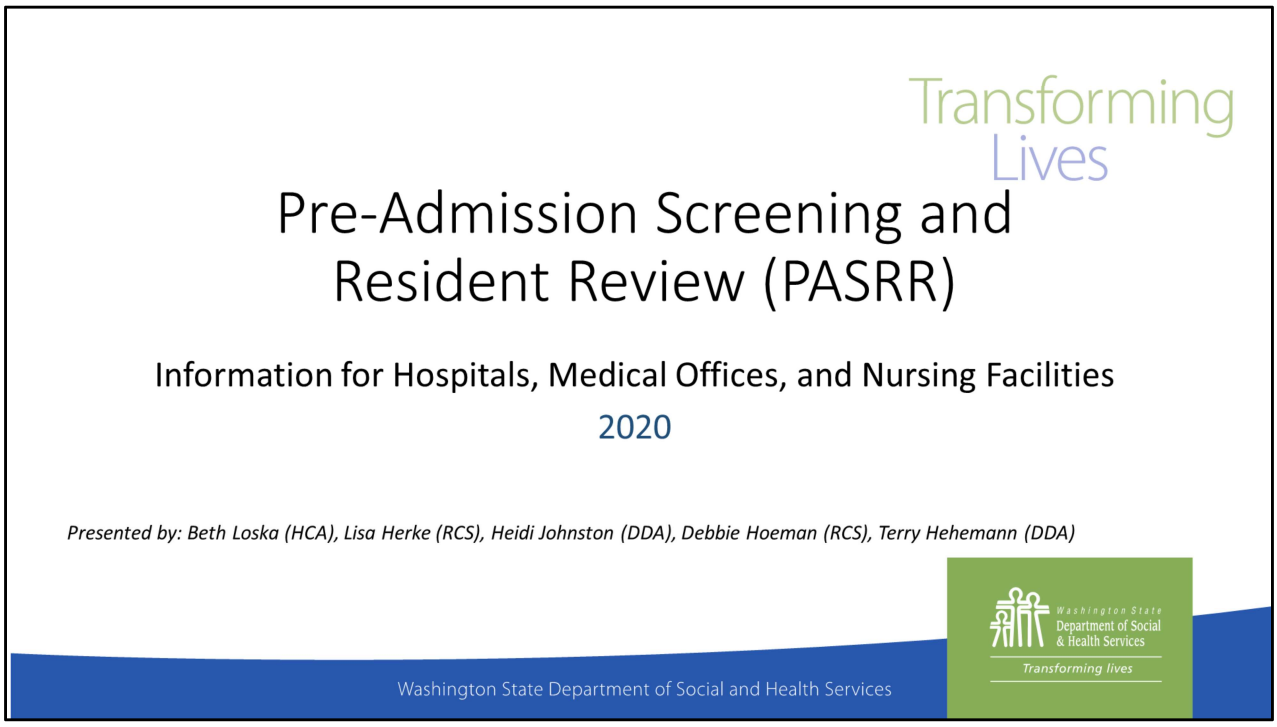


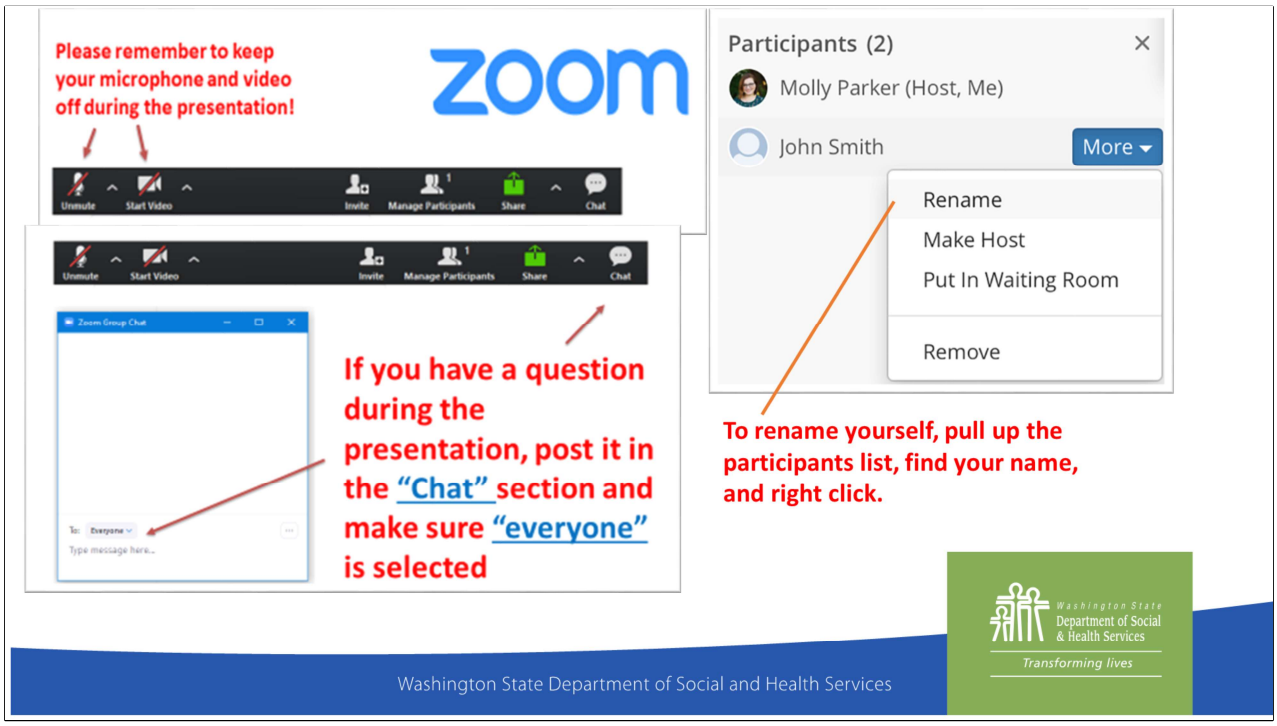
BL

Welcome to the PASRR webinar this morning/afternoon. My name is Beth Loska and I am the Behavioral Health PASRR Program Manager with the Health Care Authority.

Before we start there are a couple of housekeeping items we would like to review:

1. You will be in "listen only mode" throughout the webinar.
2. If you have questions during the webinar, please type them into the "Chat" or "Question" feature. Please do not use any resident specific information. All questions will be answered at the end of the webinar. It is very likely that most questions will be covered in our presentation today, so we encourage you to wait until we are getting close to wrapping up and then submit your question.

3. A copy of this presentation will be emailed to you in the near future after we have had an opportunity to add any questions asked during both webinars. You are free to share the final presentation with your colleagues and partners


Please remember to keep your microphone and video off during the presentation!
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Unmute
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Manage Participants
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Participants (2)
Molly Parker (Host, Me)
John Smith
More
Rename
Make Host
Put In Waiting Room
Remove
To rename yourself, pull up the participants list, find your name, and right click.
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BL

Introduction

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BL
Welcome!

So you know who is with us today, let's go around the room and let everyone introduce themselves.

Hello! I'm Lisa Herke from Residential Care Services. I am the Nursing Home Policy Program Manager.

Hello! I'm Terry Hehemann, PASRR Unit Manager for the Developmental Disabilities Administration.

Hi, I am Heidi Johnston, PASRR Program Coordinator with the Developmental Disabilities Administration.

Hi, I am Beth Loska, PASRR Program Manager with the Health Care Authority.

For Your Information …

- Today's webinar will focus on the role of hospitals and nursing facilities in the PASRR process, person-centered practices and integrated care.
- CEUs are available.

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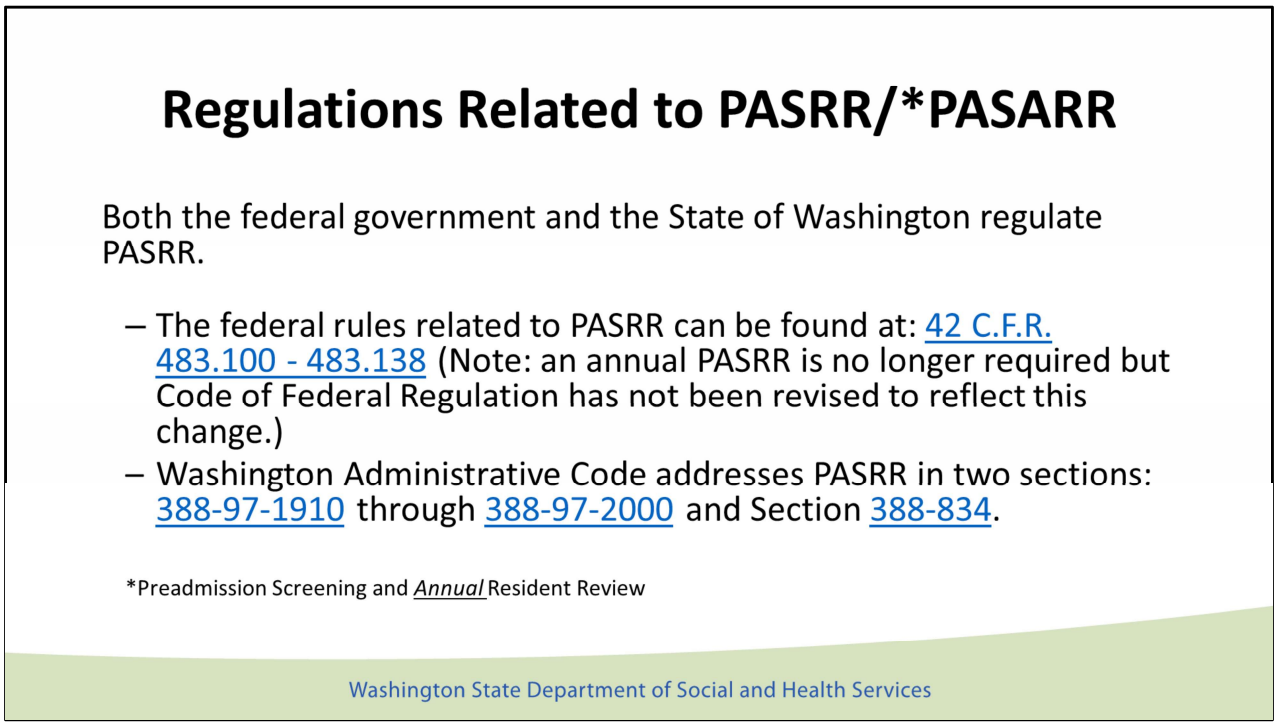
BL
We hold PASRR webinars annually. With us today we have skilled nursing facilities, hospitals, DSHS staff (DDA, HCA, ALTSA) and HCA contractors.

The PASRR process here in Washington, has continued to be refined and grow. We plan to continue with periodic updates.

If you registered for and participate in today's webinar or the next session you will be emailed a certificate with 1.5 CEU's. If you are participating as a group, it is the responsibility of the individual who registered and logged in the today's webinar to distribute the certificates to others who are in the room. Whomever registered may want to get emails for the others in the room if you are part of a very large organization.

Also important to note, that a resident who has a positive PASRR may have multiple case workers who are working with them. It is not unusual for this to occur, so we don't want anyone to be surprised if this happens in their facility.



LH –
Hello, first I'd like to clarify the PASRR abbreviations. You might sometimes see Pre-Admission Screening and Resident Review abbreviated as P-A-S-R-R and sometimes it is spelled P-A-S-A-R-R. The two acronyms are used interchangeably. The federal rules formerly required an annual review and the second "A" in the P-A-S-A-R-R spelling stood for "annual."

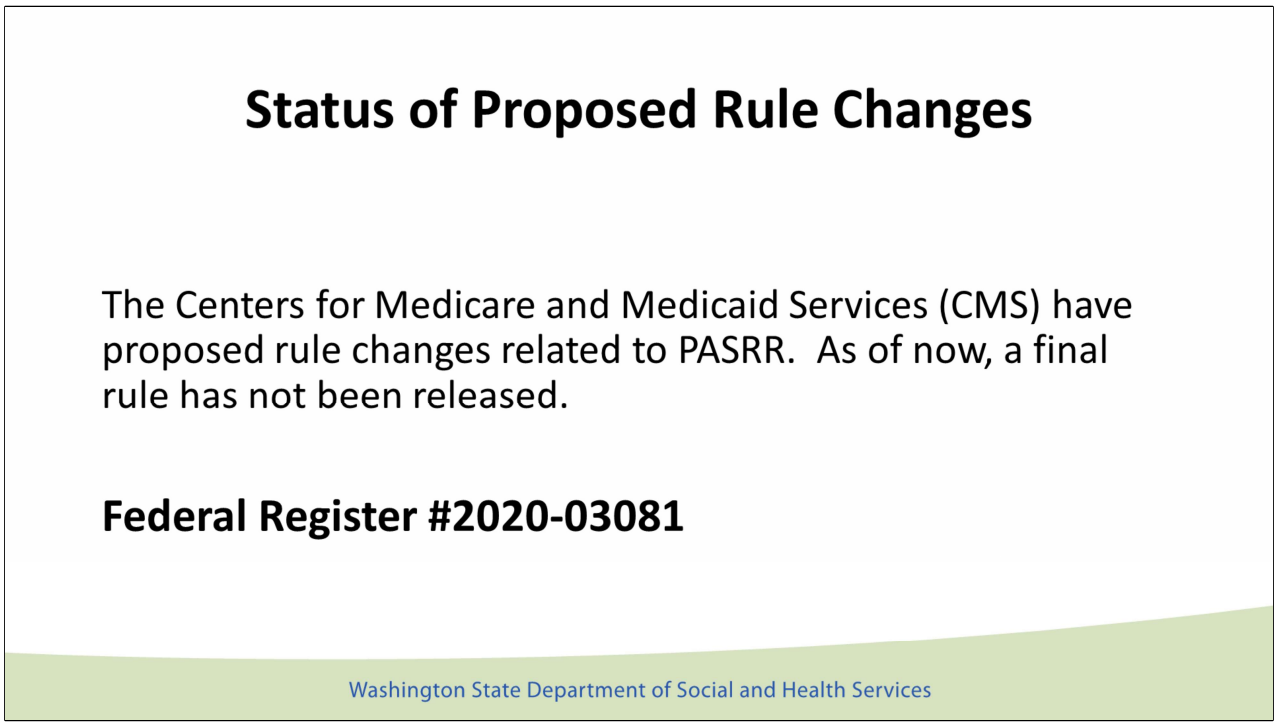
The requirement for an annual assessment was discontinued in 1996, though the Code of Federal Regulations, or CFRs, have not been updated to reflect the change.

So, a new PASRR is not required annually, but is required whenever a resident with Serious Mental Illness (SMI) or Intellectual Disability or Related Condition (ID/RC) experiences a significant change in condition, or if a resident is newly identified as having a SMI or ID/RC. Additionally, Developmental Disabilities Administration (DDA) completes follow-up evaluations for people who remain in a Nursing Facility longer than 90 days.

For your reference, this slide shows the federal and state rules related to PASRR.

- For Washington State, rules are found in the Washington Administrative Code, known as WACs. For Nursing home specific rules, look at 388-97-1910 through 388-97-2000. Rules specifically related to Developmental Disabilities are at 388-834.

- The federal regulation is found at 42 CFR 483.100 through 483.138. The guidance for those rules is found in Appendix PP, at F644 and F645.



LH

Earlier this year, the Centers for Medicare and Medicaid Services proposed amendments and additions to the federal PASRR rules. The proposed rules were placed on the Federal Register on February 20, 2020. Comments were accepted through May 20, 2020. The PASRR workgroup – representatives from Developmental Disabilities Administration, Health Care Authority, Residential Care Services, and Home and Community Services reviewed the proposed rules and submitted comments.

PASRR was first required with federal legislation that happened in 1987. The rules we are currently using were adopted in 1990. CMS wanted to update the rules to better reflect current nursing home practice. They also heard from stakeholders that some of the rules were unclear or illogical.

Facilities:

- Improve clarity of who is required to have a Level I screen with Provisional admission,
- Clean up of “annual” and
- clarifying time lines, such as how long after a significant change a facility has to report the change.

State Agencies, including

- Data reporting requirements
- Timelines for completion of work
- Face-to-face versus telework

With the Public Health Emergency, there has not been further action by CMS to formally adopt the rules. We have not heard any projected timeline for adoption. On the screen is the Federal Register number if you want to look at the proposed rules.

What does PASRR do?

PASRR has three goals:

- To identify people referred to nursing facilities who have an intellectual disability or related condition (ID/RC) or a serious mental illness (SMI);
- To determine that individuals are placed appropriately; and
- To make sure individuals receive the services they need for ID/RC or SMI.

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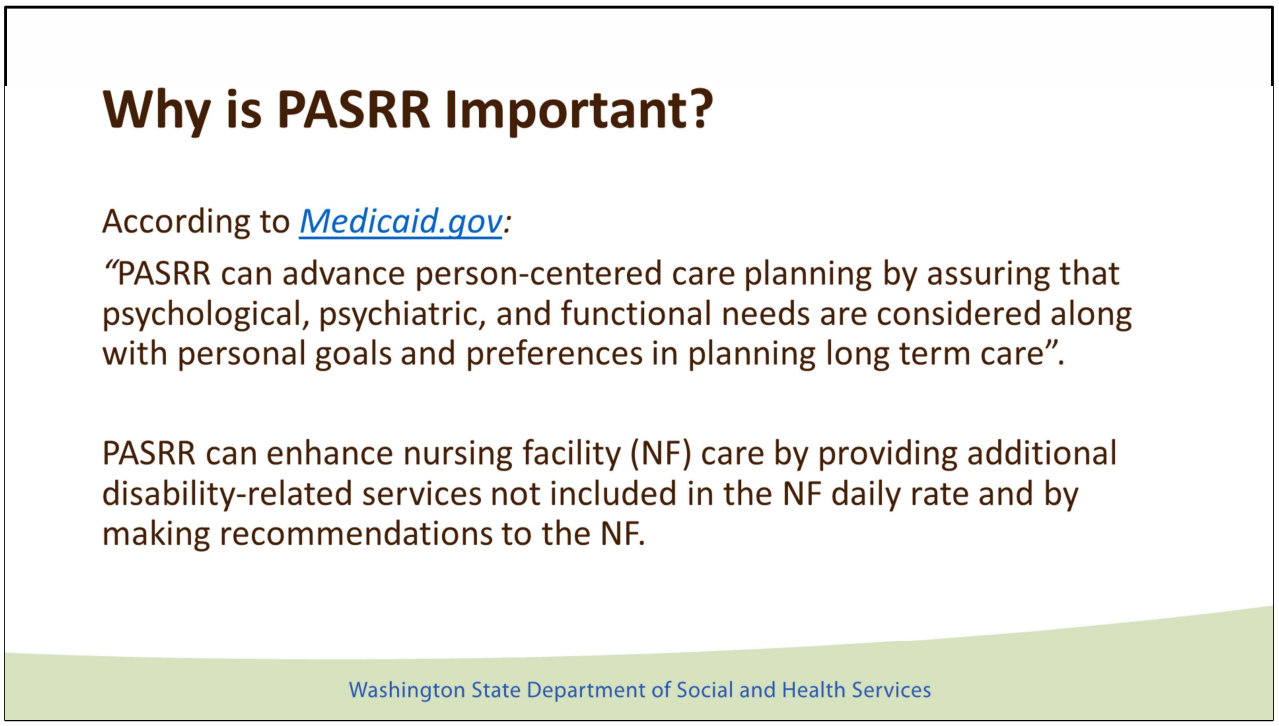
LH

PASRR has three goals:

The first goal of PASRR is to **identify** people referred to nursing facilities who have an intellectual disability or related condition (ID/RC) or a serious mental illness (SMI);

The second goal is to ensure that the individuals with the serious mental illness, Intellectual disability or related condition are placed appropriately. This means the person is placed in a home that is the **least restrictive setting** that still meets their particular care needs.

The third goal of PASRR is for each person identified through the PASRR process to receive the services they need, if they are identified as needing services. The services I'm describing are services that are specific to their serious mental illness or intellectual disability.



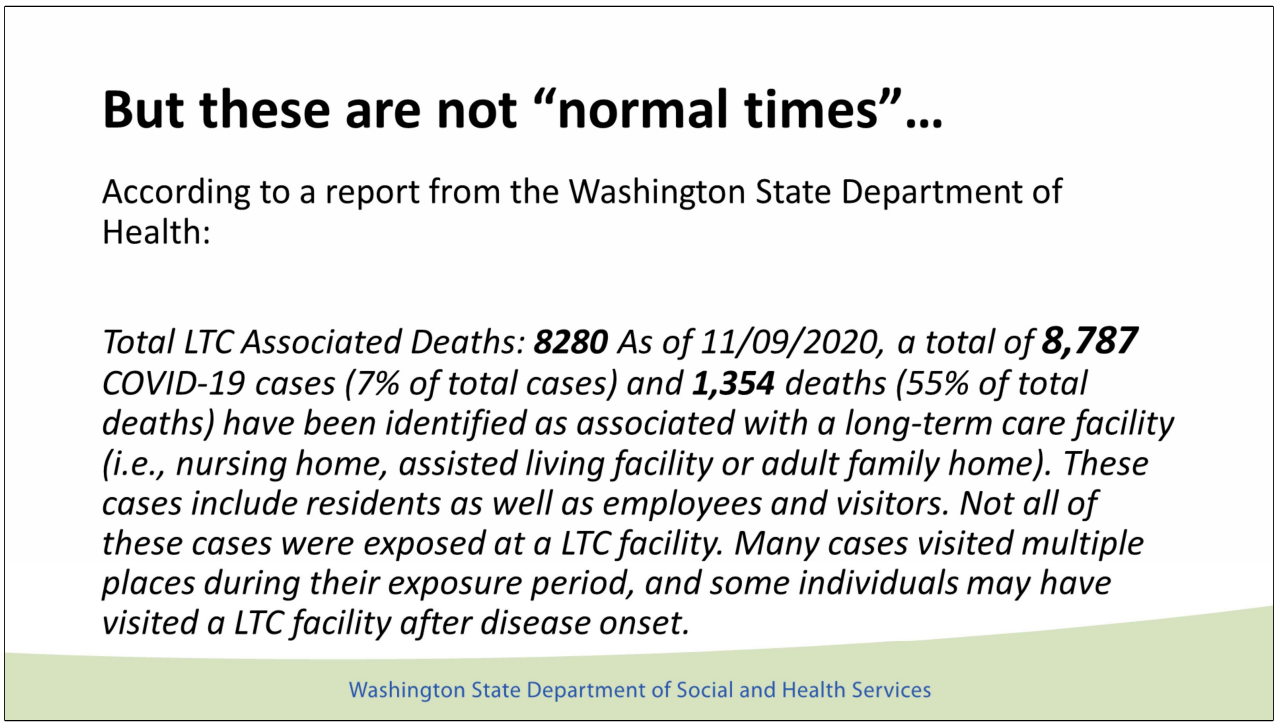
LH

So, why is PASRR important?

PASRR can improve the quality of life for residents with SMI or ID/RC. PASRR advances person-centered care planning by assuring that psychological, psychiatric, and functional needs are considered along with personal goals and preferences in planning long term care. It aslo helps assure care is done in the least restrictive setting.

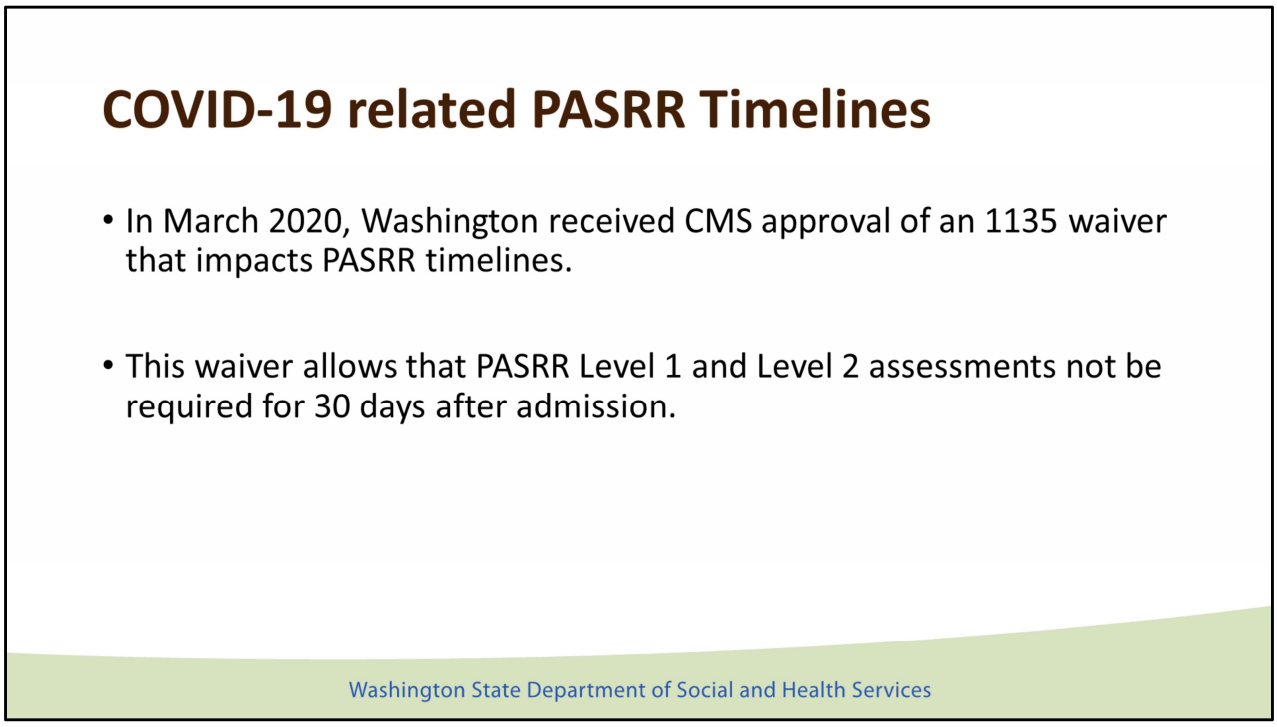
PASRR can enhance nursing facility care by providing additional disability-related services not included in the NF daily rate and by making recommendations to the nursing facility.

So, not only is the PASRR process important to ensure people with SMI or ID receive care in the least restrictive setting, it also provides evaluation and services to help ensure appropriate care is provided in a dignified and person centered manner to those who reside at a nursing facility.



DDA
Fifty-five percent of Washington State COVID deaths have been associated with a LTC facility. This includes nursing homes. This is not an indicator of the quality of care in nursing homes. COVID took the health care system by surprise. This is a clear indicator of how vulnerable the nursing home resident population is.

We want to acknowledge the dedication of our partners who work in hospitals and nursing facilities and are on the front lines of the pandemic. We know you are doing everything in your power to provide the best care for residents, at personal risk to yourselves and your families. We want to thank you for your hard work and commitment and partnership with the PASRR team.

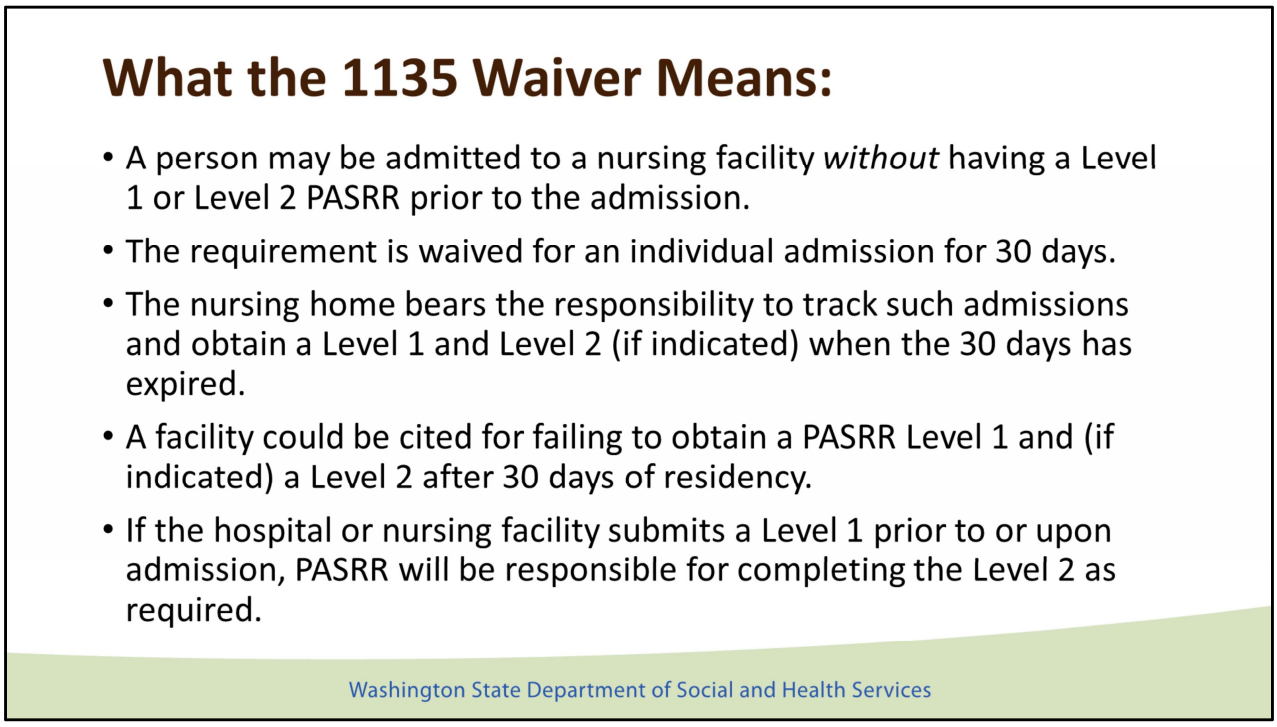


DDA

In March 2020, Washington received CMS approval of an 1135 waiver that impacts PASRR timelines. An administrator letter was issued related to the waiver, but it appears some facilities remain confused about what the waiver does, and does not, mean.

This waiver allows that PASRR Level 1 and Level 2 assessments not be required for 30 days after admission.

Note that the state rules were changed to agree with the federal rules.



DDA

- **A person may be admitted to a nursing facility *without* having a Level 1 or Level 2 PASRR prior to the admission.**
- **The requirement is waived for an individual admission for 30 days.**

The waiver allows postponement of the PASRR process for any individual for 30 days. It does not REQUIRE postponement. There is nothing prohibiting hospitals and nursing facility staff from following the regular timelines for PASRR completion.

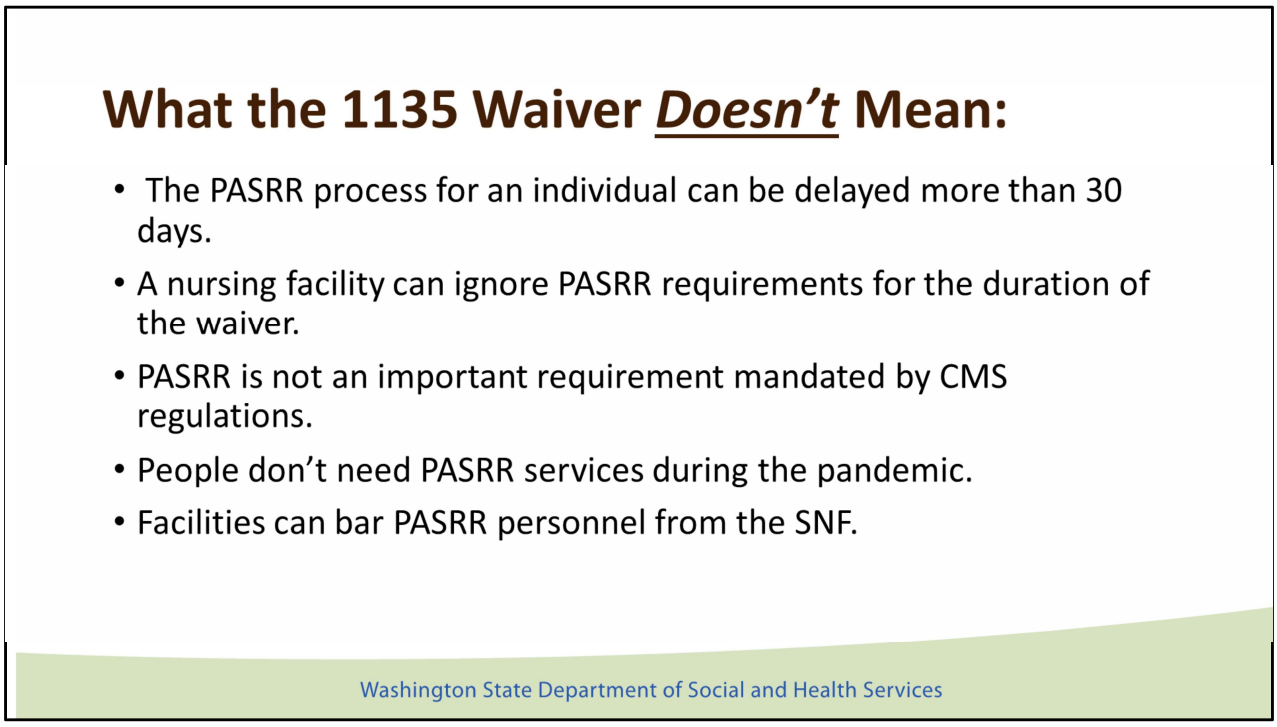
- **The nursing home bears the responsibility to track such admissions and obtain a Level 1 and Level 2 (if indicated) when the 30 days has expired.**

- **A facility could be cited for failing to obtain a PASRR Level 1 (if indicated) and a Level 2 after 30 days of residency.**

- **If the hospital or nursing facility submits a Level 1 prior to or upon admission, PASRR will be responsible for completing the Level 2 as required.**

We strongly encourage facilities to send a Level 1 upon admission if the hospital hasn't

already done so. The PASRR team will complete the process and the facility won't need to track the 30 days.



DDA

DDA

The PASRR process for an individual can be delayed more than 30 days.

- **A nursing facility can ignore PASRR requirements for the duration of the waiver.**
- **PASRR is not an important requirement mandated by CMS regulations.**
- **People don't need PASRR services during the pandemic.**

Some facilities appear to believe that the entire PASRR process has been suspended while the waiver is in effect. This is not true.

Completion of the Level 1 takes only a few minutes, and we highly encourage that facilities submit Level 1s upon admission, if the referring party has not done so already. By doing so, the facility frees itself from the responsibility of tracking the 30-day post-admission timeline.

In fact, completing Level 1s on admission is likely to be much less time-consuming than tracking all admissions to submit Level 1s within 30 days.

Reinvestment Grants

- Washington state participates in the Civil Money Penalty (CMP) Fund Grant Program.
- https://www.dshs.wa.gov/altsa/civil-money-penalty-cmp-funds

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DDA

Civil money penalties (CMPs) are fines imposed on nursing facilities that do not meet federal health and safety standards. Washington state receives a portion of the funds collected to be reinvested in support of projects that improve the overall quality of life and/or care of nursing facility residents.

Opportunities are available for nursing homes to participate in grant projects. More information is available at the link in the slide. **Some facilities are using these funds to purchase equipment to assist residents to communicate with others outside of the facility including family and friends. PASRR has found that for residents who are able to communicate with family and friends it has reduced anxiety and increased stability for the resident.**

How Might COVID-19 Impact Resident Outcomes?

- By postponing the PASRR process, critical services for people with intellectual disabilities or serious mental health conditions are delayed.
- Residents with these conditions may be especially impacted by isolation and need help with coping strategies.
- Staff at many NFs have collaborated with the PASRR team to help support good outcomes for clients.
- PASRR has supplied therapeutic equipment, assistive technology, and remote behavioral health support during this time.

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DDA

(Read slide)

Here are three examples of collaboration between Nursing Facility staff, DDA PASRR Assessors, and contracted providers:

Client #1: A PASRR Assessor worked with the NF staff regarding someone who is lonely and struggling with understand why she is no longer able to see her family for visits, whom she missed terribly. The Assessor was able to get a DOH cell phone for the client to be able to speak and FaceTime with her family.

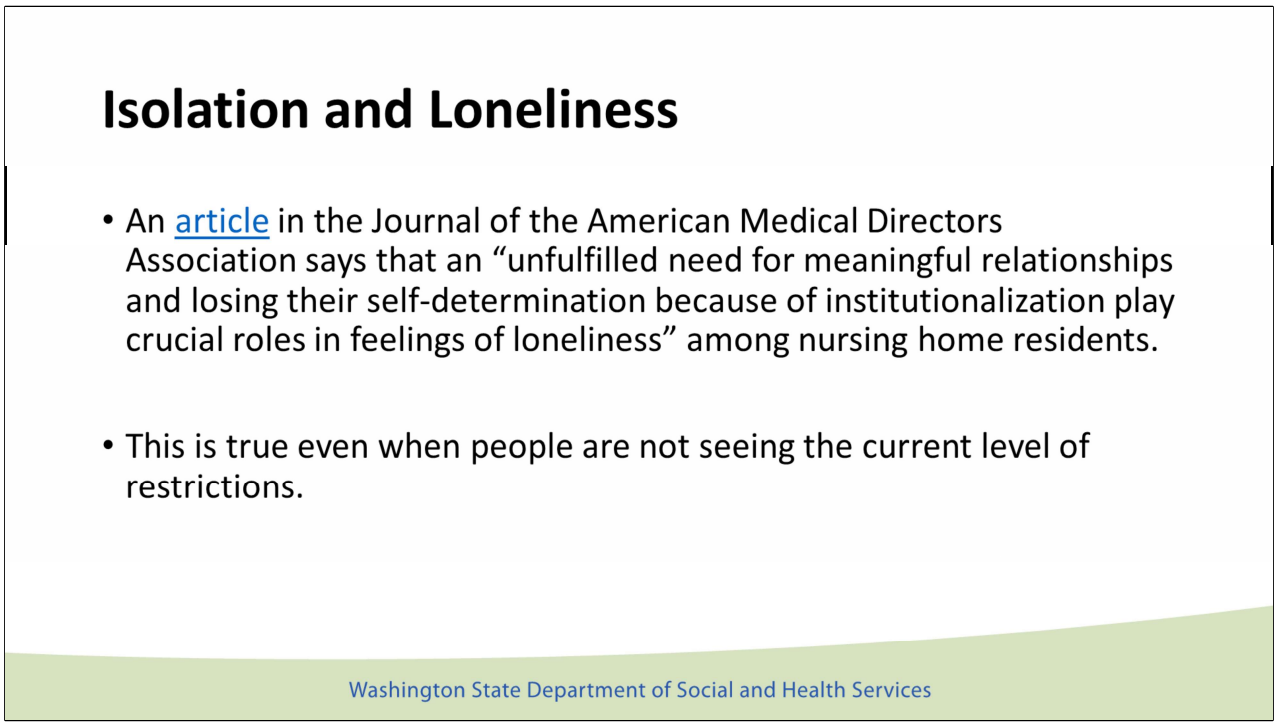
The NF staff spoke to the PASRR Assessor about devices the woman could download books and movies. PASRR purchased a Kindle. Her family was able to buy her movies and books on tape from Amazon and the NF staff assisted in helping her to be able to use the device.

The same Client had Community Engagement and enjoyed going to the library to check out books and DVDs, although, she is no longer able to physically access the library, due to COVID restrictions. The Community Engagement provider was able to

meet with the Client via FaceTime and worked with her to check out free books and movies through the library.

Client #2: Our PASRR Assessor reported to us that the Pandemic is a time of "deepening connections with NF staff, and has been working with a person, their family, and the NF Speech Language Pathologist and the Occupational Therapist to meet the needs of the individual. Speaking with each other they were able to determine that the person is an excellent gamer and has been using the switch for his gaming platform to communicate with family. They are now working on a Bluetooth item that would allow him to connect the switch to his iPad so that he can communicate with greater ease and with what works best for him!

Client #3: A contracted Speech Language Pathologist has been working remotely with a gentleman on his iPad. The SLP reported the Nursing Facility and their activities department have been "awesome" to work with and they are going to start sending data sheets of the residents progress.



DDA

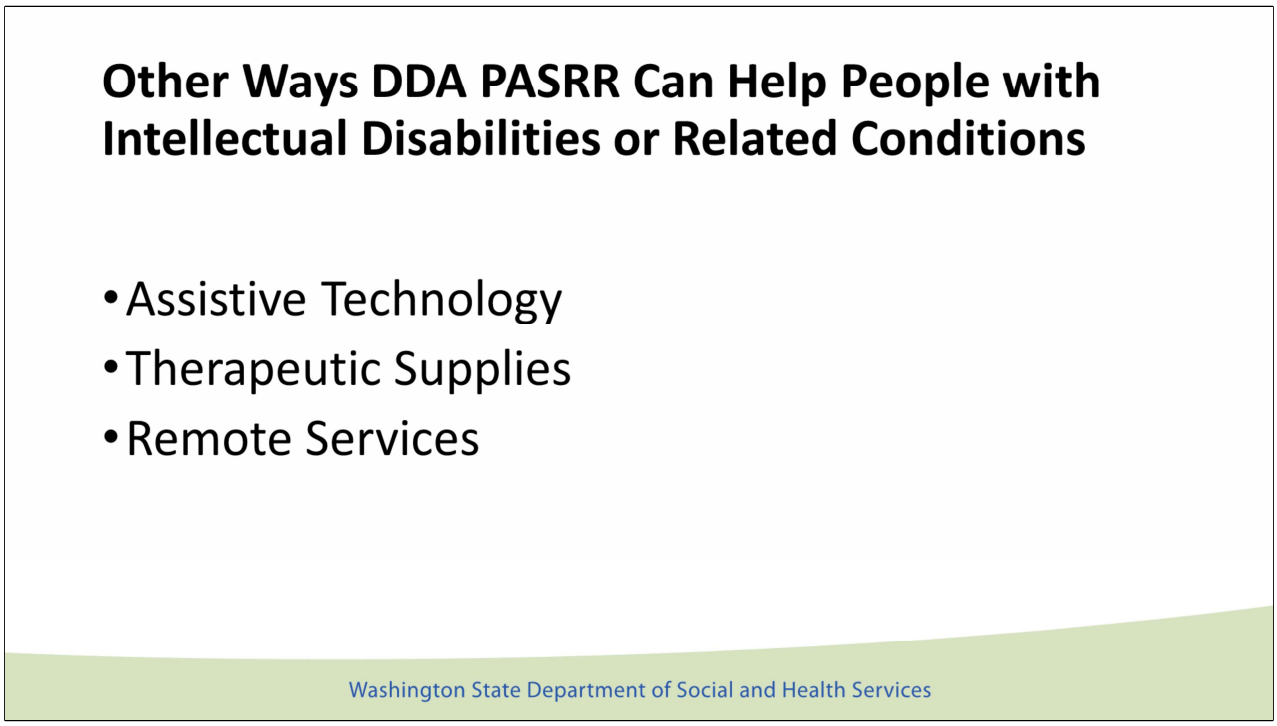
NF staff have shared our concerns about people's sense of well-being, especially during these times.

According to the Journal of the American Medical Directors Association,

"Preventing loneliness in institutionalized persons is at least as important as helping them with personal hygiene. This is especially important during the COVID-19 pandemic when residents must be protected from contact with other individuals to reduce the risk of infection. Implementation of some of the strategies listed in this article requires education of staff members and supply of required items; however, this effort can significantly improve the quality of life of residents affected by pandemic restrictions."

PASRR can help with necessary equipment for an individual, such as an iPad or other communication device. PASRR can also provide resources to train activities staff, social workers, therapists, or other NF staff, to help support use of such equipment. Look for another webinar in the coming months to provide tips and resources for additional remote supports. You will see an administrator letter with registration information.

Please encourage your staff to reach out to the PASRR team with any questions.



DDA

PASRR assessors have purchased assistive technology such as iPads to help nursing facility residents stay in touch with friends and family they may not be able to see.

Therapeutic supplies include items recommended by behavior professionals that help with self calming.

Some PASRR services have continued to be provided by phone or teleconference. These include planning for community activities and skill development.

Communication is critical. Let PASRR know if a PASRR resident:

Has a significant change in condition.
Is diagnosed with COVID.
Is hospitalized.
Is experiencing behavior challenges.
Is requesting supports in addition to regular NF care.
Passes away.

DH
We have a new resource we want to make sure everyone knows about…through funding from the Governor's Mental Health initiative, Residential Care Services has developed the Behavioral Heath Support Team.

The Team has 11 members.

We have six behavioral health quality improvement consultants who offer individualized consultations to facilities.

We have a training specialist who provides group training to providers and their staff, on a variety of behavioral health topics.

We have a policy program manager who works closely with all the LTC Policy staff to identify how our current regulations may impede an individual's ability to successfully transition to a community based setting.

We have two data experts who help us track trends and respond to all of our data needs.

And we have our unit manager who came to us with years of behavioral health experience and who keeps everything running smoothly.

DH
Our goals are for residents with challenging behaviors to remain in their current placements,

To improve the quality of the care they receive,

And improve regulatory compliance.

Again, we work towards these goals by providing consultation, training and support to providers who are caring for these residents.

DH
This is just a sampling of the kinds of challenges our team comes across.

Residents who are aggressive with each other, staff or both. Residents who frequently 'call the state' to make complaints. Staff who are dealing with inappropriate comments from residents, including racist statements.

Providing person centered care to residents who don't quite 'fit' with the rest of the population.

Weak care plans – or really good care plans that aren't implemented consistently.

We work with providers who have suicidal residents or those who engage in self harm, fecal smearing, challenging family members…the list goes on and on.

We also provide what we call Preliminary Technical Assistance

This is support we give the provider **before** they accept a resident with a history of

challenging behaviors.

This most often occurs when a provider is preparing to admit a resident from Western or Eastern State Hospital, but we can also provide this to anyone preparing to admit a resident with challenging behaviors from another LTC facility.

These Preliminary Technical Assistance consultations take a heavy regulatory focus to help providers think about different scenarios and what might be required of them, as well as resident-specific intervention ideas based on the information we obtain from their history.

Then a few weeks after the resident moves in we follow up with the provider to offer additional support as needed.

When to Consider a Referral to the Team

- Facility staff have run out of ideas on how to provide care and services.
- The resident is at risk of being discharged due to behaviors.
- Staff are concerned about staying in compliance while serving a resident with behavioral health challenges.
- There are no (or very limited) mental health supports involved.

DH

Not Sure If You Should Refer?

That's OK!

We Encourage You To Reach Out
and We Can Figure It Out Together!

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DH

How to make a referral

- We just need a little information to get started. Call or email us the following, and a member of our team will be in touch!
  - Referent name and contact information
  - Facility name
  - Resident name and date of birth
  - Brief information about the issue

BHST Email: rcsbhst@dshs.wa.gov
BHST Referral Message Line: 360-725-3445

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DH

Significant Change of Condition

Significant change definition is in the Resident Assessment Instrument (RAI) Manual, in Chapter 2

Referrals to PASRR for significant change

- Must be done promptly
- Required for individuals who have been previously identified by PASRR as having mental illness (MI), or intellectual disability or related condition (ID/RC)
- Required for those not previously identified.

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LH
Significant change:

- A "significant change" is a major decline or improvement in a resident's status that:

1. Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, the decline is not considered "selflimiting";
2. Impacts more than one area of the resident's health status; and
3. Requires interdisciplinary review and/or revision of the care plan.

A significant change is

- Interdisciplinary team determination
- Self limiting – won't normally resolve itself – if not resolved within 2 weeks, sig change assessment should occur. **For PASRR referral, DO NOT wait until the Sig Change Assessment is needed (2 weeks) – make the referral as soon as the changes are evident.**
- Two or more areas of decline or improvement, though staff can decide if one area is significant enough to warrant an assessment

1. Referral required for residents who have been previously identified by PASRR to have mental illness, Intellectual Disability, or a related condition.
2. Referral also required for individuals not previously identified to have MI, ID or related

condition, if the individual exhibits behavioral, psychiatric or mood symptoms that suggest MI, or if an ID was not previously identified and evaluated through PASRR

3. Referral required for a resident transferred, admitted or readmitted to a NF following an inpatient psychiatric stay or other equally intensive treatment

A final word about significant change

When making determination, it must be individualized – what is a sig change for one person may not be for another.

Referral to PASRR for significant change may not be necessary if…

- The Resident is expected to return to baseline function within two weeks, and:

- The interdisciplinary team (IDT) can initiate corrective action to address the symptoms, OR
- A short-term illness is causing the symptoms, OR
- Cyclical signs and symptoms are associated with a previous diagnosis.

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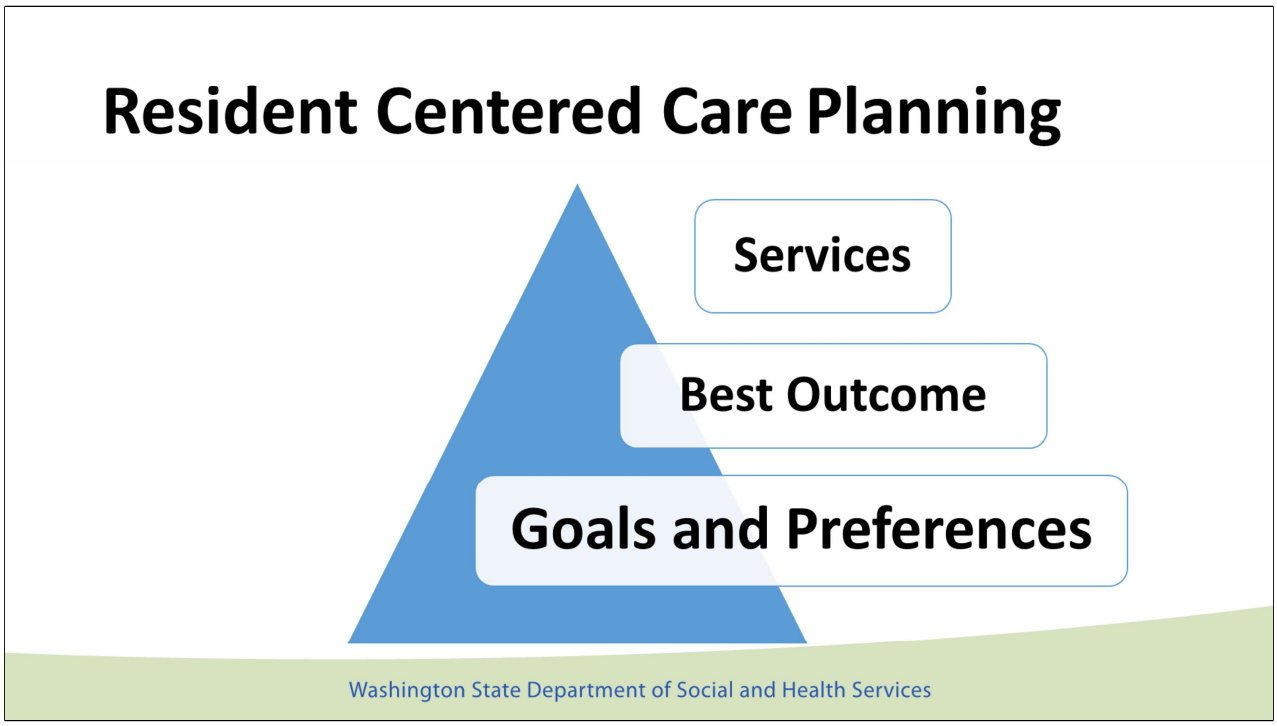
Example of the IDT initiating corrective action to address symptoms:
- When a resident is experiencing anticipated side effects from a psychoactive medication while the team is attempting to establish an effective dose level
- Corrective action = the IDT can monitor, manage symptoms, and communicate with the MD to make further med adjustments if needed.

Example of short-term illness:
- Resident has a mild fever secondary to a cold, and the IDT expects the resident to fully recover.

Example of cyclical signs and symptoms:
- Resident with previous diagnosis of bi-polar disease shows signs of depressive symptoms.

It is **always** important for the IDT to document team discussion and the team's rationale for determining whether a situation ***is*** a significant change for the resident or not. The team's thinking should be obvious to someone who was not present at the team's decision-making when documentation is reviewed.



LH:
At the bottom of the pyramid – the foundation, is the resident, and the resident's goals and preferences

Care planning must set objectives for the best outcome for the resident – highest practicable …..
Care planning must determine what interventions or services are needed to achieve the goals of the care plan

Federal and state rules require a care plan, based on the assessment

- must be updated as resident needs change, and with a significant change, but at least reviewed quarterly.
- Must be done by an interdisciplinary team – purpose of having a team develop is to have different perspectives and expertise
- The resident or resident rep must be involved in care planning
- Must be person centered,

How do I incorporate PASRR recommendations from the Level II or follow-up into the care plan?

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LH:
CMS requirements at F656 also require that PASRR recommendation be incorporated into the care plan.

First, read the entire Level II report; it contains important information about the individual's goals, preferences, and strengths, as well as support needs. It can be a useful way to gain knowledge about the resident's history. Information in the PASRR report can help to strengthen your entire care plan.

For DDA PASRRs, review the "professional evaluations" section. If an evaluation by a professional is requested, the NF must have the evaluation completed and provided to the PASRR assessor within 30 days, along with a copy of the NF care plan. The professional evaluations are important to the assessor because they often help determine what Level 2 services would be most appropriate for the resident.

PASRR recommendations are centered around the needs of each individual and support the person centered approach.

Resident Care and PASRR

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LH:
PASRR helps support better health outcomes and increased satisfaction with care.

- The PASRR evaluation and services are person centered, and designed to improve the resident's life. They are individualized to the resident's wishes and needs.
- PASRR services are integrated into the person centered care plan.
- If communication and coordination is effective, the resident, and facility and PASRR staff are all knowledgeable about the services provided to the resident.

At a minimum, when evaluating the care plan quarterly, it would be a good time to review the PASRR specialized services with the resident, to determine if the resident feel the services are still needed or if other services would work better. But be aware the resident drives the timetable, not the facility schedule and if changes are requested or needed sooner, talk with the PASRR Assessor about changes the resident would like to see.

A Final Thought

PASRR is a partnership between the resident, important people in the resident's life, hospital, NF, and state agencies.

At its center is our common desire to provide person-centered, high-quality services for each individual we serve.

LH:

PASRR Contacts

- **Developmental Disabilities Administration (ID/RC):** Terry Hehemann, ID/RC PASRR Unit Manager - teresa.hehemann@dshs.wa.gov; PASRR Program Coordinators, Heidi Johnston, heidi.toda@dshs.wa.gov , and Wendy Einer, wendy.einer@dshs.wa.gov.

- **Health Care Authority (SMI):** Beth Loska, PASRR Program Manager Elizabeth.loska@hca.wa.gov ; Maureen Craig, Medical Assistance Program Specialist Maureen.craig@hca.wa.gov

- **Residential Care Services:** Lisa Herke, NH Policy Program Manager lisa.herke@dshs.wa.gov

HJ

PASRR Contacts

- **RCS Behavioral Health Support Team:** Debbie Hoeman, Behavioral Health Policy Program Manager Debbie.Hoeman@dshs.wa.gov
- **Home and Community Services:** Julie Cope, System Change Specialist julie.cope@dshs.wa.gov
- **Department of Health:** Liz Gordon, Clinical Care Supervisor, Investigation and Inspection - Elizabeth.Gordon@DOH.WA.GOV

HJ

Where can I find more information?

ID/RC PASRR Internet Site:
www.dshs.wa.gov/dda/pasrr

SMI PASRR Internet Site:
www.hca.wa.gov/pasrr

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HJ
Both HCA and DDA maintain PASRR internet sites. At these links, you can find contact information for the PASRR teams, helpful links, FAQs, and –soon- a copy of this presentation. We encourage you to send your staff to these sites, especially when turnover occurs.

Questions and Answers from Webinars 12/2020

Q. If a person didn't require a Level 2 because no disability or mental illness was identified, does a significant change of condition require a new Level 1?

A. *No, not unless a qualifying disability or mental illness has been diagnosed or is suspected.*

Q. During COVID restrictions, is the nursing home required to allow PASRR staff to enter?

A. *PASRR is considered an essential service and efforts should be made to allow residents access to PASRR staff, if possible. When practical, PASRR work may be conducted remotely. PASRR evaluators will work cooperatively with the nursing home to keep everyone safe.*

Questions and Answers from Webinars 12/2020
(continued)

Q. How is the Behavioral Health Support Team different from ECS, and how would SNF staff know which to pursue?

A. *Expanded Community Services (ECS) is a contract between a SNF and HCS so not all SNF's have an ECS contract. If awarded the contract the SNF is provided with funding with the expectation it is spent finding mental health resources for their building. Unlike ECS, BHST services do not require a contract and are available to most LTC providers. BHST provides consultation, training and support to providers who are caring for individuals with challenging behaviors.*

Questions and Answers from Webinars 12/2020
(continued)

Q. If a Level 1 identifies a mood disorder or depression not typically present before COVID, should a referral for a Level 2 be made?

A. *If a Level 1 identifies an SMI or ID/RC according to the form instructions, a referral must be made. SNF staff may also contact the PASRR team with questions about supporting a resident with SMI or ID/RC who may not meet all the criteria to be PASRR positive on the Level 1.*