PASRR Technical Assistance Center (PTAC) Learning Module 3
CFR Compliance PASRR: Part 3
Transcript

Opening Slide

Welcome. The PASRR Technical Assistance Center, more commonly known as PTAC, Truven Health Analytics, an IBM company, and Mission Analytics, with support from the Centers for Medicare and Medicaid Services (CMS) are pleased to offer this learning module. This is the third of three modules that provide an overview of the Code of Federal Regulations (CFR) requirements, specific to State responsibilities for Preadmission Screening and Annual Resident Review (PASRR) of individuals with a mental illness, intellectual disability, or a related condition. My name is Dustin Dodson, a consultant with PTAC and I will be your guide for this module.

In this Learning Module we will be focusing on the Level II evaluation process, including the role of the evaluator, the CFR guidance on diagnosing mental illness, intellectual disability, and related conditions, and the resident review.

Slide #2

In this Learning Modules we will review basic requirements that States must meet in order to be compliant with the CFR. Modules 1, 2, and 3 should be reviewed in order to have a full understanding of those requirements.

While these modules address the "*basic requirements*", PTAC is well aware of the work being done to move beyond just a "*compliance only*" approach to PASRR. We encourage you to access the additional modules that can help you:

- Better integrate person-centered practices into your PASRR system
- Learn more about Specialized Services and how they can help you support individuals, and
- Learn about state or national health initiatives that can align with your PASRR efforts.

Slide #3

If you have already reviewed Leaning Module #1 or Learning Module #2 you will be familiar with this graphic. We reviewed some of the factors that make PASRR important, beyond the fact

that States are required to meet the CFR regulations. This module, and modules #1 and #2 address those requirements, but PTAC believes it is important for States to continually look for opportunities to move their PASRR system forward, reflecting the changes that have taken place over the years in how we support person's with mental illness or intellectual disabilities, as well as the broader changes that are taking place in our health care system.

The steps for moving forward are reflected in this graphic, moving from a compliance only approach, to an approach that is grounded in person-centered practices, and to a PASRR system that is integrated with the broader healthcare system. As the PASRR system moves forward, the range of the person's needs, support options, and stakeholder engagement expand.

This module is a continuation of our focus on what states are required to address in order to be compliant with federal regulations. This "compliance CFR" model is one of three approaches to PASRR that are reviewed over the full Learning Module listing, comprised of six distinct modules. PTAC encourages you to review all modules.

As you move through this module, and subsequent modules, it is important to think about where your PASRR system is today and where you want to be in the future.

Slide #4

So what is PTAC? Hopefully, you are already familiar with PTAC, either through prior visits to our website, participation in our monthly webinars, or as a result of having reviewed other Learning Modules. You can learn quite a lot about PTAC by further reviewing our website, at http://www.pasrrassist.org/ after you finish this module. Our contract with CMS, which began in 2009, places an emphasis on:

- Helping CMS better understand how state PASRR programs operate and where greater regulatory clarity is needed
- Conducting research or studies on key focus areas, such as our National Reports on Level I and Level II practices, and
- Helping states improve their PASRR Programs through individualized technical assistance, monthly webinars, and regional calls

The intent of this learning module, and the others you can access, is to help states improve their PASRR process, including the PASRR experience for those who do the work or who move through PASRR.

Slide #5

While this learning module, and modules 1 and 2 emphasize regulatory compliance, overall PTAC's training emphasis is on promoting development of a Holistic PASRR program. That holistic model is based on:

- CFR policies and regulations
- CMS guidance
- Lessons learned to date from the research and studies conducted
- Growing understanding of person-centered practices
- Increased awareness of how health care is changing, and
- Better understanding of what is needed to promote continuous quality improvement

Slide #6

In the next several slides we will review CFR requirements specific to the Level II process. The Level II evaluation is your states' front line for ensuring that individuals are diverted from unnecessary admission to nursing facilities and promoting access to services and supports that support transition from nursing facilities to more integrated settings.

In Learning Module #2 we discussed the front door role of the Level I evaluation, but within PASRR, it is the Level II evaluation that can make a meaningful impact on someone's life.

Slide #7

Let's start by looking at the CFR expectations for the PASRR Level II evaluation.

The Level II evaluation identifies person-centered recommendations that become part of the nursing facility plan of care. The evaluation addresses ALL of and individual's PASRR-related needs in the nursing facility, or it identifies and facilitates access to community-based alternatives that are less restrictive.

These two focuses make PASRR an essential component in a state Olmstead compliance strategy. A poor PASRR system creates risks for litigation or is a poor defense if there is litigation around Olmsted.

Slide #8

In 2015 CMS released their Proposed Rule for Long Term Care Facilities and there is an expanded emphasis on the role of PASRR within that rule. Much of the emphasis is on the importance of those facilities incorporating PASRR Level II recommendations in developing a person-centered plan of care. The rule speaks to both specialized rehabilitative services and specialized services.

The proposed rule also stresses the need for facilities to initiate a Resident Review when there is a significant change in status.

Overall, the rule reinforces the need for greater coordination between Long Term Care Facilities and the three state PASRR authorities. When this module was developed the public comment

period had ended and PTAC believes the proposed rule will be adopted without significant changes.

This new emphasis from CMS creates an opportunity for states to engage the nursing facility community in discussions around a shared vision for PASRR.

Slide #9

Here is text from a new section in the proposed rule that speaks to Comprehensive Person-Centered Planning:

PASRR: "*We propose to add a requirement to include as part of a resident's care plan any specialized services or specialized rehabilitation services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record."*

It is important to note that once adopted, these requirements will become part of the state certification and review process, which further emphasizes the importance of the PASRR process.

Slide #10

Given the growing importance of PASRR recommendations, we need to look at what the CFR says about the Level II evaluator.

Each state is responsible for defining the qualification and training requirements for Level II evaluators. Of course the process of training is critical and this is an area where PTAC technical assistance may be valuable.

Evaluators must be able to review any exclusion, such as the Exempted Hospital Discharge, or a categorical application, such as Dementia and Mental Illness, to determine if the Level I Screening was correct.

The evaluator must be able to make a judgment about the totality of the individual's condition and their needs, including determining their need for nursing facility care and any specialized services.

As has been discussed in prior modules, the evaluator must have sufficient knowledge, skills, and abilities to know when it is appropriate to end a Level II evaluation, such as confirming that dementia is indeed primary when mental illness is also present.

It is clear that that CFR places great responsibility on the evaluator. In working with states we have also learned that the evaluator can play an important role in quality assurance efforts, as they can help identify problems in the Level I process.

Slide #11

Evaluators have many responsibilities, but there is one area where they must rely on a physician, and that is for completion or review of the health and physical component of the Level II evaluation.

As we already saw, the state is responsible for defining the qualifications for the Level II evaluator, but the CFR is clear that they must be qualified to make determinations of mental illness, intellectual disability, and related condition diagnosis and recommend treatment or placement options. As such, states often use individuals with specific expertise in the respective disability fields to complete the evaluations rather than expecting the person to have cross-disability expertise.

Slide #12:

Let's now look specifically at the CFR requirement for the Level II evaluation. Unlike the lack of specificity for the Level I screening, there are clear expectations for the Level II evaluation.

First, the CFR is clear that the Level II is an "in-depth determination", which clearly implies the need to engage the individual directly to the maximum extent possible. The Level II evaluation is not a "desk review" process.

The evaluation confirms or disconfirms a diagnosis, identifies and recommends appropriate treatment and placement options and services.

The evaluation is based on tools selected by the state. Those tools need to be continually reviewed to determine if they are effective and achieving desired outcomes.

Reflecting the CFR emphasis on individualized evaluations, the evaluation needs to be adapted to the individual's culture, language and ethnic origin.

As we have already noted, the individual, family or legal representative must be involved in the evaluation. Interdisciplinary coordination must be part of the evaluation process, reflecting the intent to focus on the holistic needs of the individual.

The Level II evaluation needs to be completed within an annual average of 7-9 working days of the Level I screening being completed and referred.

Slide #13

We just reviewed the CMS proposed rule for long term care facilities, but the CFR currently speaks to the importance of the Level II evaluation in the broader sense of planning the individual's health care plan.

The Level II evaluation is an integral part of the individual's plan for services, regardless of placement. If the individual is admitted to a nursing facility, the evaluation and related report is incorporated into the Resident Assessment Instrument and becomes part of the individualized interdisciplinary plan of care.

The evaluation must also include any identified specialized services and identify where those services are available. Learning Module #5 provides a full review of specialized services.

Slide #14

Since the Level II evaluator must be able to confirm or disconfirm a diagnosis of MI/ID/RC, let's look at the CFR guidance for those diagnoses.

The CFR refers to diagnosis, level of impairment, and duration as three indicators of an individual having a serious mental illness.

For diagnosis, the CFR refers to the disorders of schizophrenia; mood; paranoid; panic or other severe anxiety disorders; somatoform disorder; personality disorder; other psychotic disorder; or another mental disorder that can lead to chronic disability. These are broad areas and it is often best to focus on any treatment history and current impact of functioning.

Learning Module #2 reviews some of the exclusions noted here, including the primary diagnosis of dementia exclusion, which includes Alzheimer's disease or a related condition. That module also reviews the criteria for the Dementia and Mental Illness exclusion.

Slide #15

This table provides a summary of the key CFR guidance on diagnosing mental illness.

The evaluator is confirming a diagnosis of mental illness that is not episodic/situational and that any diagnosis of dementia is not primary. Further guidance on the Dementia and Mental Illness exclusion is accessible in Learning Module #2.

The evaluator also considers if there are major treatment episodes more intensive than outpatient care that more than once resulted in partial or inpatient hospitalization. OR they look for significant disruptions due to mental illness that required supportive services within the past two years.

When considering the extent of the disability, the evaluator will consider any active symptoms in the last six months that resulted in functional limitations in major life activities, including interpersonal functioning, concentration, pace, persistence, or adaption to change.

Based on these criteria, diagnosis of schizophrenia, a bipolar disorder, or major depressions are offered as examples. These examples are not all inclusive.

Slide #16

Here, we look again at the CFR guidance that has shaped state practices for identifying a qualifying PASRR diagnosis.

Standardized forms and procedures will tend to guide evaluator practice. When considering duration, a qualifying treatment within the past two years is often considered, as well as functional limitations in life activities within the past three to six months.

Once again, we stress the importance of not relying solely on a history of prior hospitalization or services from a mental health professional. Rather, the focus should be on severity and recency of any impairment.

Slide #17

Finally, when considering a qualifying mental illness, there is a reliance on how the individual is functioning. Continuous or intermittent difficulty in interpersonal functioning, concentration, and persistence and pace, or ability to adapt to change are the criteria emphasized within the CFR.

In Learning Module #2 we review how this guidance may create a risk for excluding individuals with serious mental illness who are in recovery. A review of that material is recommended when developing guidance for PASRR Level II evaluators.

Slide #18

We have reviewed guidance for diagnosing mental illness; so let's now look at the CFR guidance on the intellectual disability diagnosis.

The American Association on Intellectual and Development Disabilities defines an intellectual disability as a disability characterized by significant limitations both in intellectual functioning (reasoning, problem solving) and in adaptive behavior (range of social and practical skills), and which originates prior to the age of 18.

Slide #19

As with our review of the mental illness diagnosis, this table provides a quick overview of the CFR guidance for the intellectual disability diagnosis.

An IQ of less than 70, based on standardized testing that measures capacity for learning, reasoning and problem solving, as well as other features, is the first focus point.

As noted in the AAIDD definition, onset of the intellectual disability prior to the age of 18 is a second consideration.

Intellectual disabilities are expected to be life long in duration and there will be concurrent impairments in adaptive functioning.

Several clarifications need to be made. First, while the CFR guidance is for onset prior to the age of 18 that is supported with standardized testing, CMS has been clear that when onset cannot be confirmed by prior testing, the use of reliable source information is sufficient. We will look at further clarification on the testing issue in a moment.

Secondly, the intent of PASRR is to identify needs that are evident and to identify the services that may be needed and are beyond what the nursing facility would normally be providing. As has been noted before, the emphasis needs so to be on the current functioning level and level of impairment.

Slide #20

A final thought on the intellectual disability diagnosis.

States may create tools that are more sensitive than the criteria specified in the rule, as long as those criteria do not conflict with the minimum federal standard.

There is a strong movement nationally for individuals with intellectual disabilities to be fully integrated in community-settings, rather than residing in large institutional settings that provided total health care. As such, given that other major health issues often accompany ID, these individuals are increasingly likely to interface with PASRR.

Slide #21

We just discussed the problem of not having historical testing to confirm the ID diagnosis. The information here comes directly from a PTAC Frequently Asked Question (FAQ) response that can be accessed via our website http://www.pasrrasssist.org

In brief, the emphasis here is that testing for intellectual functioning is not a PASRR requirement. It is not a required element in CFR 483.136(b), which lists the data elements that must be collected to determine whether someone has an intellectual disability.

The FAQ also clarifies the role and required qualifications of the “licensed psychologist” that interprets any testing, when it has been administered.

This FAQ is important, as every effort should be made to avoid an interpretation of the CFR becoming a barrier to individuals accessing the full benefits of PASRR.

Slide #22

This table summarizes the guidance on diagnosing Related Conditions.

The key emphasis on diagnosis is the existence of a severe disability that results in impairments that are similar to those of an individual with intellectual disability and that require similar treatment or services.

Onset before the age of 22 is what distinguishes related condition from intellectual disability, which has a prior to age 18 onset criteria. Like intellectual disability, the duration is expected to continue indefinitely.

Functional impairment in three or more major life activities are considered when determining the extent of the disability.

Related conditions could include autism, cerebral palsy, epilepsy, traumatic brain injury, fetal alcohol syndrome, muscular dystrophy, and Down Syndrome

Slide #23

Here we highlight the key features for diagnosing related conditions.

First, when considering the related condition diagnosis, the emphasis is on functional limitations that compare to those of an individual that meets the definition of an intellectual disability.

Like the timing issue with intellectual disability, it may not be possible to be definitive about age of onset, and this may need to be based on other supportive information from reliable sources.

Also, like intellectual disabilities, related conditions are likely to be life-long and the disability will require similar treatment and services.

Slide #24

It may be valuable to consider the definition of Development Disability, when thinking about related conditions, as it includes intellectual disability and related conditions, and offers a more expansive application than the term related condition. This slide and the one that follows clarify what constitutes a “developmental disability”, which is the most common “related condition”.

As has been discussed, manifestation before age 22, life-long continuation of the disability, substantial limitations in three or more major life activities, and the need for extended or life-long supports are the primary criteria.

Slide #25

Other key points to consider is the importance of looking beyond the condition to determine if the impairments exist because of the condition and looking beyond just the major life activities. Conceptual, social and practical skills, such as interpersonal skills, social responsibility and social problem solving should be considered.

Of course, looking at the ability to function independently and the need for lifelong supports, distinct from what might be necessary for an individual with intellectual disability is helpful.

One reminder: It is important to consider if there is any indication of the onset of mental illness during the developmental period.

Slide #26

So, we have reviewed the expectations for Level II evaluators, the role of the evaluation, and the steps involved with determining a diagnosis. This is a good time to review what is involved with the PASRR Notification.

First, while there is no requirement for a notice to be provided to a person being screened under the Level I phase of PASRR, it is important to recognize that the intent of notification is to inform the person. To that end, every effort should be made to ensure that individuals being screened are informed and engaged in the process.

If the screening does result in the person being referred for a Level II evaluation, the first time notification should be in writing, and clearly inform the person, or their legal representative, that they are subject to the Level II evaluation and the basis of the referral, i.e. they are suspected of having a mental illness, intellectual disability, or related condition. The notice should be adapted to the culture, language, ethnic origin, or means of communication used by the individual.

A verbal notice may be provided prior to the written notice being sent.

Slide #27

The Level II Determination Notice is a legal document and we have already discussed how that document will impact on the individual's plan of care, regardless of the setting.

It must be sent to the individual or their legal representative; the admitting nursing facility; or retaining nursing facility, in instances of a resident review; the attending or primary care physician, the discharging hospital or referring entity; and it will become part of the individual's resident medical record.

Slide #28

The notice must include a summary of the individualized evaluation; clearly specify the target condition that was present; specify whether nursing facility services are needed and appropriate; specify whether specialized services are needed; identify alternative options to the nursing facility that are appropriate to the determination; spell out what services or supports would be necessary to support the individual in the community, regardless of availability of the services, and inform the individual of their right to file and appeal.

Slide #29

We have covered this before, but once again, it is possible for the evaluation to be terminated if the evaluator finds the individual does not have a mental illness, intellectual disability, or related condition or that they have a primary diagnosis of dementia.

Slide #30

In the last few slides of this module, we will review the Resident Review guidance, including what constitutes a “significant change in status”.

Once someone has entered a nursing facility with an identified PASRR disability, they will have a plan of care that reflects the recommendations made as a result of the Level II evaluation, but the need for services can change after the individual is in the nursing facility. This is the intent of the Resident Review – to ensure that the individual’s disability specific needs are continually adapted to reflect significant changes that take place over time.

The Nursing Facility activates the Resident Review, when they are aware of any significant change in status that affects the individual’s needs. MDS guidance requires that the nursing facility must notify the appropriate state authority, which will make the initial decision about the need for the resident review - Level II evaluation being conducted. If it is necessary, the evaluation and determination must be conducted promptly. The average of 7-9 days is used here, like the timeline for a standard Level II evaluation after the Level I screening.

Slide #31

The Medicaid agency works with the state MH and ID-DD authorities to define the criteria that would lead to a resident review Level II evaluation.

Given the importance of services reflecting the individual’s current condition, good person-centered practice is to refer any individual who has a significant change in status to the appropriate authority.

Slide #32

A significant change in status is best understood by looking at three criteria identified in CMS's Resident Assessment Instrument RAI Manual, version 3.0.

The condition will not normally resolve itself without interventions,

The condition impacts more than one area of the resident’s health status,

And the condition requires an interdisciplinary review and/or revision of the current plan of care.

Slide #33

Given the importance of the Resident Review, here are two questions to consider when looking at your PASRR process.

Do nursing facility staff participate in training related to the resident review requirements?

Do nursing facility staffs have contact information for the appropriate state authority staff?

Slide #34

This concludes Learning Module #3 – CFR Compliance. Please be sure to review Learning Modules #1 & #2 for a full summary of CFR regulations for PASRR.