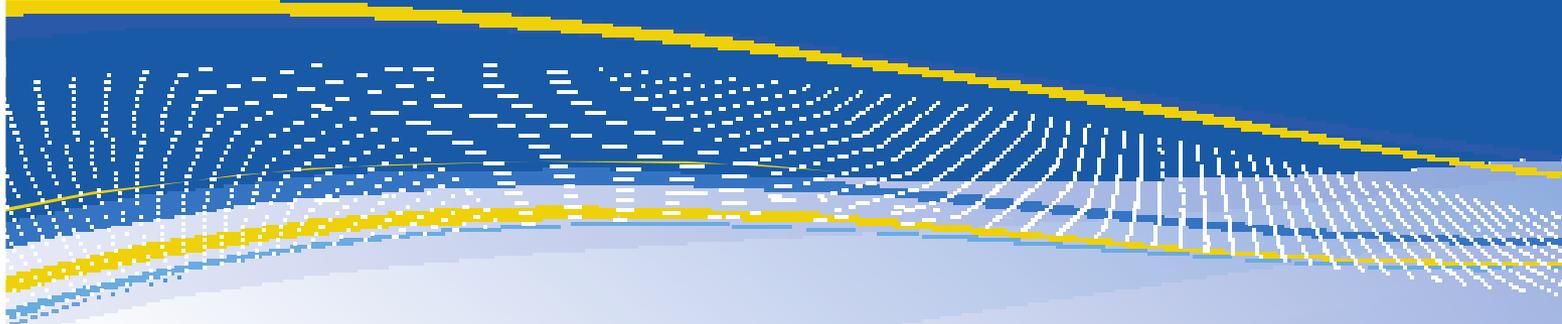
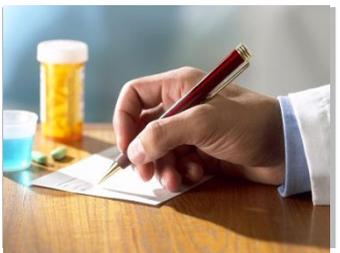




The Use of Preadmission Screening and Resident Review (PASRR) to Support Transition to Home and Community-Based Services

Division of Long-Term Services and Supports
Disabled and Elderly Health Programs Group
Centers for Medicaid and CHIP Services



Overview of Presentation

- An overview of PASRR and how it benefits individuals
- Using the Minimum Dataset (MDS) to identify states that transition PASRR-identified individuals to the community at high rates
- State interviews
- Key features of states with high rates of transition:
 - PASRR supports for transition
 - Transition monitoring & supports
- Characteristics of a strong community transition system

Overview of PASRR

1. What is PASRR?
2. Who does PASRR affect?
3. What are the purposes of PASRR?
4. How does PASRR help individuals?
5. How does PASRR work?

What is PASRR?

- Federal law and regulations place specific responsibilities on states to operate a Preadmission Screening and Resident Review (PASRR) program.
- PASRR responsibilities are established by federal law
 - Social Security Act § 1919(e)(7)
 - 42 CFR 483.100-138

Who Does PASRR Affect?

- PASRR has a role with any individual being considered for admission to a Medicaid certified nursing facility (NF).
- That role is broadened if the individual is suspected of having, or known to have, a qualifying PASRR condition of mental illness (MI), intellectual disability (ID), or a related condition (RC).
- The PASRR connection with the individual may continue throughout their residency in a NF.

What Are The Purposes of PASRR? (1 of 2)

- To ensure that individuals are evaluated for evidence of possible PASRR qualified conditions (MI, ID, or a RC) prior to NF admission.
- To ensure individuals with MI, ID or RC receive long-term services and supports (LTSS) in the least restrictive setting possible
- To identify and recommend that individuals receive the services they need and desire that are not otherwise funded under the NF rate, if a NF placement is warranted and desired by the individual.

What Are The Purposes of PASRR? (2 of 2)

- Following NF admission, PASRR resident reviews are required for any suspected change of condition to:
 - identify the LTSS needs of the person;
 - recommend community alternatives to continued stays in NFs; and
 - inform potential transition planning back to the community.

How Does PASRR Help Individuals?

- PASRR promotes *informed choice* by ensuring that individuals are aware of alternatives to NF admission.
- PASRR supports *continuity of care* for individuals with PASRR conditions who were receiving community-based services prior to seeking NF admission, or who will need those services when transitioning back to a community setting.
- PASRR *promotes engagement* of individuals with PASRR conditions in needed services if those services were not active at the time of their seeking NF admission.

How Does PASRR Help Individuals? (cont.)

- PASRR *supports NF efforts to develop person-centered plans of care that can lead to community transition.*
- PASRR *reduces the risk of hospital readmission* by ensuring individuals receive all the services and supports they need related to their PASRR condition.

How Does PASRR Work?



NF is Not the Only Service Option!

- PASRR is more than a door to a Medicaid-certified NF.
- It can be a pathway to other Medicaid or state programs that support individuals with PASRR conditions.

PASRR Level I Screening

- PASRR is required before any admission to a Medicaid-certified NF, regardless of payment source (Medicaid, Medicare, or private pay).
- It is a screen for possible serious MI, ID, or RC.
- The PASRR Level I is called an “identification function”
- The screener must issue written notice of a positive Level I screen to the individual and his/her legal guardian, with referral to the relevant authority for Level II
- The regulation leaves open personnel requirements for Level I. In practice, hospital discharge planners often administer it. NF staff can administer it as well (for residents).

PASRR Level II Evaluations

- Level II = Comprehensive evaluation of needed services and appropriate placement.
- Two components of assessment:
 - Need for NF services and NF level of care
 - Assessment of disability:
 - MI
 - ID/RC

Level II and Specialized Services

- Level II evaluations include a determination of the need for Specialized Services (SS):
- Recommendations must be incorporated into the person’s “individualized plan of care”
 - The state must “provide or arrange for the provision of specialized services”

Defining Specialized Services

- “Specialized Services” means any service or support:
 - Recommended by an individualized Level II determination
 - That a particular nursing facility resident requires due to MI, ID, or RC
 - That supplements the NF scope of services
 - That exceeds what the NF would be expected to provide under its daily rate.
- Specialized Services can help individuals maintain and improve functioning and become better candidates for transition.

Financing Specialized Services

- Specialized Services can be financed by Medicaid, Medicare, state-only dollars, private insurance, or private pay.
- States can submit a Specialized Services State Plan Amendment that allows the state to obtain federal reimbursement of Specialized Services provided to NF residents who need them.

Exempted Hospital Discharge (EHD) (1 of 2)



The Exempted Hospital Discharge is important to our analyses of transition data.

Exempted Hospital Discharge (EHD) (2 of 2)

- The EHD is the *only* exemption to PASRR. It requires:
 - Admission to a NF directly from a hospital after receiving acute care
 - Condition is the same as the one that required hospitalization
 - Certification by the attending physician that the individual will reside in the NF for less than 30 days
- If an individual's stay exceeds 30 days, a Resident Review must be conducted within 40 calendar days of admission

So How Can PASRR Support Successful Transitions from a Nursing Facility to the Community?

- The general goal of the analysis is to:
 - Use MDS data to identify states that succeed with transitions (30+ day-stay) or rapid transitions (> 30 days).
 - Next, interview state staff in eight (8) high-performing states to learn about what makes them able to transition at high rates.

Purpose of the Analysis

- Identify programs and practices that help states successfully transition NF residents back to the community.
- General Methods:
 - Use the Minimum Data Set (MDS) to divide states into quartiles of transition/diversion performance.
 - Rapid Transitions = discharge to the community within 30 days (the length of the PASRR Exempted Hospital Discharge).
 - Transitions = discharge to the community \geq 30 days
 - Conduct interviews with staff from eight (8) high-performing states.

Assessing NF Transition Rates Using the Minimum Dataset (MDS): What is the MDS?

- Assessment instrument administered to all residents of NFs shortly after admission and at regular intervals thereafter.
- Captures information about an individual's functioning and conditions at the time the MDS is administered, with a 2-week "lookback."
- Includes admission and discharge data.

Key Data in MDS

- *How long* individuals have resided in a NF.
- *When* they are discharged from the NF.
- *Where* they are discharged to – whether to another institution or – crucially, for our purposes – back to the community.
- For our analysis limited to PASRR-identified individuals, *who* has been identified as having a PASRR condition

MDS Data Fields Used to Estimate NF Discharge Rates

Key Data	MDS Item
PASRR identification	A1500
PASRR SMI identification	A1510A
PASRR ID identification	A1510B
PASRR RC identification	A1510C
Admission (entry) date	A1600
Discharge date	A2000
Discharge to community	A2100

This is a data-driven analysis, and we must rely on the data fields we have available to us in the MDS.

Method for Counting Individuals in NFs

- Individuals residing in a NF on January 1, 2018 (1,285,300).
- Number of people discharged to the community over the course of 2018 using discharge date (A2000) and discharge status (A2100).
- A2100 must = 01 = “discharge to the community.”
- Individuals discharged < 30 days = *rapid transitions*.
 - This definition is tied to the length of the 30-day PASRR Exempted Hospital Discharge.
- Individuals discharged \geq 30 days = *transitions*.

Results: PASRR-Identified Individuals

- Among 154,749 PASRR-identified individuals in NFs on January 1, 2018:
 - 7% (11,303) were discharged to the community during 2018.
 - Of this 7%, one in six (1,932) count as rapid transitions.
 - Of this 7%, five in six (9,371) count as transitions.
- Individuals with a PASRR disability are at risk of longer stays.
- Notes about analysis:
 - Did not account for all possible factors, such as hospice, that might influence length of stay.
 - Did not include information about individuals who found services in the community before admission.

Results: Separating SMI and ID/RC

- Among PASRR-identified individuals, we distinguished between individuals with SMI (A1510 = 1) and ID/RC (A1510B or A1510C = 1).
- On January 1, 2018:
 - 116,839 individuals with SMI resided in NFs.
 - 50,387 individuals with ID/RC resided in NFs.
- Rates of community discharge were similar for both groups: 7% for SMI and 6% for ID/RC.
- Rapid transition rates for both groups were about half the rate of the overall NF population.

Top Quartile: All PASRR-Identified Individuals

Rank	Discharged to Community	Rapid Transitions (< 30 days)	Rapid Transitions (30+ days)
1	CA	AL	CA
2	WI	MA	UT
3	OR	OR	WI
4	UT	WI	OR
5	MA	NM	WA
6	WA	MI	MN
7	MN	NC	MA
8	ME	PA	ME
9	MD	DC	MD
10	MI	ME	NV
11	NC	MD	NC
12	CT	HI	CT

8 States Selected for Key Interviews From Top Quartiles of Community Discharges for All NF Residents*

- Arizona
- California
- Maine
- Michigan
- Nevada
- Oregon
- Pennsylvania
 - *from top of second quartile, added for geographic diversity.
- Washington

Goals of Interviews

- To learn about how state PASRR programs:
 - Provide Specialized Services that can prepare individuals to return to their communities.
 - Are connected to community-based long-term services and supports programs.
- To learn about how states monitor transitions from NFs.
- To learn about community long-term services and supports programs that support individuals in the community:
 - Programs that support transitions.
 - Programs that help individuals who are at risk of entering or re-entering NFs remain in their communities.

Interview Protocol

- How does STATE currently provide or arrange individualized, disability-specific Specialized Services, however they are financed (Medicaid, block grants, state-only funds, Medicare, and so on)?
- Does STATE provide transition services as part of PASRR Specialized Services, however those are financed?
 - If not, has STATE considered doing so?
- Has STATE adopted a state plan amendment (SPA) to finance PASRR Specialized Services via Medicaid?
 - If not, has STATE considered adopting such a SPA?
- How has STATE focused on transitions from nursing homes?
 - Note: Staff could interpret *transitioned* according to the definition used in their state for MFP (currently > 60 days) or for other state-only programs.

Summarizing Interview Topics for Analysis

- PASRR Program: Aspects that support transitions.
- Transition Monitoring & Supports:
 - How the state tracks individuals who wish to return to the community (on MDS Section Q) + data on how many people have transitioned.
 - Community-based programs (e.g., waivers) that support transitions.

PASRR Supports for Transitions

First, we looked at how state PASRR programs were designed and implemented to shed light on why the state performed well in transitioning people from nursing facilities.

PASRR Supports for Transition: Arizona

- Managed care plans (MCPs) in AZ are responsible for services provided to PASRR-identified individuals, including Specialized Services.
 - NF residents can access all HCBS-like services provided to people living in the community.
 - The state conducts operational reviews of its MCPs every three years. These include reviews of whether MCPs have delivered the Specialized Services that are listed in a PASRR-identified person's plan of care.

PASRR Supports for Transition: Michigan

- Specialized services are funded through prepaid inpatient health programs (PIHPs), which contract with Community Mental Health Boards (CMHBs) to provide them.
 - Michigan monitors the delivery of Specialized Services through CMHBs on a quarterly basis.
- Michigan tracks the number of people in its NFs who receive specialized services annually – nearly 1,000.
- Case workers at CMHBs regularly monitor PASRR-identified individuals, whether they have SMI, ID, or RC.

PASRR Supports for Transition: Oregon

- The state reported turnover among assessors is an ongoing problem, especially in rural areas. Moreover, in the state's view, assessors often miss the “full purpose” of PASRR and thus do not reach out to diversion and transition coordinators.
- Oregon has begun to explore a range of solutions to this problem, including private-sector vendors and coordinated care organizations.

PASRR Supports for Transition: Pennsylvania & Washington

- **Pennsylvania**
 - The State Mental Health Agency (SMHA) contracts with behavioral health MCPs to provide Specialized Services to NF residents.
- **Washington**
 - In 2014, WA became the first state to have a Specialized Services SPA approved by CMS. The SPA replicated many of the services in the ID waiver.
 - By providing HCBS-like services to NF residents, WA created a “services follow the person” model – individuals can retain their providers once they transition from the NF back into the community.

PASRR Supports for Transition: Washington (continued)

- WA uses its SPA to cover as specialized services some of the same supports covered under the state's 1915(k), including the purchase of assistive technologies that promote community integration ahead of transition.
- During every visit, PASRR assessors for the SIDA provide verbal and written information about the Family Mentor program – family members whose loved ones have successfully moved back to the community.
- They recommend the service to any resident who lacks a documented discharge plan. The State Intellectual Disabilities Agency (SIDA) then tracks contact with a Family Mentor as part of its Resident Reviews.

Transition Monitoring and Supports (1 of 7)

We also looked at how states monitored transitions from NFs back to the community and what kind of transition supports a state may have, to see if the integration of PASRR activities into the broader SMHA and SIDA activities improved overall performance.

Transition Monitoring & Supports (2 of 7)

Michigan operates a transition portal that agencies use to input data about NF residents; data are used to authorize transition services, collect information on person-centered service planning, and track trends.

- When a waiver enrollee applies for NF admission, the PASRR team asks the NF for more information.
- The PASRR team has access to the waiver management database, and they examine the reasons for NF placement.
- Transition services are included in a 1915(i) SPA designed specifically for transitions.
 - 1915(i) also provides transition services to individuals who are at risk of returning to an institution.

Transition Monitoring & Supports (3 of 7)

- For individuals admitted to NFs in Nevada, managed care plans must provide transition services for at least 45 days. They are required to send a dedicated case manager to the NF every seven (7) days to ask whether a recently admitted resident is ready to return to the community.
- Nevada also has a Facility Outreach Community Integration Services (FOCIS) unit. NF residents have access to unit and to NF case managers.
 - Each FOCIS division has dedicated health care coordinators; they work with residents who have resided in the NF fewer than 30 days. They also work with NFs to conduct outreach to residents.
 - FOCIS unit staff also have regular meetings with waiver case managers and with staff from the state's Centers for Independent Living (CILs) to support transition.

Transition Monitoring & Supports (4 of 7)

- The Washington Aging and Long-Term Support Administration (ALTSA) has developed multiple reports to review nursing facility case management (NFCM) data, which in turn has informed strategic planning.
- Washington adopted a 1915(k) state plan option that includes expenditures for certain transition costs.
 - These include non-recurring set up expenses (not including room and board) for participants who are transitioning from an institutional setting to a HCB setting in which the person is directly responsible for their own living expenses.

Transition Monitoring & Supports (5 of 7)

- For all participants in their 1915(k), WA also covers items relating to a need identified in a person-centered plan, and that increase an individual's independence or substitute for human assistance, to the extent that expenditures for the human assistance would otherwise be covered.
 - For example, this could include assistive technology (like an iPad or GPS locator).
 - Additionally, for individuals who are not eligible for CFC or other Medicaid transition services or funds, certain transition services are provided with state-only dollars (including household items, community transition services, pest eradication, moving costs, one-time cleaning, first month's rent, and a utility deposit).

Transition Monitoring and Supports (6 of 7)

- Via MFP, California tracks the number of successful transitions. Transition supports include preparing the individual and their "circle of care and support" for the transition to a less restrictive environment. Different levels of support are available, including crisis services for those especially at risk of returning to an institution.
- Maine monitors its transitions under the MFP program, and also monitors how many waiver participants are admitted to NFs.
- In Arizona, the three MCPs that oversee case management for older adults and individuals with disabilities are required to reassess NF residents every 180 days. These assessments are performed by case managers not affiliated with any NF. The Medicaid Agency also contracts with the SIDA to case manage individuals with ID and RC who are in NFs.

Transition Monitoring & Supports (7 of 7)

- Oregon's 1915(k) has a robust array of transition supports, including coverage of security deposits, application fees, background check fees, clothing, wares to stock the kitchen, minimal appropriate furniture, environmental modifications, and durable medical equipment that private insurance either delays or denies.
- The Pennsylvania SIDA, Office of Developmental Programs (ODP), authorizes time-limited NF stays. Staff review data to see how many extensions are requested, per person, per facility, and state-wide. This monitoring helps ODP track individuals at risk of becoming long-stay residents and identify patterns within and across facilities that it can address through training or other interventions, to help those residents transition.
- Pennsylvania also operates a 1915(b)/(c) waiver focused on diversion and transition – Community Health Choices (CHC), operated by the Office of Long-Term Living.

Characteristics of a Strong Community Transition System (1 of 2)

1. States have experimented with a range of strategies to help individuals transition successfully from NFs. High Performing states are open to new ideas and committed to improving existing programs.
2. States with high transition rates have extensive and HCBS-like PASRR specialized services.
3. States that align PASRR specialized services with other HCBS services provide for a seamless transition to the community. This includes states with managed care in which MCPs provide Specialized Services to PASRR-identified individuals, whether in NFs or in the community.
4. States with strong systems of oversight of the delivery of PASRR Specialized Services remain focused on the goal of transition.

Characteristics of a Strong Community Transition System (2 of 2)

5. During NF stays, several states created systems that provide “eyes-and hands-on” contact with NF residents, whether to track changes in an individual’s status or to provide awareness to NF residents and their loved ones that successful transitions are possible.
6. States have made use of the time-limited admission, with regular check-ins to assess whether an individual is ready to transition.
7. States have made available robust transition services in HCBS systems via any waiver or state plan authority or state general funds.
8. Related to (6), requiring that waiver-administering entities reserve the slots of participants who are admitted to NF makes it easier for individuals to plan to transition, knowing that their services will still be available when they return home.

Conclusions

- To be an effective tool for NF transition, PASRR must be embedded in a rich and robust system of HCBS, including transition services.
- States with robust PASRR systems implement PASRR-specific policies and procedures to provide or arrange Specialized Services (e.g., through MCPs) and to track the status of PASRR-identified individuals in NFs.
- Ultimately, PASRR works as a tool for community inclusion when embedded in a robust HCBS ecosystem.