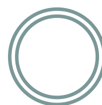
The Power and Possibility of PASRR Webinar Series

Webinar Assistance

http://www.pasrrassist.org/resources/webinar-assistance-and-faqs



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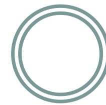
*Please note that you **must** attend the entirety (90 minutes) of this webinar if you wish to receive Continuing Education credits.*

The Relationship Between PASRR and Other Nursing Home Requirements



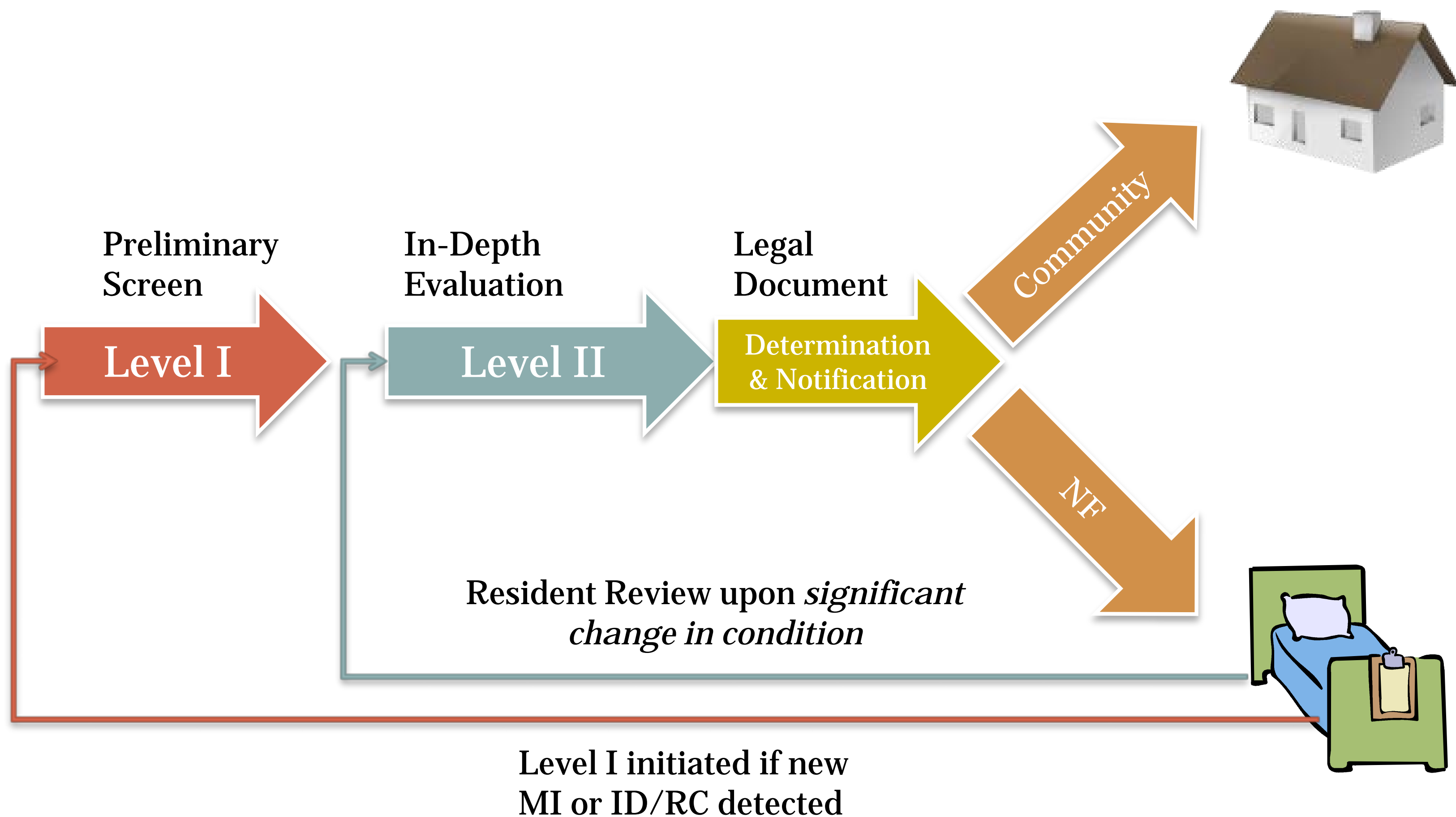
FRANK TETRICK, PTAC CONSULTANT

OCTOBER 9, 2018

Learning Objectives

- Understand the relationship between PASRR and other nursing home requirements
- Understand key areas of federal law and regulations that guide PASRR and Long Term Care Facilities (LTCF)
- Understanding of real-life application regulations within the PASRR process
- Understanding of the connection of topic with other resources accessible through the PTAC website

The PASRR Process: A Basic Sketch



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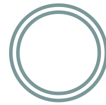
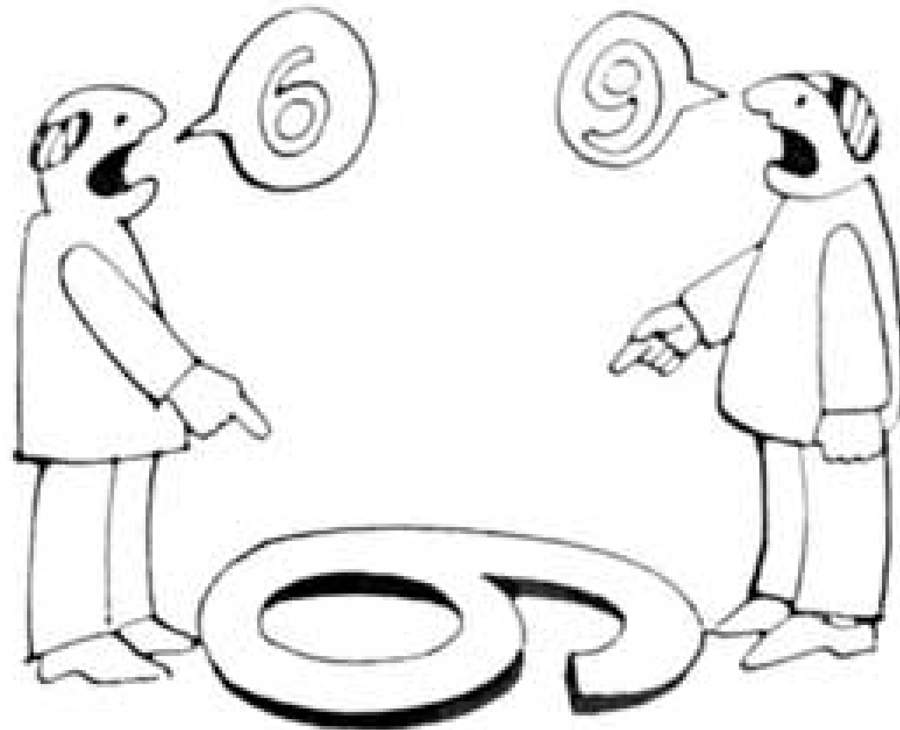
PTAC Resource



PASRR LEARNING MODULES

Regulations – The Point of View Matters



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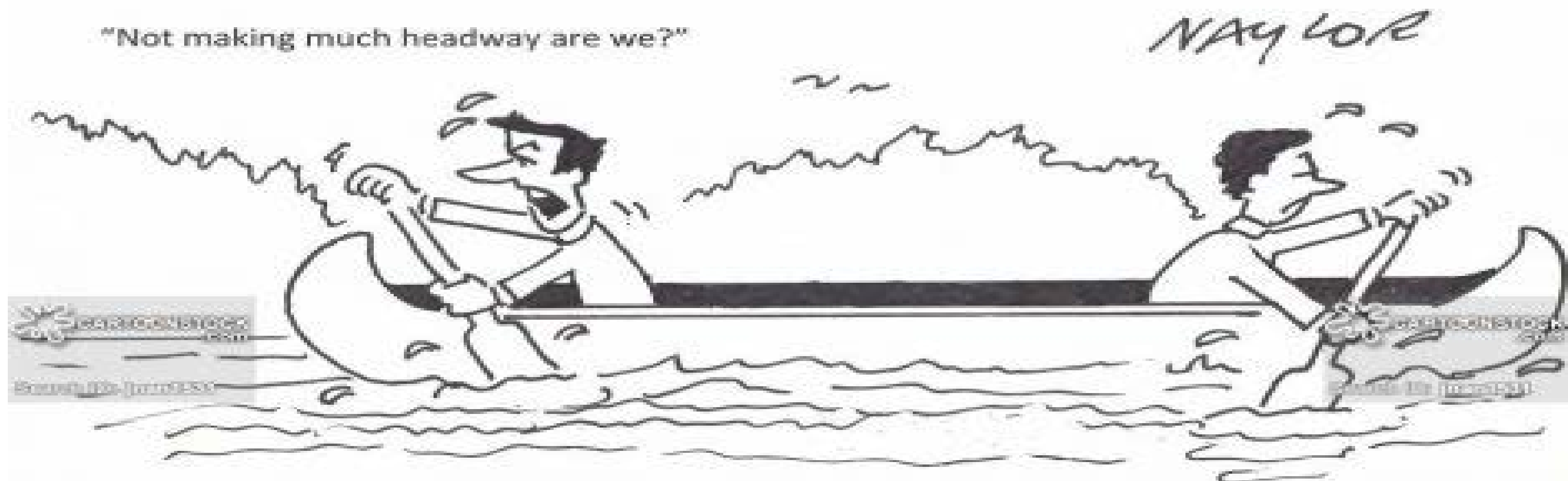
PASRR and LTCF Regulatory Relationships
"The Independent Model"



PASRR Regulations

State Authorities
and contract vendors

LTCF Regulations

Nursing Facilities

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Outcomes

- Inappropriate admissions to LTCF – less restrictive alternatives are not considered and made available to the individual.
- Inappropriate care – individuals with mental illness, intellectual disability, or related conditions (MI/ID/RC) do not have access to needed services and supports specific to their condition.
- Poor use of resources – nursing facility staff are challenged to provides services and supports to residents with MI/ID/RC that are outside their areas of expertise.
- Transition to community delayed – individuals risk remaining in the nursing facility for longer periods of time.

PASRR and LTCF Regulatory Relationships
"The Collaborative Model"

PASRR Regulations
State Authorities
and contract vendors

LTCF Regulations
Nursing Facilities

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Outcomes

- Appropriate admissions to LTCF – clear determination that the individual meets Level of Care standards and admission is based on informed choice. (More later on informed choice.)
- Appropriate care – individuals with MI/ID/RC have access to needed services and supports specific to their condition.
- Good use of resources – NF staff are better prepared to support the individual and/or services and supports are provided by those with specific expertise.
- Transition to community is timely – connectivity to community providers can help promote timely transition.

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The Power of PASRR and LTCF Regulations

The power of PASRR and LTCF regulations is realized when each entity uses those regulations to make a positive difference in the life of the individual being considered for or residing in a LTCF.

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Why Do We Do This?

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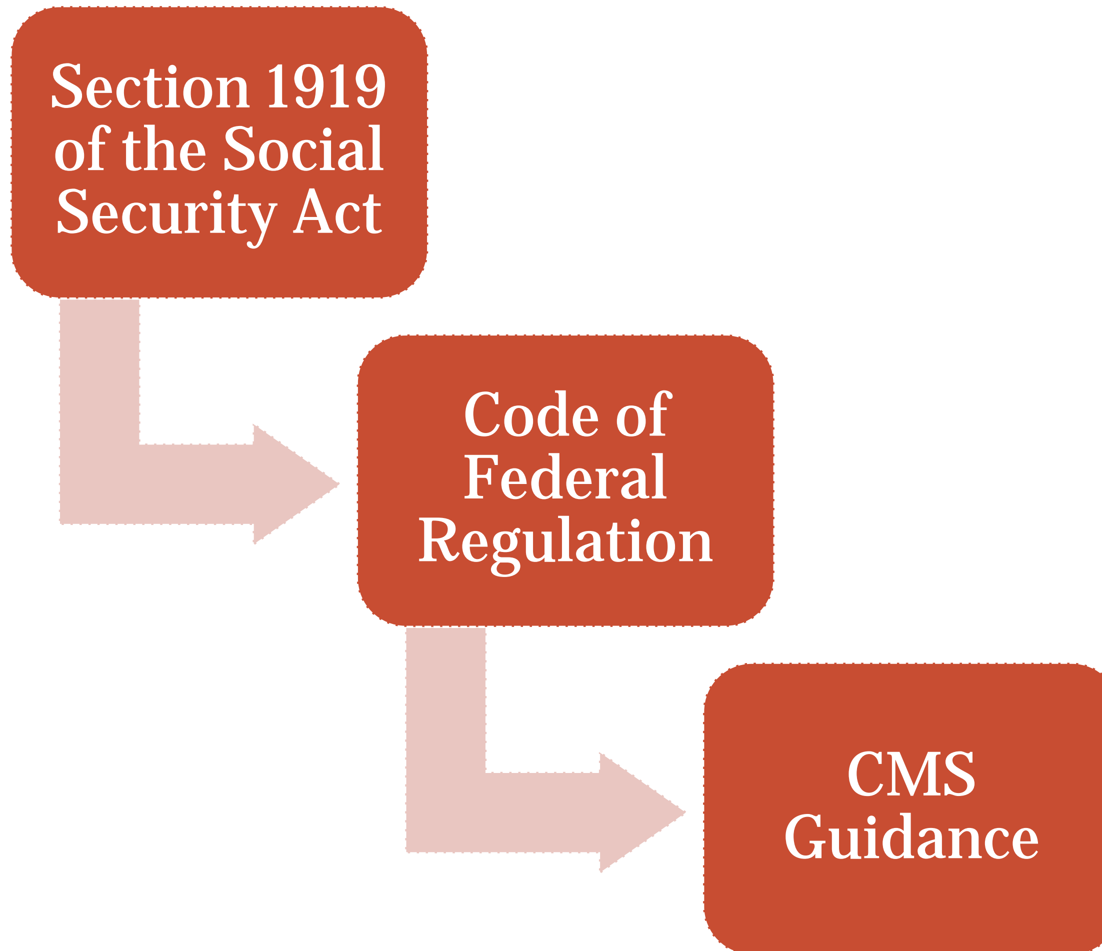
The PASRR and LTCF Connection
Law - Regulation - Guidance



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The Law
Section 1919(b)(3)(F) of the Social Security Act

- Prohibits NFs from admitting any new resident who has MI or an ID or RC,….
- ….unless it has been determined by the State Mental Health Authority (SMHA) or State Intellectual Disability Authority (SIDA)……
- ….that because of the physical and mental condition of the individual, nursing facility services are needed.

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The Law: NF services are defined in the statute at §1919(a)(1)

- Skilled nursing care and related services for residents who **require medical or nursing care;**
- **Rehabilitation services** for the rehabilitation of injured, disabled, or sick persons; or
- On a regular basis, **health-related care and services to individuals who because of their mental or physical condition require care and services (above the level of room and board) which can be made available to them only through institutional facilities.**

Reminder: Certification Status and PASRR

Individuals who are discharged from a hospital into a Skilled Nursing Facility bed in a dually certified facility must undergo a full PASRR.

- This is because the crucial fact, as noted at §483.102, is that the **certification of the facility, and not the individual's form of insurance -- private pay, Medicare, or Medicaid – determines the need for PASRR.** If a facility is certified as NF (i.e., certified by Medicaid), then PASRR applies to everyone seeking admission to that facility.

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The Law: Section §1919(e)(7)(B) of the Act

- Requires the SMHA and SIDA to evaluate and determine whether an applicant or resident with MI or ID/RC requires NF services. *
- Such evaluations and determinations are required ***before*** **an applicant's admission** to a NF and ***promptly after*** **the NF determines** a resident has experienced a significant change in physical or mental status.

*MH evaluator is independent of the SMHA

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Reminder – Conflict of Interest

- A nursing facility cannot perform a Level II pre-admission evaluation or resident review.
- 42 CFR §483.106(e)(iii) prohibits NFs (or any entity that has a direct or indirect affiliation or relationship with a NF) from performing Level II evaluations.
- Because NFs are responsible for providing nursing services, it is considered a conflict of interest for them to determine the individual's service needs.
- Additionally, while NFs are not prohibited from performing Level I screens, both Level I screens and Level II evaluations must be completed prior to admission.

See FAQ "Who can complete a Level II evaluation?"

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The Law: Section §1919(b)(2) of the Act LTCF Plan of Care Requirements

- **A NF must provide services and activities to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident in accordance with a written plan of care** which—
- (A) describes the medical, nursing, and psychosocial needs of the resident and how such needs will be met;
- (B) is initially prepared, with the participation to the extent practicable of the resident or the resident's family or legal representative, by a team which includes the resident's attending physician and a registered professional nurse with responsibility for the resident; and
- (C) is periodically reviewed and revised by such team after each assessment under paragraph (3).

The Law: Section §1919(b)(3) of the Act LTCF Plan of Care Requirements

(3) Residents' assessment.

NF must conduct a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity, which assessment -

- (i) describes the **resident's capability to perform daily life functions and significant impairments in functional capacity**;
- (ii) is based on a uniform minimum data set specified by the Secretary under subsection (f)(6)(A);
- (iii) uses an instrument which is specified by the State under subsection (e)(5); and
- (iv) **includes the identification of medical problems**.

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The Law: Section §1919(3)(E) of the Act
LTCF Assessment and PASRR

- Coordination.—Such **assessments shall be coordinated with any State-required preadmission screening program** to the maximum extent practicable in order to avoid duplicative testing and effort.
- In addition, **a nursing facility shall notify the SMHA or SIDA, as applicable, promptly after a significant change** in the physical or mental condition of a resident who is mentally ill or intellectually disabled.*

*Section 1919(e)(7)(B)(iii) of the Social Security Act, (This provision replaced the requirement that PASRR Resident Reviews must be performed annually.)

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regulations

Code of Federal Regulations (CFR)

Title 42: Public Health, Requirements for States and Long Term Care Facilities: **Long Term Care Facilities**

PART 483 - Subpart B: Requirements for Long Term Care Facilities

PASRR: Title 42: Public Health, **Requirement for States** and Long Term Care Facilities

PART 483 - Subpart C—Preadmission Screening and Annual Review of Mentally Ill and Mentally Retarded Individuals *

2010 Rosa's Law Made amendments to provisions of Federal law to substitute the term "an intellectual disability" for "mental retardation", and "individuals with intellectual disabilities" for "the mentally retarded" or "individuals who are mentally retarded"

Federal Regulations – LTCF and PASRR

Title 42 of the Code of Federal Regulations, Part 483.20(k)

A NF must not admit, on or after January 1, 1989, any new resident with—

- Mental or Intellectual disability disorder unless the SMHA or SIDA has determined, prior to admission,
  - the individual requires the level of services provided by a NF; and
  - whether the individual requires specialized services for his or her PASRR condition

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Federal Regulations – LTCF and PASRR

Title 42 of the Code of Federal Regulations, Part 483.20(e)

- A facility **must coordinate assessments with the preadmission screening and resident review** (PASRR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes—
  - **Incorporating the recommendations from the PASRR level II determination and the PASRR evaluation** report into a resident's assessment, care planning, and transitions of care.
  - **Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition** for level II resident review upon a significant change in status assessment.

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The Importance of PASRR to LTCF Access to Federal Financial Payment (FFP)

- (a) *Basic rule.* Except as otherwise may be provided in an alternative disposition plan adopted under section 1919(e)(7)(E) of the Act, **FFP is available in State expenditures for NF services provided to a Medicaid eligible individual subject to the requirements of this part only if** the individual has been determined—
- (1) To need NF care under §483.116(a) or
- (2) Not to need NF services but to need specialized services, meets the requirements of §483.118(c)(1), and elects to stay in the NF.
- (b) FFP for late reviews. **When a preadmission screening has not been performed prior to admission or an annual review is not performed timely**, in accordance with §483.114(c), but either is performed at a later date, **FFP is available only for services furnished after the screening or review has been performed,** subject to the provisions of paragraph (a) of this section.

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Reminder: Nursing Facility Transfers and PASRR

- According to 42 CFR §483.106(b)(4) of the CFR, when an individual is transferred from one NF to another NF, with or without an intervening hospital stay, the individual is not considered a "new admission".
- 42 CFR 483.106(b)(4)(ii) clarifies that the transferring NF must ensure that all copies of the resident's PASRR paperwork (including any Level II information) must be transferred with the individual.
- Depending on the individual's needs, he or she may require a Resident Review, particularly if the transfer is the result or cause of a significant change in physical or mental status.

See PTAC FAQ – "When are Resident Reviews required?"

See PTAC Webinar – "Resident Review: A Critical Component to Achieving PASRR's Vision"

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Federal Regulations - States and PASRR
PASRR regulations at 42 CFR §483.126

- Specify that admission of an individual with a mental illness or intellectual disability to a nursing facility (NF) may be considered appropriate only:
  - When the individual's needs are such that he or she **meets the minimum standards for admission**, i.e. Level of Care, and
  - The individual's **needs for treatment do not exceed the level of services which can be delivered in the NF** either **through NF services alone or**, where necessary, **through NF services supplemented by specialized services** provided by or arranged for by the state.

See PTAC "Specialized Services Resources"

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Reminder: NF Residency Requirement for Specialized Services

The CFR is clear at §483.120(a)(1)(2), that Specialized Services are provided to NF residents.

Mental illness……"**specialized services means the services specified by the State which, combined with services provided by the NF**"……

Intellectual disability……"**specialized services means the services specified by the State which, combined with services provided by the NF or other service providers**"…….

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PASRR Level II Evaluator Considerations under 42 CFR 483.132(a)

- (1) The individual's total needs are such that his or her **needs can be met in an appropriate community setting; (Diversion)**
- (2) The individual's total **needs are such that they can be met only on an inpatient basis, which may include the option of placement in a home and community-based services waiver program**, but for which the inpatient care would be required; **(Diversion)**
- (3) If inpatient care is appropriate and desired, **the NF is an appropriate institutional setting for meeting those needs** in accordance with §483.126; or
- (4) **If the inpatient care is appropriate and desired but the NF is not the appropriate setting** - another setting such as an **ICF/IID** (including small, community-based facilities), an **IMD providing services to individuals aged 65 or older**, or a **psychiatric hospital** is an appropriate institutional setting for meeting those needs.

ICF/IID – Intermediate Care Facility for Individuals with Intellectual Disability

IMD – Institute of Mental Disease.

Reminder: Informed Choice

If a person meets a state's level of care criteria and wishes to enter a NF, his or her choice must be respected, with the PASRR process leading to recommendations that allow the individual to make an informed choice.

The SMHA and SIDA may make *recommendations* to the individual about where she or he may be able to receive services, including other institutional or home and community placements, **ensuring that the individual is fully informed of all options.**

See PTAC FAQ *What is the relationship between PASRR and Nursing Facility level of care?*

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The Minimum Data Set (MDS) 3.0

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The Minimum Data Set 3.0

- The Minimum Data Set (MDS) 3.0 is a **core set of screening, clinical, and functional status elements that support a comprehensive assessment for all NF residents**.
- The MDS 3.0 is one of three components to the Resident Assessment Instrument, which all NFs must use, and which **helps NF staff develop an individualized care plan based on the resident's strengths and needs.**
- The MDS must be performed within 14 days of a resident's admission to a NF and then is periodically updated according to a specified schedule. The data collected on the MDS assessment is sent to CMS and is an **important component of Survey and Certification enforcement.**

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Key Distinctions of MDS and PASRR

- MDS captures information about a person (medical, functional, cognitive, and social) at a moment in time. **It does not evaluate individuals for the presence of disabilities defined for the purposes of PASRR.**

- Completing the **MDS does not identify an individualized set of services for specific people.**

The Minimum Data Set PASRR Role

- PASRR and MDS 3.0 are linked in ways that advance quality improvement at the program level and quality of care for NF residents:
  - MDS data have contributed to PTAC National Reports in 2014, 2015, and 2016 that measure the effectiveness of PASRR.
  - MDS PASRR questions guide State Survey Agency staff in checking for NF PASRR compliance, including:
    - **incorporating any recommended Specialized Services** identified in the Level II report **in the NF plan of car**e;
    - **confirming that PASRR** screenings and any required evaluations were done **prior to admission**;
    - and **confirming that NFs notify state authorities** when an individual admitted under the Exempted Hospital Discharge stays beyond 30 days.

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The Minimum Data Set PASRR Role

- It is important that states understand that CMS guidance to NFs on actions to take when there is a significant change in status addresses individuals:
  - who were initially identified by PASRR, as noted at **A1500 of the MDS**,
  - and who may not have been identified as having a PASRR condition at the time of admission, but who now show symptoms of a PASRR condition.

The Importance of a Shared Understanding

- While the CMS Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual requires NF's to make notification, the MI/ID authorities may exercise their expert judgment about when a Level II evaluation is needed.
- Each State Medicaid Agency, in consultation with the MI/ID authorities, may develop specific processes and guidelines for referral, and which types of significant changes should be referred.

Request for Resident Review Examples

Previously identified by PASRR to have MI, ID, or RC (note, this is not an exhaustive list):

- **increased** behavioral, psychiatric, or mood-related **symptoms**.
- behavioral, psychiatric, or mood-related **symptoms that have not responded to ongoing treatment.**
- an **improved medical condition**—such that the resident's plan of care or placement recommendations may require modification.
- a significant **change is physical**, **but with behavioral, psychiatric, or mood-related symptoms, or cognitive abilities**, that may influence adjustment to an altered pattern of daily living.
- a **condition or treatment** is, or will be, **significantly different than described in the resident's most recent PASRR Level II evaluation and determination.**

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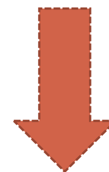
Request for Resident Review Examples

Where the individual had not previously been found by PASRR to have a MI, ID, or RC. (note that this is not an exhaustive list):

- behavioral, psychiatric, or mood-related symptoms suggest the presence of a diagnosis of mental illness as defined under 42 CFR §483.102 (where dementia is not the primary diagnosis).
- intellectual disability, as defined under 42 CFR §483.102, or a related condition as defined under 42 CFR §435.1010, was not previously identified and evaluated through PASRR.
- transfer, admission, or readmission following an inpatient psychiatric stay or equally intensive treatment.

Collaborative PASRR and LTCF Regulatory Relationships

PASRR Regulations **LTCF Regulations**



Person Centered Care & Improved Care

PASRR and LTCF Regulations Support Transition

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LTCF and PASRR Regulations Support Transition

- Although NFs are primarily responsible for helping individuals transition to the community, PASRR can play a vital role in helping NFs develop individualized plans of care that support successful transition.
- CFR for LTCF at §483.21 defines NF **requirements for comprehensive person-centered care planning**, including establishing **initial baseline care plans**, **comprehensive care plans**, and an **effective discharge planning process.**
- The capacity of the NF to develop a baseline care plan, and a comprehensive care plan, can be greatly influenced by the information detailed in the PASRR Level II report and determination.

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LTCF and PASRR Regulations Support Transition

§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.

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LTCF and PASRR Regulations Support Transition

- **The PASRR evaluation criteria** at §483.128, and the criteria for determining the need for mental health (§483.134) or intellectual disability (§483.136) specialized services**, all focus on ensuring that the PASRR findings are as person-centered as possible.**
- **PASRR findings and recommendations**, detailed in the Level II report **help ensure that the NF is aware of the need for services unique to the individuals PASRR condition**, and the information can help the NF identify appropriate personnel for providing those services

Also see PTAC Webinar, April 2018: Discharge Planning and Transitions into the Community

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Specialized Services Supporting Transition

- Continuation or development of individualized plan for habilitation, skill development, and behavior management
- Continuation or development of day or vocational program
- Development/implementation of a positive behavior support plan, emergency safety interventions, and support/consultation to reduce negative behaviors
- Additional 1:1 with a qualified MI or ID/DD professional to:
  - Maintain the person's independence with choice, ADLs, other functional skills
  - Provide advocacy, mode of communication, communication with family

LTCF and PASRR Regulations Is There Common Ground?

"We have an agreement in principle. The question is, do we all have the same principles?"

Collaboration Regulatory Relationship – The Stakeholders

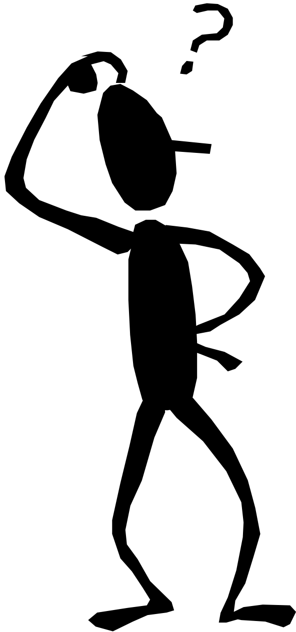
Who Could Be At Your Table?

- State PASRR Authorities
  - Medicaid Agency
  - Mental Health Authority
  - Intellectual Disability Authority
- Nursing Facilities or Associations
- Level 1 Screeners
  - Hospital Discharge Planners
  - Contract entities
- Level II evaluators
- Specialized Services providers
- Others

Summary Considerations

- Federal law and regulations provide the framework for both LTCFs and State PASRR Programs.
- The law and the regulations focus on common aspects, specific to PASRR.
- State PASRR Authorities and LTCFs determine how they wish to work together to meet these requirements.
- A collaborative approach creates opportunities for all entities to demonstrate adherence to the law and regulations.
- A collaborative approach maximizes opportunities for persons with MI, ID, or RC to receive appropriate care and transition to the community in a timely manner.

QUESTIONS



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THANK YOU!

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