PASRR Technical Assistance Center (PTAC) Learning Module 6
Integrated Healthcare PASRR & Quality Monitoring
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.

In this module we will be focusing on several initiatives that have goals and objectives that PASRR can support, and that can support PASRR. Additionally, we will review quality monitoring approaches for PASRR and a recent analysis of nursing facility Minimum Data Set (MDS) information related to individuals with mental illness, intellectual disabilities, or related conditions. My name is Sherry Snyder, a consultant with PTAC, and I will be your guide for this module.

Slide #2

This is the last of six Learning Modules. Modules 1, 2, and 3 address basic requirements that States must meet in order to be compliant with the CFR and should be reviewed in order to have a full understanding of those requirements. Module #4 reviews what is involved with Person-Centered Practices and Module #5 highlights the most recent CMS guidance on Specialized Services. That module includes three case scenarios intended to promote self-examination of current PASRR practices.

Slide #3

So, what is PTAC? Hopefully, you are already familiar with PTAC, as a result of having reviewed other Learning Modules, prior visits to our website, or participation in our monthly webinars. If not, you can learn about PTAC by further reviewing our website, at 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 tools, 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 #4

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 studies PTAC has 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

As this is the last of six Learning Modules, hopefully you will have reviewed all the prior modules already. I so, you will already know that Improving PASRR is a process that relies on a shared commitment amongst the three state authorities, but many others need to be engaged if PASRR is to reach its full potential. This is one of the focus areas in this module.

Slide #5

Our understanding of primary health has changed over the years. This graphic conveys the interconnection of the various components of healthcare that make up what we know as "primary health services". This is not intended to be "all inclusive" of other features that may be present in your state. PASRR has a role to play in each of these healthcare components.

Let's start at what would be 2:00 on a clock and move to the left. First, we see health promotion, more commonly thought of as "prevention". While we don't usually stress PASRR as a prevention model, PASRR's role in diverting individuals to less restrictive settings, or identifying unique PASRR disability needs of individuals that are admitted to a nursing facility, may have a direct impact on how well they respond to the services they need.

Moving left, PASRR plays an important role in confirming an individual being admitted to a nursing facility under the Exempted Hospital Discharge is in need of services to address the same medical condition that was treated in the hospital. Overall, PASRR interfaces with state

Level of Care criteria to ensure that the medical services provided in a nursing facility are required and that no less restrictive setting is appropriate.

Community Health & Partnerships is essential to a successful PASRR system. We will be looking at this component further a bit later in this module.

Of course, counseling and support services might best be defined as Specialized Services, a PASRR subject that is covered in Learning Module #5. PASRR plays an essential role in ensuring that services and supports that would not normally be included in the nursing facility benefit are identified and provided.

The PASRR process, especially through the recommendations included in the Level II evaluation and determination report, will also impact continuing care, or "continuity of care". Here again, any recommended specialized services are likely to need continuation when the individual transitions to the community. Learning Module #5 includes an overview of specialized services.

Slide #6

If you reviewed all prior Leaning Modules you will be familiar with this graphic. You will be aware of what is required to meet CFR regulations, and have a better understanding of person-centered practices and specialized services. This module includes an emphasis on PASRR being aligned with other state or national initiatives that may be present in your state and identifies the range of stakeholders involved when PASRR is part of an integrated healthcare system.

Slide #7

As you move through this module, and all other modules, it is important to think about where your PASRR system is today and where you want to be in the future. If you have reviewed prior Learning Modules you will recognize these self–assessment questions.

While there may be other meaningful questions to ask, and we will look at some related to quality monitoring later in this module, these six questions could help provide some perspective on where your PASRR process is at any given time.

Does the current PASRR process:

1. Support and advance state initiatives that have been developed since you first created your PASRR system? – Learning Module #1 discusses the many factors that have impacted PASRR since it became a state obligation in 1987.
2. Promote continuity of care? – Continuity of care is recognized as a key factor in good outcomes for individuals receiving mental health or intellectual disability services and supports. We will look at this question further in this module.

3. Support recovery? – Learning Module #2 discusses the role PASRR can play in supporting an individual in recovery.
4. Reflect person-centered thinking and planning? – Learning Module #4 provides an overview of what is at the core of person-centered practices.
5. Emphasize community integration? – Learning Module #5 highlights how Specialized Services can be an essential resource for promoting return to the community.
6. Promote empowerment of the individual? – Learning Module #3 identifies how the Level II evaluation offers "voice to the individual", an essential step in empowerment.

Keep these questions, and the resources in mind as we now begin to look at the strengths or challenges of having a PASRR process that is part of a healthcare integrated system.

Slide #8

There are a number of strengths associated with an integrated healthcare PASRR system. It is likely to incorporate person-centered values; convey recognition of the "holistic" connection of a person's emotional, social, economic, & spiritual needs; look for ways to create a shared commitment amongst a broad group of stakeholders; emphasize the importance of transition and continuity of care, and have a shared quality improvement process that is continuous.

Certainly there are challenges to this PASRR approach. Because it involves an extended network of stakeholders, training and education must take place on a regular basis. Also, stakeholder engagement must be maintained on a regular basis. Finally, the continuous quality improvement process must be connected to distinct interests of individual stakeholders, as "buy in" must be maintained.

Slide #9

Learning Module #1 includes a graphic showing the CFR defined roles and responsibilities of the three state agencies responsible for PASRR. While that partnership has regulatory responsibility for PASRR, this graphic likely reflects the reality of stakeholder involvement in PASRR. While this list may not be all-inclusive, the stakeholders reflected here play a key role in most PASRR systems, and each can contribute to the quality of the process and outcomes.

State Medicaid, mental health, and intellectual and developmental authorities are the essential stakeholders, even in instances where mental health or ID/DD delegate a responsibility. Level I screeners are the front door to PASRR, creating the first personal encounter with the individual being screened. Level II evaluators perform in-depth evaluations that give voice to the individual and identify alternatives to nursing facility admission, or the unique services they need if admission is appropriate and necessary.

Hospitals will have provided needed medical care and their staff will have information essential to completing a meaningful screening and evaluation. Community providers of mental health or intellectual disability / developmental disability services may have important historical

information and they may be the preferred provider of any recommended specialized services. Increasingly, Managed Care Organizations may be the provider of those services or they will be engaged in transition efforts.

Nursing facilities will develop person-centered plans of care, relying on the information and recommendations in the Level II evaluation and determination report.

Finally, the individual and their family experience the PASRR process. They need to understand the goals and objectives of that process and feel like they are partners.

Slide #10

Body, mind, and spirit. We know more today than ever before about their interconnectivity in our health and wellness. The next several slides will highlight initiatives that promote health and wellness that may be active in your state. Each offers an opportunity for a meaningful linkage with PASRR and it is important to be “at the table” when they are planned or being discussed.

Slide #11

Community-Based Care Transitions Programs are Medicare programs, created by the Affordable Care Act. The CCTP tests models for improving care transitions from the hospital to other settings, including home and community, and reducing readmissions for high-risk beneficiaries. Nearly one in five Medicare patients discharged from a hospital – approximately 2.6 million older adults – are readmitted within 30 days, at a cost of over $26 Billion every year.

If a nursing facility admission is being considered, then PASRR will play a critical role in supporting diversion to the most appropriate setting, and identifying the unique services or supports the person needs, either in the community setting or in the nursing facility. Those services can help promote a positive healthcare outcome, reducing the risk of readmission.

If you don’t know already, try to find out whether your state aging agency is involved in any way with the CCTP and make some linkages.

Slide #12

The No Wrong Door system is a collaborative effort of CMS, the Administration for Community Living (ACL) and the Veterans Health Administration. In 2012, an estimated $220 billion was spent in the United States on LTSS. Often individuals who use publicly funded services are left with high-cost options when they desire a low-cost option. The NWD system helps states use resources more efficiently and effectively.

A No Wrong Door System builds on the strength of existing entities such as Aging and Disability Resource Centers, Area Agencies on Aging and Centers for Independent Living, by providing a

single, more coordinated system of information and access for all persons seeking long-term services and supports.

PASRR's emphasis on identifying community-based alternative for nursing facility admissions and the role that long-term services and supports can play when specialized services are needed, makes the value of a linkage of PASRR and No Wrong Door evident.

Slide #13

Certified Community Behavioral Health Clinics (CCBHC) is a Substance Abuse and Mental Health Services Administration (SAMHSA) initiative authorized under Section 223 of the Protecting Access to Medicare Act (PAMA). CCBHC activities aim to integrate behavioral health with physical health care, increase consistent use of evidence-based practices, and improve access to high-quality care. Twenty-four states were initially selected for phase one of a demonstration grant, from which at least eight states will be selected for a two-year demonstration phase.

While integration of behavioral and physical health is a key emphasis, the CCBHC initiative defines the array of services that must be provided, if the behavioral health center is to be certified, and these services must be provided in settings that promote ease of access and continuity of care. All certified community behavioral health clinics must also demonstrate a strong "care coordination" capacity.

Of course the linkage to PASRR is evident. PASRR is the point where behavioral and primary care interface when an individual is being considered for nursing facility admission, and the goal of identifying and linking the individual with needed mental health services supports high quality care.

If your state has been involved in the CCBHC initiative, or if there is an interest in modeling this approach to quality behavioral health care, it is important that PASRR is part of the planning process. Additional information about the CCBHC model can be obtained through the link included on this slide.

Slide #14

Most states have transitioned to some level of managed care in recent years, often with a particular carve-out for community-based behavioral health services. Accountable Care Organizations or Managed Care Organizations share an interest in promoting access to quality of care that leads to better healthcare outcomes and lower costs. PASRR can help ACO's and MCO' achieve these goals, and both entities can help your state arrange for or provide needed specialized services.

As we have noted, the holistic focus of PASRR is grounded in an understanding of the linkage of good primary care outcomes with access to needed metal health or intellectual and

developmental services. PASRR identifies those needed service during the Level II evaluation and state contracts with MCO's often require that their services be provided to the individual, regardless of location. This creates an opportunity for PASRR – ACO – MCO partnerships.

If you have meetings of PASRR stakeholders, don't forget to include representatives from you ACO's and MCO's.

Slide #15

Delivery System Reform Initiative Payment Programs, or DSRIP's (D-srip's) are Medicaid initiatives that seek to achieve better healthcare outcomes through increased provider collaboration and innovations. Often DSRIP's are part of broader 1115 Waivers intended to improve care to Medicaid beneficiaries.

There can considerable variation in how states target a DSRP, but PASRR can play a role in any effort that seeks to improve healthcare outcomes and better manage expenditures. PASRR's focus on identifying alternatives to institutional care and needed specialized services can help these initiatives succeed.

This completes our review of the various national or state initiatives that can support your PASRR system, or that can be supported by PASRR. Let's now take some time to review some PASRR quality measures.

Slide #16

The material we will cover in the next several slides is intended to offer examples of data that can help you understand how well your PASRR system is working. You may be tracking other information and PTAC is always interested in knowing what states are learning through any quality monitoring efforts.

Slide #17

Everyone is likely to be familiar with the phrase "We get better at what we measure." If you are a runner, it may be time or distance. If you work out, it may be total weight or repetitions. If you do yoga, it is your level of flexibility. We tend to want to improve at whatever we do.

For PASRR, there is a range of measures that can help us know how we are doing. For example:

Is there a low rate of false positives? Learning Module #2 covered the Level I process and we saw that some false positives suggest we have a sensitive screening tool, but too many would suggest it is not accurate.

Is PASRR diverting individuals form nursing facility admission? PASRR's first responsibility is to identify appropriate alternatives to nursing facility placement.

Is PASRR linking individuals with needed Specialized Services? When someone does need to be admitted to a nursing facility, PASRR is responsible for identifying any needed disability specific services.

Is PASRR having an impact on nursing facility length of stay? When someone with a PASRR disability receives all the services they need, including recommended specialized services, their conditions are likely to improve and they are more likely to leave the nursing facility sooner.

Is PASRR helping individuals move back to the community? Specialized Services, identified in the initial PASRR screening and evaluation, or through a resident review, will likely help the individual make a successful transition to their original community setting, or to one that best meets their needs.

Is PASRR helping increase a sense of independence and are individuals satisfied with how they experienced the PASRR process? PASRR will give voice to the person who is evaluated through the Level II evaluation and there is a strong emphasis on engaging the person at each step of PASRR.

Slide #18

If you are thinking about starting a PASRR quality monitoring process, it may be valuable to start with some of the most basic information, which is often readily available.

For the Level I screening, it can be helpful to know how many screenings are being completed annually and how many positive Level Is became positive Level IIs and how many became negative Level IIs. You may wish to track this information specific by type of PASRR disability. While not noted here, knowing where the Level I originated can be useful (e.g., in a hospital vs. a nursing home vs. a local agency that provides aging services).

Similar information can be helpful for Level II evaluations. The annual number completed, and the numbers that confirmed, or disconfirmed, the Level I screening are basic measures. Again, knowing the source of the Level II evaluation can be a valuable data point for ongoing quality monitoring efforts.

Slide #19

Some intermediate quality measures are listed here. You are likely familiar with the first two measures, as the CFR stresses that states must complete the initial Level II evaluation, or resident review Level II evaluation, within an annual average of 7-9 calendar days of the Level I being completed and referred, or from the nursing facility notice of a significant change in status.

Tracking the number of “positive” preadmission screenings or resident reviews that lead to nursing home admission or placement in a community setting helps you understand how successful PASRR is at diverting or transitioning individuals.

If your state has categorical determinations or allows for the use of exemptions, such as the Exempted Hospital Discharge, it can be very helpful to track their use.

Finally, having the ability to identify the number of Level II evaluations that led to recommendations for specialized services can help identify resource needs.

Slide #20

These advanced measures are not likely to be the starting point for a quality monitoring effort, but they be treated as goals for down the road. These measures, and those we have discussed in the two prior slides, are more likely to be accessible if your state is using an electronic, or web-based PASRR system.

We are going to discuss the comparison of Minimum Data Set (MDS) and PASRR date later in this module, so I’m not going into any details at this point.

More in-depth measures include measures of whether specialized services that have been recommended are being delivered and the outcome of those services are in depth measurements. This likely involves coordination with the state certification and licensing entity, as well as good linkages with the nursing facilities and the community providers who delivered the specialized services.

Individual satisfaction and outcome surveys can help you “look behind” the entire PASRR process and assess what the experience is like for individuals.

All of these measures become more meaningful if specific PASRR populations, providers, and geographic areas can be identified. Again, collecting these measures would be difficult in a paper-driven PASRR system.

Slide #21

As you can tell, quality monitoring in PASRR can range from the relatively simple to the clearly complex. It can place additional demands on your resources or necessitate investing in technologies that help make quality monitoring easier.

Fortunately, there is one monitoring resource that is now readily accessible to states - the data from the analysis of Minimum Data Set, or MDS. The PTAC 2015 National Report, accessible through the PTAC website, includes national data on the effectiveness of PASRR. PTAC has state level data as well and is prepared to work with individual states that wish to use this data as part of their quality monitoring efforts.

Let's look at the national MDS and PASRR data and how this information was gathered.

Slide #22

First, what is the Minimum Data Set? The MDS is a federally mandated assessment instrument for measuring the health and welfare of all residents in Medicare or Medicaid certified nursing homes. It provides a comprehensive assessment of each resident's functional capabilities and helps nursing home staff identify health problems.

Prior to 2010, there was no way to tell from the MDS how many people were being identified by PASRR. In October of that year, question A1500 was added. The question simply asked if the individual in the nursing facility had been identified by PASRR as having a mental illness, intellectual disability, or related condition. It simply required a "yes" or "no" response. But it did not ask which *kind* of disability the person had.

In 2012 question A1510 was added, requiring that the nursing facility specifically identify the appropriate PASRR disability -- serious mental illness, intellectual disability, or related condition.

Slide #23

This is a "screen shot" of the MDS that show both questions A1500 and A1510. You can see that the two questions provide clarity on PASRR having identified the individual and the specific condition that warranted the person being identified as PASRR appropriate.

While these two questions offer valuable information, the analysis done for the National Report looked at additional MDS data that relates to PASRR populations. Let's look at those.

Slide #24

Section A of the MDS, includes question A1550, which drills down on conditions related to an individual's intellectual or developmental disability status. You can see it allows the nursing facility to note the presence of ID/DD with an organic condition, such as Down syndrome, autism, epilepsy or other organic condition related to ID/DD. The presence of ID/DD with no organic condition can also be noted.

Slide #25

Section I of the MDS includes fields that allow the nursing facility to provide more specific information about an individual's mental health diagnosis. Since the MDS is re-administered periodically, this section reflects any mental health diagnosis active within the preceding seven days. You can see that there are six psychiatric/mood disorders noted, including anxiety disorder, depression, bipolar disorder, and psychotic disorder other than schizophrenia, schizophrenia, and posttraumatic stress disorder.

Pleas note that the conditions in I5900 through I6000 are CFR examples of serious mental illness.

Slide #26

For the analysis of the MDS and PASRR data, an additional factor was considered – the existence of ICD-9 codes for both intellectual disability and related conditions and for mental illness.

Here are the ICD-9 codes used for ID & RC.

317 through 319 are specific to intellectual disability.

Code 758 refers to chromosomal abnormalities associated with ID/RC

Code V79 is for special screenings for ID/RC

Slide #27

For mental illness, an analysis was conducted using ICD-9 codes that was “narrow” -- it mirrored the most severed illnesses referenced in the CFR, schizophrenia, bipolar disorder, and other psychotic disorders.

Secondly, a “broad” definition was considered, which included all the ICD-9 diagnosis in the narrow definition, as well as the other conditions captured in Section I, anxiety disorder, depression, and posttraumatic disorder. ICD-9 codes for other psychological disorders were also included.

Slide #28

A full review of the findings of this analysis can be found at the PTAC website, under “Reports”, but let’s look at some key findings:

PASRR Level I screenings identified about two thirds of the individuals with intellectual disability or related condition admitted to nursing facilities.

PASRR Level I screenings about fewer than individuals with mental illness narrowly defined.

PASRR identified about 5% of the individuals with mental illness broadly defined.

Of course these figures are alarming, especially when we consider the number of individuals with the most serious forms of mental illness in nursing facilities that were not identified by PASRR, but it is important to recognize that there may be a range of factors influencing these findings. For example, it is possible that there are some data entry errors taking place.

A more detailed look at the findings highlights the importance of each state seeking to understand their MDS and PASRR data.

Slide #29

This table shows the 2012 through 2014 MDS and PASRR analysis for all nursing facilities, specific to the ID/RC data.

The second column shows the total number of year-end residents in nursing facilities. The third column shows the number of individuals that the nursing facility said were identified by PASRR as having a specific ID/RC condition. The fourth column builds upon the information captured for item A1510, and captures the presence of at least one diagnosis for ID or a RC in Section A. The last column includes the data already mentioned, along with any diagnoses captured in the ICD-9 codes.

If we look just at 2014, we see that 2.2% of the nursing home population has been identified by PASRR as having an ID or RC. In the last column we see that when all the other indicators of ID or RC are included, the percentage of the population increases to 3.3%. So, PASRR identified 28,531 of the 42,134 individuals that had some clear evidence of ID or RC. This means PASRR is identifying 68% of those who should be identified.

It suggests that the PASRR level I process is reasonably accurate, but it could be better.

Slide #30

Here we look at a similar table, but the focus is on the year-end census for individuals that meet the “narrow” definition of mental illness.

Again, looking at the third column, we see the total number of individuals that the nursing facilities said were identified by PASRR as having a serious mental illness. When MDS data from Section I is included, we see a significant increase in the number of individuals with mental illness. When ICD codes are included, the number grows again. This suggests that PASRR failed to identify 367,402 individuals that have a serious mental illness. In this instance, it is clear that PASRR is far less effective at identifying mental illness. There is a clear need to understand what is driving that difference.

Slide #31

The national data certainly raises important questions, but of course the national data is based on MDS and PASRR information collected from individual states. The state level MDS and PASRR data largely mirrors the national figures, so let’s look at a sample state. Here we are using 2012 data.

Using the same criteria discussed in the preceding national tables, you can see that this state's PASRR system identified 2.2% of the year-end nursing facility census as having a PASRR targeted ID/RC condition. When Section A, Section I questions about ID/RC and ICD diagnosis were added together, an additional 232 individuals were identified as having a qualifying PASRR ID/RC disability. Through their PASRR process this state is identifying 69% of the individuals the nursing facility reports having an ID/RC. That is right on the national average.

Slide #32

On this slide, we see that nursing facilities reported that 207 individuals residing in the facility at year-end were identified through PASRR as having a serious mental illness. However, looking just at the narrow definition of mental illness, when Section A questions about mental illness and ICD codes for serious mental illness are included, the number grows to 5,630. This "discrepancy" in the data should serve as a starting point for discussion among stakeholders in this state.

Slide #33

How can this information impact a state? First, consider what would happen if the nursing facilities were seeking resident reviews for each person with a serious mental illness, based on the MDS data. How would a state handle the 5,423 requests?

Slide #34

As has already been noted, we don't fully understand what this data means. At the very least, it points to the need to learn more about the data and what might be generating these patterns. PTAC is prepared to work with any state that wants to secure their state level MDS and PASRR data as the first step in understanding how their PASRR process is working, and what can be done to make it work better.

Slide #35

We have concluded our review of this Learning Module and hopefully, you have taken time to review all six modules. It is essential that you are familiar with the information in Learning Modules 1-3, as these cover the CFR requirements for PASRR, and each state is obligated to meet those requirements.

In Learning Module #1 we reviewed the timeline of PASRR and saw the various initiatives or actions that have shaped PASRR over the years. PASRR has changed, and will continue to change in the future, and states will need to adapt to that change.

If you are interested in moving your PASRR system forward, you might consider the following:

- How are your demographics changing? The “baby-boomer” generation is large. Members of this group will need to be evaluated.
- Are the expectations of those being supported through PASRR likely to change? Many now expect that they are going to be “ an active partner” in all healthcare decisions.
- Are your community resources going to change? States continually seek better ways to support individuals with mental illness, intellectual disabilities or related conditions and resource needs will likely change to reflect new approaches.
- Will changes in healthcare coverage impact your PASRR system? As individuals gain access to coverage and access to medical care, they are more likely to eventually interface with state PASRR systems.
- Are there unique forces at work in your state that will influence PASRR? States, like individuals, are unique, and there will be forces that only impact your state. It is important that you have a PASRR planning process in place that allows for those forces to be identified and discussed.

Slide #36

This concludes Learning Module #6 – Integrated Health PASRR and Quality Monitoring. Please be sure to review Learning Modules #1 - #3 for a full summary of the regulations that govern PASRR. These modules address the regulatory requirements that each state must meet. You are encouraged to review Modules #4 and #5 as well, as each speaks to core features of an effective PASRR process.

Thank you for taking time to review this module. Don’t hesitate to contact your Regional PTAC Consultant if you wish to receive any technical assistance or if you have any questions.