PASRR: OLD NEWS OR NEW FRONTIER?

Bringing Fresh Perspectives to a 30-Year Old Program

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What if you could successfully navigate wholesale preadmission process change and achieve all your goals in a super condensed time frame?

- End paper based process
- Implement electronic preadmission system
- Streamline workflow: gain speed, quality
- Implement new tool, have data for oversight/analysis
- Coordinate info across programs
- Better comply with regulations
- Leverage federal $$ for costs
A HISTORY OF PASRR, KEY PASRR TIMELINE EVENTS

- Early 1987: Start of Indiana’s Preadmission Screening program, IPAS.
- 1987: PASRR was created in 1987 through language in the Omnibus Budget Reconciliation Act (OBRA).
- 2015: Legislature passes sunset provision for Indiana’s PAS program.
- 2016: New PASRR process for Indiana launches 7/1/16 in the Ascend AssessmentPro system.
Is the sun really setting on this 30-year old statute?

- Faxes, emails, wet signatures, need for efficiency
- Low denial rates
- Legislative directive to work with stakeholders
- PTAC review of tool
Why Change Was Needed in Indiana

✅ People with mental illness and intellectual disabilities were still ending up in nursing facilities and not receiving needed services.

✅ 65,000 plus screenings every year resulting in fewer than 1% of denials.

✅ The system was inefficient and cumbersome – no one involved really was satisfied with the process.

30!

The system was 30 years old – the world is different today. Most nursing facility admissions are covered under Medicare and are short term.
What are the goals of PASRR?
What are the goals of Indiana PASRR?

IDENTIFY EVERY
Person with disability going to NF

ASSESS AND DELIVER SERVICES
Needed

REDUCE INAPPROPRIATE NF PLACEMENT
Community support gateway

Deliver services and supports to NF residents to attain the highest practicable physical, mental, and psychosocial well-being
Why is PASRR important?

PASRR recommendations help NF staff know how to care for persons with disabilities

- NF staff have high turnover, have little psychiatric or disability training
- NF staff not trained to recognize/monitor symptoms, implement interventions, or monitor treatment response
- Leads to increased likelihood of psychiatric decompensation, possible harm to individual and other residents
- Lead to placement failures, repeated psych hospitalizations, repeated NF to NF transfers
- Overall result in lower quality of life for the individual
Focus of the Redesign Effort

- Efficient use of resources
- People in the right roles
- Improved effectiveness in the process
- Enhance use of technology
  - Efficiency
  - Consistency
  - Accuracy
  - Better data
Engaging Stakeholders

- AAAs, hospitals, nursing facilities
- Shared goals
- Evaluation of options
- Made the case for change

- DA participation at demos
- State web updates and vendor web updates
- Coordinated state and vendor newsletters

Transparency

Stakeholders were involved in every phase; regular newsletters and webinars kept them updated along the way.
New Roles, New Responsibilities

- Hospitals were now primary in collecting assessment data and entering it in the system.
- Nursing facilities needed to coordinate admissions with hospitals to assure they would be in compliance with PASRR requirements.
- AAAs, no longer primary in the PAS process, could focus on options counseling as well as reviewing any level of care denials to help connect individuals to community resources.
Making It Happen

✅ Nursing facilities had to get paid
✅ MMIS project occurring at the same time
✅ Train on new assessment tool (interRAI)
✅ Deadlines were important

We did it!

Vendor selected in summer of 2015; system launched July 1, 2016.
Make a Real Difference for Individuals Across Indiana

UNLOCK THE TRUE POTENTIAL AND POWER OF PASRR
What’s Next?

✅ Surveys of users
  • Training needs
  • System user experience
  • Data users would like

✅ Continued training
  • PASRR process
  • System use
Taking PASRR to the Next Level

- Moving to real transition/diversion opportunities
- Targeting options counseling to those most and at risk of long term institutionalization
- Focusing ADRCs on the options counseling role
- More work with hospital discharge planners
  - Doorway
  - Opportunity to triage individuals
  - Long term services advisor (LTSA)
More Integration Across Populations

✓ FSSA contract for all PASRR functions
  • Mental health and intellectual disability Level II processes
  • Level of care
  • Level I

✓ More coordination between the level of care and Level II decisions

✓ Improved tracking of specialized services in nursing facilities

✓ Improved community placements through the Level II processes
TRANSITION PROCESS
3 Phases of Transition

1. LOSS
   Shock

2. NEUTRAL ZONE
   Disorganized

3. NEW BEGINNING
   Organized
Communication Tools for the 3 Phases

1. LOSS
   Listen & Validate

2. NEUTRAL ZONE
   WIIFM/Detail the Transition

3. NEW BEGINNING
   Reinforce. Reinforce. Reinforce.

© Bridges
POSITIVE TRANSITION RESULTS

7/1/16 Go Live Met
8/1/16 Provider Billing

Efficiency + Data

Day 1:
864 Level I submissions
72% auto approved

Proactive Providers,
Not Reactive
Transition Journey

A

△ LOSS  NEUTRAL ZONE  NEW BEGINNING

B

△ LOSS  NEUTRAL ZONE  NEW BEGINNING

C

△ LOSS  NEUTRAL ZONE  NEW BEGINNING

APR  MAY  JUN  JUL  AUG  SEPT  OCT

GO LIVE
It’s not the fall that kills you;
It’s the *sudden* stop.
Imagine if you could transform a moribund process to meet the needs of your program, too

<table>
<thead>
<tr>
<th>What’s the risk?</th>
<th>What’s the secret?</th>
<th>Can I do this alone?</th>
<th>What’s the payoff?</th>
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<tr>
<td>No one will believe its possible, do-able, or painless or fast enough to do now (it always seems like a bad time, right?)</td>
<td>Know when to strike, leverage watershed moments</td>
<td>Be building your network of collaborators all along, so you are ready when its “go time”</td>
<td>You have a great reputation for making it happen</td>
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<td>Your reputation is on the line</td>
<td>Radiate a can-do attitude armed with a reasoned business case and a solution</td>
<td>IN cross departmental communication and collaboration was evident</td>
<td>Compliance, modernization</td>
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<td>Stakeholders may cling to the familiar and reject the new</td>
<td>Band together to leverage skills needed to get to yes: great clarifier, great writer, great influencer/ convincer, great stakeholder communicator, great 60,000 foot view and great 50, 20, and 5,000 foot views, too.</td>
<td>Scout the field of solutions- do your market research-</td>
<td>Better service to individuals and providers- appropriate placement and more diversion transition potential</td>
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<td>Timelines often daunting</td>
<td>Leverage one recognized need to get two (system to accommodate both PASRR and LOC processes)</td>
<td>Then collaborate with experienced partner with established expertise in the arena</td>
<td>Faster streamlined process</td>
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<td>Often must rely on multiple partners to deliver or meet deadlines</td>
<td>Invest heavily in both preparing stakeholders for transformation and in actual training</td>
<td>They bring speed, efficiency, and ability to not have to learn “the hard way” what is already known</td>
<td>Data to monitor performance, quality, decision integrity</td>
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<td>Data to analyze needs, patterns, changes over time</td>
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<td>System and data to use for quality review, quality audits</td>
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<td>Flexibility to tweak process/ system to meet future needs</td>
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MAXIMUS Ascend PASRR services and solutions: Meet current needs while developing a future roadmap

- NF LOC submission and clinical review portal
- PASRR Level I screening and clinical review portal
- Integrated LOC tool with state specific algorithm
- Integrated, proven Level I tool and algorithm
- Integrated, proven Level I tool and algorithm
- Integrated quality modules
- Fosters rapid turnaround and outcomes
- Immediate access for all authorized entities
- Modules integrate with PASRR Level II system, tool, services
- Platform adaptable to expand screening and assessment tools
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