

Nursing Facility Safety Task Force – Implementation Workgroup

An outcome of the Nursing Facility Task Force on Safety was the assignment to explore elements that will enhance the Pre-Admission Screening/Resident Review (PASRR) process. The goal is to determine gaps, training needs and curriculum for such training and create an implementation schedule for introduction in early FY2011.

The PASRR Enhancement Implementation Work Group anchored this document with several basic assumptions:

1. There will be continuous, fluid and timely communication between the community hospitals staff/social service departments and PASRR screeners.
2. Inpatient discharge planning will occur as early in the admission process as possible to allow time for all necessary PAS assessment components to occur prior to actual discharge.
3. The State is committed to develop and/or enhance necessary community-based service resources as options of care for individuals who can best maximize their mental health recovery outside of a nursing facility setting.
4. The availability of adequate funding is paramount to ensure that all necessary pieces of these recommendations for systems change will be actualized.

Brief History of PASRR:¹

Congress created the PASRR program under OBRA (Omnibus Budget Reconciliation Act) 1987 out of concern that, as a result of the deinstitutionalization movement, many people with SMI or mental retardation were inappropriately placed in nursing homes, where they would not receive the care or specialized services needed. Based on both advocacy concerns and empirical data, Congress became increasingly aware that some States were using Nursing Facilities (NF) placements as a way to reduce overcrowding in State facilities for people with SMI (Serious Mental Illnesses).

The State Medicaid agency bears the ultimate responsibility for fulfilling all Medicaid requirements, including those associated with PASRR. Regulations specifically require State Medicaid agencies to include a PASRR program in their State plan and to develop a written agreement with the State Mental Health Authority detailing the operation of the PASRR program.

To determine the universe of nursing facility applicants suspected of having a mental illness, some form of screening must be conducted. Federal regulations mandate this preliminary

¹ Policy Report – Screening for Mental Illness in Nursing Facility

screening, referring to it as an OBRA screen. Because these regulations provided no rules about the tools used or personnel involved in an OBRA screening, the screening may be conducted by nursing facilities, hospitals, physicians, or other entities specified by the State's Medicaid program.

If the OBRA screen concludes that there is a suspicion of mental illness, there are two subsequent PASRR screening processes conducted: (a) Level I Screen (desk review) to substantiate if there is a clinically based diagnostic justification of a Serious Mental Illness (SMI) and (b) Level II Screen (face-to-face full assessment) that generates a determination of need that could result in services. Both Levels of PAS screens are explained on page 4:

Applicants suspected of having a mental illness (who rated "positive" for suspicion of SMI) in the Level I desk review, undergo a more extensive preadmission assessment called a Level II screening. The Level II screening requires an independent evaluation of applicants' physical and mental health status. Independent evaluators must not have any ties to nursing facilities nor may they be part of the State Mental Health Authority.

PASRR Enhancement Implementation Workgroup:

The PASRR Enhancement workgroup is composed of a cross spectrum of representatives including stakeholder advocates, a PASRR screener (retired), the Illinois Hospital Association, DHS Divisions of Rehabilitation Services and Alcohol and Substance Abuse, the Department on Aging, and the State's Medicaid Authority. This body met over the course of a seven-week period to critically examine the intricate operations of PASRR and to identify where serious gaps occur. The group looked at strategies for enhancement or change that would facilitate better decision-making outcomes in determining eligibility for nursing facility admission. The workgroup also acknowledged that the focus of PASRR, while continuing to meet the full intent of the Federal OBRA regulations, needed a philosophical foundation that embraces the direction of systems' rebalancing - realigning its alliance from decision-making for nursing facility admissions to decision-making for appropriate integrated community-based options to meet rehabilitation needs. This shift in philosophy is supported in the principles of mental illness recovery and the mission of the Department of Human Services/Division of Mental Health.

As such, this workgroup recognizes that some of the recommendations for change or enhancements proposed in PASRR will have direct implications and ramifications with internal operations of other co-PAS (Pre-Admission Screen) entities. However, it is important to remember that system change cannot occur in isolation - each part of the system will be impacted and have an intricate role in the overall operations. The serious nature of making necessary reforms in Nursing Facility/Long Term Care processes must be done as a whole. PASRR (for mental health) cannot do this in isolation of our relationship and involvement with our co-division (Department of Human Services Divisions of Developmental Disability, Rehabilitation Services, Alcohol and Substance Abuse) or Department partners (Department on Aging).

Concurrently, some of the exploration of this workgroup closely mirrored the work product of the Risk of Harm Implementation Workgroup, specifically the review of the History of Maladaptive Behaviors checklist. The goal of the Risk of Harm Implementation workgroup, which was to identify an instrument to assess risk, resulted in a formal collaboration between the two workgroups to review the existing checklist used in the PASRR process in comparison with scientifically researched instruments. It must be underscored that PASRR agents will not do a comprehensive clinical assessment to determine predictors of risks. That level of clinical skills must be relegated to highly experienced psychiatrists or psychologists trained in the administration of standardized risk assessment instruments. However, PASRR will use risk information to determine the most clinically appropriate service option.

This collaboration resulted in a presentation and discussion with Dr. Reid Meloy, national expert in Forensic Psychology, who provided recommendations for changing the existing History of Maladaptive Behavior checklist (currently part of the Level II screen). He also recommended inclusion of a modified risk indicator checklist across all PAS entities regardless of the disability, and specifically applicable with the completion of the OBRA screen.

The Task Force Workgroup addressed a three-phase process to enhance PASRR. The three phases are:

Phase I – Modifications of the PAS/MH screening Instruments (OBRA screen, Level I and Level II)

Phase II- Modifications of the overall PAS/MH processes (system and community-based linkages/referrals)

Phase III – PASRR Training Curriculum

Each of these Phases will be detailed with corresponding recommendations.

Phase I: Modifications of the PAS/MH screening Instruments (OBRA Screen, Level I and Level II)

- I. OBRA Screen (conducted by nursing facilities, hospitals, physicians, or other social service providers, or other entities specified by the State's Medicaid program) – will include a simple five-question, non-clinical checklist on maladaptive behaviors (see attached).

Potential maladaptive or acting out behaviors can occur regardless of disability group, age, gender or payer source. Entities making a referral to PAS (MH, DD, DRS or DoA) must share rudimentary information on any adverse behaviors identified from observations or record reviews. Any positive indications noted on the five-question checklist are to be shared with the next level of PAS assessments.

This form will be completed by all parties generating an OBRA Screen, regardless of the disability population.

The Division of Mental Health, in collaboration with DDD, DoA and DRS, will work with Dr. Reid Meloy, to identify “triggers” of behaviors that will be folded into documentation reviewed in the Level I process. These “triggers” will become baseline thresholds to determine if a more comprehensive risk assessment is necessary.

Individuals who exceed established thresholds in the Level I desk assessment and who are determined not to have a serious mental illness will be referred back to the responsible Division/Department for a Comprehensive Risk Assessment. It will be responsibility of that receiving Division/Department to retain the professional expertise of qualified trained staff to conduct this Comprehensive Risk Assessment.

Individuals who exceed established thresholds in the Level I desk assessment and who are determined to have a serious mental illness will be referred to a DMH professionally trained staff to conduct the Comprehensive Risk Assessment.

The Division of Mental Health will also retain consulting services of a Gero-Psychiatrist and/or a Gerontologist. This professional level staff will complete the decision tree determination with PAS/CCUs and PAS/MH on complicated OBRA Screen referrals, provide professional consultation to PAS/CCUs and PAS/MH in situations where more clarity is required on the responsible service agency, and communicate with inpatient medical personnel, as needed, in order to make appropriate determinations for the required level of care.

II. Level I (desk review) – inclusion of more substantive information to make an informed determination is an absolute necessity in the Level I desk review. Historically, the only information provided to the PASRR screeners, as generated from the OBRA Screen has been limited to the individual’s name and location. For the desk review to have merit, it is recommended that the referring source include at a minimum with the OBRA Screen, a psychiatric evaluation or signed medical documentation to support the “suspicion” of serious mental illness.

In addition to retrieving all supporting information to substantiate or not a serious mental illness, the Level I PAS will now include gathering documentation of Historical information from the History Clinical Risk (HCR) -20². This will include information (if available) on (a) previous violence; (b) young age at first violence, (c) relationship instability, (d) employment problems, (e) substance use problems, (f) major mental disorder (g) early maladjustment, (h) personality disorder, (i) prior supervision failure. The outcome of the HCR-20 (Historical) may prompt a referral for the more Comprehensive Risk Assessment if the individual is determined eligible for a Level II screen.

² Webster et al. 2010

III. Level II (full PAS/MH) - assessment is conducted face-to-face. If the individual is in a hospital setting, the Level II PAS assessment must be conducted prior to discharge and before a commitment to transfer and admit to a nursing facility. In addition to required psychiatric, medical and social history, the Level II screen will be enhanced by incorporating all (a) five diagnostic Axes, (b) an assessment instrument to identify the severity and intensity of cognitive impairments, (c) a NIDA-Modified Alcohol, Smoking and Substance Involvement Screening Test (to identify the severity and intensity of substance abuse) (d) an assessment instrument to identify co-morbid medical/physical conditions, (e) the START³, (f) the LOCUS⁴ and (g) a Decision Tree to assist with the determination of appropriate community based alternatives. The determination on the Level II screen will identify the most appropriate level of care, that will include exploration of community based support and residential service options to meet the individual's needs.

Introducing the START:

The Short-Term Assessment of Risk and Treatability (START) was presented by Dr. Reid Meloy as a recommended replacement instrument to the existing History of Maladaptive Behavior checklist. This instrument is currently used in British Columbia and has proven to have good outcomes. It has been extensively researched and based on scientific evidence as a reliable tool. The instrument can be enhanced with other indicator items as identified as appropriate for inclusion. The instrument can also be repeated during the scheduled Resident Review processes, allowing a baseline of behavior to be established and progress charted.

PASRR agents will receive training on the START and annual retraining will be included as a component in the training curriculum.

Phase II. Modifications of the overall PAS/MH processes (system and community-based linkages/referrals)

In order for the Department to better manager, monitor and control the PASRR processes, the PASRR Enhancement workgroup recommends the following⁵:

- I. PAS/MH (including Resident Review (RR) will be contracted out, statewide, through a Request for Proposal to a limited number of independent agents. Division of Mental Health contracted vendors, as well as other entities, will be eligible to respond to the RFP. Specifications on the qualifications of applicants will be detailed in the RFP. This will ensure no conflict of interest between the PASRR entities, community based direct service providers or nursing facility ownership.

³ Short-Term Assessment of Risk and Treatability (START)

⁴ Level of Care Utilization Scale (LOCUS)

⁵ It should be noted that these recommendations apply only to the enhancement of the PAS/MH process

- II. PASRR screeners employed by the independent agent(s) will be licensed by the Illinois Department of Professional Regulation as a License Professional of the Healing Arts (LPHA) (preference given to social workers, psychologists, psychiatrists, LCPC and certified psychiatric nurses), with a minimum of 3 years experience in the field of mental health. PASRR entity will use state of the art technology, including telemedicine practices, in remote areas as deemed appropriate.
- III. The PASRR agents will have clearly defined, measurable performance deliverables, that will include, but not limited to:
- (i) Specification on the time frame in which a PAS screen must be conducted.
 - (ii) Specification on the time frame when a PAS screener submits finding reports back to the initial referral source.
 - (iii) Specification on the time frame in which the assessment findings must be inputted into the Unified Health System.
 - (iv) Specification on the quality of the information gathered (consumer, family, hospital records, hospital personnel, community mental health providers and others).
 - (v) Specification on the quality and content of documentation findings (including interim plan for the most appropriate level of care)
 - (vi) Specification on PASRR decision making processes to select appropriate community based alternatives

Recommendations to enhance the PASRR System:

- I. Implementation of PAS Quality Improvement Indicators and Quality Management and tracking.

Measures of PASRR quality:

- % Sample of reviews of PAS screens, monthly
- % Of corrective actions submitted

Measure of PASRR quality/improvement benchmarks in different geographic areas:

- % Of individuals referred/recommended for and transitioned to integrated community based service settings from determination of the Level II screen.
- % Of individuals referred for community based service settings from NF level of care – through Resident Review

Measures of DMH/Community system performance:

- % Of individuals on a wait list by specific services
- % Of services availability/accessible on referral, by geo area

- II. Technology enhancement – Develop real time web-based information and access to a community-based directory of available services, specifically crisis step-down

and treatment options. Technology must be coordinated between systems to allow for cross systems' database communication.

- III. Modify the Unified Health System (UHS) to ensure timely processing, as well as access to all PASRR data collected and reported. Expand access to UHS to allow currently restricted information to be retrieved by the Medicaid Authority, Healthcare and Family Services (HFS) or the Department of Public Health (DPH).
- IV. Modify existing practices of collecting, processing and inputting nursing facility admission information to the data warehouse. Change the existing system operation by removing responsibility from DHS Human Capital Development for handling and processing this information and centralized nursing facility admission data with the Department of Healthcare and Family Services. Changing this process will increase the turn around time for obtaining knowledge on nursing facility admissions, as well as timely flagging residents admitted for time limited eligibility for Targeted Case Management.
- V. Nursing facilities will be required to submit admission information on all new admissions and transferred admissions to the responsible governmental entity within 48 hours post admission. Accomplishing this change will allow for timely tracking individuals (who get lost with transfers between facilities), as well as timely identification of individuals who have been admitted under time limited eligibility. This knowledge will be an asset in Resident Review process and Targeted Case Management in preparation for discharge planning.

Recommendations to enhance PAS/MH knowledge and understanding of community-based options

- (i) Develop real time web listing of geographically based supported/supervised residential service options and supportive housing admission availability, including crisis step down services.
- (ii) Provide a central web-based repository of service definitions eligibility qualifications and criteria for medical necessity.
- (iii) Develop web-based listing and location of outpatient agencies with access time frames for intake appointments.
- (iv) Develop listing of community-based referral options and services for individuals diagnosed as primary substance abuse disorders - inclusive of a shared clearinghouse with DASA - to facilitate referrals.
- (v) Identify listing or references of other community service resources for individuals who do not have mental illnesses.
- (vi) Provide listing of community-based resources with immediate housing options and service access as potential options for determinations to divert from nursing facility admission (non-scatter sites)

Phase III. Recommended Training Curriculum

Training for PASRR agents should include face-to-face and web-based learning. New employees must be trained before service implementation. Existing employees will be retrained annually.

The following is recommended content to be included in the developing training curriculum. A curriculum writer will be retained to best structure how this information should be outlined in an actual training design.

A. General Information on PAS:

- (i) Overview of OBRA's history and Federal regulations for PAS:
 - a. Purpose of PAS
 - b. Purpose of Resident Review (mental health)
- (ii) Specifications of Pre-Admission Screening (across disability populations)
 - a. PAS/DD
 - b. PAS/Aging
 - c. PAS/DRS
 - d. PAS/MH
- (iii) Who are the PAS screeners (directory of PAS contacts) *
- (iv) Presentations from DRS/DoA:
 - a) What is the Determination of Need (DON)?
 - b) Who does the screening?
 - c) Who should be the recipients to benefit from this tool?
 - d) What age range is applicable?
 - e) What is the outcome from the DON
- (v) Presentation from DD:
 - a) What is the process for screening an individual who has a suspicion of DD and a suspicion of SMI?
 - b) Who does the screening and the process?
 - c) What information is needed?
 - d) What is the outcome from this process if the individual is found not to have a Developmental Disability/found to have a Development Disability?
- (vi) The Decision Tree – understanding when/how to make OBRA I referral based on available information *
- (vii) The OBRA I –screening form and functionality – (this will be mandatory cross disability training for all PAS agents)*
 - a. What is the purpose?
 - b. Who initiates?
 - c. When should it be initiated?

- d. What content and identifying information must be included in the OBRA referral?
 - e. How is this information documented?
 - f. What is the working time frame for completion?
 - g. Who to contact for dispute resolution?
 - h. What happens once this form is referred and accepted?
- (viii) Maintaining open communication between PAS agents
 - (ix) Understanding the PAS forms (across disability population) and the purpose/use
 - (x) DASA overview – community based services, resources and access
 - (xi) Explaining Waiver programs and basic terms and HBCS
 - (xii) Understanding specialized assessment components: *
 - a. Cognitive Screen
 - b. Addictive Behaviors
 - c. Self management
 - (xiii) How to maximize information obtained when conducting a Level I (desk) review.
 - (xiv) Interviewing skills to conduct a Level II PAS/MH assessment.*
 - (xv) Maximizing time to conduct a thorough assessment
 - (xvi) When to use START^{6*}
 - (xvii) Requirements for sharing pertinent information post assessment
- B. Specific Information on PAS/MH *:
- (i) PAS/MH Processes
 - (ii) PAS/Resident Review Processes
 - (iii) PASRR Service Elements
 - (iv) Time Frames for completion of PAS/MH and Resident Reviews
- C. Level I Initial Identification Process *:
- (i) Purpose of Level I Initial Identification Screen

⁶ Short-Term Assessment of Risk and Treatability

- (ii) Level I PAS/MH procedures
- (iii) Exceptional Circumstances for Categorical Eligibility
- (iv) Outcomes for a Level I Screen
- (v) Reporting and Recordkeeping Requirements

D. Level II Screen/Assessment and Resident Review*:

- (i) Purpose of Level II Screen
- (ii) Who must have a Level II Screen
- (iii) Required elements of a Level II Screen
- (iv) Additional PAS/MH Level II Assessment instruments (training required):
 - a. LOCUS
 - b. Risk Indicators' tool (recommendation – Short Term Assessment of Risk and Treatability (START))
 - c. NIDA-Modification Alcohol, Smoking, and Substance Involvement Screening Test
 - d. Adult Needs and Strengths Assessment (Resident Review, only)
- (v) Resident Reviews (90 days, 6 months and annually)
- (vi) Required Forms to be completed for NF Level of Care (including 2536)
- (vii) Required Forms to be completed for Community Placement

E. Principles, Philosophy and Practices of Recovery*:

- (i) Elements of Recovery (what is recovery)
- (ii) Wellness Recovery Action Planning – what it is

F. Identification of Integrated Community based-Options and medical necessity*:

- (i) Understanding DMH service taxonomy definitions, residential setting options and supportive housing models
- (ii) Decision Tree - determinations of appropriate, least restrictive options
- (iii) Determining Medical Necessity
- (iv) Identification of appropriate community based options and support services (using the web directory)
- (v) Using web-based real time technology to identify to community based service vacancies
- (vi) Linkage and referrals to community mental health centers
- (vii) Conflict resolution

G. Relationship development strategies for decision making with hospital personnel and discharge planners *

- (i) Techniques of engagement
- (ii) Collaborative interface to ensure appropriate discharges planning & linkages

(iii) Empowerment to say “No” to recommendations for NF level of care

H. Training on the Unified Health System (UHS) web data-based *

* represent annual retraining

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