The Power and Possibility of PASRR Webinar Series

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*Please note that you **must** attend the entirety (90 minutes) of this webinar if you wish to receive Continuing Education credits.*

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Discharge Planning and Transitions into the Community

THE COMMON GROUND OF STATE PASRR AUTHORITIES AND NURSING FACILITIES

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Learning Objectives

1. Understand the PASRR Code of Federal Regulations (CFR) requirements that support effective discharge planning and transition into the community.
2. Understand the Conditions of Participation Requirements that support nursing facility (NF) effective discharge planning and transition to the community.
3. Understand the interface of state PASRR programs and NFs in the discharge and community transition process.
4. Understand the array of options that can support discharge planning and transition into the community.
5. Understand the importance of a State Authority/Nursing Facility "common ground" strategy to promote discharge planning and transition to the community.

Scope of the Problem

- Just over 1.4 million residents were living in US nursing homes on December 31, 2014

  (CMS Nursing Home Compendium 2015 Edition, "Nursing Home Residents" – page 2)
- This is roughly equal to the number of persons receiving home and community-based services (HCBS)
- It is unclear how many individuals might have Mental Illness (MI) or Intellectual Disability/Related Condition (ID/RC), but from PTAC analysis, the number could be as high as:
  - 3 percent for ID and RC (upper bound)
  - 70 percent for MI (upper bound); 20 percent for serious MI

PASRR

THE FRONT DOOR FOR EFFECTIVE DISCHARGE PLANNING AND TRANSITION INTO THE COMMUNITY

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Key PASRR Features

- No individual can be admitted to a NF until PASRR has been completed.
- *Additional considerations* granted to individuals with mental illness (MI), intellectual disability (ID), or a related condition (RC) to receive long term services and supports (LTSS) in the most integrated setting.
- Identification of service needs related to their condition that are over and above those in the NF benefit (Specialized Services).
- Resident Reviews required to:
  - identify changes in LTSS needs;
  - recommend community alternatives to continued stays in NFs; and
  - coordinate transition planning back to the community.

Definitions of PASRR Disabilities

- Categories defined in CFR, with incorporation by reference of two key documents:
  - Mental illness: DSM III-R (1987) [483.102(b)(1)(i)] except in cases of primary dementia: 483.102(b)(1)(i)(B)
  - Intellectual disability: Manual of American Association for Mental Deficiencies (AAMD, 1983)(now AAIDD) [483.102(b)(3)(i)]
  - Related conditions: A term of art unique to PASRR, stated diagnostically – conditions related to ID because they create similar needs [435.101].

See PTAC FAQ January 2018: *Can states refer to the DSM-5 in their operations guidelines related to PASRR, or do they need to incorporate the CFR reference to the DSM III?*

PASRR- Alignment with Mental Health (MH) and ID Authority Advocacy Roles

- PASRR can foster **continuity of care** for individuals with MI, ID, or RC that were being supported with community-based services prior to seeking NF admission, or that will need those services when transitioning back to a community setting.
- PASRR can **promote engagement** of MI, ID, or RC individuals with needed services, if those services were not active at the time of their seeking NF admission.
- PASRR can **support NF efforts to develop person-centered plans of care.**
- PASRR can **support state "community first" and "self-determination" initiatives.**
- PASRR can **reduce the risk of hospital/NF readmission**.

NF Conditions of Participation References Related to the Discharge & Transition Process

PHASE I AND PHASE II

STATE OPERATIONS MANUAL APPENDIX PP – GUIDANCE TO SURVEYORS FOR LONG TERM CARE FACILITIES

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Phase I – 11/28/16
Phase II – 11/28/17

The new Conditions of Participation include an emphasis at §483.21 on specialized services and the importance of NF plans of comprehensive and person-centered care planning, including:

- Incorporating PASRR recommendations where applicable
- Documenting rationale for any disagreement on PASRR recommendations
- Services **provided or arranged** are delivered by individuals who have the skills, experience and knowledge to do a particular task or activity
- Referral for Level II resident review upon significant change in condition

Significant Change in Condition

A "Significant Change" is a decline or improvement in a resident's status that:

- Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions; is not "self-limiting";
- Impacts more than one area of the resident's health status; and
- Requires interdisciplinary review and/or revision to the care plan.

See PTAC FAQ December 2017: "What is considered a significant change in condition?

Discharge Planning

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

(c)Discharge planning—(1) Discharge planning process. The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and **effectively transition them to post-discharge care**, and the reduction of factors leading to preventable readmissions.

Nursing Facility Plan of Care

CREATING OPPORTUNITIES FOR TRANSITION

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Care Area Assessment

Care Area Assessment (CAA): (page V5)

Items V0200A 01 through 20 document which triggered care areas require further assessment

- Decision as to whether or not a triggered care area is addressed in the resident care plan, and the location and date of CAA documentation.
- The CAA Summary documents the interdisciplinary team's and the resident's, resident's family or representative's final decision(s) on which triggered care areas will be addressed in the care plan.

MDS 3.0 – The Twenty Care Areas

Return to Community Referral (page 4-41)

"The discharge assessment process requires nursing home staff to apply a systematic and objective protocol so that every individual has the opportunity to:

- access meaningful information about community living options; and community service alternatives;
- with the **goal being to assist the individual in maintaining or achieving the highest level of functioning and integration possible**."

MDS 3.0 – The Twenty Care Areas, cont.

Return to Community Referral

This includes ensuring:

- that the individual or surrogate is fully informed and involved, identifying individual strengths, assessing risk factors,
- implementing a comprehensive plan of care,
- **coordinating interdisciplinary care providers, fostering independent functioning, and**
- **using rehabilitation programs and community referrals**.

Section Q

Participation in Assessment and Goal Setting (page Q1)

- Section Q of the MDS uses a person-centered approach to ensure that all individuals have the opportunity to:
  - learn about home- and community-based services, and
  - to receive long term care in the least restrictive setting possible.

Transition to Community

DELIVERING ON THE NF PLAN OF CARE

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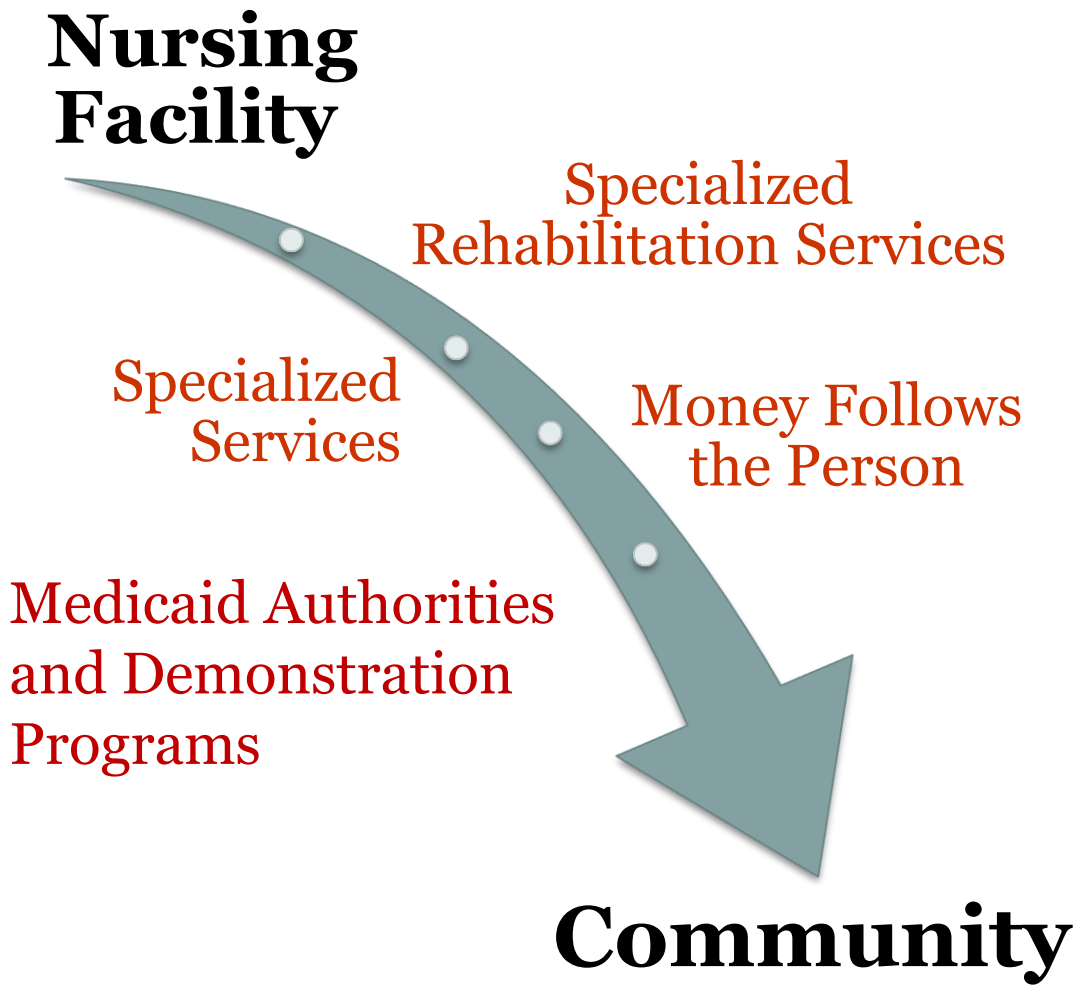
Key Transition Considerations

- No defined time limit to accomplish transition to the community
- Process starts upon admission (no waiting period)
- PASRR Determination and Level II Report promotes individualized Plan of Care (POC)
  - Unique needs related to the individual
- Use of community providers for specialized services promotes continuity of care
  - maintain existing linkages
  - continuation of services upon transition to the community

Transition Services and Supports



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Specialized Rehabilitation Services

§483.65 Specialized rehabilitative services. (NF section of CFR)

- (a) *Provision of services*. If specialized rehabilitative services such as but not limited to physical therapy, speech-language pathology, occupational therapy, respiratory therapy, **and rehabilitative services for a mental disorder and intellectual disability or services of a lesser intensity as set forth at §483.120(c), are required in the resident's comprehensive plan of care, the facility must—**
- (1) **Provide** the required services; **or**
- (2) In accordance with §483.70(g), **obtain the required services from an outside resource that is a provider of specialized rehabilitative services** and is not excluded from participating in any federal or state health care programs pursuant to section 1128 and 1156 of the Act.

Specialized Rehabilitation Services, cont.

§483.120(c) Specialized services (*PASRR Section of CFR*)

- (c) *Services of lesser intensity than specialized services*. The NF must provide mental health or intellectual disability services which are of a lesser intensity than specialized services to all residents who need such services.

Specialized Services: Assurances

- "If a determination is made to admit or allow to remain in a NF any individual who requires specialized services, the determination must be supported by assurances that the specialized services that are needed can and will be provided or arranged for by the State while the individual resides in the NF." §483.130 (n)

Specialized Services

- While not required, it can be valuable to have services provided by community-based providers with expertise in PASRR condition or familiarity with the individual.
- Can be included as a nursing facility benefit with change to the Medicaid State Plan.

See PTAC FAQ February 2018: *What should States consider when including Specialized Services in State Plans?*

See PTAC Webinar February 2014: *Paying for Specialized Services: New Mechanisms for States*

Provide or arrange for provision of SS

- Possible Options for Specialized Services
  - Private insurance
  - Managed Care Organization (MCO)
  - Medicare
  - Medicaid (State Plan Amendment (SPA))

See PTAC White Paper May 2017: *Financing or Arranging for PASRR Specialized Services for Individuals with Serious Mental Illness: Medicaid and Medicare Options*

Specialized Services – The importance of **continuity of care** and initiating treatment

Specialized services can be "look alike" services that continue LTSS being provided prior to NF admission, or that connect the individual to new services that can continue on transition to the community.

The importance of connecting individuals to needed services is evident in a recent evaluation of the Money Follows the Person demonstration.

National Evaluation of the MFP Demonstration: "Use of community-based LTSS before an institutional stay appears to increase the likelihood a beneficiary will transition to the community; upon the transition, previous users of community-based LTSS are more likely to once again use community-based LTSS".

Specialized Services

PTAC holds calls every other month to discuss state questions related to specialized services. State initiatives have been highlighted, including:

- Vermont
- Idaho
- Washington

State Examples of Specialized Services

Vermont:

- The Developmental Disability Services (DDS) Specialist requests that specialized services be provided by the individual's local provider agency.
- The Specialist negotiates the amount of service provision and rate with the agency – up to 25 hours per week.
- The rate is a bundled, fee for service rate that includes: service coordination, direct support, transportation.
- The agency must modify the person's Individual Support Agreement (plan of care) to address needs identified in the PASRR evaluation.
- **The agency suspends the person's DD HCBS budget while the individual is in the NF, and bills a fee for service code for specialized services.**
- If/when the person leaves the NF and returns to HCBS, their formerly allocated budget is re-activated.

See PTAC Webinar December 2015: ID/DD/RC Specialized Services

State Examples of Specialized Services, cont.

Idaho

- Transition Manager - to assist with discharge to a more integrated community setting –– both living situation and mental health services
- Skills Training and Development
- Cognitive Stimulation Activities/Exercises
- Peer Support – Ambassador

See PTAC Webinar April 2015: PASRR Specialized Services and Specialized Rehabilitative Services

State Examples of Specialized Services, cont.

Washington

- Assistive technology
- Behavior support and consultation
- Community access
- Community guide
- Habilitative therapies
- Staff/family consultation and training
- Supported employment
- Transportation
- Other habilitative services

See PTAC Webinar August 2017: The PASRR Initiative

Medicaid Authorities and Demonstration Programs

CMCS Informational Bulletin – June 2015: This Bulletin identifies how these housing-related activities and services can be incorporated into a Medicaid benefit design for individuals needing LTSS and in states' strategies for transforming systems to achieve optimal community integration.

CMCS Informational Bulletin

- Money Follows the Person
- 1915(c) HCBS Waivers
- 1915(i) HCBS State Plan Optional Benefit
- 1915(b) Waivers
- 1905(a) State Plan Services

HCBS information found at CMS.gov

State Authority and Nursing Facility Collaboration

FINDING THE COMMON GROUND – EFFECTIVE DISCHARGE AND TRANSITION INTO THE COMMUNITY

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Steps to Consider

- 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.

The Path to Discharge and Transition to the Community

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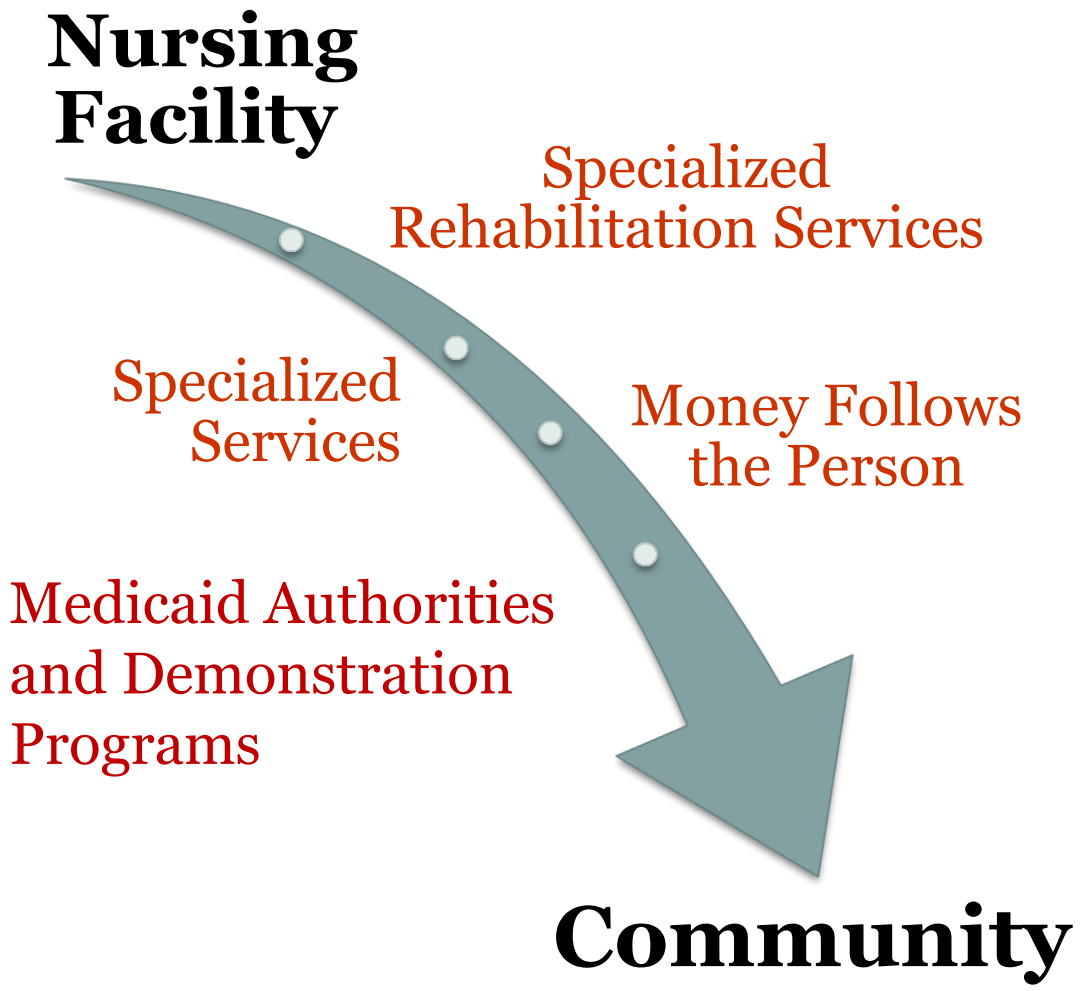
Transition Services and Supports



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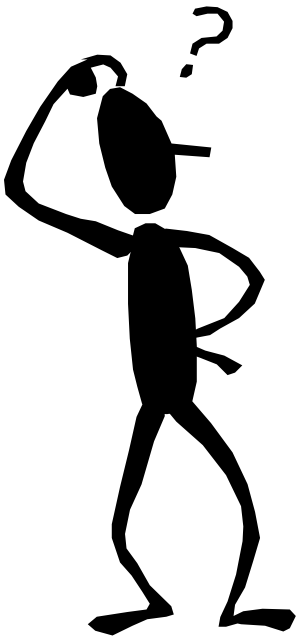
QUESTIONS



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THANK YOU!

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