What has happened after 20 Years of PASRR?

Preadmission Screening & Resident Review of nursing facility residents

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Number of residents with MI (other than dementia) in a US nursing home on any given day: > 500,000

Far more than in all other health care institutions combined.

New admissions with MI trend to younger with longer length of stay

“Nursing home” can mean facilities:

<table>
<thead>
<tr>
<th>Certification Type</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid-certified</td>
<td>3.2%</td>
</tr>
<tr>
<td>Medicare-certified</td>
<td>2.2%</td>
</tr>
<tr>
<td>Dually-certified</td>
<td>94.5%</td>
</tr>
<tr>
<td>Total # Certified Facilities 2007</td>
<td>15,281</td>
</tr>
<tr>
<td>Non-Medicare/Medicaid</td>
<td>?</td>
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Annual can mean:
- Persons admitted in 1 year (unduplicated or number of admissions?)
- Admitted at any one point in time
- Or a subset of the NH population that is available in a year of data, such as OSCAR — facilities surveyed that year.
By Certification vs. by Payer

Proportion -- Surveyed in a Year (OSCAR):

- Number of certified beds: 1,613,942
- Number of residents: 1,368,230
- Residents by payer:
  - Medicaid: 64%
  - Medicare: 14%
  - Private / Other: 22%

2007 Harrington et al
Proportion of MI Increasing

- 2001 to 2007 Percent of residents —
  - with dementia increased 7 % (to 45.6 %)
  - with other serious psychiatric diagnoses increased 33 % (from 16.1 to 21.4 percent of residents)
  - with need for psychological & behavioral management is increasing
  - with limitations in ADLs remained fairly stable; the need for physical assistance is not increasing

2007 Harrington et al (Oscar data – only surveyed NHs)
Staffing Declines

- **RN hours per resident day**
  - 1998 to 2000: declined by 25 percent
  - 2001 to 2007: declined by 14 percent to 0.6 hours
  - 2007 avg total of all staff hours / day: 3.5
- Number of nursing assistants increased to make up for reduction in RN hours
- A dramatic decline in skills and training of NH staff since Medicare prospective payment system implemented in 1998
  - Facilities with more RN staffing have higher quality of care on average
Future is scary

- Market is rejecting NH (old, medical model) as setting for LTC
- NH are increasingly admitting those without other options — and persons with SMI are prime among them
- One hopeful note: Grabowski et al point out large state variations in NH residents and state policies — this means solutions are possible at state level. You!
½ million served in MR/DD home and community-based services (HCBS) waivers

ICFs/MR are getting fewer, smaller, and less institutional in character

Psychiatric hospitals declining in number & LOS

The Olmstead decision put ADA in LTC

Nursing home occupancy is slightly down

PASRR must be working!
We don’t really know who has MI in NFs

Lawsuits in several states claim thousands with MI are inappropriately placed in NFs

Lots of Level II evaluations later, how many have been diverted or discharged?

In most states specialized services have not resulted in a continuum of supports

PASRR must not be working!
Has PASRR worked?

Wrong Question

How could PASRR “work”, when —

- The US still has no healthcare system
- No real LTC MH benefit for most people
- PASRR continues to find, one person at a time, that NF is the only available LTC option for many persons w/ SMI
- PASRR has no data or evaluation requirements to measure success or failure
What would success be?

- When the service gaps are so wide
- When Medicaid is the biggest payer of MH services, but has no LTC MH benefit except
  - PRTF for under 22 years
  - IMDs over 65 years, most of which are NFs!
  - 4 states: home and community-based services
- Define PASRR “success” for you
Specific problems after 20 years

- PASRR
  - Has not prevented thousands of individuals with SMI to be placed in NFs, per several lawsuits
  - Is highly variable state to state
- NF is the wrong model for LTC
- Quietly suffering vs. “behavior problem”
  - Suicide
  - Deaths by “passive” giving up and starvation
- You list the issues . . .
Why are we doing this?

- Given the limitations from the last 20 years, what should we be doing with PASRR?
- Yes it’s a law, but that does not stop us from considering why we are doing this.
- What can we, what should we, be doing with all this required PASRR activity?
What can we do with PASRR?

- Step back, look at the system, look at the needs, look at your PASRR activities as new.
- Now, what are your PASRR activities best able to accomplish?
  - Not what are you doing now
  - Or what will others in your system say . . .
  - Use our collective imagination. That’s the unique resource we have here only today and tomorrow.
Let's Recap

For PASRR MR

- We have (some) LTC for individuals with MR/DD; PASRR has prevented a class of bad actor facilities; and most Level II evaluatees are known to the state DD system
- Not perfect, but we can help individuals with PASRR MR, or at least continue to prevent large numbers of inappropriate placements
- We know a lot about the population
PASRR MI — Different picture
- We lack placement alternatives other than NF in most states
- For whatever reasons (variable by state) we don’t identify SMI in the NF population well
- Few states have devised MH services for NF residents (whether you call them specialized services or not)
- So, due to our environment, PASRRR is not helping individuals in proportion to the effort
So maybe PASRR MI is not just about individuals. Think about that!
Keep trying to help individuals, of course!
• Continue to identify, evaluate and place creatively
• Pursue clinical options (per other sessions)
• In absence of placement options, figure out how to deliver person-centered care within facilities

But what are the real opportunities to make use of your efforts — all these evaluations?
National View of Opportunities

- Think Macro, not Micro, for a few minutes
- Imagine that we are assembled here in Iowa to address for the first time the problems of SMI in elders, particularly in NHs. We don’t know about PASRR
  - What would we want to know?
  - How would we go about finding the information?
  - What resources would be needed?
We undertake a really really big study of SMI in NHs

- 100% sample of all NH residents with SMI!
- Clinical evaluations of each person!
- Required data elements across all states!
- A donor offered to fund 75% of individualized evaluations of every person in the sample!
  - Forever. No time limit to funding
  - And states just had to agree to pick up the rest
  - Penalties for not participating
Imagine . . .

- What we could learn from this extravagant and impossible study
  - What would you want to know?
  - Researchers? State and Federal policy makers? Providers? Advocates?

- That in every state the infrastructure already exists to implement this study
This is, or could be, PASRR

Before we leave Iowa, anyone with goose bumps over this possibility, let’s talk!

We can do this

- Mostly it just needs cross state collaboration
- Who wants in on designing the investigation?
- Running a state program no one understands often allows you to do more or less what you want
- You could talk the Feds into providing guidance to states to support the idea . . .
§ 483.134 (PASRR/MI) (b) Minimum data collected must include—

1. Comprehensive history & physical exam:
   i. Complete medical history;
   ii. Review of all body systems;
   iii. Neurological: motor, sensory, etc.;
   iv. For findings that are basis for NF placement: specialist evaluations.
Data elements required by reg

(2) Comprehensive drug history, noting possible psychiatric side effects.

(3) A psychosocial evaluation including housing & current supports.

(4) Comprehensive psychiatric evaluation.
Data elements required by reg

(5) Functional assessment:
- ADLS
- IADLS
- Intellectual functioning
- Affect
- Attitudes and overt behaviors,
- Self-monitoring health status,
- Self-administering medication
- Compliance with treatments
- Self-monitoring of nutritional status,
- Level of support needed to live in community
You will awake feeling refreshed

- OK, now you are back in your majorly irritating bureaucracy and the way you have always done things and you have to keep your job to pay for your kid’s college
- But as long as we are going to expend all this effort doing 100% evals on the population — let's really think about it
- You’ll hear about some PASRR innovations in some sessions, and our PTAC will be ferreting out all the cool stuff anyone is doing
What can you include?

• Imbed standardized validated instruments
• Person-centered elements
• Quality of life indicators
• Quality of care indicators
• Plans for foreseeable variable course
• Measures after placement
• Cause of death
• Your ideas
What can you link to? Either for evaluations, or in analyzing your evaluation data

- Public safety databases
- Insurance warehouse
- State rebalancing data
- Quality of care indicators
- Your creativity
Find Allies

- There are people with skills you need, who want what you have
  - E.g., academics who want your data, and can help you improve it
  - Make a community advisory group
  - (Or, maybe under-the-radar consultations)
- Keep in touch with the people you meet here!!
What’s happened after 25 years of PASRR? We will have a different answer

- Health care reform may or may not have come to LTC and mental health
- But we will know exactly what is happening to who with MI in NFs, and what they need
- We will know what the service gaps and opportunities are
- You and your incredible PASRR data will be in demand at the policy table in every state
Acknowledgements

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