# PASRR: Partnering with Hospitals in Meeting Patient's Needs

PASRR Technical Assistance Center
February 14, 2012
90 minutes
Presenter:
Jackie Birmingham, RN, BSN, MS, CMAC

# Agenda

- Introduction – why PASRR
- Timeline of Federal Regulations for hospitals
- Barriers to Level I and Level II
- Suggestions
  - Strategies:  What hospitals can do
  - Strategies: What States can do
- Q&A

# Message from presenter:

- The content is from the perspective of PASRR in acute care settings
  - Regulations discussed relate only to the discharge of patients from acute care to Nursing Facilities
- The suggested strategies are ‘general’
- Please review within in your organization
- The presenter has no conflict of interest

# PASRR –A personal view

What lead to OBRA ′1987?

- 30 years before OBRA: late 50's early 60's
  - Psychiatric/Mental Hospitals (2,000 beds +/-)
- Discovery & use of chlorpromazine
- Goal of "deinstitutionalization"
- Patients more 'functionally' stable
  - Discharged to the community
  - Community services 'not there' or if available not accessed by clients

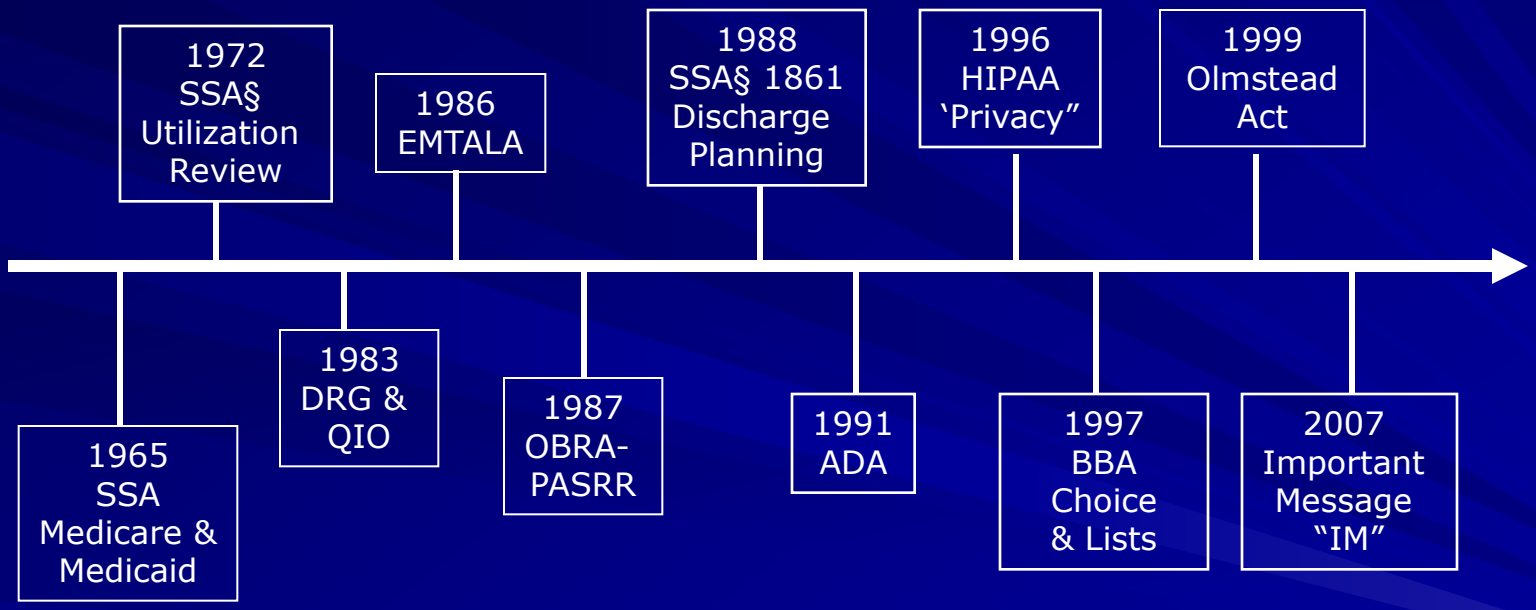
# Patients Discharged from Mental Health facilities to ‘the community’…

- Patient in the community has a mental health emergency
- Taken to an Emergency Department
  - Patient can’t be discharged –
  - ‘Risk to self or risk to others’
- Admitted to acute care hospital
  - Still can’t be discharged to the community
- Admitted to a Nursing Home

# “Unintended Consequences”

- The ‘unintended consequences’ from closing Psychiatric Hospitals
  - Without strengthening community based services
- Significant ‘burden’ on Acute Care Hospitals
- Burden then passed on to nursing homes
  - Nursing home not equipped to provide mental health services – not their mission

# A Time line of Federal Rules



# Regs 1965: Medicare and Medicaid

1965- Medicare & Medicaid

- Title XVIII—Health Insurance for the Aged and Disabled (Medicare)
  - Average life expectancy in 1965 – was 65,  now 78
  - “Extended Care Benefit”  (3 midnight rule)
- Title XIX - Grants to States for Medical Assistance Programs (Medicaid)

# Regs 1972: Utilization Review

**1972**- SSA§ 1861(k) – Utilization Review

- Hospitals must have UR committees & UR plans
  - Members must be physicians and appropriate staff

- 'Concurrent' Review
  - Appropriateness of Admission
  - Continued Stay
  - Professional services provided

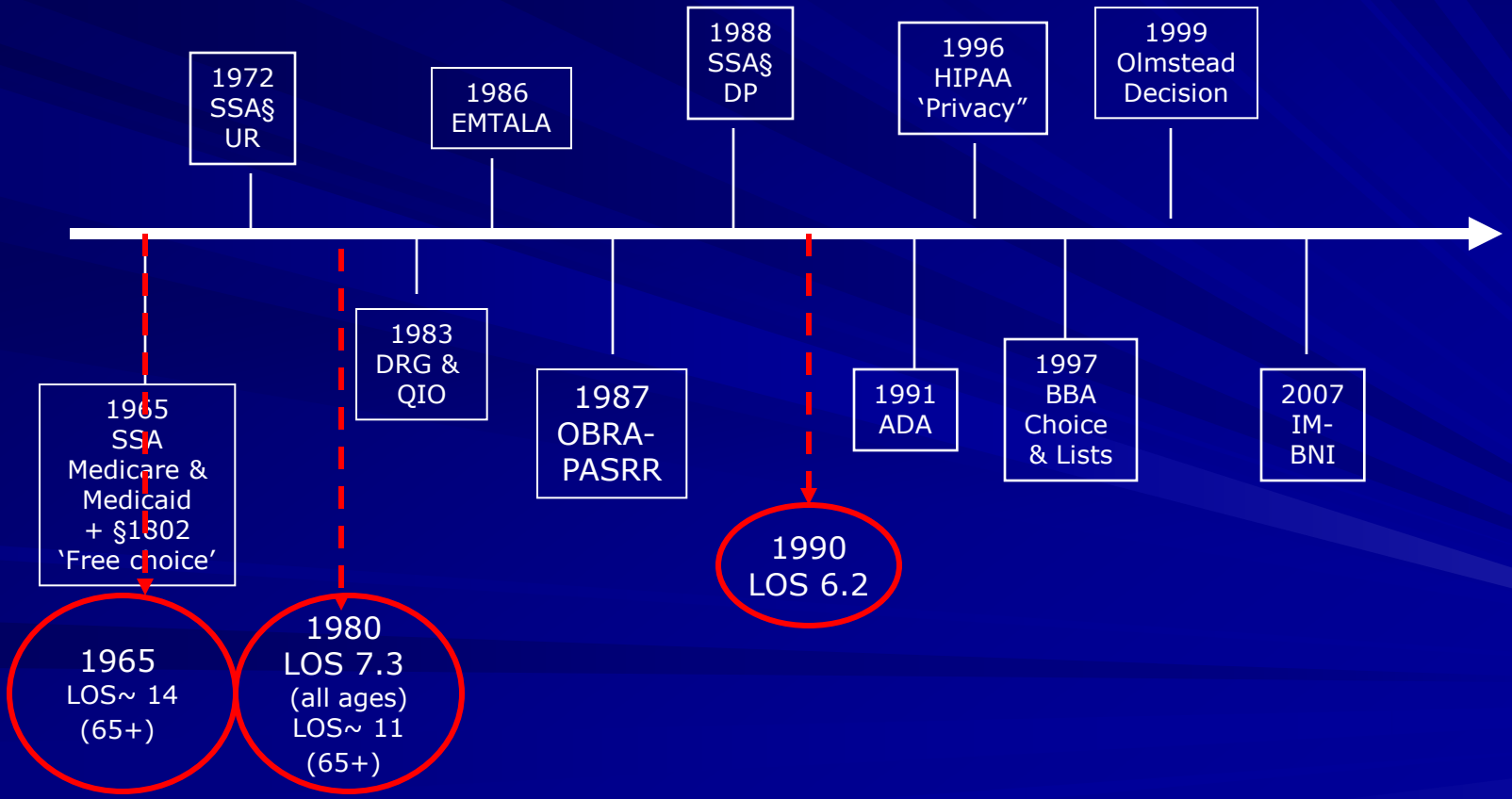
# Regs 1983: TEFRA

- **1983** – Tax Equity and Fiscal Responsibility Act:
- Prospective Payment System
  - DRGs ('bundled payment per admission')
  - PRO (Peer Review Organization)-
    - Now QIO (Quality Improvement Organization)
    - 'External Review' by physician organization
- Start of "Observation Services" - option
  - inpatient admission is not-medically necessary,
    - it is unclear how long presenting problem will take to resolve or get worse
  - Impact on patients presenting with mental health symptoms

# Impact: Acute Care Payment Rules

- As psychiatric hospitals were closing acute care hospitals were being financed differently
  - July 30, 1965 – Medicare and Medicaid
    - Pay per day, charges, costs, admit whomever
  - October 1, 1983 –
    - Prospective Payment System (PPS) for hospitals
    - Diagnosis Related Groups
    - Pay per stay (if appropriate)
- Payment incentives had impact on practice patterns
    - Length of stay drops

# Length of stay drops



# Regs1986: EMTALA

- Emergency Medical Treatment and Active Labor Act
- Antidumping Law: Any patient who
  - "comes to the emergency department"
  - requesting "examination or treatment for a medical condition"
  - must be provided with "an appropriate medical screening examination"
  - to determine if s/he is suffering from an "emergency medical condition", or an emergency mental health condition

# Regs: 1987 PASARR

- Nursing Home Reform OBRA '87
  - New opportunities for potential and current residents with mental retardation or mental illnesses for services inside and outside a nursing home
- Preadmission Screening and Annual Resident Review
  - Now PASRR
- Screen for "MI/MR" Mental Illness or Mental Retardation
  - Now MI/ID/DD (Mental Illness/Intellectual Disability/Developmental Disability)

# Regs 1988: "Discharge Planning"

- SSA§ 1861(ee) Discharge Planning
  - Screen, evaluate, plan, implement
- Applies to ALL patients,
  - regardless of payer (or no-payer)
- Focus on post-acute needs
  - Not admission criteria, or continued stay
  - Focus on what is needed post-discharge

# Regs 1991: ADA

- ADA – Americans with Disabilities Act
  - Least restrictive community setting
  - If reason for admission changes ‘disability status’
    - Need to develop a plan to send patient to a level of care different from his/her admission
- Post-acute needs for rehabilitation
  - Determine which post-acute level most appropriate
  - Help get patient to pre-hospital level, or maximum potential level
  - Rehabilitation setting choice depending on
    - Appropriateness
    - Coverage
    - Eligibility

# Regs 1997: BBA

- BBA – Balanced Budget Act
- Strengthened choice of post-acute providers
  - All types of providers for which Medicare pays
- Required patients be given a list
  - Of available and appropriate post-acute providers
    - SNFs, Home Health, and Hospice
  - Note: August 4, 2011 – CMS clarified
    - Okay to limit the list to SNFs with available beds

# Ruling: 1999 – Olmstead Decision

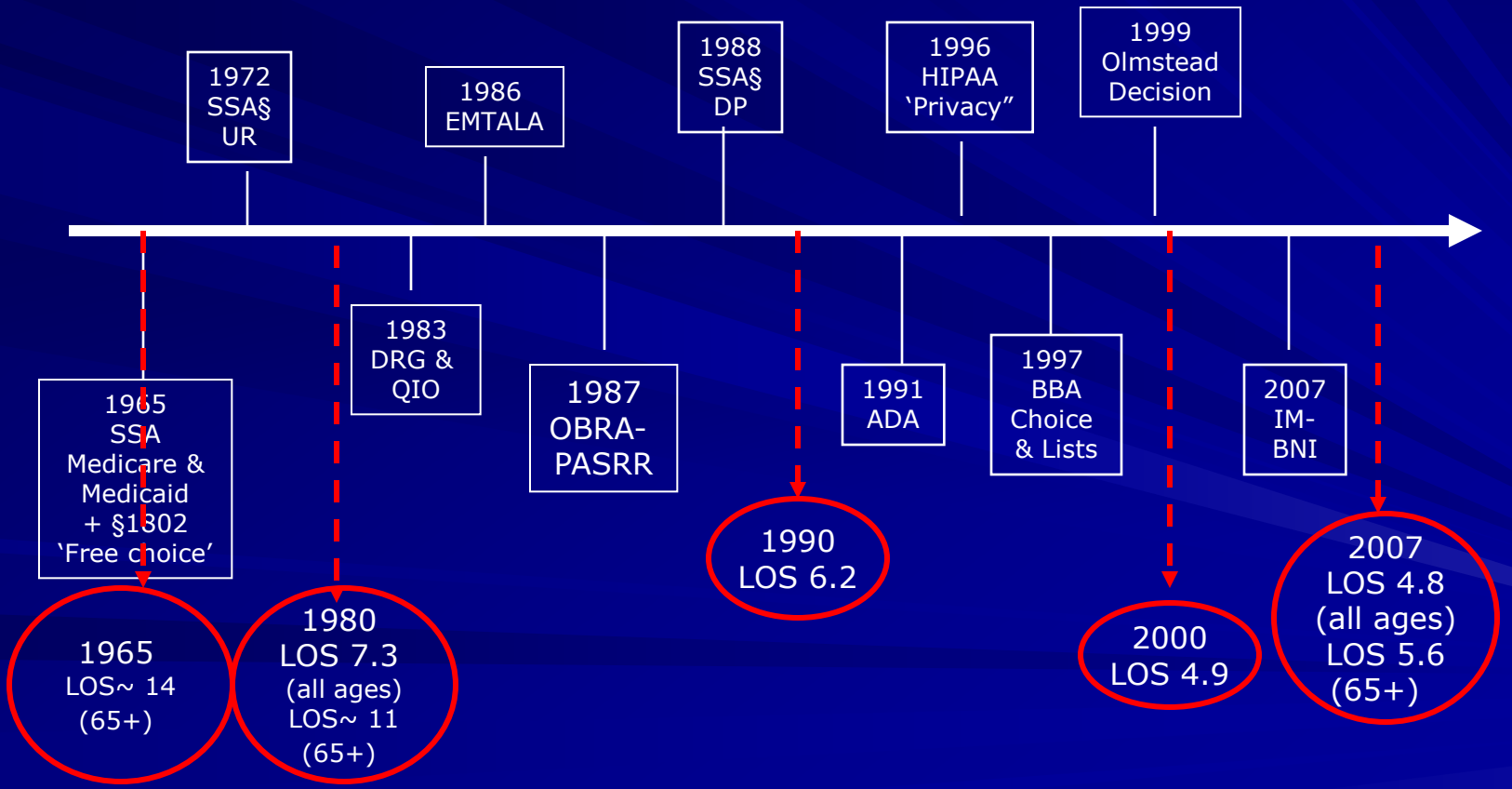
- The Olmstead Decision
  - Discharge to least restrictive setting
- Impact on hospitals
  - Patient met acuity for admission
  - Short length of stay for acute reason
  - Post acute care focus on continuing care related to reason for admission

# Revised Reg 2007: 'IM'

The 'Important Message' – patient's informed of their rights to appeal a discharge

- IF patient or family is not 'satisfied' with the discharge plan – for whatever reason-
  - submit an Appeal to the QIO for review (24 hours)
- IF review in favor of hospital –
  - Beneficiary Notice of Non-Coverage process (Hospital Issued Notice of Non-coverage)
- IF review in favor of the patient
  - No discharge – start over

# Length of stay drops even more



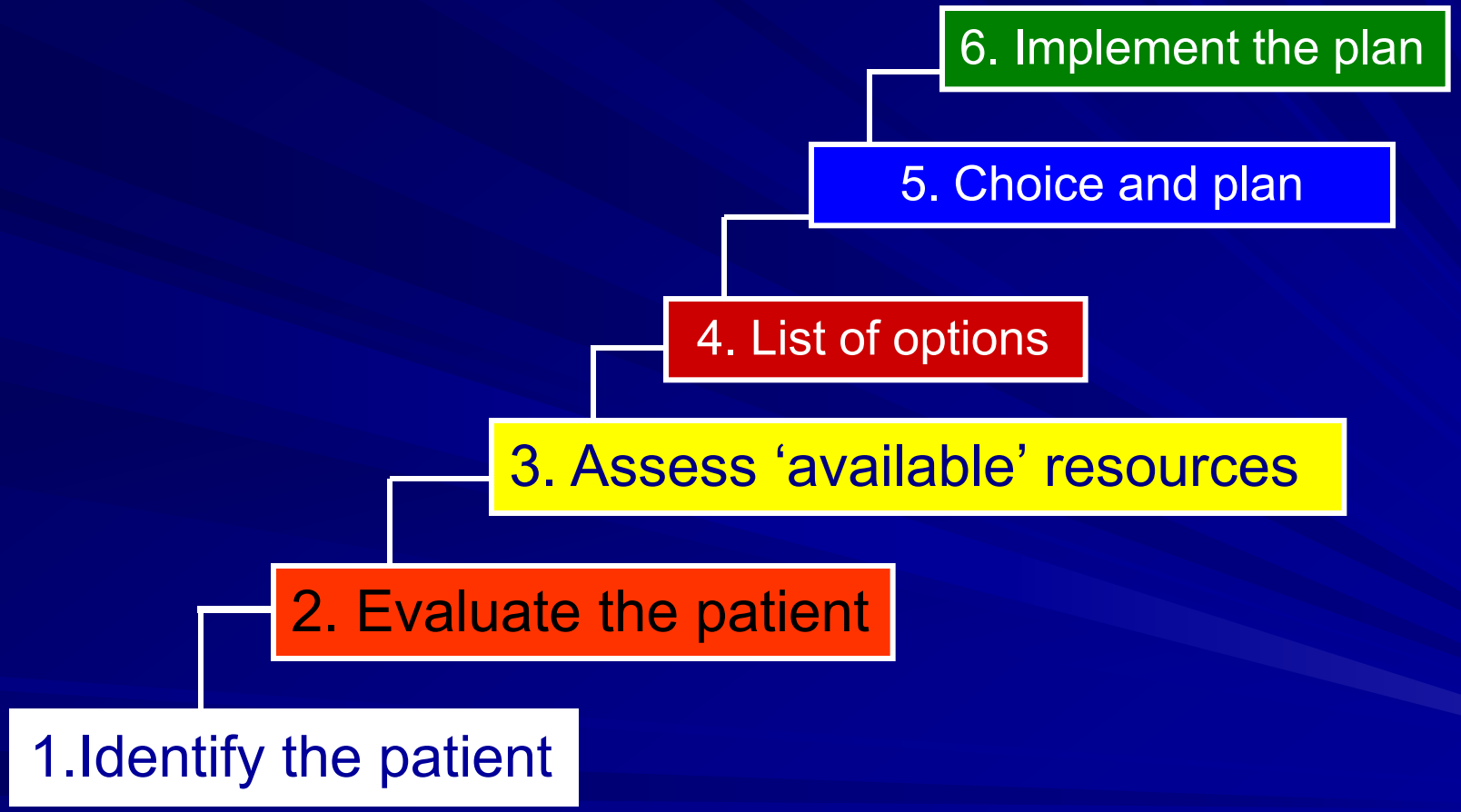
# What Hospital Based Case Managers do in 2012:

- Discharge planning
- Utilization Review
- Education of non-CM
- Case Facilitation with Physician Advisor
- Denials/appeals
- Crises intervention
- Psychosocial counseling
- Delivery of the IM copy
- Manage Recovery Audit retractions & appeals
- Abuse identification and reporting
- Completion of Advance Directives
- Benchmarking and outcome management
- Documentation Improvement
- Present on Admission Screening
- Quality Improvement
- Concurrent Coding
- Clinical pathways management and development
- Core measure data collection

# Primary functions for Hospital CMs:

- Two ‘basic services’ – SSA Conditions of Participation
- Utilization Review 1861(k) § Sec. 482.30
  - Admission, continued stay, professional services
- Discharge Planning 1861 (ee) § Sec. 482.43
  - Identify, evaluate, plan, implement
  - Select best level of care: STCH, IRF, LTCH, SNF, Home Health, Inpatient Hospice, Home Hospice,
  - Order: DME, Ambulance, medications, lab tests, non-medical services
  - Coordinate with payer

# Hospital Process to Discharge a Patient



# Ideal "To-do list" for Discharge to SNFs: in average +/- 4 days!

1. Identify patient in need of post-acute care
2. Determine next level of care need with MD, SW, Therapist
3. IF SNF - Find an available bed
4. Initiate/Complete PASRR screen – Level I
5. Review geographic location
6. Review if patient met 3 midnight qualifying stay for payment
7. Give patient's and representative a list of providers
   a) Choose among providers
   b) Review geographical location with patient/family/MD
   c) Notify selected provider
   d) Determine if bed is still available
8. Issue the IM (Important Message)
9. Wait for acceptance reply – notify patient/family/MD
10. Order ambulance transport

N.B.: If anything goes wrong anywhere – the process starts over from step 2.

# Selected factors in PASRR Compliance

- Higher patient acuity due to ‘admission review’
  - Observation status/service conundrum
  - Emergency department overuse
- Staff shortages/realignment/add functions
  - Consolidation of departments
  - Decrease in social services
- Length of stay
  - More rapid turnaround
  - Do more in less time

# Barriers to completion of Level I

1. Confusion by staff about the ‘rules’
2. Lack of information about patient’s developmental disability when admitted for a medical condition
3. Access to the forms
4. Confusion about when is it needed by the SNF?
   (Is it really ‘pre-admission’?)
5. Unclear about distribution of the Level I assessment
   1. Who needs what, when and how do they get it
   2. If by electronic submission, how do I access it, how do I use it and how do I get a reply
6. Screening of patients in the Emergency Department

# Barriers to completion of Level II

1. Need for Level II not identified early in admission
2. Unclear steps in how to coordinate appointment with Level II clinician (Who is a Level II clinician and how do I find him/her?)
3. It is unclear about which staff is responsible to Inform patient/representative about status and schedule the appointment.
4. With EMR, and paper records, it is unclear about the process to select and get 'other' information to the Level II clinician. Can the CM release the H&P or does it need to go through Medical Records?
5. If not already documented, how does the attending physician address the MI/ID/DD in his/her medical plan of care
6. The impact on the LOS scorecard the attending physician when the patient can't be discharged when he/she is medically ready
7. How are 'delay days' monitored and documented to appeal a denial when the patient's claim is audited

# PASRR – Passport or Bottleneck?

- PASRR is seen as a painful process and a bottleneck to discharge.
- PASRR is not seen as a PASSPORT to services for patients with mental or behavioral needs

# What to do?

Next are some suggested strategies

- Each type of strategy has been assigned to either ‘hospital’ or ‘state’
  - But strategies can be used by either

- It’s difficult for many to grasp the whole picture of PASRR because it crosses so many boundaries

# Strategies for stronger Partnerships: Hospitals

Actions Hospitals may consider: :

1. Make PASRR a job expectation
2. Educate hospital staff
3. Provide Access to screening tools and programs
4. Collect MI/ID/DD clinical data
5. Integrate PASRR into electronic software tools
6. Give feedback to States

# Strategy # 1 Hospitals: Job Expectation

- Include language in job descriptions and evaluations of staff assigned to do PASRR Level I screens
- Provide orientation and inservice training for hospital staff
  - Include overview for all staff
- Give access to Web Enabled interactive training available where available
  - Record attendance in inservice records

# Strategy # 2 Hospitals: Educate staff

- Educate staff about PASRR
  - Purpose and benefits
- Help de-stigmatize mental health and disability issues
  - Work directly with hospital management – in particular Social Work and Case Management, Care Coordination departments
- Work with Medical Staff office to provide education to hospital physicians, including Emergency Department Physicians and Hospitalists

# Strategy # 3 Hospitals: Provide Access to 'tools'

- Educate hospital 'stake-holders' about the required 'screening tools' (forms):
  - How do the individuals responsible for completing PASRR Level I keep up with 'versions' of the forms?
  - When the state changes how the process works, how is that communicated?
- Develop a plan for Screeners when a patient is being discharged to another state, usually a bordering state

# Strategy #4 Hospitals: Collect clinical data

- Require collection of information about MI/ID/DD indicators into existing or routine clinical workflow
  - Use required history and physical, Initial Nursing Assessment, Assessment for continuing care needs
  - Require that findings shared with screener
  - Require screener to give feedback
- Hospital staff have ready access to necessary Level I information-
  - Teach 'indicators' of MI/ID/DD per State guidelines:
    - E.g.: does taking anti-depressants constitute MI
  - Include Physicians, care coordinators, discharge planning staff, social workers, nursing unit staff
- Save time and money (impact LOS)

# Strategy #5 Hospitals: Workflow Tools

- Integrate PASRR Level I information into software/electronic work-flow tools for Case Management
- Incorporate into workflow that the Level I screening is completed
  - as soon as it is apparent that NF may be an option
- When a Level II is required – take immediate action
  - Identify steps to schedule Level II evaluators
  - Determine how/when/what medical and mental/behavioral health records are required

# Strategy #6  Hospitals: Give feedback

- Case management department staff with State directors in person
  - Share ‘case examples’ of difficult situations
  - Identify learning needs of Screeners and communicate to State
- Discuss where there are gaps in service for patients that impact ‘least restrictive’ discharge
  - As simple as ‘no prescription coverage’

# Strategies for stronger Partnerships: States

Actions States may consider:

1. Train/credential Screeners
2. Communicate directly with Screeners
3. Work with Organizations
4. Work with Associations
5. Educate all stakeholders
6. Give feedback to hospitals

# Strategy #1 States: Train Screeners

- Train and certify those eligible to ‘screen’
- Require “Attestation statement” signed by Level I screener at time of completion of training
- Send a copy to their employer
  - Hospital management will be fully aware that they, and the screener must assure the information is accurate, complete and timely
  - Hospital management will possibly have a broader understanding of PASRR
  - Support that there must be adequate staffing to comply with PASRR

# Strategy #2 State: Communicate with Screeners

- Create a way to communicate directly with Level I screeners
  - Listserve with updated email lists, interactive website
  - Include program initiatives, changes in process, education opportunities.
- Involve hospital staff, especially discharge planners (case managers) in PASRR Level I stakeholder discussions
  - Involve hospital staff, especially discharge planners in piloting changing processes or tools
  - Involve contracted PASRR entities in piloting PASRR initiatives and for training on PASRR
- Communicate with Screeners in Bordering States
  - Let a 'border' state know of any changes

# Strategy #3  State: Work with Organizations

- Work with the QIOs (Quality Improvement Organizations)
  - Discuss impact of patient's rights to appeal (IM)
- Readmission factors
  - Was a referral to a SNF a 'safe harbor' or the right level?
  - Are high SNFs 'rehospitalization' rates associated with the 30 day exemption, or an inadequate Level I screen?

# Strategy #4 State: Work with Associations

- Work with the American College of Emergency Physicians
  - Monitor the proposed standard changes by The Joint Commission on Accreditation of Hospitals http://acep.org
  - 'Patient Flow in the Emergency Department'
    - Look at 'Boarders' with emotional and mental health needs
- Work with The American Medical Directors Association
  - Public Policy: Resolution H10: SUBJECT: Improving Care Transitions between the Nursing Facility and the hospital settings
    - http://www.amda.com/governance/whitepapers/H10.pdf

# States: more outreach

- Work with hospital trade associations to hold PASRR trainings,
  - coordinate pilot projects
  - arrange disability awareness trainings
  - teach about diversion and transition options in the community
- Create accessible manuals and/or on demand video training regarding Level I tools, purpose and “how to” issues
  - Provide Continuing Education Credits for Nurses and Social Workers for all content

# Strategy # 5: Educate all ‘stakeholders’

- Educate all PASRR Stakeholders
- When coordinating/discussing PASRR with other ‘state level’ professionals, include a representative from a hospital that does PASRR screens
- Reach out beyond the PASRR walls
  - Write for journals that case managers read
  - Present lectures at case manager meetings
  - Design web enabled education programs for all stakeholders, not just those who complete the screen

# Strategy # 6 State: Give Feedback

Give 'Feedback' to Hospitals: Include 'the good-the bad- the ugly'

- **Good** –
  - Have a structured method for validating the quality/outcome of Level I information submitted
    - E.g.: random audits of negative Level I screens – the 30 day exemption rule
  - provide 'sample' case studies of patient(s) who received needed mental health services – not readmitted, able to live in the community
- **Bad-** delay of needed services for patients admitted to SNF under the 30 day exemption
- **Ugly** – Share 'bad-outcomes' when patients with mental health issues are sent to nursing homes without adequate services

# Best Strategy: Both States & Hospitals

- Hospitals want to do the right thing for patients
  - In the chaos of transition, so many items on the radar screen for the staff working with patients
- PASRR professionals want to do the right thing
  - In the chaos of identifying needed services and finding them at the right time, and communicating the information to hospital staff is a challenge
- Patients need PASRR to be a Passport to better care and better outcomes!
- Partnering is the best strategy

# What to Watch from 2010 ACA

- Patient Protection and Affordable Care Act (ACA)
  - Value Based Purchasing (VBP)
    - Includes readmissions
    - Includes patients perception of care (HCAHPS)
  - 'Bundled payment' demonstrations
  - 'Shared savings' initiatives
    - Accountable Care Organizations
- Where will patients with mental/behavioral health needs fit

# Thank you.

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# Q & A

Comment submitted to PTAC:

We have a couple of major hospitals in our state that appear to ignore PASARR because we RARELY get referrals from them and they are known to have multiple admissions annually of folks who would meet criteria for being screened prior to nursing facility placement.

When we've done trainings for them, referrals seem to pick up for a few months and then fall off all together.

References & Further Reading
PASRR Partnering with Hospitals
Jackie Birmingham, RN, MS
Jbirmingham@curaspan.com
(860)668-7575 Suffield, CT

Downloaded between December 27, 2011 and January 27, 2011
References listed in random order. Please note: if you are concerned with the safety of the website in some references below, please do not open. Safety of the site is not guaranteed by the author. If you are unable to click on a link to open, please copy and paste the link into your browser. Thank you.

American College of Emergency Physicians (ACEP)
http://acep.org
Click on option in middle menu bar titled: "ACEP Sends Comments to TJC on Patient Flow", January 19, 2012
Excerpt:

> "The College also supports the focus on the needs of patients requiring mental health care, as this population is a significant proportion of the patients boarded in many EDs. There was concern that the elements of performance, as written, imply that EDs should be able to meet all the needs of mental health patient's in the ED. Patients requiring mental health services are being boarded in the ED due to the lack of available resources in the community. The physical layout and the operating conditions of most EDs preclude creating a therapeutic environment for boarding mental health patients consistent with their identified needs. Moving patients to the appropriate care environment should be the focus of the elements of performance not providing mental health services in the ED."
>
> Further information: If you have any questions about the input provided please contact Margaret Montgomery, RN, MSN, at (972) 550-0911, ext. 3230.
> Signed by: David C. Seaberg, MD, CPE, FACEP, President

Joint Commission Accreditation for Hospitals
https://jointcommission.qualtrics.com/CP/File.php?F=F_5bxfC3pzeZe4Too
Patient Flow in the Emergency Department: Hospital Accreditation Program
Proposed changes including 'boarding' in the Emergency Department

Mentally ill flood ER as states cut services
By Julie Steenhuysen and Jilian Mincer | Reuters - Sat, Dec 24, 2011
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The Department of Justice: ADA Home Page
"Revised ADA Regulations Implementing Title II and Title III"
Accessed December 27, 2011
http://www.ada.gov/regs2010/ADAregs2010.htm

Accountable Care Act (ACA ) Demonstration Project – 10 page background for Emergency Medicaid Psychiatric Services
https://www.cms.gov/DemonstrProjectsEvalRepts/downloads/MEPD_Solicitation.pdf
Posted August 3, 2011. Downloaded January 26, 2012

National Association of PASRR Professionals: NAPP Survey Jan 2011 findings
http://www.pasrr.org/pdf/NAPP_PASRR_survey_summary.pdf

CDC Vital Statistics http://www.cdc.gov/nchs/data/series/sr_13/sr13_124.pdf
Trends in Hospital Utilization: United States, 1988–92
Table 6. [Excludes newborn infants] Average LOS – 10.7 for > 65 ; for all ~ 9 days)CDC Current Length of Stay (2007) \http://www.cdc.gov/nchs/fastats/hospital.htm
Average length of stay in days: 4.8

CDC Statistics to 2008
http://www.cdc.gov/nchs/data/hus/hus10.pdf#001
Includes age in population (Page 115) , admissions to mental health organizations (page 342)

CDC Chart Book – Older Americans
http://www.cdc.gov/nchs/hus/older.htm#access

CDC National Hospital Discharge Survey October 2011
http://www.cdc.gov/nchs/data/nhsr/nhsr029.pdf

CDC FastStats – LOS by diagnosis, age, gender 2010
http://www.cdc.gov/nchs/data/hus/hus10.pdf#102

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J Gen Intern Med. 2010 September; 25(9): 930–935.
Published online 2010 April 29. doi: 10.1007/s11606-010-1370-5 PMCID: PMC2917661
http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2917661/

Society of General Internal Medicine 2010
Decreased Length of Stay and Cumulative Hospitalized Days Despite Increased Patient Admissions and Readmissions in an Area of Urban Poverty

OIG (Office of Inspector General) Compliance Guidance
http://oig.hhs.gov/compliance/compliance-guidance/index.asp
Includes hospitals, skilled nursing facilities, home health agencies.

EMTALA Resource – CMS
http://www.emtala.com/law/index.html

Princeton University – Trends in hospital length of stay
http://www.princeton.edu/~ota/disk3/1983/8329/832904.PDF

Centers for Medicare and Medicaid – Conditions of Participation for Hospitals
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482.30 Condition of participation: Utilization review.

482.43 Condition of participation: Discharge planning.

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Patient Flow in the Emergency Department: Hospital Accreditation Program
Proposed changes including 'boarding' in the Emergency Department

American Medical Directors Association: Policy Resolution H 10 (March 2010)
SUBJECT: IMPROVING CARE TRANSITIONS BETWEEN THE NURSING FACILITY AND THE ACUTE-CARE HOSPITAL SETTINGS INTRODUCED BY: PUBLIC POLICY COMMITTEE (March 2010)
http://www.amda.com/governance/whitepapers/H10.pdf

More resources (tools, guidelines): http://www.amda.com/tools/index.cfm

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Special Issue: "Elder Mental Health—The Next Frontier
Leveraging the PASRR Process to Divert and Transition Elders With Mental Illness from Nursing Facilities"
DOI: 10.1080/08959420.2011.579512 pages 305-322

http://www.tandfonline.com/doi/abs/10.1080/08959420.2011.579512#preview
Requires subscription or purchase of single article on line.

The phasing out of mental hospitals in the United States: Am J Psychiatry 1975: 132:1135-1140

Abstract **(1975 Abstract only)**

The authors view the current wave of closing state mental hospitals against the background of trends in mental health services during the past 20 years. Although a small number of hospitals has been totally closed, the overall number of institutions has remained stable due to the opening of new hospitals, and many states will be forced to consider phasing out additional hospitals in the immediate future. The closing of hospitals is a social phenomenon that involves the lives and welfare of patients, personnel, families, and the community and poses a substantial political and logistical challenge. The authors make a few suggestions for those who are contemplating closing hospitals in the future.

http://ajp.psychiatryonline.org/article.aspx?Volume=132&page=1135&journalID=13

**Questions from Hospital staff 2008-2011 during education sessions (Jackie Birmingham)**

Use to open discussion with hospital based staff:

1. When does the 30 day exemption rule apply?
2. Does a 'negative' Level I mean they do, or do not have MI/MR?
3. What if the patient with a MI/MR based on Level I is subsequently sent home with a home care referral?
4. Why does it apply to Hospice referrals?
5. With HIPAA regulations, why is it okay to send Mental Health information to the next provider?
6. Who 'may' complete the screen?
7. If a hospital has only a few approved screeners, and both are on unplanned days off, what are the options?
8. If a patient is confused and can't give a history, what do a do?
9. If a nursing home staff tells me they will do Level I after the patient is admitted, is that okay?
10. If a patient is being discharged from the Emergency Department to a SNF, who does the PASRR Level I?
11. If a patient is admitted from a SNF, is a PASRR Level I needed?
12. If a patient is admitted to a hospital on a SNF Bed Hold status, is a PASRR Level I needed?
13. What happens if I miss something on a PASRR and the State finds out?
14. If a patient enrolled in Managed Care has a mental illness and the payer has approved placement what do I do?
15. What if a patient has Mental Health Coverage but is going to a SNF for rehab, do I still need to do PASRR?
16. If a patient's mental health actions seemed to be involved in a 'reportable action' (abuse, neglect, exploitation) what do I do?
17. Question submitted to PTAC:

We have a couple of major hospitals in our state that appear to ignore PASARR because we RARELY get referrals from them and they are known to have multiple admissions annually of folks who would meet criteria for being screened prior to nursing facility placement. When we've done trainings for them, referrals seem to pick up for a few months and then fall off all together.