Promising Practices for Diversion and Transition of Persons with Mental Illness Through the PASRR Processes

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Brief Chronology

1965: Medicare & Medicaid Passed
1966-1976: Dramatic increase in NF population
1981: Medicaid HCBS Waivers authorized
1987: OBRA Nursing Home Reform Act
1989: PASRR implementation
1990: Americans with Disabilities Act
1999: Olmstead Decision
2000-2009: Grants for NF Transition, Real Choice, Money Follows the Person, ADRCs, NF diversion, Systems Transformation
2007: Office of the Inspector General’s reports on PASRR
2008: CMS letter regarding PASRR
PASRR: Different Impacts for MR vs MI

Persons with Intellectual disabilities

- Smaller population in NFs
- ICFs-MR available under Medicaid
- Criteria for Specialized Services (SS) are broader
  - Persons with MR/DD can receive SS in nursing facilities
- HCBS waivers are readily available to support persons with MR/DD in community

Persons with Mental Illness

- Larger population in NFs
- IMDs excluded under Medicaid for ages 22-65
- Criteria for specialized Services can be limited to Acute Inpatient care
  - Most states chose narrow definition
  - Narrow definition effectively excludes persons needing SS from NF admission
- Few states have HCBS waivers for persons with MI
Changes in Population with Mental Illness in Nursing Facilities

*Mechanic and McAlpine (2000)
**Fullerton et al (2009)
Admissions of Persons with Mental Illness to Nursing Facilities

- 2005 (narrow): 315,188

Years: 1999, 2005 (narrow), 2005 (broad)
Olmstead Mandate

• “A public entity shall administer programs and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities.”

• “Unjustified isolation [...] is discrimination based on disability.”
PASRR Mandate

• “The assessment must determine whether this level of support can be provided to the individual in an alternative community setting or whether the level of support needed is such that NF placement is required.”
  -- PASRR Federal Regulations, § 483.134

• PASRR evaluations & determinations must consider community-based alternatives to nursing home placement.
  -- CMS letter to states in 2008 reinforcing regulation
Study Purpose

• To learn about promising practices across selected states regarding diversion and transition efforts for persons with MI as part of the PASRR process.

• The key products of the study will be a white paper and policy briefs on the findings for potential wider dissemination.
Methods

• **Literature Review**
  - Overview of MH care for elders and how PASRR and NF care
• **Collection of Data from States**
  - This included collecting PASRR screens, state regulations and other documentation to understand states PASRR practices
• **Key Informant Interviews**
  - Informants were selected from 12 states
  - The interview guide focuses on:
    1) States PASRR processes
    2) How practices differ across states (i.e.) definition of specialized services for MI and
    3) Diversion and transition efforts for those with MI and how they are linked to PASRR
Selected States

States were selected by:

Doing an online search and literature review regarding which states were linking their process to their:
1) MFP grants
2) HCBS waivers
3) Other state programs or practices that promote diversion or transition

- California (MFP)
- Colorado
- Connecticut (MFP)
- Florida (MFP)
- Illinois
- Indiana
- Michigan (MFP)
- Nevada
- Ohio (MFP)*
- Virginia (MFP)*
- Washington (MFP)
- Wisconsin (MFP)

* Not yet interviewed all staff for the study
Overview

• Many states are in the process of revamping various aspects of their PASRR operations including revising screening tools or tightening other processes to promote linkages with other programs that promote diversion or transition and using the CMS self-assessment tool to improve their processes.

• In many cases states are in the process of revamping their data systems so some states were able to share data on the number of diversions and transitions and others were not able to share data.
### California

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<tr>
<th>Diversion Efforts</th>
<th>Transition Efforts</th>
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| • **Specialty Mental Health Waiver** (1915b Freedom of Choice waiver)  
  • **Olmstead plan** promotes recovery oriented community based services  
  • **Level II** screens include detailed questions about the persons ability to function in the community and Level II contractors are trained to consider waiver services based on questions in the Level II screen | IMDs case managers are incentivized to transition people and connected to their county mental health programs who work to transition persons with mental illness. |
# Colorado

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<th>Diversion Efforts</th>
<th>Transition Efforts</th>
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<tr>
<td>• They have a small <strong>HCBS/MI</strong> waiver in place</td>
<td>• Planned improvements to promote transitions from NFs by increasing <strong>transition planning between NF staff and CMHCs</strong> to identify barriers to community placement</td>
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<tr>
<td>• Provides day programming, in-home care, medical transportation and services in Alternative Care Facilities (mainly medical supports)</td>
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<td>• Available to those in NFs for 6 months or longer</td>
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Indiana

Transition Efforts

Indiana has just begun linking their MFP grant to their PASRR process via increased cooperation with their CMHCs
Michigan

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<td>• Increased money to their Community Mental Health agencies to help place people from NF into the community and is linked to the PASRR process that helps some people transition as part of a Nursing Facility Transition Initiative</td>
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## Nevada

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| • As part of their Level II process they have a categorization of “Level II-A” of persons needing services outside the nursing facility | • As a result of their Olmstead decision the Medicaid authority developed their **FOCIS program (Facility Outreach & Community Integration Services)**  
• Providers, state staff and others can refer anyone they feel could be transitioned |
## Washington

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| **MFP grant** (not connected to the PASRR process) | • **Minority mental health specialists** that assist with Level II process. They offer additional consultation along with MH contractors  
• This is a state service in Washington |
## Wisconsin

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<tr>
<td>• MFP grant</td>
<td>• They have an <strong>HCBS/MI waiver</strong> that has been in operation 1.5 years that helps to relocate people out of NFs</td>
<td>• They want to work to do <strong>more outreach to increase enrollment</strong> and education about the HCBS/MI waiver</td>
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<td>• Nursing Home Diversion Initiative which began in April 2006</td>
<td>• <strong>Community Support Programs</strong> provide services up to 3 months while a person is in a short term stay to ensure they can transition back to the community</td>
<td>• <strong>Family Care Program</strong> in which ADRCs act as a SEP to provide information about community based services</td>
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Promising Practice Summary

• States are in various stages of linking diversion and transition initiatives (i.e. to MFP) or practices to their PASRR process. Many states interviewed noted that they were in the beginning stages.

• Most states have noted that coordination and cooperation across programs has been key in their efforts to divert or transition persons with MI from NFs.
References


Nursing Home Diversion & Transition Program: Linking with PASRR

A Time for Transition: Policy, Practice, and Research in Aging and Mental Health

Des Moines, Iowa October 18-21, 2009
CT recognizes that........

In order to meet the needs of its citizens, CT must re-balance its long-term care system, changing the focus and funding priorities from institutions to home and community-based services.
Nursing Home Diversion & Transition Program

Goal

To ensure that DMHAS clients (or eligible clients) are informed of community alternatives and that only clients who require significant physical assistance and/or significant skilled medical services are admitted to, or continue to stay in, nursing homes.
Nursing Home Diversion & Transition Program

Objectives

- To divert inappropriate admissions of DMHAS clients to nursing homes; and

- To transition NH residents with SMI back to the community when they no longer require that LOC.
Program Structure

- DMHAS funds six Nurse Clinicians attached to local mental health authorities (LMHAs).
- Nurses responsible for activity in a geographic area.
- Program “housed” in the same unit as the new HCBS waiver for persons with SMI.
- Person-centered recovery model.
To divert inappropriate NH admissions......

- Pre-OBRA screen used for state hospital/agency clients; identifies functioning; behaviors; skilled needs.
- Collaborate with Medicaid agency (DSS) in identifying persons with SMI who do not meet NH LOC (PAS Level I screens & LOC determinations).
- Investigate Level II history and/or DMHAS client history.
- Go into hospital EDs & inpatient units to work with patient & staff re: community alternatives; work with community providers, families, & conservators.
To transition NH residents with SMI who no longer need that LOC.....

- Use Level II report for assignments; also referrals from NHs; clients; families/conservators; or MFP/MI waiver.
- Use Level II evals and/or DMHAS data base to collect clinical and service history.
- Engage with resident & collect info (psychosocial; skills; physical; medications; financial; resident’s personal vision & goals; etc.)
- Monthly meetings at nursing homes.
For both objectives.....

- Act as liaisons between Medicaid Agency; hospitals; NHs; LMHAs; MFP staff; MI Waiver staff; etc.

- Establish relationships with all the above.

- Educate, educate, educate.
Essential Question

What do you expect the nursing home to do for a person with serious mental illness?
Results So Far

- SFY 2009: 45 transitions; 162 diversions.
- Biggest Challenges: housing & substance abuse.
- Improved relationships between all entities involved with CT long-term care initiatives.
Other Re-balancing Initiatives

- Medicaid Home and Community-based Services Waiver for Persons with SMI (one of 4 in the country)
- Money Follows the Person Demonstration Grant
- No person left behind: if not eligible for the above, Diversion & Transition Program will kick in.
Contact Information

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Contact Information

DMHAS HCBS Waiver for Persons with SMI
Working for Integration, Support & Empowerment (WISE)

www.ct.gov/dmhas/wise

CT Department of Social Services
Money Follows the Person Demonstration Grant
www.ct.gov/dss
Florida

Diversion and Transition Efforts

A Time for Transition: Policy, Practice, and Research in Aging and Mental Health

Des Moines, Iowa
October 20, 2009
Florida Department of Elder Affairs

- State Unit on Aging
  - 11 Planning and Service Areas
  - 11 Aging Resource Centers/Aging Disability Resource Centers
  - Comprehensive Eligibility Services
  - Home- and Community-Based Services (HCBS)

- Consumer Advocate Services
Medicaid HCBS Programs for Elderly and Physically Disabled Individuals

- Adult Day Health Care
- Aged and Disabled Adult
- Alzheimer’s Disease
- Assistive Care Services
- Assisted Living for the Elderly
- Channeling
- Consumer-Directed Care Plus
- Nursing Home Diversion Program
- Traumatic Brain and Spinal Cord Injury
- Program of All-Inclusive Care for the Elderly (PACE)
Florida Elders Served

- 4.4 million seniors in Florida (23% of state population).
- DOEA programs served approx. 638,500 Floridians age 60 and older in FY 07-08.
- 209,305 unique clients served in HCBS programs (1/1/07 through 8/20/09).
  - GR and OAA programs 165,262
  - Nursing Home Diversion 24,161
  - Alzheimer’s Disease Waiver 550
  - Other Medicaid Waivers 19,332
CARES Role
(Comprehensive Assessment and Review for Long-Term Care Services)

- Nursing home pre-admission screening
  - Determine medical eligibility or level of care for the Institutional Care Program and 12 of Florida’s Medicaid waiver programs
  - Choice-counsel and refer elders on available Medicaid programs/services.
- Level I screens (82,497 in FY 08-09).
- Level II requests and repository for PASRR Level I and Level II screens.
- Diversion and transition.
Current Florida PASRR Regulatory Process

Agency for Health Care Administration
AHCA / Medicaid

- Dept. of Elder Affairs/ CARES Level I
- Dept. of Health/ Children’s Medical Assessment Team Level I
- Dept. of Health/ Early Steps Level I & II
- Agency for Persons with Disabilities MR Level II
- Dept. of Children and Families/ Substance Abuse and Mental Health MI Level II
- AHCA Quality Assurance NH Surveys and PASRR Monitoring
Florida Nursing Home Transition Program

- Involves the voluntary transfer of an eligible Medicaid beneficiary residing in a nursing home to an appropriate community setting (family member’s home, individual’s apartment or home, assisted living facility, adult family care home, etc.)

- Collaboration among Department of Elder Affairs, Department of Children and Families, Department of Health, and Agency for Health Care Administration.
Transition Program Goals

- Promotes the integration of state and community supports.
- Respects all individuals and their need to be treated with dignity.
- Provides outreach and education targeted to individuals in nursing homes.
- Utilizes data collection to track outcomes and improve the transition process.
Nursing Home Transition Initiative
Community Resources

- Home- and community-based programs being used to transition eligible individuals from nursing homes to the community.
- 2009 Florida Legislature authorized the transfer of Medicaid nursing home funds to certain Medicaid waiver programs for this purpose.
- Seeking federal approval for transition case management services.
Success To Date

- Between March and October 2009:
  - 1,519 Clients Considered for Transition
  - 544 Clients Transitioned (Not in NH or hospital)
  - 289 Clients Transitioned to a Medicaid Waiver
  - 70% in nursing facility for more than 60 days.

- Individuals currently identified through:
  - Self, family, and friends
  - Nursing facility staff
  - CARES and Long-Term Care Ombudsmen
  - Analysis of Minimum Data Set (MDS) information.
Transition and MI/MR Populations

- Alternative settings available for MR population
  - Linked to PASRR Level II

- Barriers exist to transitioning MI population
  - Housing
  - Limited resources to serve MI in community (SAMH, Medicaid HCBS, and Medicaid State Plan Services).

- Potential exists to
  - Focus transition efforts on MI population
  - Better link PASRR Level II to transition efforts
  - Make use of transition case management services
Put in the Positive

- PASRR is designed to prevent inappropriate placements of individuals in nursing facilities.
- Rather than PASRR just acting as a gatekeeper for entrance to nursing facilities, the PASRR process can also be a gateway to the community.
CARES Online

http://elderaffairs.state.fl.us/english/CARES/pasrr.html

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Questions and Comments?

Please share your states experiences with diversion/transition or ask questions.