the state Medicaid, Mental Health, and Intellectual Disability Authorities
  - Ensuring PASRR is effective and affecting positive change both at the macro level and also for each person involved
- Macro Level Collaboration in Florida resulting in positive outcomes for individuals, families, providers, and agencies
- Micro examples of person-centered care in California and Ohio

Quality Assurance

- Effective PASRR programs collect, analyze and improve outcomes by using a variety of data elements
  - Level I outcomes (both positive and negative)
  - Hospital Exemptions
  - Level II outcomes
    - Categorical Determinations and Dementia Exclusions
    - Met/Did not meet the criteria for Serious Mental Illness
    - Appropriate/Not appropriate for Nursing Home level of services
    - Require/Do not require Specialized Rehabilitative Services
    - Require/Do not require Specialized Services (SS)
      - SS coordination and follow along
      - Individual outcomes
  - Quality Measures

What are some barriers and effective strategies for states?

- It is extremely important to reduce burdens whenever/ wherever you can without jeopardizing the quality of care.
- Mindful and meaningful care
- Increase efficiencies while adhering to best practices
- Decrease barriers and see an increase in collaboration and cooperation



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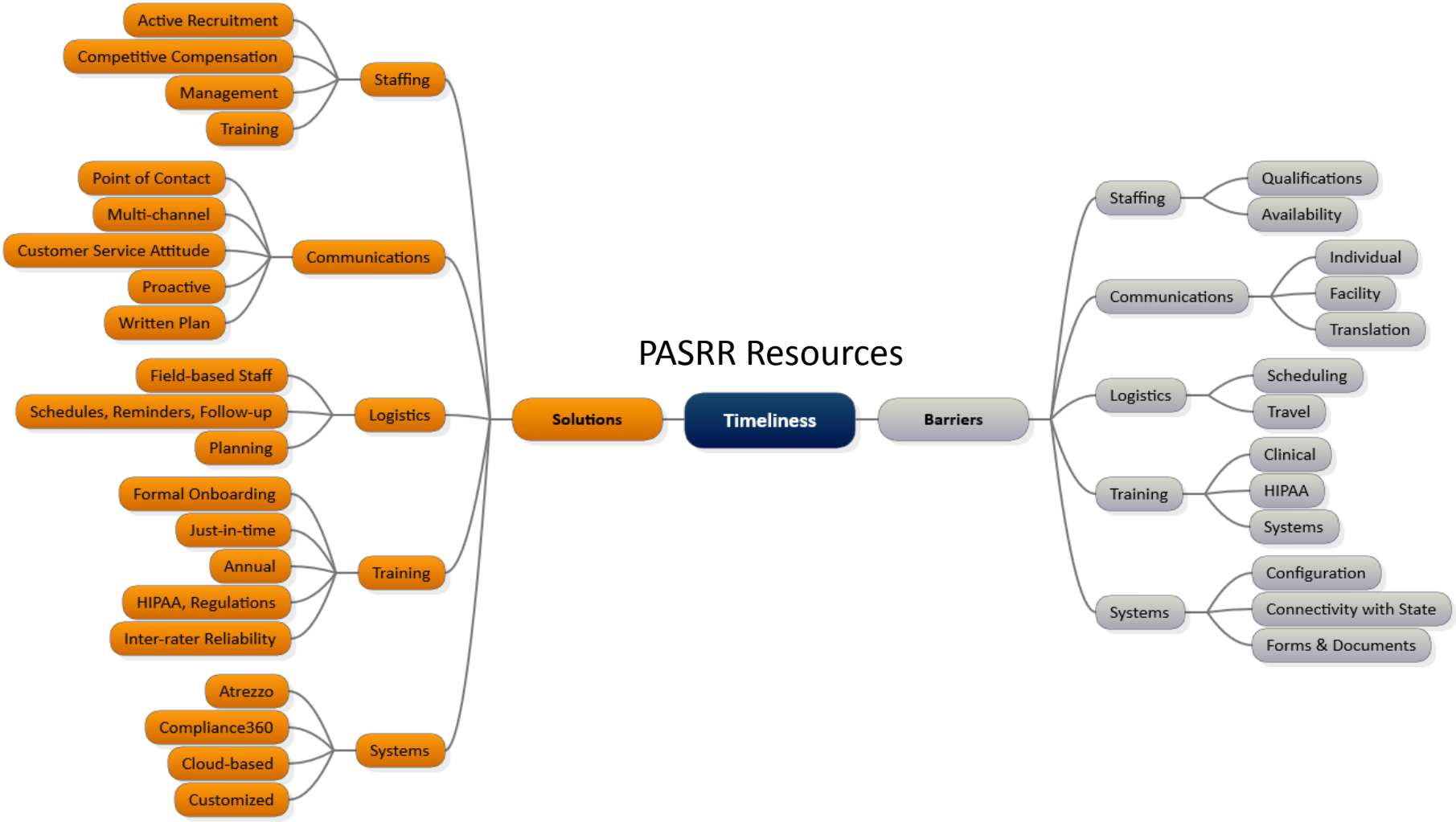

PASRR Resources

- The PASRR Technical Assistance Center (PTAC) www.pasrrassist.org
- The National Association of PASRR Professionals (NAPP) www.pasrr.org
- CMS www.medicaid.gov
- State and community level Resource Directories
- State PASRR agencies (Medicaid, Mental Health, and Intellectual Disabilities)

Questions?

PERSON-CENTERED CARE IN PASRR

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Discussion Topics

- Understanding the person centric approach to PASRR
- California's individualized PASRR Process and personalized determinations.
  - Trend shows that PASRR recommendations are useful and play a role not only in determining the level of specialized care that residents receive relative to mental illness and specialized needs, but individual goals that residents have either within or outside facility.

CA PASRR Role in Person-centered Care?

PASRR is also intended to identify and evaluate individuals with so-called "related conditions" – conditions that are not a form of intellectual disability, but which often produce similar functional impairments and require similar treatment or services (hence the term "related").

These aspects are individually specific e.g.,

- Self-care
- The understanding and use of language
- Learning
- Mobility
- Self-direction
- Capacity for independent living

CA PASRR Role in Person-centered Care?

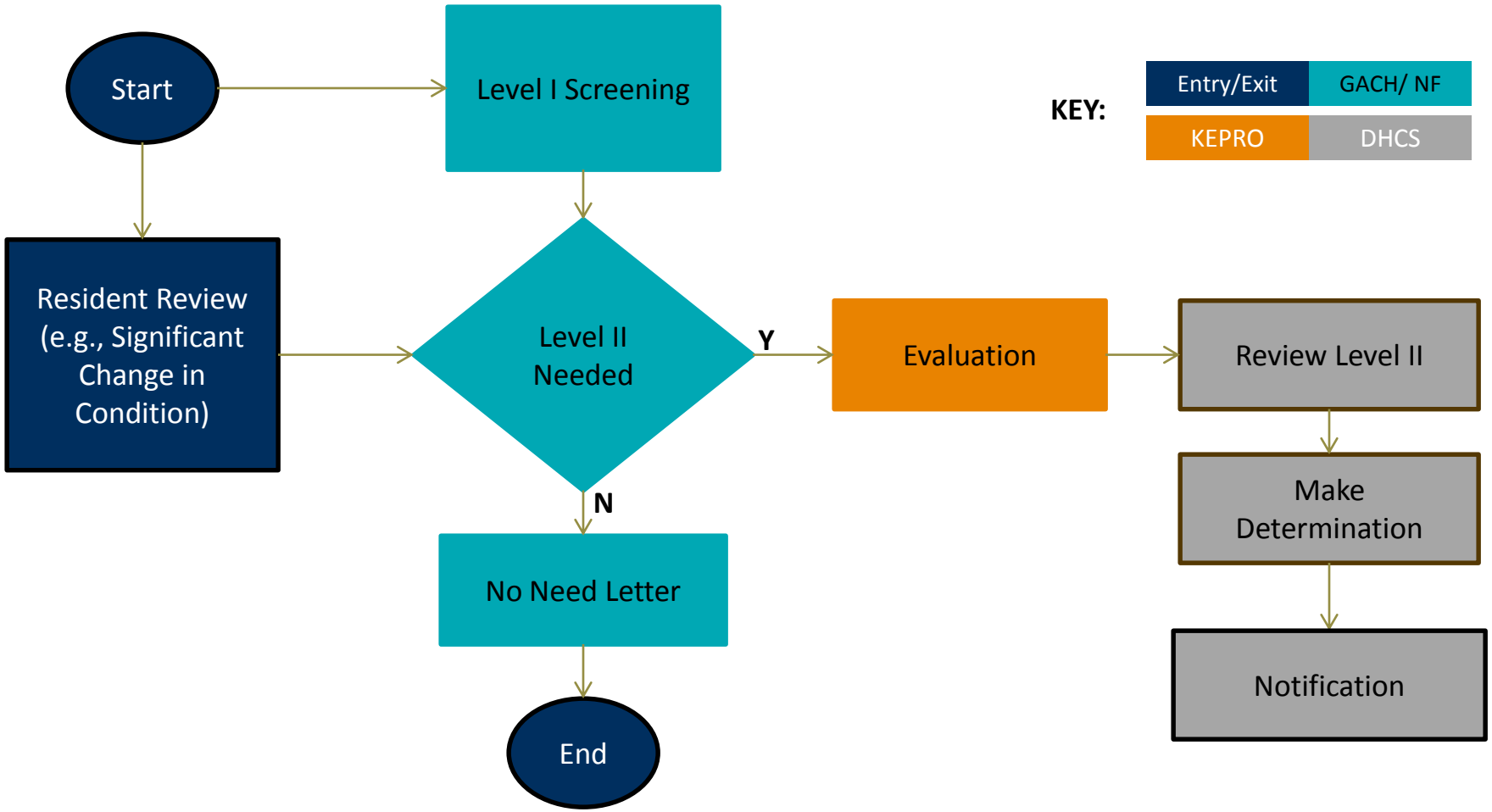
- Partner with the referred individual to ascertain their needs, personal goals and preferences in planning long term care through:
  - Patient interview
  - Caregiver interview
  - Legal Guardian/Interview
  - Psychosocial history review
  - Medical review
- 100% of qualifying Level II referrals receive a face to face evaluation
- Personalized determination letters in a language incorporating individual goals and input
- Determination letter received by Facility & provided to resident/chart

Examples of Resident Person-Centered Level II Goals

- " I need to be able to talk my guardian regarding new pants"
  - (55 Year old narrative during evaluation assessment)
- "'I want to improve my compliance with taking my blood pressure medicine"
  - (A 61 Yr. old goal during assessment interview)
- " I want the social worker to talk to my daughter to increase my monthly allowance and smokes"
  - (63 year resident during his assessment)

The determination letter sent to the facility and residents incorporates these goals to improve services in addition to the determination of MI and specialized services needs.

CA PASRR PROCESS OVERVIEW



Questions?

PASRR in Ohio

Introduction

- Person-centered Care and Ohio PASRR Data System
  - Data system designed to follow the consumer from receipt of the Level II request form through completion of assessment, review, determination, and beyond.
  - Able to facilitate participation of multiple departments/stakeholders in PASRR case processing and discharge planning for consumers for whom indefinite NF placement is not needed.

Pre-Admission Screening/Resident Review (PASRR)

"Successful strategies support an ecological approach to meeting individual, family, organizational, and community needs. This includes **creating/sustaining a culture of discharge**, encompassing **informal and formal community supports** in the discharge process, proactively addressing **physical environment needs**, and assisting individuals and their family members in **managing** physical and mental health conditions."

Successful Strategies for Discharging Medicaid Nursing Home Residents With Mental Health Diagnoses to the Community. Skye N. Leedahl, Rosemary K. Chapin, Carrie Wendel, Beth Anne Baca, Leslie K. Hasche & Grace W. Townley; Pages 172-192 | Published online: 24 Nov 2014.

PASRR Process in Ohio

- Level I: State designated PASRR authorities (DODD & MHAS) are not responsible for Level I
  - Department of Aging-contracts with 13 PASSPORT Administrative Agencies (PAA) to conduct Level I screenings
- Level II: State designated authorities use the comprehensive Level II assessment as the foundation to render a final determination
  - DODD: County Boards of DD
  - MHAS: Assessments completed by licensed mental health professionals under state contract with KEPRO

KEPRO PASRR System Highlights

- Level II applications (form 3622) received into system in real time either directly from submitters (by fax) or by feed received twice hourly directly from the State of Ohio's HENS system (electronic submission).

Faxes

Display: Active Only | Inactive Only | All

View Fax	File Name	Received	Active	Activation
VIEW	A5519951-4989-4B75-91FF-BBA494F7D5DF-285652-IF.pdf	8/24/2016 12:42:31 PM	✓	Change
VIEW	A5519951-4989-4B75-91FF-BBA494F7D5DF-285570-IF.pdf	8/24/2016 12:49:31 PM	✓	Change
VIEW	Ohio Demo File 03.pdf	8/26/2016 8:06:17 AM	✓	Change
VIEW	Ohio Demo File 04.pdf	8/26/2016 8:06:19 AM	✓	Change
VIEW	Ohio Demo File 05.pdf	8/26/2016 8:06:31 AM	✓	Change
VIEW	Ohio Demo File 06.pdf	8/26/2016 8:06:39 AM	✓	Change

Review	Review ID	Received Date	Current TAT	Status
SELECT	9422	08/31/2016 10:34 AM	0	Application Received
SELECT	9421	08/31/2016 10:33 AM	0	Application Received
SELECT	9420	08/31/2016 10:33 AM	0	Application Received
SELECT	9417	08/31/2016 09:55 AM	0	Application Received

KEPRO PASRR System Highlights

- System automatically assigns date/time stamp and starts turnaround-time clock upon receipt.
- Administrative staff assign priority (expedited) cases to field-based licensed mental health professionals for assessment, or forward directly to MHAS in the case of rule-out conditions, valid PAS already in place with no break in services, consumer located out of state, etc.
- Field-based staff may self-assign non-expedited cases by searching for open cases in their area by county or facility:

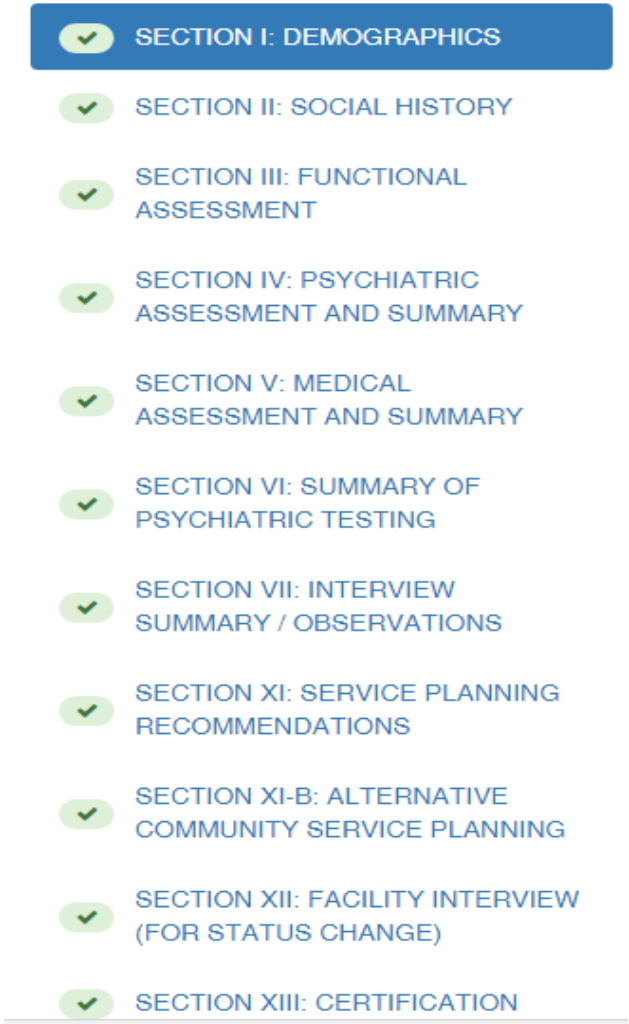
Current Facility	County	Sub-Type	Dual	Expedite	Outcome	Date Sent to MHAS	KEPRO Assessor	MHAS Reviewer
Liberty Health Care Center Inc	Trumbull		N	N				
Summit Behavioral Healthcare	Hamilton		N	N				
University Hospitals of Cleveland	Cuyahoga		N	Y				

Role-based Security

- Users receive access appropriate to their roles.
  - For example, DODD only sees cases in the system with a dual diagnosis. The Department of Medicaid, which reviews extension requests, only sees extension requests.
  - Has the capability to include a provider portal, should a state wish to include electronic data entry of a request by the requestor into the system.
  - Can allow access based on zip code, county, etc. to allow entities such as county boards to access information only for consumers in their region.

KEPRO PASRR System Highlights

- Level II Evaluation Smart Form
  - Evaluators may enter assessment data directly into the secure web-based form which contains the sections listed to the right.
  - Most fields are mandatory, requiring the evaluator to make each assessment as thorough as possible.



Level II Evaluation

- The comprehensive evaluation captures:
  - Demographics, including current location, and family/guardian information and participation.
  - Social history, including primary living situation, reason for admission, education, significant recent life events, employment history and current vocational ability, current support system, potential for transfer to community, recreational/leisure time activities, strengths/positive traits, weaknesses/problems, and socialization.

Level II Evaluation

- Functional Assessment, including responsiveness to the evaluator, level of assistance needed to perform ADL/IADL, types of assistive equipment needed, communication/learning needs, identification of maladaptive or inappropriate behaviors

- Psychiatric Assessment, including services utilized, MSE, SI/HI, functional capabilities/need for assistance with self-monitoring of health status, triggers for decompensation and suggestions for a formal decompensation plan, memory, judgment, cognitive impairment, and history of substance use

Level II Evaluation

- Medical assessment
  - Including current medications, medications that may mimic symptoms of mental illness, medical diagnoses, therapies (e.g., PT/OT), level of assistance needed to maintain adherence to medication regimen.
- Interview summary
  - And observations by assessor
- Service Planning Recommendations
  - Including services currently receiving/recommended, with rationale for recommendations; mental health treatment impressions
- Alternative community service planning
  - i.e., services/ resource needed by this applicant in order to live successfully in the community as an alternative to NF

Determination Summary Report

- The KEPRO PASRR system allows the MHAS reviewer to produce a DSR populated from both the assessment data and the reviewer's own free text recommendations/rationale:
  - Consumer information
  - Current situation (location, social supports, reason for admission, type of evaluation, etc.)
  - Medical issues
  - Mental health issues
  - Specific limitations and needs
  - Recommendations
  - Rationale
  - Determination / need for specialized services

Notification

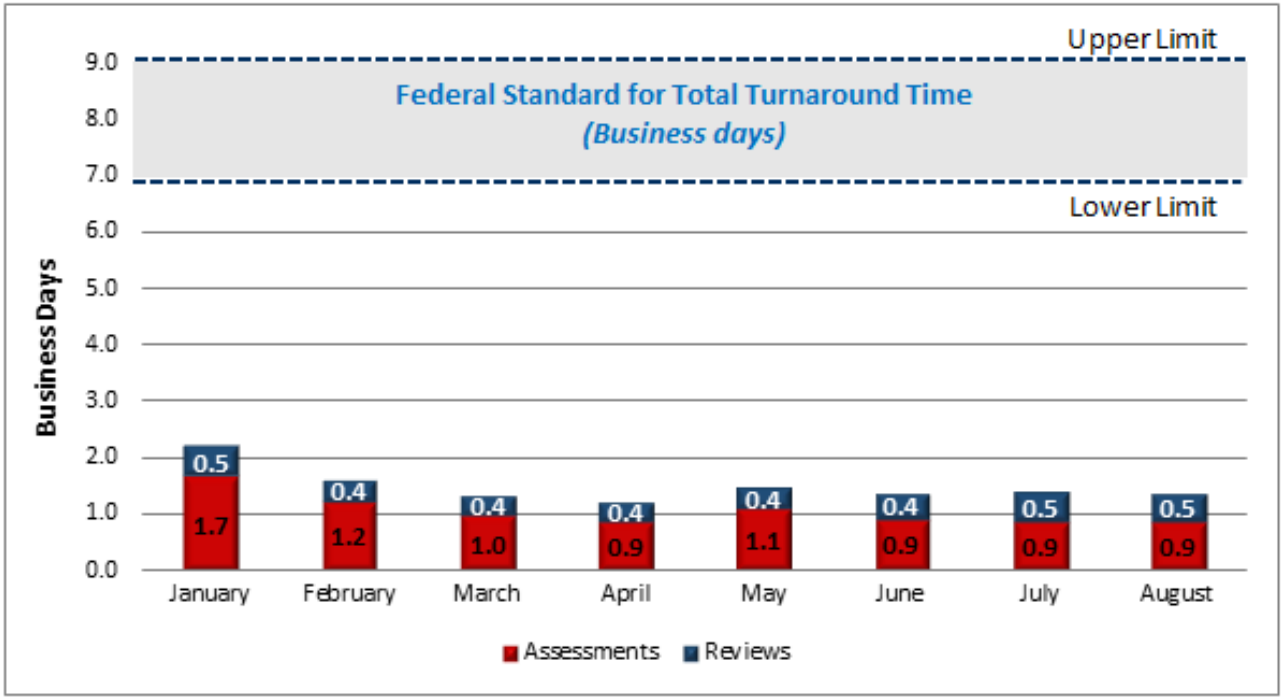
- Once the determination is completed, the reviewer can fax the determination directly from the system to the submitter/PAA, the hospital, and/or the NF, as appropriate. KePRO administrative staff mail hard copies to legal guardians, when appropriate.
  - Faxing the determination stops the turnaround time clock
  - Each consumer has a record in the system that contains all documentation from all episodes of care—applications, assessment forms, notifications, notes, documentation of calls, etc.

Select Review	Review ID	Status	Outcome	Creation Date
SELECT	9192	Decision Finalized	Approved Emergency	08/18/2016 10:38 AM
SELECT	6154	Decision Finalized	Approved / No SS	05/18/2016 03:22 PM

PASRR Compliance

- KEPRO system allows MHAS to follow up on cases where determination is a specified or categorical (time-limited) approval or denial.
- Allows accurate tracking of turnaround time

Average Turnaround Time for All Reviews to National Standard



Community Transition Resources

All notifications include a *Nursing Facility Community Transition Resource Packet* containing information and forms regarding:

- **Home Choice**: assistance with moving into the community, including locating housing, setting up a household, and connecting to necessary goods and services
- **Recovery Requires a Community**: temporary housing or utility assistance, or goods and services
- **Residential State Supplement**: helps pay for accommodations, supervision, personal care services
- **Home and Community Based Waivers**: allow individuals with disabilities and chronic conditions to receive care in their homes and communities rather than in long-term care facilities.

Case Example: Mr. C

Mr. C is 58 year-old male who has been diagnosed with schizophrenia and was living at home with his mother.

- **Initial PASRR request-** for 14-day Respite (approved)
- Mr. C required the services provided at a Nursing Facility at this time due to the need for supervision with 2 or more ADL's, hands on assistance with at least 3 IADL's, multiple medical concerns and hands on assistance with medication administration. Mr. C was approved for respite care expedited review as his caregiver (elderly mother) was leaving town.

Case Example: Mr. C

Three Months Later: Mr. C was admitted to the hospital voluntarily with disorganized thoughts, delusional thinking, and inability to take care of daily routines.

- He had experienced gradually worsening agitation during the week prior to admission. He had been wandering from the home, and his 82 year-old mother/guardian no longer felt able to care for him. Upon Level II evaluation, he was found to need supervision with almost all ADL and hands-on assistance with most IADL. At that time, he required supervision with medication administration. He was connected with psychiatric services through the local MH center.
- The reviewer found that Mr. C needed short-term NF placement and recommended ongoing medication review by a physician and/or psychiatrist, crisis intervention, a behavior management plan, socialization activities, mental health counseling, speech therapy, an audiology evaluation, and, when appropriate, case management services for transition to community.

Case Example: Mr. C

Sometime after this determination, Mr. C was admitted to the hospital for medical care and was then discharged to a NF using the hospital exemption. There was a resident review completed due to an expired hospital exemption.

- His medical diagnoses at this time included Hypertension, Diabetes, and Hyperlipidemia. He was receiving PT/OT/ST daily. His psychiatric decline has been very challenging for his 82 year old mother. Mr. C has ongoing challenges with focus, concentration, sleep, as well as having begun to experience increased wandering and confusion, which is of grave concern to his mother. Mrs. C explained that the combination of his mental and physical health decline has contributed to her inability to provide the care that he needs, on a long term basis.
- Mr. C is currently placed in the same NF and has been referred to MHAS for assistance with applying for some of the resources for community living that are available to him. MHAS is working with Mr. C's case manager to determine what community-based services and living options are available to him in the rural area in which he resides.

Questions?