

GOLD STANDARDS WORKGROUP

Maximizing the Effectiveness of PASRR¹

PASRR originally targeted individuals who had been trans-institutionalized from state hospitals to nursing facilities (NFs) and who were presenting as needing acute, *specialized* services. The litmus test primarily used to measure the effectiveness of PASRR has historically been based

upon the numbers of individuals who have been determined to require specialized services (though most states highly restrict services that fall within the rubric of *specialized*). However, PASRR fulfills an important need in an area that is critically underserved and unmet, and prior meas-

ures of effectiveness have failed to measure the impact of PASRR on the quality of care of residents other than those who require specialized services.

Problem

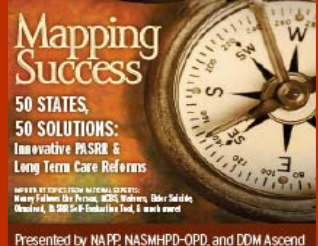
PASRR fulfills an important need in an area that is critically underserved and unmet

- With the 75+ age group representing the fastest growing segment of our population, the U.S. is experiencing a 'gray tsunami'. By 2030, 1 in 5 will be 65+. 1 in 5 older adults currently have a serious mental disorder and that number will only increase. In planning for service impact, the aging cohort will require the greatest amount of resources in terms of health care and supports.
- NFs are increasingly serving residents with a wide range of mental illness, most particularly depression² and mental health services are insufficient and/or inadequate to meet their needs³. In fact, up to 50% of surveyed NFs reported a lack of resources to provide mental health services and, of those who contracted for mental health services, ½ reported reluctance of professionals to treat their residents. 90% of state Medicaid programs cover only *basic* psychiatric consultation in NFs⁴.
- Many NF staff are not trained to identify even basic MH symptoms and contact PASRR authorities only for externalizing/disruptive resident behaviors, often missing residents with vegetative 'non-disruptive' serious symptoms.
- Many NF staff are not trained to address the needs of residents with MR/RC – placing residents at risk for losing critical skills and capabilities – reducing independence and lowering quality of life. It is often easier to 'do for' than to 'do with' residents.
- NFs are experiencing a staffing crisis, with critically high turnover, staffing shortages, and difficulties maintaining the pace between turnover and training demands (training for NF staff about mental disorders is generally inconsistent and of limited priority)⁵.
- Suicide is disproportionately high among the elderly (who represent 13% of the U.S. population but 1/5 of all suicides). Although persons in NFs are less likely to overtly attempt suicide, they have high levels of suicidal ideation⁶ and untold, unreported numbers die from indirect suicide and indirect self-destructive behavior.

²Cohen, et. al. 2003; ³SAMHSA, 2007; ⁴SAMHSA, 2007 ⁵SAMHSA, 2006; ⁶Schmidt et al, 1994;



Recommended
Gold Standards
are provided on
the following
page.




The October 2008 Baltimore conference, 'Mapping Success: 50 States, 50 Solutions: Innovations in Long Term Care Reforms', provided conference attendees with an opportunity to network and share 'solutions that work'. The participants from forty states included Medicaid divisions, mental health and developmental disability divisions, providers from nursing homes and hospitals, the Centers for Medicare and Medicaid Services regional and central office staff, representatives from the Substance Abuse and Mental Health Services Administration, as well as consumers, advocates, and others, representing a broad range of stakeholder groups. This document represents a series of recommended gold standards in a variety of important areas related to managing LTC.

⁴Excerpted from presentations by Dennis Temple, M.A., CMSW, NAPP Co-Chair, PASRR Coordinator, TN Department of Mental Health and Developmental Disabilities; Willard Mays, M.A., Assistant Deputy Director for Public Policy for the Indiana Division of Mental Health and Addiction and co-chair of the NAPP Steering Committee; Beverly Morgan, PASRR Consultant and Geriatric Specialist, VA Department of MHMRAS.

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GOLD STANDARDS



The workgroup identified the following gold standard recommendations for improving quality of care for NF residents in LTC settings

The Power of PASRR is in the recommendations and efforts to leverage NFs to integrate recommendations for our growing number of vulnerable elderly.

Solution

It is the responsibility of PASRR professionals to address the gaps in services for our growing aging population. These are being addressed through innovations across states which include:

- Methods for increasing behavioral health resources (e.g., working at local levels to bring providers to NF settings)
- Developing innovations and use technology to improve training opportunities for providers (e.g., web-based training to outreach larger audiences, phone training with individual providers to address behavioral health needs of high risk residents) to improve understanding about the PASRR advocacy roots and goals as well as the mandatory compliance related requirements. Where possible, offer incentives, such as CEs). Emphasize incentives for integrating PASRR in training sessions (comprehensive care plan, mandatory compliance, improving workforce competency). Also include training about cognitive and depression scales and the importance of ongoing universal screening.
- Developing recommendations in PASRR reports which are comprehensive, useful, applicable, and individualized.
- Methods of monitoring provider service deliver for rehabilitative service recommendations and for targeted monitoring of flagged residents to assess whether status changes have occurred (e.g., Tennessee flags and conducts phone follow-up with providers about residents who demonstrate heightened potential for decompensation; Indiana directly incorporates PASRR assessed residents into survey and certification audits and review for residents who should have, but did not, receive PASRR evaluations. Indiana also conducts one year follow-up reviews to ensure residents receive appropriate behavioral health services).
- Implementation of compliance sanctions for providers to comply with PASRR recommendations (e.g., partnerships between PASRR and Survey and Certification entities).
- Implementation of uniform mental health screening and risk reduction strategies to identify depression among NF populations and to teach about modifiable suicide factors and risk and prevention strategies.

Each time someone stands up for an ideal, or acts to improve the lot of others, or strikes out against injustice, he sends forth a tiny ripple of hope.

- Robert F. Kennedy

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GOLD STANDARDS

Suicide Among the Elderly: Transforming Nursing Facilities to Improve Responsiveness and Capacity to Address Psychiatric Need & Suicide Risk Among Elders¹

With the changing demographics in our aging population, the impact on our mental health and substance abuse treatment systems is becoming increasingly significant. Our

existing systems are not currently adequate to meet the behavioral health needs of elders with psychiatric conditions, and that gap is only widening. There is a shortage of mental health

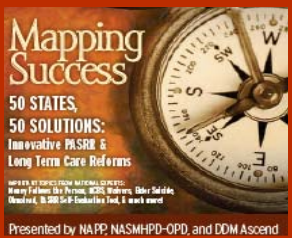
providers across the country, and providers in NF settings frequently describe significant limitations in meeting behavioral health needs of their residents.



Problem

- By the year 2030, the number of older adults with major psychiatric illnesses is predicted to reach 15 million.
- Older adults with mental illnesses often receive inadequate or inappropriate care.
- Without appropriate treatment, older adults are at risk for adverse outcomes, including reduced functioning, increased morbidity and mortality, and increased risk of institutionalization.
- There is a shortage of professional providers with expertise specific to mental health and aging.
- Minority elders are among the fastest growing segment of the population; cultural beliefs are strongly associated with dramatic differences in use of mental health services among older adult ethnic groups.
- Elders with mental illness are experiencing an epidemic of early mortality. Despite life expectancy in the U.S. at 77.9, individuals with mental illness die 25 years earlier on average (with average life expectancy at 53 years). In fact, the differential mortality gap for persons with schizophrenia has *increased* over recent decades, largely due to modifiable risk factors associated with cardiovascular disease (obesity, smoking, diabetes, hypertension, dyslipidemia).

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¹Excerpted from presentations by: Kathryn Power, Director of Center for Mental Health Services, Substance Abuse and mental Health Services Administration; Stephen Bartels, Professor of Psychiatric and Community & Family Medicine, Director, Dartmouth Centers for Health and Aging.

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Gold Standards for Transforming Nursing Facilities to Improve Responsiveness and Capacity to Address Psychiatric Need & Suicide Risk Among Elders

- Establish processes for universal depression screening in institutional settings.
- Develop culturally appropriate interventions which recognize that cultural beliefs are strongly associated with dramatic differences in use of MH services among older adult ethnic groups.
- Utilize free resources such as SAMHSA's evidence-based resource kit (<http://ncadistore.samhsa.gov/catalog/>) and information relating to national model programs (<http://modelprograms.samhsa.gov/>) to raise stakeholder awareness of the needs of older adults.
- Psychiatric care must be integrated with medical rehabilitation and should include prevention, health skills training, and health self-management skills through skills training classes and frequent skills practice (e.g., making the most of leisure time, communicating effectively, using medications effectively, making and keeping friends, making the most of health care, healthy living, etc.; Health care visit training might include: pros and cons of taking medications, sharing health information with your doctor, reporting physical symptoms, asking about treatment options, naming a health care agent, etc.).
- Train health care providers about skills related to recognizing and responding to suicidal ideation among residents. Many states have implemented the QPR (*Question, Persuade, and Refer*) community training method for raising provider skills in screening for suicidal ideation. QPR (<http://www.qprinstitute.com/>) uses a 3 step model to help participants recognize the warning signs of a suicide crisis and how to question, persuade, and refer someone to help.

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G O L D S T A N D A R D S

Administering the PASRR Self-
Evaluation Tool (SET)

Dan Timmel, Medicaid Policy Analyst for the Centers for Medicaid and Medicare Services, developed the PASRR SET to be used as a working document (subject to modification) and technical assis-

tance resource for states. The SET is not intended to be used as a compliance tool for CMS, although it will provide important information about CMS expectations for compli-

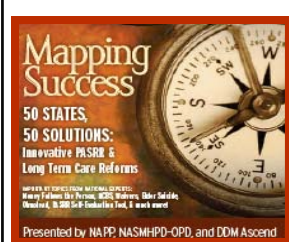
ance. Workshops at the NAPP/ NASMHPD ODP conference addressed national strategies used across states to maximize the effectiveness of the SET experience.

Strategies Used by States

- Thoroughly review all Medicaid, MH, and MR authority PASRR policies, procedures, protocol and overall operations (from PASRR Level I through deliver of specialized services). Review should include state code, policies and procedures, interagency agreements/ MOUs, etc.
- Conduct desk review of materials, onsite interviews/review in nursing facilities, and review PASRR work directly. Compliance evaluation should specifically include residents who were determined to require specialized or rehabilitative services to assess whether recommended services were delivered.
- Avoid getting ‘bogged down’ in details – focus on whether the program is meeting the regulatory/statutory intent.
- Engage a broad stakeholder group, including Medicaid, MH, DD, and other constituents with specific assigned tasks. Candidly discuss workgroup findings.
- Establish a firm and detailed timeline for accomplishing associated tasks (estimate up to 4 months).
- Once an item is identified as requiring corrective action, identify assignments for remediation.
- Establish an ongoing PASRR program compliance review after completion of the SET. Continue to engage the stakeholder evaluation committee ongoing.
- Seek guidance from CMS if and as needed.



Outcomes reported by states after completing the SET are provided on the following page.




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¹Excerpted from presentations and/or workshops facilitated by: Dan Timmel, Medicaid Policy Analyst, Centers for Medicaid and Medicare Services Dave Caloiaro, PASRR Program Manager with the State of Nevada Division of Mental Health and Developmental Services

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Outcomes Reported by States since Administering the SET

State authorities reported many benefits and favorable changes which occurred as a result of administering the SET. These included:

- As a result of redesigning Level I and Level II strategies, a substantial increase occurred in the number of Level I screens and Level II determinations. This increase demonstrated that **states were more effectively identifying individuals with known/suspected MI and MR/RD.**
- **Increased public awareness among stakeholder groups**, through implementing trainings which addressed areas of concern revealed by the audit. Many states reported that, as a result of budget limitations, the challenge to develop cost effective training strategies resulted in innovations in the manner in which trainings were offered (e.g., web-based tools, phone based trainings, etc.).
- Through engaging inter-departmental/inter-divisional collaboration to complete the SET, **commitment was broadened and strengthened within state governments.**
- Analyzing processes increased emphasis on designing **more efficient data collection system for improved analysis and evaluation.**
- **Compliance**; although a shift in the locus of PASRR from strictly a compliance focus to realizing real improvements the quality of long-term elder services
- **Improvements in meeting the needs of individuals with disabilities.**

Stand up to your obstacles and do something about them. You will find that they haven't half the strength you think they have —Norman Vincent Peale

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**GOLD STANDARDS
WORKGROUP**

**Gold Standards in Conducting
PASRR Level I Screening¹**

The quality and effectiveness of a Level I screening tool depends devising an effective match between the types of questions asked and the qualifications/experience of personnel responding to those questions. The CMS Self Evaluation Tool (<http://pasrr.org/pdf/selfAssessment.pdf>) identifies personnel requirements for Level I as follows:

- **States determine the personnel qualifications for conducting the Level I**

screen.

- **In some states Level I screeners are not capable of discovering previously undiagnosed individuals...the role of dementia, distinguishing serious mental illness from lower level conditions, and so on.**
- **Some states address both efficiency and accuracy by using a centralized process in which [layperson] screeners submit their findings to**

more highly qualified persons for [clarifications and] a decision.

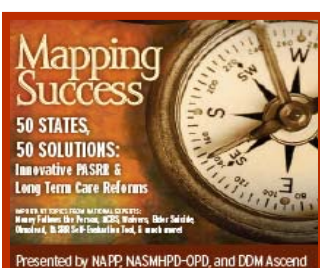
- Note that **flexibility in Federal requirements re Level I screener qualifications does not reduce the state's responsibility for accurate screens.**
- Training requirements are not a substitute for **state evidence of monitoring for accurate screens.**



Problem

- Lay personnel often do not recognize nuances of mental illness and how to judge whether symptoms are present or fall under the rubric of *serous* mental illness.
- Discharge planners are familiar with acute issues associated with the applicant's/ resident's hospitalization but, if the individual's hospitalization is associated with a medical condition, they may not be familiar with other chronic issues such as a mental illness.
- The more vague and general the Level I screen, the greater the expertise necessary to administer the screen. The broader and more in-depth the Level I questions (and the more cues offered to the individual completing the screen), the greater the likelihood of identifying individuals with *known* and *suspected* mental illness, as required by federal code.

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¹Excerpted from workshop facilitated by Nancy Shanley, Director of Advocacy and Special Populations, Ascend Management Innovations (d/b/a DDM Ascend) and Dennis Temple, M.A., CMSW, NAPP Co-Chair, PASRR Coordinator, TN Department of Mental Health and Developmental Disabilities



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Solution

An effective and compliant Level II tool:

- Must capture *all* persons with **suspected or** known SMI, MR, or RC/DD (looking beyond reported diagnoses)
- Be Sensitive (Identify everybody you meant it to identify)
 - No matter the person's diagnoses, history, current presentation
 - No matter who the informants are and given available information
 - No matter who conducts the screen or where it is done
- Be Specific (Include few people who did not need to be targeted)
 - This is about using resources wisely
- Should tailor questions to match the skills and qualifications of respondents completing the screening form. Some considerations follow:

<i>If these personnel administer the Level I Screen...</i>	<i>The following reflect strengths and limitations related to that administration.</i>
NF or Hospital Staff	+ Easy access to individual, -NF staff may experience financial disincentive to trigger Level II -Hospital staff may experience disincentive/ pressure to discharge -Clinical/ disability laypersons require more training -Clinical/ disability laypersons require more monitoring +/- Need layperson oriented tool to cue good info
Clinical or Disability Expert	Must travel to access to individual + Clinical expert- less training/ monitoring cost + Likely to be sensitive and specific +/- Can have simple reporting tool
Layperson collect - Central clinician interpret	+ Easy access to individual + Uses clinical expertise only when triggered by signs/ symptoms- can be cost effective +/- Need layperson oriented tool to cue and training + Likely to be sensitive and specific

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GOLD STANDARDS WORKGROUP

Gold Standards in Conducting PASRR Level II Evaluation and Developing the Summary of Findings Report¹

Because a fully *compliant* PASRR program does not necessarily equal an *effective* program, the CMS and NAPP workshops and sessions focused on methods for increasing effectiveness of PASRR by featuring inno-

ventions used by states (see *Maximizing the Effectiveness of PASRR* in the NAPP *Gold Standards* series). This document includes preliminary workshop recommendations specific to the Level II evaluation. NAPP's objec-

tive over coming months will be to continue to distill specific methods used by states by gathering national approaches to Level II and posting those on pasrr.org.

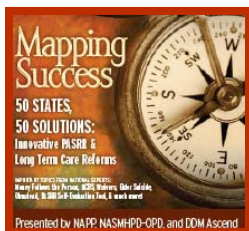


Questions to Consider in Evaluating Your State's Model

1. How would a gold standard tool differ from a merely compliant tool? (what distinguishes good from great?)
2. Is there a mechanism to track potential community candidates and their support needs?
3. Is there an interface with waiver/MFP services?
4. What would you consider mandatory elements of a meaningful individualized report?
5. Is there a way for the report to cue or trigger situations that need follow up?

NAPP is in the process of developing an archive of PASRR Level I screens and Level II evaluations and reports to be posted on our website for states to share. These can be **de-identified** (removing the name of the state). If you are interested in participating in this project (accessing these protocols or providing samples), contact Jennifer Burns at jburns@ascendami.com or 877.431.1388 ext. 3287.

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¹Excerpted from presentation facilitated by Beverly Morgan, PASRR Consultant and Geriatric Specialist, VA Department of MHMRSAS and the workshop on *gold standards* facilitated Dennis Temple, M.A., CMSW, NAPP Co-Chair, PASRR Coordinator, TN Department of Mental Health and Developmental Disabilities and Nancy Shanley, Director of Advocacy and Special Populations, Ascend Management Innovations (d/b/a DDM Ascend)

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Gold Standards

What a PASRR evaluation should do well

- it should be **highly customized**
- **Confirm or disconfirm** PASRR related diagnoses
- **Exceed compliance standards - capture important clinical information** (e.g., baseline behaviors & symptoms; history, course and triggers; changes that signal concerns; treatments that work or do not work; optimum psychopharmacologic combination, factors which have effectively improved stability)
- **Capture/describe community placement potential and related support needs** (including those to maintain placement in the community)
- **Provide meaningful, specific and clear recommendations** about **where, by whom, and how** the individual's SMI, MR (ID), and RC(DD) needs can be met. Recommendations should include tangible and individualized expectations (type and degree of monitoring, recommendations for services, clear information about psychotropic medication regimen and needs and the facility's obligation to provide certain services and monitor specific symptoms).
- **Be written in lay-language** which meaningfully can be incorporated into care plans and which clarify needs for the individual's stability/level of functioning to be maintained
- **Deliver expert insights** which help NF providers allay need for more intensive treatments
- **Spell out State responsibility** and NF responsibility
- **Determine that NF is not appropriate when community alternatives are possible & best**
- **Give institution specific determinations**- can *this* NF serve the individual's needs?
- **Clarify symptoms which should be reported or charted and symptoms which should trigger a medication review** by psychiatric staff
- **Change lives**

Recommendations to teach the provider (to optimize placement success by providing basic educational information about the individual and the population being served):

- Interaction skills for residents with challenging, externalizing behaviors
- Education about diagnoses to reduce misconceptions and fears and, ultimately, symptoms, by empowering staff to interact in ways that lead to positive change
- Education on recognizing symptoms specific for each individual based on their history and how to recognize behaviors/symptoms by diagnosis; how to discriminate and identify general chronic symptoms from more acute, serious symptoms; How to identify symptoms which are precursors to escalation; quality of life issues and expectations about honoring resident capabilities, needs, and strengths

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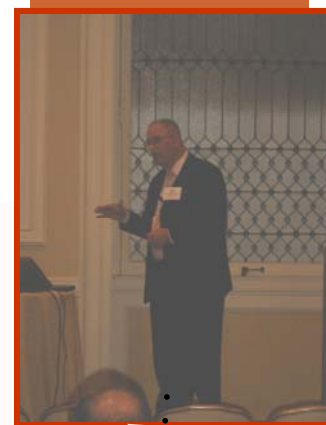
GOLD STANDARDS

Resources in Balancing Continuums of Community Based Options¹

Many initiatives have demonstrated the commitment of the federal government to transform the financing and delivery of long-term care services. The Money Follows the Person (MFP) Rebalancing Demonstration is the largest demonstration program in

the history of Medicaid (\$1.75 billion over 5 years funding 31 state transition programs). Rebalancing is directed at reaching equity between the proportion of total Medicaid long-term care support expenditures used for institutional services versus com-

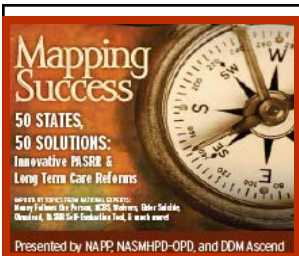
munity-based supports. Provided for under the Deficit Reduction Act, MFP supports targeted reforms to transition eligible individuals from institutions to community settings.



Initiatives

- Recent (2007) changes in federal code permit states to offer **HCBS as a state plan optional benefit** (rather than a waiver). This option breaks the 'eligibility link' between HCBS and institutional care and permits states to forgo the waiver requirements of cost neutrality and HCBS renewal. However, unlike 1915(c) options, states cannot target groups of individuals under the SPA.
- The State Plan option under **1915(i) for self directed Personal Assistance Services** enables individuals to purchase assistance services using an individual budget and service plan. Under this plan, the individuals may hire, fire, supervise, and manage service providers and may purchase certain items that increase independence or substitute for human assistance (e.g., microwaves, accessibility ramps). Personal Assistance services are not subject to comparability or statewideness requirements.
- The **DRA expanded coverage and HCBS for children vis-à-vis:** 1) Enabling states the options to allow families with income up to 300% FPL to buy Medicaid coverage for their disabled children. Under this program, states may impose monthly premiums based on a sliding scale, but cost sharing is capped (<200%-5%; 200-300%-7.5%). CMS is developing additional guidance; 2) Focus on community alternatives for children through Psychiatric Residential Treatment Facilities (PRTF) involving over \$218M over 5 years to conduct demonstration projects in up to 10 states, with a focus on improving services for children under age 21 with SED by expanding the availability of DBS; 3) Promoting personal responsibility through LTC partnership programs to help individuals take more responsibility in planning for and financing their future LTC needs. Assets are protected when the Medicaid application is made and when estate recovery provisions take effect after death.
- The **Money Follows the Person program** is directed at rebalancing the long-term care system by right-sizing our institutional and community-based system through eliminating barriers that restrict the use of Medicaid funds. MFP projects to transition 35,572 individuals. Under this program enhanced FMAP is provided for 12 months for each qualified transitioned individual, after which the state provides community services for as long as the person needs community services and is Medicaid eligible. MFP grantees must incorporate the same level of QA/QI found in the new 1915c HCBS waiver application and must include a risk assessment and mitigation process, emergency back up system for critical services, and an incident reporting system. Consumers and consumer-run organizations must have a role in all phases of the project.

Recommended
Programs & re-
sources are pro-
vided on the fol-
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¹Excerpted from presentations facilitated by Jim Pezutti, Director for the Bureau of Community Development within the Office of Long Term Living and the Pennsylvania Department of Public Welfare and Aging; Marie Williams, Assistant Commissioner, Division of Recovery Services & Planning, TN Department of MHDD.

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Featured States

- **Pennsylvania's 'Total Senior Care' Initiative** is rooted in an overall paradigm shift that motivated providers to reallocate assets away from institutional services and toward HCBS. The objective was to enable true System Change through expending resources in a manner that would motivate private businesses to change their models. Specifically, LTC providers began delivering waiver services based upon a financially attractive and flexible system of incentives that motivated providers to reconfigure assets according to market realities and consumer preferences.
- **Tennessee's Creating Homes Initiative (CHI)** was not designed for waiver participants or for the elderly. However, the principles of community development are highly relevant to MFP models. The emphasis of this project was to develop quality, safe, and affordable housing for individuals with disabilities. To date, CHI has developed over 7,000 placements (and leveraged over \$200 Million) ranging from supported living to independent home ownership and the goal is to increase that number to 8009 by 2009. These initiatives occurred through leveraging a combination of funding, i.e, THDA, HUD, Federal Home Loan Bank, other federal, local, and state resources, integrating non-traditional resources to fully fund housing options ranging from ground-up apartment complexes, to fully rehabbed homes which are **fully funded** (which makes them affordable) and which include supported living components (which makes them successful) for different settings and populations. An important additional benefit identified through this model was a 95% statewide decrease in psychiatric re-hospitalization for persons served through CHI.

Resources for States

- The DEHPG Strategic Plan supports and implements the CMS vision for long-term care at <http://www.aoa.gov/ABOUT/strategic/AoA%20Strategic%20Action%20Plan%202007-2012.pdf> & <http://www.cms.hhs.gov/NewFreedomInitiative/downloads/DEHPG%20Strategic%20Plan%202007.pdf>
- The New Freedom Initiative: www.cms.hhs.gov/newfreedominitiative
- Deficit Reduction Act: www.cms.hhs.gov/deficitreductionact/
- First year results from the rebalancing initiative: www.cms.hhs.gov/newfreedominitiative/035_rebalancing.asp & http://www.hpm.umn.edu/lrcresourcecenter/research/rebalancing/Rebalancing_state_ltc_systems.htm
- A model profile of PA's LTC system (designed for replication) and technical assistance guide at: www.cms.hhs.gov/newfreedominitiative/037_stateprofiles.asp
- Tennessee's Housing Within Reach Program: <http://housingwithinreach.org/>
- http://www.cms.hhs.gov/NewFreedomInitiative/Downloads/PA_Profile.pdf
- http://www.cms.hhs.gov/NewFreedomInitiative/Downloads/TA_Guide.pdf
- Real Choice Grants: www.cms.hhs.gov/realchoice/
- MFP Rebalancing Demonstration: www.cms.hhs.gov/deficitreductionact/20_MFP.asp

NATIONAL ASSOCIATION OF PASRR PROFESSIONALS

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The National Association of PASRR Professionals (NAPP) is comprised of caring people who partner together to improve the quality of long term care for individuals with mental illness, developmental disabilities, and related conditions. We are the federal and state agency staff who develop and implement the programs. We are the social and human services groups that provide oversight and advocacy. We are the nurses, social workers, doctors, and other professionals who conduct the assessments. We are the hospital and nursing facility staff caring for residents needing review. We are the counselors comforting people in need. We are individuals and families with long term care needs. We are NAPP - and with PASRR, we are improving long term care.



GOLD STANDARDS

Establishing Single Point of Entry Screening for LTC Services and Programs¹

Many states strive to develop Long Term Care systems which offer single entry points. The benefits of integrated systems enable admission strategies which reduce confusion to the recipients because they are standardized and less complex. State benefits include assurances of uniformity and improved quality control, while enabling more efficient data collection and analysis and improved capacity for planning.



Problem

Separate systems and screening processes result in:

- Fragmentation across processes, programs, and services.
- Inconsistent utilization review decisions across programs and geography.
- Increased likelihood of noncompliance within the state oversight agency.
- Reduced effectiveness of provider oversight opportunities.
- Slow and unpredictable screening for providers and service applicants.

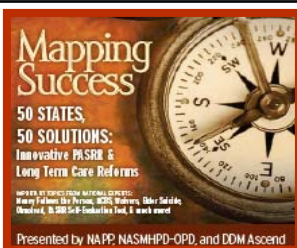
Without those things, we couldn't ensure that individuals were receiving the least restrictive services. We couldn't effectively plan the types of services needed across geography, across populations and across diagnoses. —Joan Ehrhardt

Process for Attaining Compliance

- Created consensus and stakeholder buy-in through involving key players across programs
- Analyzed existing systems and processes to identify gaps and barriers.
- Linked approved (utilization control, PASRR Level I, and PASRR Level II) decisions with provider payments.
- Conducted multiple provider trainings across the state which included screening requirements, expectations, best practices in treatment (behavioral health, motivational enhancement, universal screening, co-morbid diagnoses/treatments, discharge planning, etc.)

Providers obtained consistency, uniformity, clear expectations, and timely payments. The State obtained consistency and uniformity as well as effective methods for quality control, data analysis and, most importantly, the capacity to accurately trend and plan to address recipient needs. We have increased the quality for the individual and provider, and we have the ability to prove it.

State outcomes
are provided
on the following
page.




The October 2008 Baltimore conference, 'Mapping Success: 50 States, 50 Solutions: Innovations in Long Term Care Reforms', provided conference attendees with an opportunity to network and share 'solutions that work'. The participants from forty states included Medicaid divisions, mental health and developmental disability divisions, providers from nursing homes and hospitals, the Centers for Medicare and Medicaid Services regional and central office staff, representatives from the Substance Abuse and Mental Health Services Administration, as well as consumers, advocates, and others, representing a broad range of stakeholder groups. This document represents a series of recommended gold standards in a variety of important areas related to managing LTC services.

¹Excerpted from workshop facilitated by: Joan Ehrhardt, former Director for the North Dakota Department of Human Services, Division of Medical Assistance and Deborah Sumruld, DDM Ascend

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GOLD STANDARDS



The workgroups and sessions identified the following gold standard recommendations for improving quality of care for NF residents in LTC settings

Result/Process

- Integrated LTC programs (e.g., waiver services, NF, Swingbed, MFP, PASRR Level I and Level II) into one data system with heuristics that drive decision making
- Outsourced to develop one stop screening model (integrated with PASRR) with centralized data system development - 'Programmed out' fragmentation and 'programmed in' quality decisions through a centralized data system that enabled secure, web-based submission of screening information by providers
- Incorporated a web-based online tracking component so that providers may update transfer and discharge information of residents
- Reviews were designed around federal and state code, with information gathered based upon specific criteria identified by providers in the online screening submission and by embedded heuristics which cue questions based upon medications and symptoms
- Established continued stay review points for approved applicants who demonstrate the capacity to recompensate medically
- Integrated an onsite assessment component for potentially denied candidates
- Through a combination of web-based and desk reviews, providers are able to receive same-day utilization control decisions by medical reviewers
- Approved State authorities may access real time, web-based data and reports which enable trending by region, diagnosis, provider, and any other variables of interest

'Fortunately, CMS informed us we were not compliant'- J. Ehrhardt

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G O L D S T A N D A R D S

Implementing Uniform Assessments for Individuals with Intellectual and Developmental Disabilities¹

As state government agencies implement uniform assessments for waiver participants in response to CMS quality mandates and for planning, rate-setting, and utilization review, many struggle with how to select a single tool to be administered across populations and programs. Other challenges include selecting a tool that offers sufficient reliability and validity to enable statewide administration in a standardized and consistent way – yielding data that is comparable across programs, settings, and populations.

Problem ~ To Identify uniform assessment strategies that:

- Identify service gaps and redundancy
- Enable equity and fairness across programs and participants
- Demonstrate consistency across waivers in measuring need and determining allocations
- Emphasize person-centered planning and supports
- Assign rates which are transparent, flexible, fair, and equitable
- Maintain psychometric properties (reliability, validity, and standardization) across norming tables

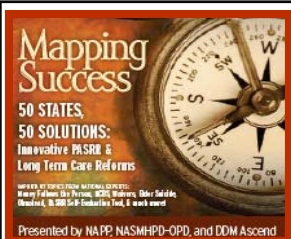
Pre-selection Considerations & Options

- *Ensure key questions are incorporated:* What is important to the person; What is important for the person; How does the person want to be supported; What is and is not working?
- *Focus on Person Centered planning:* Combine identification of the person’s hopes, capacities, interests, preferences, needs and abilities with a systematic method of aligning resources to the person’s goals. Efforts come from the same value base of autonomy and empowerment.
- Several tools are currently used [DDP (Developmental Disabilities Profile), SIB-R (Scales of Independent Behavior-Revised), NC-SNAP (NC Supports Needs Assessment scale), MD Individual Indicator Rating Scale, CT DDS Level Assessment, etc.]. The more commonly used

tools include the ICAP and SIS. Strengths and weaknesses of those tools are described in the table.

(continued on reverse)

ICAP (Inventory for Client and Agency Planning)	SIS (Supports Intensity Scale)
<ul style="list-style-type: none"> • Measures adaptive and problem behaviors with adequate psychometric properties, although with aging norms • Relatively straightforward to learn and quick to administer • Has been tied to estimated funding need • Good at separating or clustering people into groups with similar <i>intensities</i> of support need • Not good at identifying what supports should ‘look like’ • Not ‘face valid’ for stakeholders • Deficits based approach (older paradigm) 	<ul style="list-style-type: none"> • Strong psychometric properties with newer norms and widening research base • Intensive training required for AAIDD ‘gold standard’ • Focus is on <i>supports</i>, rather than diagnosis, disability, or limitations • Thorough and highly useful in planning • Resource intensive if efforts are to ensure fidelity to gold standard



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¹Excerpted from workshop facilitated by Nancy Shanley, Director of Advocacy and Special Populations, Ascend Management Innovations (d/b/a DDM Ascend)

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Quality that is not measured is a slogan...not a system

-Unknown

GOLD STANDARDS

Post-selection Considerations & Strategies

1) Administration - methods to ensure conflict-free assessment (e.g., minimizing gaming or bias); qualifications and time commitment.

Providers	Support Coordinators	State	Independent Vendor
+Typically know the individual well	+/- bias concerns vary from state to state	- Not viewed by stakeholders as independent	+Independent/non-biased
+/- Variable qualifications	+/- Variable qualifications	-Labor/ manpower intensive	+Single purpose/can hold assessors accountable
+/- State must assume training and quality oversight roles	+Relative ease translating information to planning		+Vendor contract shifts time and effort burden for training, reporting, and quality
-Increased potential for bias/gaming	- Competing demands for SC time (need to ensure they will/can commit time and resources necessary to assure assessment fidelity)		-Do not already know the individual
-Labor intensive training and quality oversight demands	- Labor intensive training and quality oversight demands		+/- Must develop strategies for translating information for planning use

2) Overcoming procedural drift, gaming, and bias

- Use a small cadre of independent interviewers who are intensely trained
- Employ strong quality oversight model to measure and track consistency, identify red flags, and provide assessor feedback
- Use multiple informants across settings (interviewed separately, if possible) who sign attestations, and combine interviews with observation
- Obtain documentation for key variables associated with greatest support need or cost
- Use analyses strategies for measuring administration reliability across assessment staff (avoiding drift through ensuring fidelity measures)
- Implement strong initial and ongoing training models for assessors and stakeholders and ensure training model is consistent with protocol demands
- Employ additional 'strong method' strategies which can be applied depending upon structure and goals

3) Logistics and Informatics

- Use heuristic IT strategies and informatics to minimize demands on providers, SCs, families, etc. – group assessments by logistics, priority, due date, and providers
- Develop workflow strategies which plan for fidelity, efficiency, and integrity with strong self righting mechanisms
- Engineer a dedicated data/information structure and heuristics to access, store, analyze and communicate project related information and which will enable effective analysis of composite and individualized data

4) Stakeholder Investment strategies

- Implement mechanisms for stakeholder involvement pre-project, at implementation, and ongoing
- Use a variety of strategies for outreach and education

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