PASRR 101: Collaboration and A Successful PASRR Program

PASRR 101-THE PASRR TECHNICAL ASSISTANCE CENTER (PTAC) STATE TRAINING SLIDES

&

INGREDIENTS IN A SUCCESSFUL PASRR PROGRAM

PASRR 101

PASRR TECHNICAL ASSISTANCE CENTER (PTAC)

STATE STAFF TRAINING

PTAC

PASRR Technical Assistance Center

PASRR Overview

A BRIEF HISTORY OF PASRR WITHIN LONG TERM CARE

THE PURPOSES OF PASRR

THE LEGAL AND REGULATORY FRAMEWORK

&

COLLABORATION

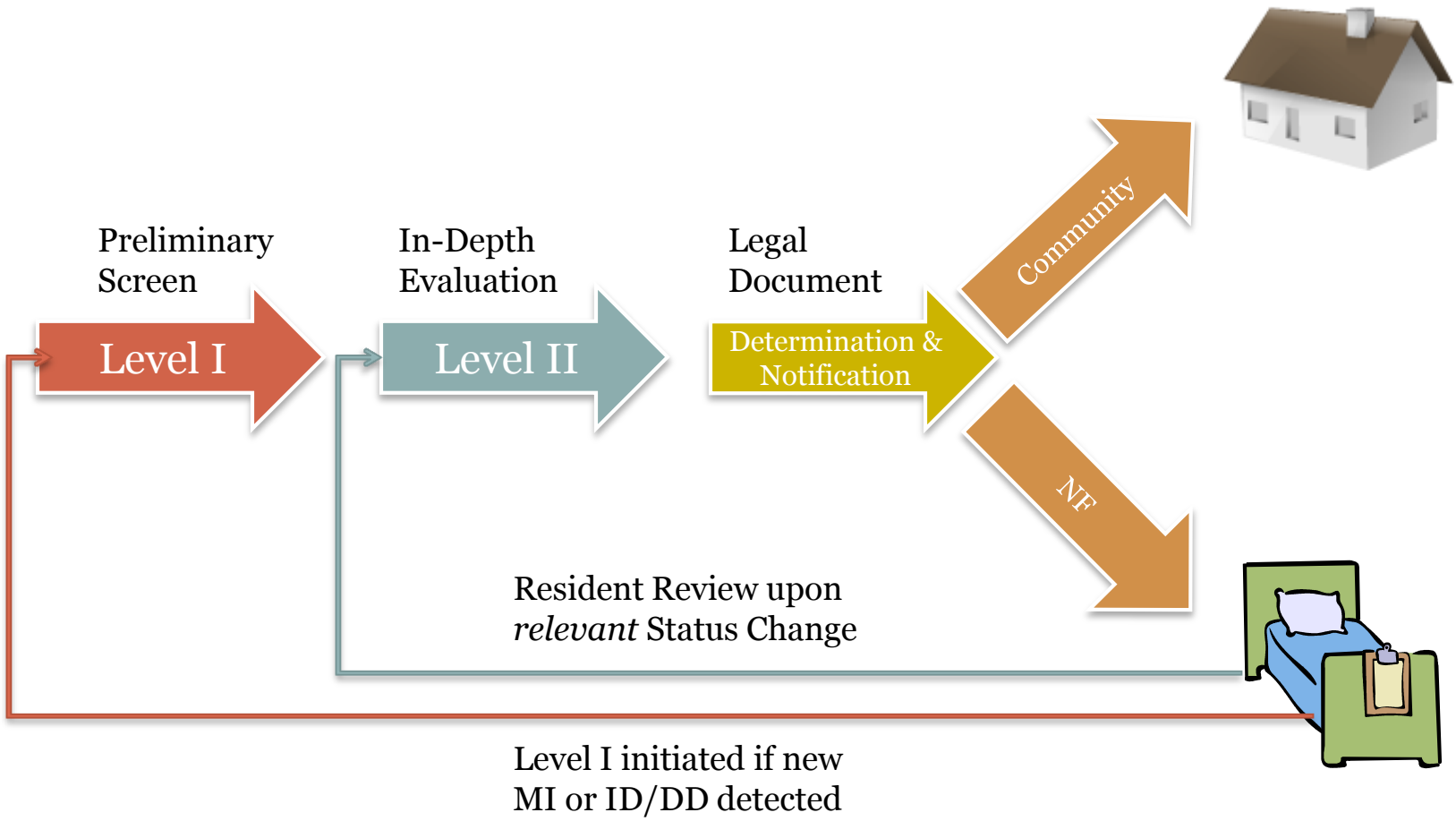
The Purposes of PASRR

1. To ensure that individuals are evaluated for evidence of possible mental illness (MI) and/or intellectual or developmental disabilities and related conditions (ID/DD/RC).
2. To see that they are placed appropriately, in the least restrictive setting possible.
3. To ensure they receive the services they need, wherever they are placed.

Key Milestones in PASRR & Related Efforts

Legal/Regulatory Milestone	Act	Year
Establishment of Title XIX (Medicaid)	SSA	1965
Creation of 1915(c) waivers	SSA	1981
Establishment of PASARR	OBRA	1987
Required start of PASARR	OBRA	1989
Americans with Disabilities Act (ADA)	ADA	1990
Publication of PASARR Final Rule	--	1992
Incorporation at 42 CFR 483.100-138	--	1994
Elimination of Annual Resident Review (now PASRR)	BBA	1997
Olmstead v. L.C.	--	1999
Establishment of 1915(j), 1915(i), MFP	DRA	2005
Changes to 1915(i), creation of 1915(k), more MFP	ACA	2010
Roll-out of MDS 3.0 with Q.A1500 and new Section Q	--	2010

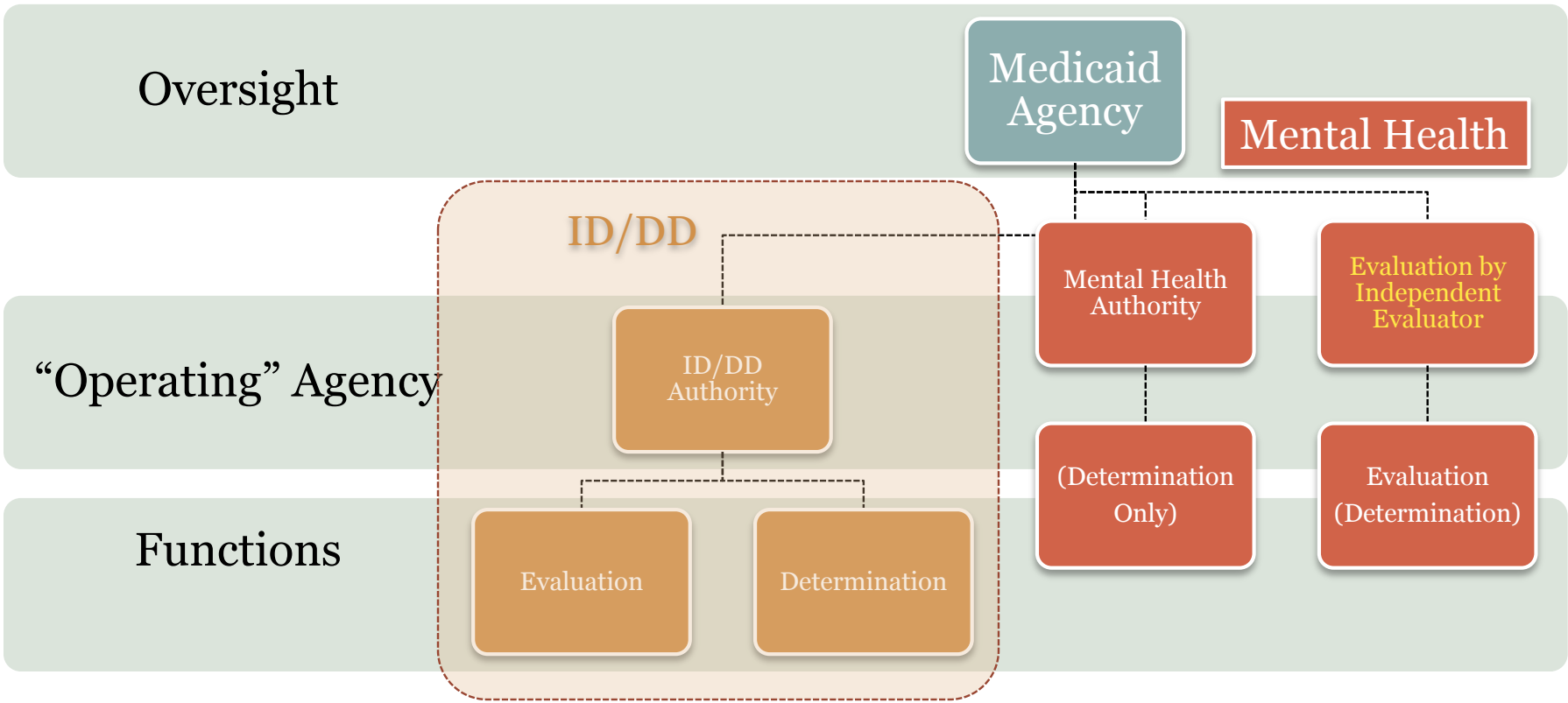
The PASRR Process: A Basic Sketch



A Few Obvious Preliminaries

- Medicaid is a partnership between States and the Federal government.
- PASRR is part of Medicaid.
- PASRR is a required part of the Medicaid State Plan.

Roles & Responsibilities



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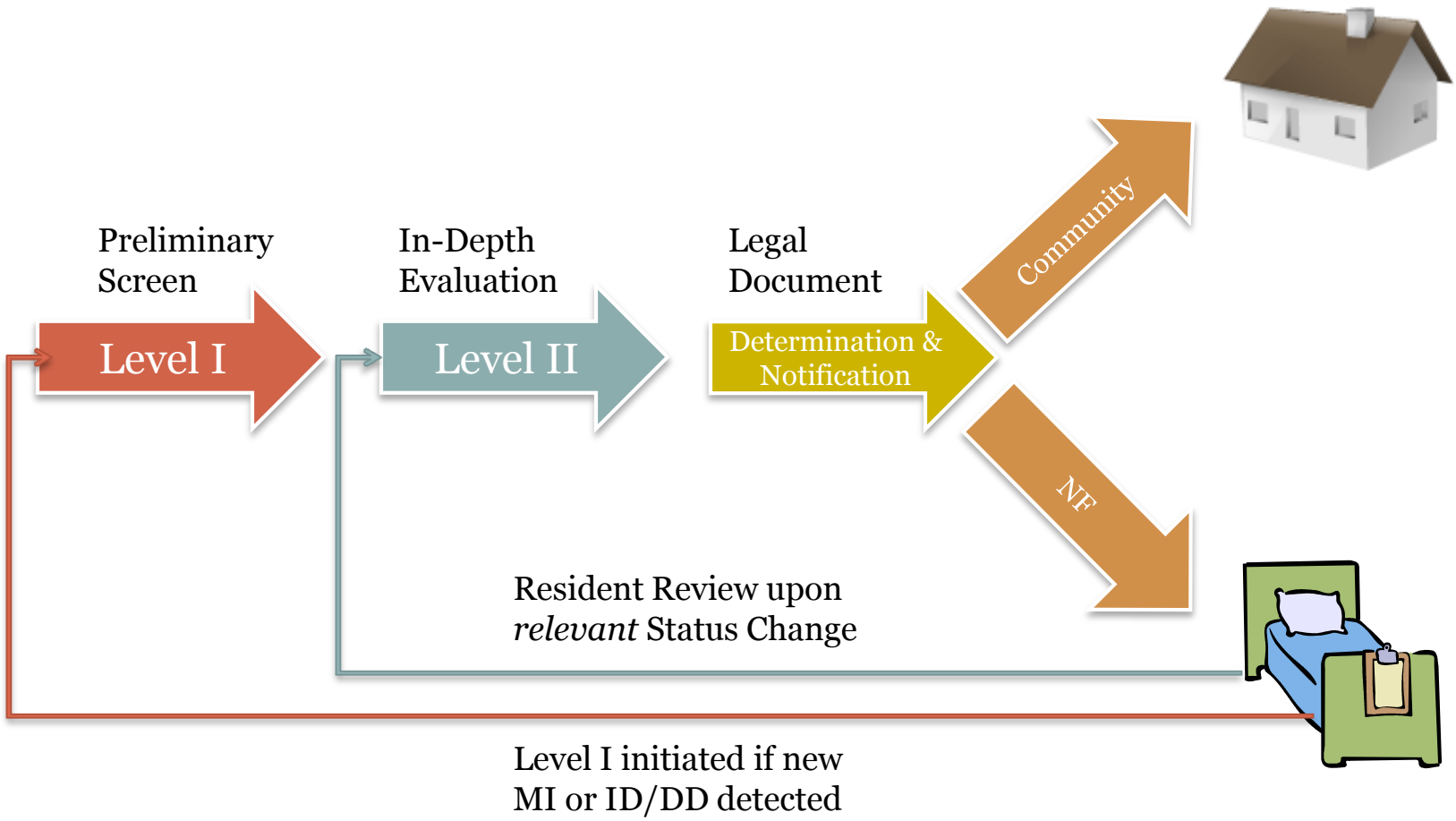

Categories & Qualifiers, Part I

DIAGNOSIS OF MENTAL ILLNESS, INTELLECTUAL DISABILITY, AND DEVELOPMENTAL DISABILITY

HOSPITAL DISCHARGE EXEMPTION

CATEGORICAL DETERMINATIONS

DEMENTIA

Diagnoses: Mental Illness

Diagnosis	Make or confirm a diagnosis of major mental illness that is *not episodic/situational and that does not include a primary diagnosis of dementia (dementia to be discussed later)*
Timing	Recent major treatment episodes OR significant disruption within past 2 years
Disability	Active symptoms last 6 months: • interpersonal functioning • concentration/pace/persistence • adaptation to change
Examples	(e.g., schizophrenia, bipolar disorder, major depression)

Diagnostic categories from DSM III-R, 1987

Diagnoses: ID/DD

Diagnosis	IQ < 70 per standardized, reliable test
Timing	Onset before age 18
Duration	Likely to be lifelong
Disability	Concurrent impairments in *adaptive functioning*

Criteria from AAIDD (formerly AAMR), 1983

Diagnoses: Related Conditions

Diagnosis	Related to ID/DD because they: • Result in similar impairments to intellectual functioning or adaptive behavior AND • Require similar treatment or services
Timing	Present before age 22
Duration	Expected to continue indefinitely
Disability	Result in substantial functional impairments in 3 or more major life activities (e.g., self-care, mobility)
Examples	autism, cerebral palsy, epilepsy, TBI

The Hospital Discharge Exemption

- The *only* true **exemption** from PASRR
- For post-acute stays lasting < 30 days
- If longer, PASRR must be completed by calendar day 40

Two Types of Categorical Determinations ("Advance Group Determinations by Category")

- **Purpose:** Allow a State to skip the individual NF evaluation and *in some cases* the SS evaluation, based on existing documentation
- **Type 1:** Unlikely to benefit from Specialized Services
- **Type 2:** Time-limited

Categorical Determinations: Type 1

- Individuals unlikely to benefit from specialized services, e.g.:
  - Coma
  - Hospice
- States can be plausibly creative in creating new categorical determinations

Categorical Determinations: Type 2

Case	Type	Length
Delirium	Provisional	Until delirium clears
Protective services	Provisional	7 days max
Respite	Temporary	“up to a fixed number of days”* (brief & finite)

*up to the State

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Categorical Determinations

- Allow a State to skip the individual SS evaluation based on
  - Existing documentation
  - Provisional nature of admission
- Not part of basic State Plan
- Must be introduced via State Plan Amendment
- State Plan preprint at 4.39A is blank
- Categorical Determinations *are* a completion of Level II:
  - Evaluation
  - Determination
  - Notification

Dementia and Mental Illness

- When it is discovered that a person has dementia, PASRR may be terminated *if* an individual has:
  - A serious mental illness AND
  - Evidence of dementia that is *primary* (i.e., more serious than the MI)
  - These determinations must be made and documented by an appropriately qualified medical professional
- In case of ID/DD:
  - PASRR may *not* be terminated
  - But SS may still not be necessary

Categories & Qualifiers, Part II

LEVEL OF CARE

SPECIALIZED SERVICES

PERSONNEL QUALIFICATIONS

PLAN OF CARE

KINDS OF SERVICES

What about Level of Care (LOC)?

- NF LOC definitions have been left to the States
- The PASRR Final Rule (1992) contemplated that LOC would be integrated with PASRR
- For most States, LOC:
  - Is (deliberately) restrictive
  - Precedes PASRR

Specialized Services: Two Definitions

- **Definition 1:** Admit to NF
  - Services provided to NF residents beyond what NF provides under its per diem (e.g., day program, behavioral support)
- **Definition 2:** Not admitted to NF, but provided with Services that *cannot* be provided in the NF
  - Community programs, including waiver programs
  - In-patient psychiatric
  - ICF/MR
- The CFR supports *both* definitions

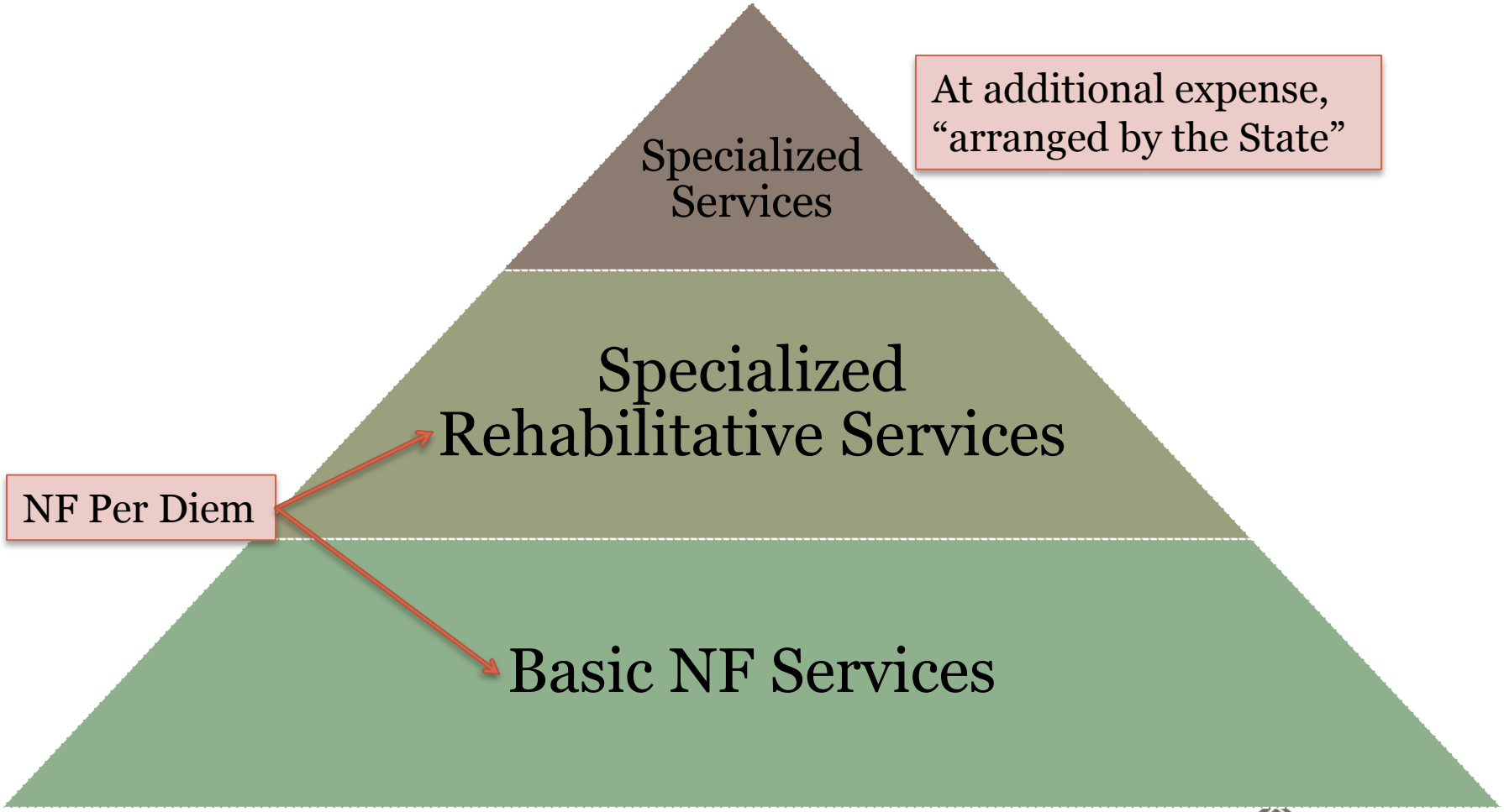
Personnel Requirements

Population	Requirements	Notes
All Individuals	H&P by physician (MD or DO)	Can be performed under physician review
Individuals with MI	Qualified Mental Health Professional	State sets QMHP standards
Individuals with ID/DD	IQ test by licensed psychologist; Other evaluations by Qualified Mental Retardation Professional	State sets QMRP standards

Plan of Care

- PASRR recommendations must be incorporated into individual's plan of care
- Important wrinkle:
  - PASRR good on the "front end"
    - Preadmission Screen
    - Resident Review
- Plan of care monitoring falls to Survey & Cert – currently a weak spot

The PASRR Pyramid



Complexities of the PASRR Determination

- PASRR determination = *this* NF for *this* individual's *total needs*
- <u>BUT</u> Resident Review need not be done:
  - Upon inter-facility transfer ($NF_1 \rightarrow NF_2$)
  - Before return from outpatient stays (if uninterrupted):
    - $NF_1 \rightarrow$ Psychiatric hospital or ICF/MR $\rightarrow NF_1$
    - $NF_1 \rightarrow$ Psychiatric hospital or ICF/MR $\rightarrow NF_2$

A Note about the PASRR Regulations

- Several things are out of date
  - *Annual* Resident Review (removed by law in 1990s)
  - Definitions of mental illness and ID/DD tied to 1980s diagnostic criteria
  - Use of the phrase "mental retardation" instead of "intellectual disability"
- Regulations will be revised at some point in the next few years, but it's what we have to work with for now

Useful Rules of Thumb

- PASRR inherits all the requirements of Medicaid (facility definitions & certifications, fair hearing, etc.).
- States have wide latitude in many ways, e.g.:
  - Categorical determinations
  - Specialized services
  - Personnel qualifications
  - Timing of LOC
- States can exceed Federal requirements.

Useful Questions to Consider

- Does the system (practice) fulfill the three main goals of PASRR?

1. To ensure that individuals are evaluated for evidence of possible mental illness (MI) and/or intellectual or developmental disabilities and related conditions (ID/DD/RC).
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- Is the system (practice) person-centered?
- Does the system (practice) lead to better outcomes for individuals?

Moving from Categories & Qualifiers to a Successful Program

COLLABORATION

KEY AGENTS IN COLLABORATION

BUILDING COMMUNITY BASED SUPPORTS

STAFF SUPPORT

STRONG INTERAGENCY RELATIONSHIPS

SUCCESSFUL INTERAGENCY MEETINGS & INTERAGENCY AGREEMENTS

COLLECT AND USE DATA

EFFECTIVE INTEGRATED SYSTEMS

What Factors Support Collaboration?

Developing shared issues, values, and shared solutions

- Use dialogue, resource education, and cumulative learning between partners to facilitate collaboration
- Engage multiple stake holders who influence process and outcomes
- Explore and clarify key PASRR stake holder's differing perspectives
- Optimize strengths, use available resources
- Build on previous collaborative experiences
- Unified Vision: Incorporating desired outcomes

What Factors Support Collaboration?

- Develop shared implementation strategies
- Consider whether clinical expectations will be met
- Understand your own responsibilities and requirements
- Incorporate the benefits of diversity
- Are there cooperative efforts & shared planning, problem solving, and decision making?
- A broad program change requires integrated solutions for productive resolution

Key Agents in PASRR Collaboration

- Key players from Medicaid, SMHA and SMRA.
- Level of Care staff
- Level I screeners
- Level II evaluators
- PASRR determination staff (State MH and ID/DD authority designated staff)
- Transition/ Medicaid long-term care staff
- Hospital discharge planners
- NF admission, MDS, administrators, & direct care staff
- Medicaid Surveillance and Utilization Reviewers

Strong Relationships with Providers

- Successful States cultivate strong relationships
  - Nursing home association, hospital association
  - Other professional associations (e.g., nursing associations, associations of clinical social workers)
  - Ombudsman
  - Nursing Facility License and Survey Staff
  - Community Mental Health Centers (e.g. Emergency Service)
  - Community ID/DD Providers
- Successful States cultivate PASRR training opportunities with providers

Examples of Collaboration in PASRR

- Screening for Level II needs during LOC process
- Hospital discharge planner screening need for Level II prior to hospital discharge
- Availability of web based training, collaborative procedures, and telephone consultation with mental health or ID/DD specialist
- Procedures for PASRR screeners to refer for specialized evaluation to identify need for Level II
- A NF team approach to identify need for PASRR (e.g. Hospital Discharge planner coordination with NF admission process, NF admission review process, NF MDS coordinator, NF charge nurse staff, NF dietician/activity staff)

Collaboration in Building Community-Based Supports for Individuals

- Robust system of community based long-term services and supports (LTSS)
- All individuals involved in PASRR know about related services
  - State Plan services
  - 1915(c) waivers
  - State Plan Amendments (e.g., 1915(i))
  - Money Follows the Person (MFP)
  - Aging and Disability Resource Centers (ADRCs)

Successful PASRR and Staff Support

- Managers understand the importance of PASRR
- Dedication of sufficient staff time to implement and monitor PASRR programs
- Promote on-going professional development and performance rewards
- Access technical assistance ("in-house", by the State itself, or by external parties)
- Use of Regional Offices, PTAC, and state-to-state consultation for support and technical assistance

Strong Interagency Relationships

- Strong relationships among the main players in PASRR –
  - The Medicaid agency
  - The Mental Health authority
  - The ID/DD authority
- Maintain active communication
- Mechanisms ensure coordinated efforts, compliance and person-centered goals

Inter-Agency Agreement & Meetings

- How do different agencies ensure that their efforts are coordinated? Is the interagency agreement effective in supporting the goals of PASRR?
- How often do different State agencies meet?
- How is meeting agenda developed?
  - Are there areas where change can easily be made?
  - Is there an opportunity to streamline PASRR ?
  - Is interagency cross education beneficial?
  - Are there component or process deficiencies?
  - Are there efficiencies/deficits in the PASRR outcomes?
  - What is an effective PASRR program?

Collect & Use Meaningful Data

- Collect a variety of measures, including quality measures and longitudinal data, to detect trends
  - Identify improvements or declines
- Collect and use "qualitative signals"
- Use of data "dashboard" helps staff monitor their progress, compliance, and quality assurance
- Dashboard data helps states recognize need to seek technical assistance (e.g. CMS, PTAC, other parties)

A Seamless, Efficient or Technologically Sophisticated System

- Easy storage and retrieval of PASRR-related data
  - screens, assessments, determinations
- Ability to monitor quality and outcomes
- Technology to make PASRR more efficient and effective
- Procedures to ensure services identified are provided to individuals with mental illness and/or intellectual and developmental disabilities

What Are Next Steps in Program Reform? Does It Include Collaboration?

- Does the system (practice) fulfill the three main goals of PASRR?

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THANK YOU!

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